EVAN B. DONALDSON

adoptioninstitute

KEEPING THE PROMISE:
The Critical Need for Post-Adoption Services
to Enable Children and Families to Succeed

Policy & Practice Perspective

October 2010

Funded by: Harmony Adoption Services and
The Evan B. Donaldson Adoption Institute

TABLE OF CONTENTS

EXECUTIVE SUMMARY

S everal months ago, when the media focused the nation's attention on yet another sensational adoption story – this time about a Tennessee mother who put her 7-year-old son on a plane back to Russia – all sorts of disquieting questions flowed through people's minds. They ranged from the rhetorical ("What kind of mother would do such a thing?") to the important ("Are children in orphanages being adequately cared for before adoption?") to the inadvertently stigmatizing ("If a child can be so easily `returned,' is adoption really permanent?").

Most child welfare and adoption professionals watched the drama with better-trained, more-experienced eyes, however, and so they raised very different questions. For example: "Did the mother get accurate information about the boy before adopting, as well as training and education, so she would be prepared for the challenges of parenting a child who had been institutionalized?" And, most pointedly: "Were post-adoption services readily available to her so that she could help her son, and herself, rather than giving up?"

Over the last two decades, our nation has seen steep increases in the number of adoptions from foster care in the United States and from orphanages abroad – which, combined, make up the vast majority of non-stepparent adoptions; i.e., we have made considerable progress in finding enduring families for girls and boys who have suffered from abuse, neglect, multiple placements, institutionalization and other pre-adoption experiences that can cause them physical, psychological, emotional and developmental harm. Now the paradigm has to shift, and our priority must be not only to achieve permanency, but also to assure that adoptive parents receive the supports they need to raise their children to healthy adulthood.

This research-based report by the Evan B. Donaldson Adoption Institute represents the most extensive compilation of knowledge in the area of post-adoption services to date, and it's goal is unambiguously ambitious: It is to broaden the understanding of this critical issue by the public, professionals and policymakers – and to promote a commensurate realignment of state and national priorities and resources – so that effective, accessible supports for sustaining and strengthening adoptive families become a routine, ongoing reality. The bottom line is that best practices should entail not only helping to form families, but also enabling them to succeed.

In an overwhelming majority of cases, adoption is genuinely beneficial and permanent; it's important to remember that "man bites dog" is a story and so, by definition, accounts such as the one about the boy sent back to Russia are the exception rather than the rule. That is the good news. The bad news is that, when adoptions do fail, the economic and social costs to our country are considerable, and the toll on the children and families involved is even greater. Furthermore, for every adoption that doesn't work out, there are many more – though it must be stressed, still a minority – in which the families struggle every day to address the often-serious, sometimes-unnerving problems their children developed *before* they were adopted.

In addition to assistance for adopted children and their families, post-adoption services for birthparents and their families also are vitally important, although much less developed. A few adoption agencies and foundations have devised supports to meet the needs of birthparents, but there is no research on how well they work, so this is an area that requires far more attention. The Adoption Institute has done some work relating to women and men who relinquish their children – including our 2006 report "Safeguarding the Rights and Well-Being of Birthparents in the Adoption Process" – and we are currently engaged in additional research on the subject. This current publication, however, centers solely on supports for families after adoptions take place, with particular emphasis on those adopting boys and girls who have suffered early adverse experiences.

It is important to underscore the breadth and depth of sentiment in the fields of adoption and child welfare regarding the need for heightened attention to post-adoption services in national and state policy, in professional practice, and in families' everyday lives. Toward the end of demonstrating this consensus, this paper – including its findings and recommendations – is being endorsed by major organizations and agencies including: the Child Welfare League of America, the North American Council on Adoptable Children, the Dave Thomas Foundation for Adoption, Voice for Adoption,[1] the American Academy of Adoption Attorneys, the National Council for Adoption, the Joint Council on International Children's Services, the Adoption Exchange Association, the Kinship Center, Lutheran Social Services of New England, Spence-Chapin Services to Families, The Cradle, Bethany Christian Services, the Center for Family Connections, the Center for Adoption Support and Education, the New York State Citizens' Coalition for Children, Wide Horizons for Children, Adoptions Together, Children's Home Society of North Carolina, and Adoption Resources of Wisconsin. Additional organizations support this work and plan to utilize and disseminate it, but are constrained by governmental or other regulations from becoming official "endorsers." All these organizations, and many others across the U.S., recognize that the development and use of post-adoption services is a critical need to sustain adoptive families and are united in advancing the recommendations below.

Primary Findings

"Keeping the Promise" examines the range of service needs for adoptive families. It describes the challenges faced by these families, examines the research on adoption outcomes, and discusses the risk and protective factors for children and families that predict more positive, as well as more negative, adjustments. To date, there has not been a synthesis of knowledge in the field of post-adoption services that surveys the many clinical and family-support approaches being used and derives insights from research and program evaluations. This report by the Evan B. Donaldson Adoption Institute seeks to provide such a synthesis and to identify key directions for the future development of post-adoption services. Our primary findings include:

- Most adopted children, because they suffered early deprivation or maltreatment, come to their new families with elevated risks for developmental, physical, psychological, emotional, or behavioral challenges. Among the factors linked with these higher risks are: prenatal malnutrition and low birth weight, prenatal exposure to toxic substances, older age at adoption, early deprivation, abuse or neglect, multiple placements, and emotional conflicts related to loss and identity issues.

- Protective factors in children and families (such as the child's easygoing temperament, parents having realistic expectations and thorough adoption preparation, open communication and warm, positive parenting style, as well as support from extended family and others) can buffer the impact of adverse beginnings, help prevent and resolve problems, and promote resilience. Indeed, the majority of adopted youth are functioning within the normal range, including those who came from adverse situations, and well over 90% of parents in every type of adoption are satisfied with their adoptions.

- The utilization of clinical services by adoptive families is about triple the rate reported by birth families (Howard, Smith, & Ryan, 2004; Vandivere, Malm, & Radel, 2009). Part of this difference is due to a greater willingness or desire to seek help, but it also is related to a greater need for assistance. Adopted children also are more likely than their non-adopted peers to score in the clinical range on standardized behavior problem measures.

---

[1] The Voice for Adoption is a coalition whose Board is composed of Adoption Advocacy, Adopt America Network, Adoption Exchange Association, the Adoption Exchange Inc., Casey Family Services, Child Welfare League of America, Children Awaiting Parents, Family Builders Network, Kinship Center, Lilliput Children's Services, National Adoption Center, New York Council on Adoptable Children, North American Council on Adoptable Children, Spaulding for Children, and Michigan Three Rivers Adoption Council.

- The layers of issues and dynamics present in complex, chronic adjustment difficulties are often not understood by adoptive parents or the professionals they contact – i.e., teachers, school personnel, pediatricians, and others. The type of help parents seek most is adoption-competent therapy, but research indicates that most mental health professionals lack relevant training. Furthermore, additional types of services shown to be most effective in meeting the needs of many families are not readily available.

- The development of specialized post-adoption supports began primarily in the late 1980s and 1990s, but it has slowed considerably over the past decade. These services include information and referral, education and training, support groups and mentoring, respite care, advocacy, crisis intervention, search/reunion services, and therapeutic counseling.

- Many exemplary services have been developed, primarily through federally funded demonstration projects and initiatives supported by state child welfare systems, but funding constraints have led some to be terminated, others to be scaled back, and yet others to be offered on very limited bases. In addition, many such services are available only to families who adopt from foster care and not to others, regardless of need.

- Research on post-adoption programs is scarce, and few, if any, studies rise to the level of rigor needed to substantiate empirically based effectiveness. This is an area of critical need for the development of services that will help the greatest number of children and families.

Recommendations

Creating effective post-adoption services and making them accessible to all families who need them are the primary challenges in the field of adoption and child welfare to assure permanency for children who cannot live with their birth families and to help them develop to their fullest potential. In order to promote progress in these areas, based on the year-long research for this report, our recommendations include:

- Create a national task force to provide strategic planning and legislative leadership for the development of post-adoption services – composed of representatives from the U.S. Children's Bureau and the U.S. Department of State, as well as post-adoption experts, practitioners, and researchers. The task force needs to collect information, discuss key issues, and draft proposals/legislation to promote additional funding, policy changes, and practice improvements. This needs to be a long-term, sustained initiative to ensure that the effort is not ephemeral, but brings about continuing progress.

- Develop private and public funding partnerships to maximize services and access to them for families, including a dedicated federal funding stream for post-adoption services. Providing consistent support from the top would not only create a reliable financial base, but also would serve as a clear message – or even a mandate – about the import of such supports.

- Public policy and child welfare officials at every level – federal, state, county and local – should re-examine their current budgets, staffing and other resources to determine whether sufficient priority is being given to helping families succeed as well as forming them. Going forward, post-adoption services should become a clearly defined, integral operational and programmatic component of adoption-related planning and financing at all levels. In conjunction with other stakeholders, each state should develop a strategic plan for developing and delivering a comprehensive continuum of post-adoption services.

- The amount of funded research on post-adoption interventions should be increased significantly in order to create an evidence base on services that are most effective, and the resulting findings and information must be systematically disseminated to adoption practitioners. Creating a workgroup of multiple federal research entities, including experts in this field, would provide leadership for promoting such research.

- University, graduate and continuing education curricula on adoption issues need to be created for and provided to the professionals who work with adopted children and their families. Teachers, school counselors and psychologists, medical professionals, social workers and other mental health professionals would all benefit from training in this area.

Additional recommendations, as guidance for professionals and policy-makers, include:

- Minimize damage to children in the child welfare system and elsewhere. Providing sensitive nurturance after separation from birth families, minimizing moves in care, finding the right home as early as possible, and giving support through transitions are all aspects of this goal.

- Prepare parents to expect some ongoing challenges and to understand the benefits of post-adoption services. Parents need help to understand the specific children they adopt, including the needs they may have because of the personal histories they bring with them.

- Identify children at high risk of developing later difficulties and provide their families with early intervention services and linkage with ongoing resources. Supports for these families are essential to help them gain a firm foundation and optimize their prospects for success.

- Halt reductions in subsidies and post-adoption services, and raise them wherever possible by realigning priorities. Such cutbacks only serve to discourage families from adopting, resulting in greater expenses for foster care and higher costs to the state in other areas.

- End state policies that effectively force adoptive parents to relinquish their children to the child welfare system in order to receive services they need. Everyone's interests are better served when these children and youth are permitted to get services, such as residential treatment, while remaining as members of their families.

Conclusion

This report's title, "Keeping the Promise," refers to the covenant that is inherent between parents and children when adoptions take place: to become a safe, permanent family. In practice, however, the covenant is far broader – and should be. It is also between adoption professionals and the families they serve, and between state or federal governments and the families they help to create. Over the last 15 years alone, Americans have provided families for over a quarter of a million children who had been relegated to institutions abroad. Through legal and policy changes during the same period, the federal government has aggressively supported the adoptions of close to three-quarters of a million children from foster care, and now it needs to act just as forcefully to sustain them. We have a long way to go on the road toward finding safe and loving homes for the most vulnerable members of society, but we have made honest progress. Now it is time to refocus our attention and broaden our priorities if, as a culture, we are to move beyond well-intentioned rhetoric – and be good to our word.

INTRODUCTION

Adoption historically has been the preferred solution for ensuring the well-being of children who cannot grow up in their original families, and research has demonstrated that children fare far better in adoptive homes than in institutions or long-term foster care (Hoksbergen, 1999; Triseliotis, 2002; Selwyn & Quinton, 2004; van IJzendoorn & Juffer, 2005; Lee, Seol, Sung, & Miller, 2010). Over the past two decades, our nation has experienced steep increases in the number of adoptions from foster care and from other countries; i.e., we have made considerable progress in finding families for girls and boys who need them. Now, our next challenge must be to assure that adoptive parents have the supports they need to raise their children to healthy adulthood. The aim of this research-based report by the Evan B. Donaldson Adoption Institute is unambiguously ambitious: It is to broaden the understanding of post-adoption services by the public, professionals and policymakers – and to promote a commensurate realignment of priorities and resources – so that effective, accessible supports for sustaining and strengthening adoptive families become a routine, ongoing reality. The bottom line is that best practices should entail not only helping to form families, but also enabling them to succeed.

While adoption has existed for centuries, the types of adoptions practiced in the U.S. today have changed dramatically over the past 50 years. In the first half of the 20th century, adoption primarily involved the placement of babies relinquished by unwed mothers into homes headed by infertile, married couples. For the past several decades, most adoptions have been of children who were removed from abusive or neglectful families, or of those from other countries who, most commonly, were living in institutions. In addition to adopting because of infertility, a growing number of individuals and couples who can conceive choose to adopt for humanitarian reasons, and many are parents to both their biological and adopted children; indeed, over half of U.S. families with adopted children also include birth or stepchildren (Kreider, 2003).

The relinquishment of newborns has become rare, declining almost nine-fold since the early 1970s; current estimates of domestic infant adoptions range from approximately 7,000 to 22,000 annually. Based on available data, the Adoption Institute's best estimate of domestic adoptions of voluntarily relinquished infants is about 14,000 a year.[2] Unlike infant adoptions, for which reliable statistics have never been available, we have accurate counts of intercountry adoptions – because children entering the country must have visas – and for child welfare adoptions – because states must track these and report them to the federal government. So we know that, as domestic infant adoptions have dwindled dramatically in recent decades, adoptions have mushroomed in the other two categories.

The most common type of adoption today (other than by stepparents, who account for approximately 40% of the total) is of children placed from the child welfare system – a number that has soared since the passage of the Adoption and Safe Families Act of 1997. Adoptions with public child welfare agency involvement increased from about 15,000 in 1988 to 31,030 in 1997 and, in the most recent count, to 57,466 for FY2009 (USDHHS, 2010). (Thirty-two percent of these adoptions are by relatives, and another 54% are by foster parents.) During roughly the same period, intercountry adoptions into the U.S. tripled – from 7,093 in 1990 to a peak of 22,884 in 2004, though the number

---

[2] According to the National Center for Health Statistics, the number of infants relinquished for adoption in their first month of life declined from 8.7% of births to "never-married" women prior to 1973 to 1% in 1996-2002, suggesting that fewer than 7,000 infants under 1 month are relinquished for adoption by "never married" women each year (Jones, 2009). Applying this relinquishment rate to national birth statistics for "unmarried women" in 2008 (Hamilton, Martin, & Ventura, 2010) would result in about 17,000 infants relinquished for adoption. (This number is likely to be lower since about half of births involving unmarried mothers are to cohabiting couples.) A fair estimate of the number of domestic infant adoptions, that is, of babies voluntarily relinquished in the U.S. each year, most likely falls between these two figures – 7,000 and 17,000. A 2002 survey by the National Council for Adoption (Placek, 2007) reported approximately 22,000 unrelated U.S. adoptions of infants under age 2; however, current AFCARS statistics report over 7,600 children adopted from foster care who are under age 2. The high number of infant adoptions reported in NCFA's study likely combines voluntarily relinquished newborns and young children adopted from foster care. The Adoption Institute defines domestic infant adoptions as those involving children voluntarily relinquished within six months of birth, who are not state wards.

has subsequently declined to 12,753 in 2009 (U.S. Department of State, 2009; Evan B. Donaldson Adoption Institute, 2002). The number of such adoptions also has declined globally since its peak in 2004 (Selman, 2009).

The chart below gives an approximation based on the most recent data of the proportion of adoptions, other than those by stepparents, occurring in the U.S. in the following categories: infants voluntarily relinquished within first six months after birth (17%); internationally adopted children (15%); and children adopted from the public child welfare system (68%).[3] Private agencies may facilitate adoptions of children in any of these categories, whereas public agencies focus on placing children in the child welfare system. It is important to remember that these are estimates and fluctuate annually.

Figure 1: Proportion of Non-stepparent U.S. Adoptions by Type
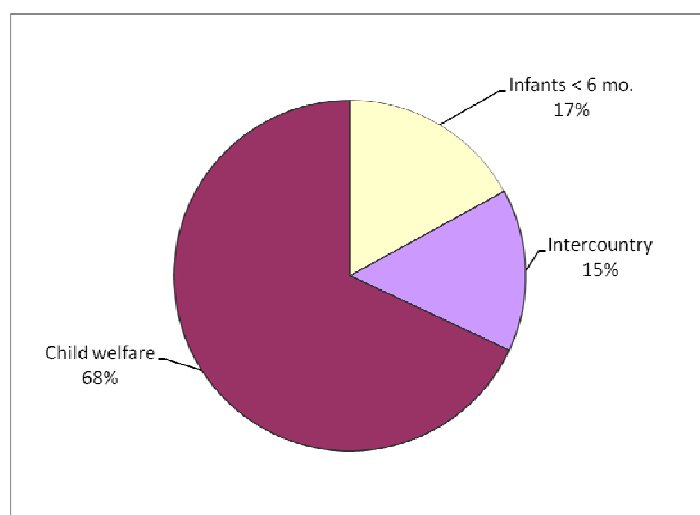
During the last 15 years, nearly a million children have been adopted into families in the U.S. from foster care (almost three-quarters of the total) and from abroad.

In any discussion of adjustment in adopted children it is very important to stress that the vast majority are functioning normally and that their parents are highly satisfied with their adoptions. At the same time, given the realities of the types of adoptions occurring today – that is, most are from foster care in this country and from institutions abroad – the majority of children come to their new families from backgrounds that can lead to elevated risks for developmental, health, emotional and/or behavioral issues. These include an array of adverse prenatal and early-life experiences, including malnutrition before and after birth, inadequate nurture, prenatal exposure to drugs or alcohol, physical or sexual abuse, and multiple placements, as well as potential genetic vulnerability. The impact of such experiences poses challenges for these children and their families at various times in the adoptive family life cycle. Unfortunately for everyone involved, many parents do not receive preparation to understand these challenges, to successfully navigate them, or to access the types of resources that could help their children develop to their fullest potential.

The term *special needs* is often used in descriptions of children with specific medical, mental health, or other conditions who are awaiting adoption or who have been adopted, generally from the public child welfare system; in particular, it has referred to those children who qualify for adoption subsidies because they are considered harder to place. Each state sets its own criteria of what constitutes

---

[3] For this approximation, we used an estimate of 14,000 voluntarily relinquished domestic infant adoptions, and the most recent figures for child welfare (57,466) and international (12,753) adoptions.

"special needs," but generally it applies to older age, certain racial/ethnic groups, sibling group status, or known medical, emotional and/or behavioral challenges. These criteria do not necessarily equate to a developmental delay or problem in the child, and definitions vary widely from one state to another. Overall, 89% of children adopted from public care in FY2008 officially met these criteria and qualified their adoptive families to receive Adoption Assistance (USDHHS, 2009b). More broadly, virtually all of the children in foster care have a need or needs that are "special" by virtue of the fact that they were removed from their homes because of some form of abuse, neglect and/or prenatal substance exposure; and many, of course, experience interrupted attachments resulting from multiple placements.

Likewise, most children coming to the U.S. through intercountry adoptions have experienced conditions, both prenatally and after birth, that can pose challenges to their development; in addition to possible abuse and neglect, these include malnutrition, poor medical care, and deficits in emotional nurturance and sensory stimulation associated with institutionalization or inadequate foster care. Children can be amazingly resilient, and most of them make major progress after moving into permanent families. But significant or long-term adverse experiences can lead to ongoing developmental issues, depending on the temperament and genetic vulnerability of the child, and these challenges often are not fully manifested until the child enters school and has difficulties in adjusting to classroom expectations or mastering academic work.

In addition to assistance for adopted children and their families, post-adoption services for birthparents and their families also are vitally important, although much less developed. A few adoption agencies and foundations have devised supports to meet the needs of birthparents, but there is no research on how well they work, so this is an area that needs much more attention. This report by the Adoption Institute focuses solely on the range of service needs of families after adoptions take place, with particular emphasis on those adopting children who have suffered early adverse experiences.

The field of post-adoption services may be characterized as a checkered landscape of programs, intervention models, therapies developed by adoption experts who provide training across the nation and have authored books, and innovative new approaches that seem promising but are much less well-known or empirically tested. While a small number of studies have been conducted on these latter programs and interventions, few, if any, have used research designs or samplings required for the highest level of evidence-based practice. A few surveys have been done of post-adoption services funded by state child welfare departments, but many of these programs operate for a time and then lose funding. This report by the Adoption Institute constitutes the most thorough compilation of knowledge in this field to date. It is the culmination of a year-long examination of research on adoption outcomes and the needs of families after adoption and synthesizes the knowledge that can be gleaned from the array of currently utilized programs and interventions. Our hope is that, by offering critical insights into existing services and by identifying key directions for the future, the Adoption Institute can help to improve policy and practice so that families who would benefit from supports can obtain them – and so that more children who don't yet have homes will get them.

CHALLENGES IN ADOPTIVE FAMILIES

Normative Developmental Challenges

Adoption is a more complex way to form a family than having children by birth. Consequently, adoptive families face issues that are different from (though not better or worse than) families formed biologically. It is important to recognize that all families face challenges, – whether because they include divorce, single or stepparents, parents of different races, family members with chronic health problems, or an array of other realities – and all families bring their own strengths to coping with their particular challenges. Like all others, adoptive families each are unique and fall along a continuum on a variety of measures of family functioning. The most recent census data indicate that adopted children have parents with more education and higher incomes than do the families of stepchildren or biological children, and adoptive parents are on average five years older than those of biological children.[4] Maturity of life experiences and economic viability bring strengths to adoptive families.

One of the first scholars to recognize the significance of "difference" for adoptive families was 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 addressing the additional tasks and challenges that adoption brings to parenting and family life. In his view, "rejection of difference" was a coping pattern that interfered with positive adjustment in adoptive families. Others have built on Kirk's work, recognizing that denial of difference inhibits open communication and honest exploration of a range of adoption issues and conveys to children the idea that difference is somehow deviant or bad. Overemphasizing adoption or "insistence of difference," however, has been identified as an extreme coping pattern linked with maladjustment (Brodzinsky, 1987; Kaye, 1990).

Many 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. The most commonly cited conceptual framework for adoption issues is Silverstein and Roszia's (1988) seven core issues of adoption: loss, rejection, guilt and shame, grief, identity, intimacy, and mastery and control. These psychological themes are interwoven in psychosocial development over the life course of individuals and families. Adoption scholars have identified critical family developmental tasks confronting adoptive families as they work through core adoption issues at each stage of psychosocial development (Rosenberg, 1992; Brodzinsky, Schechter, & Henig, 1992; Pavao, 1998; Brodzinsky, Smith, & Brodzinsky, 1998; Schooler & Norris, 2002; Brodzinsky & Pinderhughes, 2002). In addition, other adoption-related issues – such as coping with infertility for some parents, older child placements, or issues related to transracial and/or transcultural adoptions – add additional layers of complexity to the developmental tasks that adoptive families may face.

For example, adopted children typically confront identity-related issues in different ways at different ages. Preschool children learn their own adoption/birth stories; elementary-age children may struggle with feelings of rejection, because they are recognizing the loss aspects of adoption and experiencing peer reactions to adoption; adolescents usually seek a deeper understanding of who they are in relation to both adoptive and birth families and may struggle with independence; and young adult adoptees come to terms with genealogy in making choices about marriage and parenthood and in deciding whether or not to search for birthparents (if they are not known).

---

[4] For example, 33.4% of adoptive parents had a college or graduate education as compared with 25.8% of biological parents. The median family income for adopted children was $56,000 as compared to $48,000 for biological children. The average age of parents of adopted children was 43 as compared to 38 for biological children (Kreider, 2003). It is important to keep these figures in context given that most parents of adopted children are not college graduates, and approximately 43% of them have incomes below $50,000/year. The incomes of adoptive families differ by type of adoption as well. Most parents adopting from foster care are either foster families or relatives, and a substantial number of them have relatively low incomes (Vandivere, Malm, & Radel, 2009).

Sometimes life events such as divorce, death of an adoptive parent, or having children can trigger the surfacing or resurfacing of certain adoption-related issues.[5]

Another normative challenge present in adoptive families is addressing the dynamics of the adoptive kinship network over the life course (Grotevant, 2009; Grotevant & McRoy, 1998). Adoption joins children's kin by birth and by adoption in fundamental ways, since all the affected individuals are to some extent "psychologically present" in each others' lives, regardless of whether they have actual contact with each other (Fravel, 1995: Fravel, McRoy, & Grotevant, 2000). Furthermore, even when contact is not initially planned, it may take place years or even decades later as a result of one or more of the parties' searching or deciding to establish a connection. In all family systems, members regulate the closeness in their relationships, and in adoptive kinship networks where contact is occurring, there is an ongoing process of negotiating the closeness in these relationships or "emotional distance regulation" (Grotevant, 2009, p. 295).

While many if not most adoptive parents deal with these normative challenges without seeking professional help, they could benefit from pre-adoptive preparation and post-adoption education about how best to navigate them – for their own benefit and, most pointedly, so that the process and relationships work best for the children. Studies also show that adoptive families are two to five times more likely to seek counseling or other professional help (McRoy, Grotevant, & Zurcher, 1988; Howard, Smith, & Ryan, 2004; Keyes, Sharma, Elkins, Iacono, & McGue, 2008) and are four to seven times more likely to seek residential treatment for their children than are families raising the children born to them (McRoy, Grotevant, & Zurcher, 1988; Hoksbergen, 1997; Landers, Forsythe, & Nickman, 1996; Elmund, Lindblad, Vinnerljung, & Hjern, 2007).

Examining Adoption Outcome Research to Understand Challenges

Adoption clearly benefits children who otherwise would grow up in less stable and nurturing situations; however, many boys and girls have higher risks for ongoing developmental issues before their adoptions. 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 than are peers raised in their families of origin. In this report we include an overview of research on variables linked with both positive and problematic adoption outcomes, because understanding these dynamics is essential for assessing families' needs after adoption and for gaining insights into the complexities of solutions for meeting those 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 – has raised questions among adoption experts about the reasons for these differences and led to increased research. Clinical studies have found that adopted youth are more likely to be diagnosed with externalizing problems (such as conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder) rather than with internalizing disorders[6], such as anxiety or depression (Deutsch, Swanson, Bruell, Cantwell, Weinberg, & Baren, 1982; Weiss, 1985; Fullerton, Goodrich, & Berman, 1986; Kotsopoulos, Walker, Copping, Cote & Stavrakaki, 1988; Kotsopolous, Cote, Pentland, Chryssoula, Sheahan, & Oke, 1988; Rogeness, Hoppe, Macedo, Fischer, & Harris, 1988). Studies have also found higher rates of substance abuse problems (Marshall, Marshall, & Heer, 1994), learning challenges and special education placements (Brodzinsky & Steiger, 1991) among adopted youth.

---

[5] Much of this knowledge and theory is based on infant adoptions that were closed. It is unclear how these developmental issues vary with older child adoptions or adoptions involving openness.

[6] Later, more rigorous studies found higher rates of both internalizing and externalizing problems among adopted youth (Juffer & van IJzendoorn, 2005).

While some of the overrepresentation of adopted children and their families in clinical populations may be 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 outside the family as a solution, 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 (Kirschner & Nagel, 1988), social scientists recognized the need for studies on large, community-based samples of adopted youth and comparisons of representative populations of adopted and non-adopted youth.

Community-Based Studies of Adopted Youth

Since the 1980s, there have been more studies of large samples of adopted children and their families using standardized instruments and scientific methodologies 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 indicates a somewhat higher risk for a range of problems among adopted youth. Also, studies looking primarily at early-placed adoptees show that differences generally are not manifested until children are school age, they intensify during adolescence, and they level off in young adulthood (Coon, Carey, Corley, & 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.

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 did the birth children; however, they had lower scores on withdrawn behaviors and showed greater pro-social 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, stepparent, 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, as well as lower levels of school adjustment, among the adopted adolescents. 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; data was subsequently collected approximately 2, 4, 8, and 14 years after adoption, beginning with responses from approximately 1,200 families in the first wave and with some attrition at each successive point. Families studied primarily included domestic adoptions (95%) done independently or through public and private agencies, and most of the children were placed as infants (mean age=7 months). Successive analyses of these data have focused largely on examinations of externalizing symptoms in adopted children, outcomes for children with prenatal drug exposure and those adopted from foster care, pre-adoptive risk factors associated with outcomes, and service usage. Overall at Wave 3, 29.9% 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 behavior problems among children on the total Behavior Problem Index (BPI)

scores and the five subscale scores increased over data collection periods. In comparing foster care adoptees (who were somewhat older at adoption) with those not adopted from foster care, differences between the two were pronounced at Wave 1, but much less so at Wave 3. For example, on the total BPI score, 30% of foster and 11% of non-foster groups of adoptees met the cutoff scores for clinical impairment at Wave 1, and at Wave 3 the rates were 34% (foster) and 27% (non-foster) (Simmel, et al., 2001; Simmel, et al., 2007). This suggests that, over time, differences between these two groups of adoptees may be less pronounced; in other words, they are more similar than different.

<u>Dutch Longitudinal Research</u>

Some of the best research on the adjustment of internationally adopted children has been conducted in the Netherlands, where population records enable the identification of adopted children. One longitudinal study by Verhulst and colleagues began in 1986, with large sample sizes and a high response rate, and evaluated approximately 2,000 internationally adopted youth (ages 10-15) and a random sample of non-adopted youth. About 1,500 adopted teens and their peers were evaluated again at ages 14-18, and a third time at ages 24-30. Child Behavior Checklist scores of adopted youth at Time 2 indicated a worsening of problems since the first evaluation; nearly 29% of adopted boys and more than 17% of adopted girls were in the clinical range on their total problem scores, compared with less than 10% of the teens in the non-adopted sample. As young adults, 1,484 intercountry adoptees were evaluated again, along with a sample of non-adopted peers, for the prevalence of psychiatric disorders and an assessment of 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 non-adopted 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 non-adopted 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). Overall these findings indicate that internationally adopted youth manifest more emotional and behavioral problems, particularly for males and during adolescence.

<u>U.S. Census Data</u>

Beginning in 2000, the U.S. Census added the category "adopted son/daughter," thereby allowing comparisons of adopted and non-adopted children. Data on those aged 5-15 showed that the rate of disabilities – sensory, physical, mental, and self-care (able to dress self, bathe, etc.) – among both domestically and internationally adopted children was approximately double that of the general child population. Disability rates for internationally adopted children ranged from a low of 3.7% for those from China (below the general child population rate of 5.8%) to about 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
As stated earlier, the vast majority of adopted youth are functioning normally and 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 functioning (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, some continue to struggle throughout childhood with ongoing challenges. **Understanding these challenges, how they are manifested, and the subgroups of adoptees**

likely to have greater difficulties is a prerequisite to addressing their needs and maximizing their 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 them.

While all adopted children have differing strengths and needs, research and experience tell us that school is a primary place in which they and their families confront significant 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 child welfare 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. Very few parents of any type, however, reported that their children showed "poor" adjustment at home (Howard, Smith, & Ryan, 2004). Thus, 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 the myriad factors contributing to these adjustment issues is foundational for consideration of solutions.

FACTORS THAT SHAPE ADOPTION ADJUSTMENT

A range of factors contribute to children's adjustment after they are adopted. Some pertain to their families and the environments in which they live, and many relate to the children themselves, such as their genetic histories, prenatal experiences, circumstances of birth, pre-adoption experiences, and individual characteristics such as temperament and gender. The family characteristics that help to shape children's adjustment to adoption include the emotional health of the parents and their marriage or partner relationship; parental expectations for their children; their social support system; the style of discipline and communication within the family; and family structure, including sibling relationships and family adaptability/resiliency. Of course, the communities and society that individuals live within also shape their adjustments – i.e., societal values and beliefs, the adoption service system (the adequacy of its services and preparation of families), the supportiveness of social institutions, and the services available to them.

In his discussion of the ecological context of adoption adjustment, Palacios (2009) recognizes the complexity of the systems involved and the importance of the "Process-Person-Context-Time" perspective, which recognizes the ongoing interaction between individuals and the systems that influence their adjustment. Unfortunately, most research on adoption has been narrowly focused on the behavioral outcomes of adopted persons, and less on the impact in adoption adjustment of family processes such as parent-child attachment, communication, family problem-solving, or parenting style. The impact of interactions with many other important systems, such as schools, peer groups, birth families, and adoption and mental health service systems, remain largely unexamined.

Risk Factors among Adopted 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, safety 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 before considering 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 everyone who experiences 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, IQ levels ranged from mental retardation to superior (Rutter, O'Connor, ERA Study Team, 2004).

Many children may also come from very different background situations yet be diagnosed with the same conditions, with some having no identified risk factors. Primary risk factors that have been linked to developmental challenges in adopted children, along with research findings associated with these risk factors, are summarized below. **Appendix III contains a more thorough explanation of research demonstrating the impact of these factors on adopted children.**

Prenatal Malnutrition and Low Birth Weight

Malnutrition in mothers during pregnancy, other maternal health problems, 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, and healthy brain development, and can increase other health and developmental risks as well. Low birth weight in itself poses some long-term risks for cognitive impairment and learning problems (Gunnar & Kertes, 2005).

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 low birth weight are common consequences for the children of parents who use these substances, including alcohol, cocaine, marijuana, nicotine, amphetamines, and opiates such as heroin.

The chronic impact of heavy alcohol consumption during pregnancy results in some of the most devastating long-term challenges, described as fetal alcohol spectrum disorders. The most severe form, fetal alcohol syndrome, is characterized by irreversible neurological and physical abnormalities. 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). For adopted children, prenatal exposure to drugs and alcohol is associated with an increased rate of externalizing behavior problems, particularly hyperactivity (Barth & Needell, 1996; Barth & Brooks, 2000; Crea Barth, Guo, & Brooks, 2008).

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, et al., 1996b; Merz & McCall, 2010). For example, the study by Sharma and colleagues compared adopted teens in four groups by age at adoption: 0-1, 2-5, 6-10, and older than 10; the researchers found that infant-adopted youth were most similar to their non-adopted peers and those adopted after age 10 had the worst adjustment levels. The behavior of the teens in the middle two groups generally ranked between the early- and late-placed groups.

Some researchers have argued that it is not age *per se* but the adverse experiences 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 the former had a lower incidence of problem behaviors in adolescence than did adoptees placed in infancy, whereas those in the latter group (with adverse beginnings) had many more problems than those adopted as infants.

Early Deprivation, Including Institutionalization and Chronic Neglect

Adequate nurture 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 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 six months in institutions characterized by severe neglect (Rutter, 2005). For children adopted internationally, the level of deprivation varies across institutions within the same country and across caretakers, and differences in the caregiving environment are 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 moving into new families (Tan, 2006).

One problem frequently found among children experiencing institutionalization and deprivation or neglect is sensory integration difficulty – a condition in which the brain cannot analyze, organize, and integrate sensory messages efficiently (Cermak & Groza, 1998). Children with sensory integration problems may demonstrate a range of atypical behaviors, including oversensitivity to tactile sensations such as shirt labels rubbing their necks 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, & Sunshine, 2007).

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). Neglect is sometimes erroneously perceived as less serious than physical or sexual abuse; however, a longitudinal study of at-risk children in the U.S. found that neglect in infancy was a significant predictor of aggression at ages 4, 6, and 8, whereas early abuse or later neglect or abuse were not significant predictors of later aggression for this group of children (Kotch, et al., 2010).

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/or emotional abuse, as well as witnessing violence. Research indicates that cumulative trauma experiences are associated with greater complexity and severity of symptoms (Briere, Kaltman, & Green, 2008). 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 conditions (attention deficit hyperactivity disorder, oppositional defiant disorder, or conduct disorder) have trauma histories (Ford, Racussin, Ellis, Daviss, Reiser, Fleischer, & Thomas, 2000). The causal pathways for understanding the relationship of trauma to behavior is complex and needs further theory development and research.

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 related to such behaviors (Berry & Barth, 1989; Verhulst, et al., 1992; Rosenthal & Groze, 1994; Simmel, et al., 2001; Juffer & van IJzendoorn, 2005). Sexual abuse – even more than physical abuse – has been shown to be

associated with a high level of acting out behavior problems and adoption instability (Rosenthal & Groze, 1992; Smith & Howard, 1991, 1994; Simmel, 2007). The maltreatment of children also puts them at increased risk for depression (Ji, Barth, Brooks, & Kim, 2010), and can affect their adjustment into adulthood, especially when the maltreatment is severe (van der Vegt, van der Ende, Ferdinand, Verhulst, & Tiemeier, 2009).

The impact of abuse on children can be insidious. The psychological effects can include pervasive fearfulness, anxiety, depression, low self-esteem, difficulties in regulating feelings and behaviors, and PTSD-related symptoms (Cook, et al., 2005). The physiological consequences of maltreatment also involve changes in the neurochemistry and physiology of the brain, as well as neurodevelopmental changes in brain functions (Perry, 1998; Lansdown, Burnell, & Allen, 2007). There is a certain amount of malleability or recovery potential in the neural systems involved in early life trauma, involving both stimulating development of underdeveloped brain cells and the potential for other brain cells to take over functions carried out by damaged cells, particularly when children are very young (Fisher & Gunnar, 2010).

Trauma experts have coined the term "complex trauma" to describe the cumulative effects of prolonged exposure to traumatic experiences and have identified seven domains of impairment in children with this condition: attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept (Cook, et al., 2005). These children often 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).

Number of Placements Prior to Adoption
An additional factor before adoption that has been linked to greater risk for children's ongoing adjustment problems is the number of placements they had prior to moving into a permanent family, resulting in multiple relationship disruptions and ambiguous losses. 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).

Studies have found that foster placement instability has more of a negative impact on children than the single event of removal from original family and placement into foster care (Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007). A 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 three 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 their understanding into their identities. It is common for adopted children to struggle at times with their feelings about being adopted, and studies have documented that emotional turmoil and difficulty related to adoption issues are associated with greater adjustment problems, including depression, lower self-worth, anxiety, and behavior problems (Smith, Howard, & Monroe, 2000; Smith & Brodzinsky, 2002; Juffer, 2006). Also, loss is a central issue in adoption, and becomes particularly salient for children placed at older ages who have experienced many traumatic separations; these children typically have not been helped to mourn their losses, which can contribute to ongoing emotional problems.

Generally, children adopted as infants do not become aware of the loss aspects of adoption until they are school age (Brodzinsky et al., 1992), although some preschool adoptees may react to differences between themselves and adoptive family members and begin to grapple with separation from their birth families. 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) found that greater curiosity and preoccupation about birthparents, as well as a coping pattern of behavioral avoidance, was associated with higher levels of externalizing behavior problems. Similarly, research with adopted adolescents has linked very high levels of preoccupation with adoption with 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 feelings about adoption and behavior problems in transracially adopted children, finding that those who expressed the wish to be White and/or to have been born into their adoptive families had higher levels of behavior problems. A study of adoptive families receiving 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). In addition, an English study of children placed from care in middle childhood found that the minority (27%) – those who had not yet developed an attached relationship to at least one parent by one year after placement – were much more likely to have serious behavior problems than those who had formed an attached relationship (Rushton, Mayes, Dance, & Quinton, 2003). It is not clear whether the problems negatively affected development of an attachment relationship, or if the lack of an attachment relationship contributed to children's behavior problems.

Protective Factors among Adopted Children

Resilience is the ability to overcome adversity and function better than expected based on the high-risk or traumatic experiences of the child. A number of protective factors – buffers that mediate the impact of stressful events – exist within children, families, and their environments. Conversely, the absence of these factors, such as parental warmth and sensitivity, can be viewed as a risk factor for poor adoption adjustment.

As discussed earlier, a group of children can experience the same treatment or adversity and experience different outcomes. Some of this variability 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, temperament and genetic susceptibility can make children more or less vulnerable to negative outcomes.

Gender
Generally, in the body of research on child development and on adoption, being born female is a protective factor. In the former category of research, for instance, girls have shown 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).

Temperament
Children's temperaments, which are both genetically predisposed and environmentally shaped, can be protective and can 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, 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

thereby suffer fewer ill effects of institutionalization. Research also has shown that children with difficult temperaments are more susceptible to negative discipline, resulting in more acting out, but they also are influenced more by positive discipline than children with relatively easy temperaments (van Zeijl, et al., 2007). Children with difficult temperaments may evoke dysfunctional caregiving, and their parents may need support in maintaining effective discipline strategies.

Capacity to Develop Strong Attachments

Attachment is an emotional connection between a child and caregiver. It involves a healthy capacity to give and receive affection, physical touch such as hugging, and looking to an adult to meet needs such as getting reassurance during a frightening situation. The child is invested in the relationship and wants to spend time with the caregiver, trusts her/him, and tries to behave in a way consistent with caregiver expectations. The capacity of a child to attach to another person is another protective factor. Attachment styles and capacities of young children are shaped through interaction with the environment. There is also an emerging body of research indicating that there are genetic factors in children that make them more or less susceptible to inadequate caregiving and to positive changes in caregiving environments[7] (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 them and their caregivers, and that attachment is shaped by both parties. 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 an Illinois study of the adjustment of youth adopted from foster care, the child's ability to give and receive affection (rated as 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 or partner relationship with good communication; 2) a warm, cohesive pattern of family interaction; 3) an authoritative but 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 (Brodzinsky, 2008).

Realistic Expectations and Thorough Parental Preparation

Parents' cognitive appraisal of their situation helps to shape both 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 those expectations and the child's capacities to meet them. The importance of parents having realistic expectations for adoption is a recurring theme in adoption literature and research (Barth & Berry, 1988; Groze, 1995; Pinderhughes, 1996; McRoy, 1999; Reilly & Platz, 2003). According to the latter study of 259 child welfare adoptive families, parental expectations represented the only one of five variables assessed that had a significant influence on all four adoption outcomes evaluated (parental satisfaction, quality of parent-child relationship, and impact of the adoption on the family and the marriage). Also, a qualitative study of 37 successful adoptions of teens from foster care found that a major key to

---

[7] 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).

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 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).

An important means of achieving realistic expectations in parents and in older children placed for adoption is thorough preparation. For parents, this includes accurate and up-to-date background information on the child (Barth & Berry, 1988; Nelson, 1985; Rosenthal, 1993), yet many families report not having received enough information. For example, in a study of 259 families adopting from foster care, 58% reported getting insufficient information on the child, and 37% reported the child's problems were more serious than the placement agency originally described (Reilly & Platz, 2003).

Adoption preparation 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 adoption from foster care found that while parents felt they had learned to understand children's issues, they needed more preparation on skills to manage difficult behaviors (Rushton & Monck, 2009). Such preparation is especially important when adopting children with serious difficulties (Rushton & Monck, 2009). In a study of adoptions from foster care, Simmel (2007) concluded that for those whose children had externalizing behaviors (aggression, tantrums, etc.), the less prepared the family was to parent children with such problems, the less able they were to regulate negative behaviors. Simmel compared 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, good 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 with the child (Benzies & Mychasiuk, 2009). Some examples of research on adoptive families that establishes the importance of positive parenting aspects 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) were a significant predictor of fewer externalizing behavior problems among child welfare adoptive families (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 and fewer behavior problems. The protective factor, level of family cohesion, had a greater impact on behavior problems than any pre-adoption risk factor (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 adoptive and non-adoptive families indicates children from families with "consensual" communication (high in frequent, spontaneous, unconstrained conversation and high in maintaining harmony) have the fewest externalizing behavior problems (Rueter & Koerner, 2008). This study classified family communication patterns into four styles (consensual, pluralistic, protective, and laissez faire), finding that the percentage of adolescents with high externalizing behaviors varied across communication patterns. The researchers concluded that having fewer adjustment problems was associated with emphasizing conversation orientation. Adopted adolescents had more externalizing behaviors than non-adopted adolescents, but this varied from 3% (in families with consensual styles) to 27% (laissez faire styles) 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 also indicates that parents often underestimate the difficulty their children have in talking about adoption, and the level of communicative openness can vary between a child and each parent 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).

Capacity to Cope with Stress and Challenges
Adoptive families have been studied to better understand the aspects of family functioning and environment that predict adoption outcomes. The importance of many aspects of family environment in shaping adoptee adjustment has been demonstrated by research, including the family's capacity to cope with stress. The California Long-Range Adoption Study demonstrates that adoptive families' ability to cognitively manage stress and challenges is linked with better psychosocial adjustments in their children (Ji, Brooks, Barth, & Kim, 2010). Having parents who scored low on a standardized measure evaluating the family's cognitive orientation toward managing stress and challenge was a more powerful predictor of adopted children's psychosocial adjustment problems than any of the four pre-adoption risk factors analyzed. The researchers recommended greater attention to family stressors and coping mechanisms, both in adoption research and in post-adoption services.

Environmental Protective Factors

Family well-being is influenced not only by the characteristics of children, parents, and their interactions, but also by their social networks – organizations such as schools and churches – and their communities. Some environmental factors that research has identified as promoting 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 services (Benzies & Mychiasiuk, 2009).

In families where adoptive and birth relatives have contact, a significant protective factor is their ability to collaborate with each other for the children's best interests (Grotevant, Ross, Marchel, & McRoy, 1999). Also, in interactions outside the family, the supportiveness of other systems impact adopted children and their families. For example, Grotevant and colleagues describes the "fit" of transracial adoptive families within their communities, where children of a minority race may experience a range of reactions from open arms to teasing and denigration (Grotevant, Dunbar, Kohler, & Lash Esau, 2007).

Sufficient Informal and Formal Social Supports

A poignant response from a single 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)*

Social support is particularly critical for families adopting children with multiple challenges. The consequences of caring for a family member with extraordinary health or mental health problems are far-reaching – economic cost, impact on family and other relationships, restrictions on personal and social activities, stigma, and psychological overload or burnout. When parents experience chronic stress with their children, it can lead to shrinking social networks (fewer friends), reduced feelings of competence, and restriction of their interactions outside the family (Armstrong, et al., 2005). For example, a qualitative study of challenges in intercountry adoptive families reported that some experienced a lack of support from friends or relatives that resulted in their feeling disconnected from others who did not understand their situations 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 at many levels – within their own extended 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, Birnie-Lefcovitch, & Ungar, 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 increases families' stress rather than helping them to manage it. Research on child welfare adoptive families indicates that the amount and quality of support that adoptive families receive contributes to family permanency and positive adjustment (Barth & Berry, 1988, Groze, 1996; Leung & Erich, 2002; Houston & Kramer, 2008).

A Texas study of families who adopted children with special needs found that a higher level of support from some sources – specifically from spouses, other adoptive parents, physicians, and daycare providers – predicted a higher level of family functioning and fewer child behavior problems. However, families who were functioning at lower levels were actually receiving more support from relatives, schools, and professionals than were 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 who received more services prior to finalization were more stable and experienced less conflict three years later (Houston & Kramer, 2008). That was the case even though the families' contact and satisfaction with these formal and informal resources declined from the pre-adoption period to three years later.

When families are unable to meet their needs for support within their informal social support systems, they may seek formal helping services from professionals who may or may not have training about the adoption issues they are being asked to address. Research on the needs of families after adoption yields insights into the types of services that they desire and use.

WHAT WE KNOW ABOUT THE NEEDS OF FAMILIES AFTER ADOPTION

First, a note of caution: The discussion of risks and potential problems in adoptive families can distort our perspective and lead to the pathologizing of adopted children and their families. In reality, adoptive families are more similar than different from families parenting birth children. Adoption outcome studies show that over 90% of parents in any type of adoption (domestic infant, intercountry, child welfare) are satisfied with their experience and would choose to adopt again knowing what they now know (Berry, Barth, & Needell, 1996; Howard, Smith, & Ryan, 2004; Rosenthal & Groze, 1994; Fuller, Bruhn, Cohen, Lis, Rolock, & Sheridan, 2006). At the same time, adoptive families utilize clinical services at about triple the rate reported by birth families (Howard, Smith, & Ryan, 2004; Vandivere, et al., 2009). As discussed earlier in this report, part of this difference is due to a greater readiness to seek help, but it also is due to a higher rate of problems (Miller, Fan, Grotevant, Christensen, Coyle, & van Dulmen; 2000).

While unique challenges may arise in any adoptive family and all may benefit from education and support, those with children who come from higher-risk situations – particularly those with significant emotional and behavior problems – have the greatest service needs after adoption (Wind, Brooks, & Barth, 2007). For example, a needs assessment of 562 families in three states who adopted from foster care found that almost 70% of those reporting that their children had emotional and behavior problems, as compared to 35% in the full sample, reported a need for respite care (Rosenthal, Groze, & Morgan, 1996).

An innovative British study, using a methodology described as "matching needs and services," conducted a needs assessment on a consecutive sample of 103 children placed for adoption from foster care; the research identified the needs of these children in relation to ongoing parenting and support that were apparent at the time of adoptive placement (Randall, 2009). These were categorized into nine levels of need, ranging from the lowest to the highest level of complexity and difficulty. At the lowest level (*apparently straightforward*) were children placed at very young ages, with no known prenatal or genetic risk factors, and demonstrating normal development. These children were assessed as needing support around lifebook work to address identity issues, transfer of attachment from previous caregivers, and work in addressing contact plans with birth families (when appropriate). The top level (*complex, high risk*) involved children with many previous placements, significant maltreatment histories, and challenging behaviors; the list of needs for these boys and girls, beyond normal parenting, included 13 items. Among them were:

- Parents with secure attachment histories who can cope with low levels of rewards
- Therapeutic parenting
- Parents who can understand children's behavior in light of their histories
- Child receives assistance to get in touch with feelings
- Access to mental health services and therapy
- Supportive school environments that understand children in context of their histories

In an ideal world, children with high levels of need could be matched with parents who already have the insights and skills for therapeutic parenting, as well as access to other necessary services; in

reality, however, these ongoing needs often are not known or clearly articulated at the time of placement, nor are they linked with ongoing services. Adoptive families with knowledge and experience in parenting challenging children are in scarce supply. Also, for children who are preschoolers at the time of adoption, developmental and emotional consequences related to risk factors in their backgrounds emerge over time, such as when they start school or reach adolescence. It is vitally important that families be able to access services when needs arise across the adoptive family lifespan.

Outcomes Linked with Post-Adoption Services

The availability and size of financial subsidies is one predictor of the likelihood of a child in foster care being adopted (Hansen, 2007; Hansen, 2005; Hansen & Hansen, 2006; Children's Rights, 2006; Barth, Wildfire, Lee, & Gibbs, 2003; Dalberth, Gibbs, & Berkman, 2005). Hansen and Hansen (2006) found that the amount of the adoption assistance payment was the most important determinant of such adoptions. A Children's Rights (2006) survey of current and prospective adoptive parents in six states found 81% of all respondents reported that the availability of a subsidy was important to their decision to adopt, and 58% said they would not have been able to adopt without a subsidy. In a New York survey of adoption workers responsible for placing the longest-waiting children, 60% indicated higher subsidies might or would improve their probability of adoption (Avery, 1999). There is also some evidence linking adoption subsidies with adoption stability (Berry & Barth, 1990; Sedlak, 1991; Barth, 1993). It is important to note that the number of children whose families receive adoption subsidies varies dramatically from state to state, with some smaller states having only 1,000 or so children on subsidies, ranging up to above 50,000 in large states.

The availability of post-adoption services also has been linked with parents' greater ability and willingness to adopt children from foster care. The lack of such services was identified by both agency staff and adoptive parents as a barrier to adoption from foster care in McRoy's study (U.S. Children's Bureau, 2007), with 43% of parents responding to a survey reporting that this represented a major barrier for them. There are many families who are totally committed to their foster children, but will not adopt them for fear of losing essential services. Providing incentives for adoption, rather than for keeping children in foster care so they can retain the support they need, is an important policy issue.

Receiving post-adoption services also has been linked with more positive outcomes, such as greater parenting satisfaction; the converse is also true – that is, having needs that are unmet is associated with poorer adoption outcomes (Gibbs, Barth, & Houts, 2005; Reilly & Platz, 2004). For example, the latter study of 249 parents of 373 adopted children with special needs found that those receiving post-adoption services reported higher parental satisfaction and those with unmet counseling needs (as well as several other types of service needs) reported lower perceived parent-child relationship quality and more negative impact of their adoptions on their family and marital relationships.

Family Needs and Usage of Post-Adoption Services

Families' usage of post-adoption services increases dramatically over time. The California Longitudinal Adoption Study (sample comprised of 42% from public agencies, 18% private agencies, and 40% independent adoptions) found that clinical post-adoption services use grew from 9% to 19% to 31% over the three waves, at two, four, and eight years after adoption. General post-adoption services use (support groups, visits with caseworkers) was much higher, increasing from 31% to 76% to 81% of families over the three waves (Wind, et al., 2007).

The 2007 National Survey of Adoptive Parents reported that usage of most supportive services was highest among families with children from other countries. For example, 50% had met with someone at the agency to discuss post-adoption services, and 38% had attended a parent support group. For

services classified as rehabilitative, mental health care for the child was the most commonly used, with 33-35% of private domestic and international adoptive families and 46% of foster care adopters reporting that they had received such services for children over age 5 (Vandivere, Malm, & Radel, 2009), as compared with 10% in the general population (National Survey of Children's Health, 2007). Also, as children got older, the percentage who had received rehabilitative services rose – from 9% among adopted children under age 5 to 54% among those ages 12-17 (49% private domestic, 55% intercountry, and 60% foster care). It is important to note that seeking counseling does not necessarily mean the child has serious problems; however, as a group, children receiving mental health care score much higher on standardized measures of child behavior and emotional problems than do those who do not receive such care.

Several studies have assessed post-adoption service needs and usage by child welfare adopters and sought to identity the most critical gaps in availability. The categories of services assessed vary across many studies. Typically, parents are presented with a long list of up to 35 or so services and asked to identify the ones they have used, those they need, and their levels of helpfulness. Some studies have found that a minority of parents report problems in obtaining the services they need. For example, a Kansas survey of 159 parents 18-24 months after adoption found that 80% reported no problems in obtaining the services they needed (McDonald, Propp, & Murphy, 2001); in an Illinois phone survey of 348 adoptive parents, 81% reported no unmet service needs (Fuller, et al., 2006). Other studies, however, have reported a significant gap between those needing services and those receiving them (Rosenthal, et al., 1996; Reilly & Platz, 2004; Festinger, 2006). Across these studies, parents with children with serious behavioral and emotional problems were more likely to report more and greater unmet service needs (Rosenthal, et al., 1996; Wind, et al., 2007).

In the child welfare context, the need for and usage of services varies by adoption type. For example, in Howard and Smith's (2003) study of over 1,300 adoptive families in Illinois, child and family counseling and support groups were utilized least often by relatives who adopted and most often by non-relative parents who were "matched" with their children, with foster parent adopters falling in between. While this finding might be influenced by socio-demographic factors, relatives who adopted also reported fewer behavior problems among their children, higher ratings for their children in every domain of adjustment, greater adoption satisfaction, and fewer service needs.

Findings related to a range of service needs among different types of adoptive families are summarized below.

Financial and Medical Assistance Needs
Studies assessing financial needs have focused exclusively on families adopting from foster care. By far the most commonly received services, the ones rated as most essential – and often the areas of greatest unmet need – are financial supports through adoption subsidies and medical benefits (Rosenthal, Groze, & Morgan, 1996; McDonald, et al., 2001; Barth, Gibbs, & Siebenaler, 2001; Howard & Smith, 2003; Reilly & Platz, 2004). Currently 89% of families adopting from foster care receive such subsidies, an increase from the past (USDHHS, 2010). Typically, families also receive Medicaid cards to help with dental and medical costs, including psychiatric and mental health expenses.

Most adoptions from the child welfare system are by either the children's foster families or relatives. A substantial number have very low incomes and depend heavily on subsidies to care for their children. An Illinois study reported that the majority (56%) of families had annual incomes lower than $35,000, excluding adoption subsidies (Howard & Smith, 2003), and a later study in the same state found 30% had annual incomes of less than $20,000, including their subsidies (Fuller, et al., 2006). Two studies in Northwestern states (Oregon and Washington) found that just under half of special needs adoptive families (47-48%) had incomes of under $40,000 a year (Fine, 2000; Fine, Doran, Berliner, & Lieb, 2006).

Both federal and state spending on adoption subsidies has increased dramatically as more and more children have been adopted from foster care; this emphasis on adoption is both cost effective, yielding billions in governmental savings compared to keeping children in foster care, and more beneficial than long-term foster care (Barth, et al., 2006). Beginning with FY2002, the number of children supported in adoptive homes on federally subsidized adoption assistance has exceeded the number receiving federally subsidized foster care payments nationwide. The number receiving adoption assistance payments under title IV-E has risen dramatically[8] and is projected to reach 514,000 children by FY2013 (U.S. Ways and Means Committee, 2008).

Adequacy of Subsidies

The amount of adoption subsidies varies widely from state to state and, across age categories, and children's levels of special needs within states. Monthly basic subsidy amounts range from a low of $222 to a high of $907 per child, with median amounts in the $400s (NACAC, 2007; Fuller, et al., 2006). Evaluations of the adequacy of subsidies consistently report that they are not sufficient to cover children's needs. Sixty-three percent of families in an Illinois survey reported that their subsidies did not cover their children's needs, and most (62%) said an additional $200 or less would be enough to do so (Fuller, et al., 2006). Others' analyses of subsidy rates in specific states have reported that subsidies cover a little over 60% of basic costs in New York and California (Avery, 1997; Barth, et al., 2003).

In relation to health-related expenses, only 35% of parents in one study reported that their health insurance (whether Medicaid or private) covered their children's medical expenses (Rosenthal, Groze, & Morgan, 1996). In addition to the inadequacy of subsidy payments for some adoptive families, many report having difficulty finding providers who accept their Medicaid cards, particularly dentists (Howard & Smith, 2003; McDonald, Propp, & Murphy, 2001; Rosenthal, Groze, & Morgan, 1996; Fuller, et al., 2006).

The North American Council on Adoptable Children's (2008a) analysis of adoption subsidies recognized the vulnerability of these payments, reporting that 28 states and the District of Columbia were facing budget problems, and the state-funded adoption assistance funds were at risk for reductions or eliminations. Indeed, several states have reduced subsidies and others have cancelled built-in increases that previously came as children reached older ages. Many states also have seen recent declines in the percentage of children receiving federally supported adoption subsidies due to Title IV-E requirements linking these funds to birthparents' income in an outdated 1996 standard, a practice that will now be phased out by 2018 (NACAC, 2009). Increases are needed in subsidy amounts in most states, and all of them need to guarantee the availability of continuous medical coverage for these children after adoption.

Services to Provide Social Support Such as Support Groups
Adoptive families may experience a host of challenges related to inadequate social support, particularly if they are parenting a child with special needs. These include such things as generalized feelings of isolation, conflicts between spouses regarding parenting that may leave one partner feeling unsupported, a constricted social network, rifts in relationships with extended family, or feeling that teachers or other professionals are unhelpful. Social support needs are met both informally through social networks, including informal connections between adoptive families, as well as through formal services. The "service" solutions to best address these needs are as varied as individual family situations and might include traditional services such as organized support groups or adoptive parent mentors. They also might involve advocacy at school to achieve a more

---

[8] Federal expenditures for the Adoption Assistance program under Title IV-E more than doubled in the five years from 1997 to 2002 (U.S. Ways and Means, 2008).

supportive relationship, a marriage retreat, or counseling to help couples become more united and supportive of each other in parenting. Support groups, whether developed and led by parents or by agencies, are very valuable resources for families.

Utilization of support groups is associated with greater parenting satisfaction (Reilly & Platz, 2003; Gibbs, Barth, & Houts, 2005). These groups can be a powerful source of information, social support, and validation for parents and children who may not be connected to other adoptive families. Being able to share frustrations, joys and feelings that have gone unexpressed or unheard with others coming from similar situations can be very healing and can normalize perceptions of their situations. An adoptive parent whom the author interviewed for a program evaluation put it this way:

> After being [in the group] the very first time, I went home crying, realizing it wasn't all my fault. The people here told us why they were here, and I was hearing the same kind of stories from most of them. It helped me accept that [my son's] anger, even though it's directed at me, is not because of anything I've done, but because of the incredible pain he has because of things that happened to him as a very young child (Smith & Howard, 1999, p. 219).

Similarly, support groups or social activities in which adopted children can interact with each other can be invaluable experiences for them. In one evaluation of their participation in a support group, children were most likely to report that they fit in with this group more than others, and they liked spending time with other adopted kids. When asked to describe what they liked best about being in the group, one child wrote: "Now that I know more kids that are my age that are adopted, I feel much better about being adopted and having the same feelings as I do" (Smith & Howard, 1999, p. 223).

In a California study of a broad range of adoptive families, parent support groups were used by 27%, and this service received the highest rating of helpfulness (Brooks, Allen, & Barth, 2002). Several others have reported that support groups are rated at or near the top in helpfulness by parents using them (Howard & Smith, 1997; Reilly & Platz, 2003), although ratings are more modest in some studies (Rosenthal, et al., 1996; Fuller, et al., 2006). In studies of families adopting from foster care, parent support groups were used by a fairly low number (6-22%) (Reilly & Platz, 2004; Festinger, 2006; Rosenthal, et al., 1996; Howard, et al., 2004; Fuller, et al., 2006). Child support group usage was even lower, ranging from 6-13% across four of the previous studies (not all included this service). Overall, 30-38% of parents expressed their need for a support group for themselves across three studies (Reilly & Platz, 2003; Festinger, 2006; McDonald, et al., 2001), although only 9% of parents gave this response in an Illinois study (Fuller, et al., 2006). Finding a child support group is even more difficult, with four to six times the number of parents reporting a need for this service as those who are able to access it (Reilly & Platz, 2004; U.S. Children's Bureau, 2007; Festinger, 2006).

There is little research on support group usage among families adopting internationally. One study reported a higher usage rate of support groups among intercountry adoptive families (52% for parent groups and 25% for child groups) (Howard, et al., 2004). Another survey of adoptive parents of 475 children adopted from Romania reported that 37% of parents used support groups and 88% spent time with other adoptive parents (Groza & Ileana, 1999). Also, online support groups are a growing source of information and support for adoptive families; however, one study of intercountry adopters found that some parents of children with severe problems reported that online support groups were not accepting of them out of concern that they might scare others away from adopting (Linville & Lyness, 2007).

Counseling/Clinical Service Needs

Studies on broad populations of adoptive families have established that 25 to 45% of families use post-adoption counseling services, and child welfare adopters are most likely to use these (Berry, Barth, & Needell, 1996; Brooks, Allen, & Barth, 2002; Howard, et al., 2004). Families vary in the extent to which they seek counseling to meet the needs of their children, and many first seek advice from a professional already in the picture, such as a teacher or a doctor. An interview study of 40 child welfare adoptive families found that, for concerns related to child development, education, and the child's behavior, parents were most likely to turn to a "formal, non-agency" source of help, most frequently the child's teacher (Kramer & Houston, 1998).

There are few studies of post-adoption service use in families adopting internationally. One exception is a Canadian longitudinal study of service use that compares 36 families adopting children from Romanian orphanages, 25 who adopted very young Romanian infants (not institutionalized), and 42 families of non-adopted children, at 11 months after adoption and when children were ages 4½ and 10½ years (LeMare, Audet, & Kurytnik, 2007). Service use related to seven problem categories revealed the top category was assistance for behavior problems (63% in previously institutionalized children, 46% in non-institutionalized adoptees, and 17% for Canadian-born children). The two next most commonly used categories were for help with health and academic problems. Overall, 53% of families adopting institutionalized children reported some inability to access needed services.

In trying to determine what proportion of child welfare adoptive families use counseling or have unmet needs in this area, it appears that these two categories total approximately 55-60%[9] (Festinger, 2006; Reilly & Platz, 2003). A recent Illinois survey (Fuller, et al., 2006) reported a lower percentage (35%) either receiving or needing services in these areas. This same study surveyed states as to whether they provided a range of post-adoption services, and all but one state reported some provision for counseling (with limits in some states).

Parents in a Nevada study rated counseling as the service area they most needed (50%) but could not adequately get (Reilly & Platz, 2003). (A composite of 10 aspects of counseling were combined in this category and, while 69% reported receiving services for at least one type of counseling need, many still had other unmet counseling needs.) Other studies have listed counseling at the top of the list of services parents had trouble getting for their children (Howard & Smith, 2003; Rosenthal, et al., 1996). The latter study found that counseling related to the child's future was the type they had the most difficulty accessing (47% needed and only 12% received). Adopted youth who have significant learning or behavioral challenges are not ready for independence at age 18, and many of their families need help to transition the youth to adulthood.

Other kinds of clinical services, such as psychiatric hospitalization or residential treatment, are used by about 10-15% of child welfare adoptive families. One study reported 10% of such families had children who had been in a psychiatric hospital since adoption and 5% in another type of out-of-home placement. In this study, 9% reported each of these areas as a needed service, so it is hard to determine the degree of overlap among these ratings (Rosenthal, et al., 1996). Seventy-two percent of states have provisions for covering post-adoption residential treatment (Fuller, et al., 2006).

Child Care and Respite Needs

Of course, all families need help with child care when parents are working and when they need to be away for other reasons, but this need is harder to meet for families with low incomes or whose children's needs are difficult for traditional services to meet. When a child cannot be accommodated in after-school programs or conventional day-care centers, or when family members or friends cannot or will not care for the child, specialized assistance is needed.

---

[9] It is somewhat difficult to draw conclusions due to the fact that several studies include multiple categories related to counseling – such as child counseling and family counseling – with 30% receiving one type and 40% receiving the other. Some overlap likely exists between these categories.

In most needs assessment surveys, about half of child welfare adoptive families either received or expressed the need for assistance with day care, and many more require this service than receive it (Festinger, 2006; Rosenthal, et al., 2006). Only half of states have any provision for providing assistance with day care after adoption. Typically when provided, it is a special service that is written into the subsidy agreement at the time of adoption (Fuller, et al., 2006).

Also, for caregivers of children with extraordinary needs and no other sources of childcare, respite (temporary care that provides a break to the caregiver) is essential for the adults' mental health and ability to sustain their functioning. For example, a respite needs assessment among families receiving therapeutic post-adoption services in Illinois found that a high level of parenting stress was associated with greater levels of depression and greater adoption instability, and that a high unmet need for respite predicted greater adoption instability and negative impact on the family (Howard, Smith, & Ryan, 2003).

There are few well-designed studies on the outcomes of respite care for children with serious emotional and behavioral problems. One exception is a study of such families receiving 23 hours per month of planned respite care, which found fewer out-of-home placements, greater optimism by parents about caring for their child, and reduced caregiving stress among those receiving respite compared with similar families on a waiting list (Bruns & Burchard, 2000).

In an evaluation of a respite program for adoptive families whose children had severe behavioral or medical challenges, many parents reported that respite was a lifesaver. The reported benefits included a chance to gain perspective, time for relationships with others (including other children), the opportunity to address one's own needs, improved relationships, and others. One parent expressed the gains in these words:

> *I was at my wit's end, was ready to walk out. I thought the thread holding this family together was going to break. Respite gave us the strength to continue. It gave us a chance to recharge. When you have even a brief break from their constant, overwhelming needs, you can love them so much more. You look at them differently* (Center for Adoption Studies, 2005, p. 30).

Most states (88%) do have some provision for respite care for at least some families (Fuller, et al., 2006), but it is hard for most families to access this service. For example, the New York study showed that only 2% of families received in-home respite; 7% received out-of-home respite; and an additional 40-46% expressed the need for such care (Festinger, 2006). Respite care receives a very high rating of helpfulness by families who receive it (Rosenthal, et al., 1996; McDonald, et al., 2001).
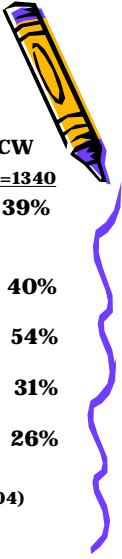
Education-Related Needs

School is where adopted children face the most challenges and parents express the most concerns. The table below reports the percentages of school-related issues present in a comparative study of birth families and different types of adoptive families (domestic infant, intercountry, and child welfare) conducted in Illinois (Howard, Smith, & Ryan, 2004).

Issues in School Performance by Family Type

	Birth n=175	Infant n=481	Int'l n=89	CW n=1340
Unmet educational needs	15%	18%	27%	39%
Special education services for learning problems	9%	24%	32%	40%
Teacher complaints/behavior	18%	35%	34%	54%
On medication for behaviors	3%	28%	21%	31%
Repeated 1 or more grades	6%	4%	3%	26%

(Howard, Smith, & Ryan, 2004)

In this study, 39% of child welfare adoptive parents indicated that their children had educational needs that were not being adequately met. When asked to identify the services that would help, the most overwhelming response was tutoring, particularly with reading. Some whose children did not receive special education services felt that their children needed such services for learning disabilities or speech and hearing problems (Howard & Smith, 2003).

A study of 159 children adopted from Eastern European countries, conducted within the first year after their arrival in the U.S., found that services utilized related to the children's development and education – professional evaluation (61%), speech therapy (20%), early intervention (15%), and English as a second language (12%) (Judge, 2004).

About half of child welfare adoptive families in two surveys expressed their children's need for tutoring, but only 15-19% received this service (Rosenthal, et al., 1996; Festinger, 2006). Most state child welfare systems (58%) do not offer assistance with tutoring after adoption, and most providing this service require that it was specified in the subsidy agreement.

Educational advocacy is provided by a trained professional to some child welfare adoptive families and assists them in obtaining needed educational services or placements from their school systems. It is available only in 30% of states, typically to a very limited number of families. In Illinois, which has such a program, 13% of parents identified a need for this service, but only about half received it (Fuller, et al., 2006).

Advocacy and Service Coordination

Some children need other types of specialized assistance including clinical services such as speech or occupational therapy. Another area of need for a large number of families is help in connecting to services and possibly advocacy to obtain a service that is not easily accessed, such as a therapeutic day school or a residential treatment program. A Kansas study identified advocacy as a service that was in lesser demand but significantly unmet – while the New York phone survey found that 21% of families had received help connecting to post-adoption services, and another 45% identified this as a need, totaling two-thirds of all families in this research. Another study reported 27% received social work service coordination, and an additional 46% identified it as needed (Rosenthal, et al., 1996).

As might be expected, the need for post-adoption services is greatest for the families of children with high levels of special needs; i.e., those with diagnosed mental health issues, with physical health

challenges, and/or behavior problems (Fuller, et al., 2006). For example, families whose children had diagnosed mental health problems identified the need for 5.3 services, compared with 2.2 services for other families. Also, kin caregivers reported fewer service needs than did non-kin caregivers.

A national survey of state child welfare administrators (Fuller, et al., 2006) reported that the majority of states indicated a need for additional post-adoption services. The most common service needs identified included:

- Adoption-competent therapists who understand issues faced by children and families

- Respite care

- Availability and accessibility of existing services across the state

RECOGNITION OF THE NEED
FOR POST-ADOPTION SERVICES

Increases in Special Needs Adoptions & Concerns about Adoption Instability

Beginning in the late 1980s and following on the heels of the permanency planning movement in child welfare, adoption professionals began to call for the development of post-adoption services to sustain families who had adopted children from foster care. Many children who were deemed to be "unadoptable" were indeed adopted by families. The risks associated with "hard to place" children resulted in greater attention to disruption (terminating an adoptive placement before legal finalization). Disruptions were tracked and studied, and the field recognized that a significant number of placements do not result in finalized adoptions. Studies of large child welfare populations generally reported disruption rates of 10 to 15%, and a range of risk factors linked with disruption were identified (Festinger, 1986; Barth & Berry, 1988; Urban Systems Research & Engineering, 1985; Smith & Howard, 1991, 1994). There were fears that the large increases in placements occurring after the Adoption and Safe Families Act would lead to an increase in the rate of disruptions; available evidence does not indicate that this is the case, however (Barth, et al., 2001; Smith, Howard, Garnier, & Ryan, 2006).

In addition to disruptions, other types of adoption instability became apparent. Some adoptions were dissolved – that is, legally terminated – and the children were placed back into care; yet other children were placed in foster care or other residential settings because their families could not handle them, but without the formal dissolution of their adoptions. Very little research exists on adoption dissolution or post-adoption placement into foster care or residential treatment. Festinger (2002) reported that 3.3% 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 if not most of these children were expected to return home. A recent study using FY2005 AFCARS national data identified 2,642 adopted children entering care during that year and 3,166 children exiting care who were previously adopted. Of those in the latter category, the adoptions of 1,241 children (39%) were classified as legally dissolved, while most (59%) of the remaining children leaving care were reunified with their adoptive parents (Festinger & Maza, 2009).

Adoption failures have a clear, negative impact on society. In terms of human costs, the emotional toll is huge for the families and the children. The financial costs for society also are steep, from the money it takes to support these children until they reach adulthood to the price of services they will need down the road. From a financial standpoint alone, researchers have found that:

- Each adoption from foster care yields on average a net savings of $143,000 to state and federal governments (Barth, et al, 2006).

- Successful adoptions produce other public financial benefits in human services and reduced crime, estimated as a total savings of $302,418 per adoption (Hansen, 2007).

Also the outlays for residential treatment (for children who cannot remain at home) are very high; for example, a Tennessee executive director reported the average cost of residential care in that state as approximately $65,000 per year as compared to the average adoption subsidy of $4,824/year (Pam Wolf, personal communication, May 8, 2009).

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 small minority of those adopted from high risk situations, but the human toll of severe unresolved difficulties can be hard to grasp. One adoptive mother served through a post-adoption program in Illinois expressed it in these words:

> *We were lost, sinking, destroying our family rapidly before these services. We spent thousands upon thousands of dollars, not counting the time involved in seeking help. This was the only place we could find help, information, relief … an understanding of how these troubled kids work and how to try and cope with their behaviors. How to deal with the emotions these kids stir up in us. How to still love them … It's so hard to try to put into words the devastating effects on the family these kids could have … It is so difficult … the destruction, the financial drain, the breakdown of the marriage, breakdown of physical health … At times, the fear of your life and safety of the siblings … (Smith, 2006, p. 170).*

Situations at this level of severity occur in only a small minority of adoptive families (estimated as approximately 10% of those adopted from foster care or very deprived orphanage situations[10]); these families need and deserve services to address their painful, chronic difficulties. The extreme compounding of unresolved problems in families can even lead to child fatalities – approximately 20 deaths at the hands of their parents have occurred over the past 10 years among children adopted internationally into the U.S. (Miller, Chan, Reece, Tirella, & Pertman, 2007; Gunnar & Pollak, 2007).

The Continuum of Post-Adoption Services

Prior to the marked increase of child welfare adoptions beginning in the 1980s, it was assumed that existing community services for all families could meet the therapeutic needs of adoptive families. As adoptive parents were unsuccessful in finding effective help for their children, however, the need for specialized services became apparent. The importance for service providers to understand the unique aspects of adoption and the developmental impact of neglect, abuse and interrupted attachments on children in order to effectively serve these families was stressed by experts and parents. As post-adoption services began to develop, there was a debate as to whether state mental health or child welfare systems should take the lead in this arena. Responding to this debate, Watson (1991) argued that public child welfare agencies needed to be at the forefront of developing public-private partnerships in post-adoption services. According to Watson, the public agency should provide the leadership and vision, training, and funding for planning services tailored to the existing state agency's capacities and patterns of interagency cooperation – services to be delivered by a network of agencies.

---

[10] This estimate is based on responses to a survey of over 1300 child welfare adoptive parents – 12% rated their children poorly on each of three questions: level of difficulty to raise, their children's ability to give and receive affection, and having been in a psychiatric placement or residential treatment center at some point; only 4% stated that the adoption had an overall negative impact on the family (Howard & Smith, 2003). It also is based on a study of Romanian adoptees in which the percentage of children rated with "marked disinhibition" (severe attachment disturbance) at age 11 was 10% (Rutter, et al., 2007).

The federal government provided funding for a National Consortium for Post Legal Adoption Services, composed of representatives from adoption and mental health systems in several states. The National Consortium (1996) developed a model for the ideal continuum of community-based services to sustain adoptive families; it is contained in Appendix I of this report. These services were conceptualized as drawing on the expertise of adoptive parents and adopted persons, as well as on multiple professional disciplines, and were intended to help all members of the adoption triad. Ten categories of services were identified:

- advocacy
- family education
- information and referral
- financial supports
- family support
- community support
- psychosocial services
- reunions and record inquiries
- medication and problem solving
- service coordination

The need for post-adoption services, as well as the challenges of developing and financing them, were the focus of several national conferences in the late 1990s. During the following decade, however, the development of post-adoption services slowed and, in some cases, stalled. There were many years in which federal Adoption Opportunities Grants for post-adoption services were not offered. Some states had to stop or scale back funding for post-adoption programs; others have kept programs at the same level for many years, so they have been unable to meet growing demands.

A number of leading child welfare experts and organizations have championed the need for the development of knowledge on post-adoption services (Howard, Smith, & Oppenheim, 2002; Casey Family Services & Annie E. Casey Foundation, 2002; NACAC, 2007; Barth, et al., 2001); however, progress has been hampered by both the paucity of knowledge and funding in this still-emerging field.

Guiding Principles & Goals of Post-Adoption Services

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

Active Engagement: Empathic Listening & Accepting, Non-blaming Approach
Some adoptive parents not only blame themselves for their children's difficulties, but also feel that professionals with whom they have worked have been judgmental toward them. Mental health professionals traditionally have viewed children's behavioral problems as stemming primarily from inadequate parenting. 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 an accepting 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 and respond with empathy. 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, when needed, going to the home; responding promptly to families with crises or immediate needs; and ensuring that workers return calls and follow through consistently and reliably. Being able to talk to someone between scheduled sessions when there is a crisis is also very valuable. Also, being able to receive services for as long as they are needed rather than for a time-limited period is linked with more positive outcomes (Atkinson & Gonet, 2007). Another element, described as "avoiding assessment paralysis," involves not requiring an extended period of formal assessment or specialized evaluations prior to beginning solution-focused work with the family (Hart & Luckock, 2006). Comprehensive assessment, while important, may need to be spread over time.

Joining with and Supporting Parents: Increasing Parental Entitlement

Some 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 children. In working with adoptive families, professionals must first form alliances with the parents, recognize that the parents know their children better than anyone else, and join with and empower the parents to find solutions to their problems. When professionals also work individually with children, parents should be kept abreast of the focus of the work and the children's progress and should learn how they can work 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 children (Smith, 2006; Smith & Howard, 1999; Hart & Luckock, 2006).

Helping Parents Understand Children in Light of their Histories

Children served through post-adoption programs have often 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 those past experiences have influenced 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 their actions as coping or survival mechanisms – a technique known as "reframing." Educating parents also involves helping them to understand their children's special needs and to have realistic expectations (Smith, 2006; Smith & Howard, 1999; Hart & Luckock, 2004). For example, a special California program for families adopting children from foster care who experienced prenatal substance exposure found that the families benefitted greatly from being helped to understand their children's behavior in the context of their early experiences, before and after birth (McCarty, et al., 1999).

Enhancing Therapeutic Parenting Skills While Supporting Attachment

Parents need to be helped to establish control and deal with their children's behaviors in ways that are nurturing and support attachment. This process involves depersonalizing the child's anger, responding in a rational and not angry manner to set limits, and learning therapeutic parenting skills. Therapeutic parenting shapes children's behaviors both proactively (creating a structured environment; being emotionally available to the child; promoting emotional regulation and reflective thinking) and reactively (holding child accountable for actions while addressing the root causes of behaviors) (Smith & Howard, 1999; Hart & Luckock, 2004). When parents are unable to modify difficult behaviors, they often resort to increasingly extreme means to manage them, and it is common to have escalating power struggles between parents and children. Parents may report feeling angry all the time and fear losing control themselves. They need assistance in gaining self-awareness and learning therapeutic parenting skills that effectively meet their children's needs.

Exploring Adoption Issues and Honoring Previous Attachments

It is of paramount importance to achieve a sense of belonging for adopted children in their families, while at the same time acknowledging and facilitating communication about their birth families and other significant past affiliations. Children may be struggling with unresolved loss, grief, or adoption

identity issues. 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 children are not talking about birth family members, they are not thinking about adoption issues, and parents may wait for their children to ask questions before sharing critical information. Promoting open communication between children and parents about these issues is important and, at times, between adoptive family members and birth family or other attachment figures. 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 connections (Hart & Luckock, 2004; Smith & Howard, 1999).

Listening to Children and Addressing their Emotional Issues

Accessing the inner lives of children may involve individual therapeutic work to help them 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 adoptive parents in the therapeutic process and to help them develop strategies for addressing these issues with their children. As adopted children grow older, they often will grapple with these issues at each new developmental stage. Their developing cognitive abilities will lead to different perceptions of their situations and different questions and concerns will arise (Smith & Howard, 1999).

Opening Family Communication

Communicative openness is critically important in adoptive families, but it is not necessarily simple to achieve. 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). In some adoptive families, professionals may work to support collaborative relationships with members of birth or former foster families, or parents of siblings of the adopted child in another family.

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 specific children's ambivalence or fear of trusting again and risking another loss. The internal tension can result in a push-pull dynamic where the children alternately seek closeness and then push the parents away. Parents' own anger at times interferes with their feeling empathy for their sons or daughters. They need to find ways to initiate positive interactions and to claim the children as their own through concrete evidence of belonging. For children who received very poor early nurture, playful and nurturing interactions similar to how parents may relate to infants can help to promote healthy attachment. Theraplay (Booth & Jernberg, 2010) is a type of attachment therapy that 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 to Access Support

Finally, it is important to identify and address the issues of parents, whether it is their reactions to traumas their children have experienced, processing their unresolved losses, helping spouses or partners support each other and present a united front in parenting, or self-care issues. Parents whose children require an inordinate amount of care often are emotionally exhausted and 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 the post-adoption needs of families requires multi-systemic interventions, including working with multiple constellations of family members; coordination and advocacy with systems such as schools and medical or mental health providers; and linking families with a range of resources. It can require broader availability than the typical office-based therapist can deliver, for example, and may entail responding to a crisis on a weekend, organizing a wrap-team,[11] 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 the multiple-level approach this way: "I really do believe it was the comprehensive nature of the whole aspect of the program that helped us the most. She [the worker] 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."

THE DEVELOPMENT
OF POST-ADOPTION PROGRAMS

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 a permanent family is the only thing needed to enable children to recover from their losses and traumas. In addition, the need for specialized 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 families in seeking help for their children – combined with their own advocacy – have led to the development of specialized post-adoption services.

The First Decade of Post-Adoption Services

The development of specialized post-adoption support and therapeutic services began in earnest during the late 1980s and early 1990s, although some programs existed prior to that time. 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 include information and referral, education and training, support groups and mentoring, respite care, advocacy, crisis intervention, search and reunion assistance, and therapeutic counseling (Howard & Smith, 1997; Howard, Smith, & Oppenheim, 2002).

In order to advance the development of therapeutic services for troubled adoptive families, additional 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, & Corcran-Rumppe, 1991; Prew, Suter, & Carrington, 1990; Barth, et al., 2001). These evaluations are largely descriptive and do not have comparison group research designs. They provide insights into the nature of this work, however, and are summarized briefly below. The first three early demonstration projects operated for several years and then ended; the Casey and Illinois programs are ongoing.

---

[11] "Wraparound" services organize a team of persons (including professionals, relatives, friends, and others) to meet with the family and participate in planning services and working together on goals.

Oregon Post-Adoption Family Therapy Project

This project used co-therapists (an adoption worker and a family therapist) who worked with families primarily in their homes and focused largely on helping parents develop better ways of interacting with their children to modify children's negative beliefs about themselves and parents stemming from the children's early maltreatment and loss experiences. Adoptions were not preserved in 8% of these families at the end of the service period, a median of 3.5 months (Prew, Sutter, & 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 from many disciplines and community agencies. The team assessed cases and recommended one of three types of treatment: 1) referral to adoption-sensitive community professionals; 2) adoption counseling services for three to six months, approximately two hours a week, or 3) adoption preservation services of up to 10 hours a week for 45-90 days including therapy, parent training, crisis intervention, and short-term, temporary placements. Treatment utilized co-therapists in working on family integration, normalizing the experiences of adoptive parents, re-parenting, and linkage with resources. Among the 39 families who participated, 29% of children were placed outside their homes at the end of services, primarily due to sexual offending by the child (Groze & Gruenewald, 1991; Barth, et al., 2001). The Special Needs Adoption Family Preservation Treatment Team (SNAFPTT) Project was an extension of the previous project. It combined family-based mental health services and adoption practice and served 41 families. In the families served, there was a significant decrease in children's scores on the Child Behavior Checklist on both the internalizing and externalizing scales (Groze, Basista, & Persse, 1993).

Washington State's Medina Children's Services

This collaborative initiative between Medina Children's Services and HOMEBUILDERS of Tacoma provided four 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 22 children were still living at home (Barth, et al., 2001).

Casey Family Services Post-Adoption Services Program in New England

The Casey Family Services Post-adoption Services program was established in 1991 in five of the New England states, and case data on over 400 families that 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 families served involved child welfare adoptions for 62% of children and nearly all families had used other services previously, including 60% who had received individual child counseling. The most common family concerns included children'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 five months. Counselors assessed the greatest improvements as being in the areas of children's behavior, understanding adoption issues, and effective communication; gains were greatest for cases with more sessions and longer duration (Barth, et al, 2001; Lenerz, Gibbs, & Barth, 2006).

Illinois Adoption/Guardianship Preservation Program

In 1991, Illinois initiated an Adoption Preservation Project in two agencies that expanded within a few years to a statewide program serving any type of adoptive family that was at risk of child placement or dissolution. Standard services included intensive therapeutic counseling, support groups for parents and children, 24-hour crisis-call response, very limited cash assistance, advocacy, and respite services at some sites. The initial evaluation of services to 234 children in 204 families found that 88% scored in the clinical range on the Child Behavior Checklist. Almost half of the families had considered adoption dissolution as an option, and about one-quarter of the 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% of children remained in their homes (Smith & Howard, 1994).

A later evaluation of the Illinois program – for 1999-2001 – analyzed services and outcomes for 1,162 children in 912 families, finding that 80% of the children served were adopted from foster care. The 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 of 72 service hours. The possibility of ending the adoption was raised as an issue by 30% of the parents served. 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, 13% of children were placed outside the home, although many of these (39%) had a goal of returning home. Children who were adopted from foster care were not more likely to be placed at the end of services than others (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 their children (87%). Seventy-four percent reported improvement in their children's behavior (Smith, 2006). These findings were similar to an evaluation of a Canadian post-adoption program, reporting a greater impact of services on parents' knowledge of where to get help and understanding of their children than on children's behaviors (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 in the late 1980s. Approximately 65 projects were funded from 1989 to 1994, along with a synthesis report describing the knowledge gained from these projects (Howard & Smith, 1997). Adoption Opportunities grants have continued to enable the development of post-adoption programs around the country; however, many of these programs could not be sustained once the federal funding ceased (after 3-5 years). For example, the report based on the first years of these grants found that only a small minority of sites were able to fully maintain their programs after the grant ended, primarily by obtaining state funding.

This pattern of three steps forward, two steps back has continued throughout the history of post-adoption services. Nevertheless, many states have been able to establish some services statewide. Some offer only one or two services, while a few 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 programs or to provide these services to all families who need them.

Organizations such as the Annie E. Casey Foundation, the North American Council on Adoptable Children, and Casey Family Services have consistently provided leadership for the development of post-adoption services across the country. They have been joined by public child welfare entities and private agencies in providing important impetus and direction in this area.

Recent Research on Post-Adoption Services

Since the beginning of the 21st century, only a few evaluations of post-adoption programs have been published, and only one of these used a randomized experimental design – the Maine Adoption Guided Services model (MAGS) (Lahti, 2006). In partnership with the Maine Department of Human Services and supported by a Title IV-E Waiver, Casey Family Services designed and implemented the services for this project, a family-centered case management and therapeutic model that was implemented statewide in collaboration with the state of Maine and the Muskee Institute. 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 six months and typically more. 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 in the characteristics of the children in both groups of families. However, after two years, the children in the MAGS group scored significantly lower on the Child Behavior Checklist. Also, after five 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, 2005, 2006). These findings support the more positive outcomes and cost-effectiveness of the guided post-adoption services model.

EVIDENCE-BASED AND PROMISING PRACTICES APPLICABLE TO POST-ADOPTION SERVICES

While the evaluations described earlier offer insights into the nature of problems in families who seek services and factors associated with the severity of those problems, more in-depth research is needed in order to develop a greater understanding of the dynamics of challenges in these families and the types of interventions that can effectively help them.

Evidence-Based Practices

There is a growing emphasis in professional education of psychologists, social workers, and other mental health professionals on the use of evidence-based interventions in practice, and many reviews in journal articles and by associations have rated the scientific evidence attesting to the efficacy of specific treatment models; for example, see the websites of the California Evidence-Based Clearinghouse for Child Welfare or the National Child Traumatic Stress Network. While continued development and dissemination of evidence-based practices is one important step in the evolution of post-adoption services, it is not a panacea.

Many articles in professional journals have discussed the barriers to widespread implementation of evidence-based interventions. First of all, the sheer number of these approaches is overwhelming; at the beginning of the 21st century, Kazdin (2000) identified over 500 different, named therapies for working with youth. Despite a general belief in the importance of using interventions with established efficacy, integration of evidence-based therapies (EBT) in professionals' everyday clinical practice has been very slow. There are many reasons for this, including that clinical training programs do not teach more than one or two EBTs, and their inclusion in doctoral programs has actually declined in recent years (Woody, Weisz, & McLean, 2005; Weisz & Gray, 2008). After beginning practice, training on EBTs is not easily obtained – most lack manuals or videos, and clinicians are not keen on following manuals anyway (Chorpita, Becker, & Daleiden, 2007). Moreover, the trainings can be extremely costly (thousands of dollars) and require ongoing supervision programs and, for some, agreement to adhere to manuals.

The conditions under which most EBTs are developed differ significantly from the conditions of everyday practice. For example, adopted youth frequently present with complex combinations of developmental delays and mental health conditions, yet efficacy studies often exclude clients with multiple conditions. These EBTs typically are researched in controlled laboratory conditions with highly skilled therapists adhering strictly to prescribed protocols, and the research findings often do not reveal their effectiveness under ordinary practice conditions (Weisz & Gray, 2008; Chorpita, Becker, & Daleiden, 2007). Whittaker (2009) discusses the challenge of integrating evidence-based interventions in services for high-resource-using youth and their families, underscoring the importance of investigating effectiveness of practices by creating a feedback loop whereby those on the front-line (child-care workers, social workers, teachers, and parents) provide their insights and experiences regarding interventions to the researchers. Whittaker also identifies the need for

interventions to be delivered in a community context (home, school, and neighborhood) and to coordinate the efforts of multiple service systems.

There has been some 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 with other groups of at-risk youth. Some of these treatments include multisystemic therapy (MST) (Heneggeler & Lee, 2003; Ogden & Hagen, 2006); trauma-focused cognitive behavioral therapy (TF-CBT) (Cohen, Mannarino, & Deblinger, 2006); child-parent psychotherapy (Lieberman, Ghosh, & Van Horn, 2006), and two approaches to parent training – parent-child interaction therapy (PCIT) (Timmer, Urquiza, & Zebell, 2006) and the positive parenting program (Triple P) (Prinz, 2009; Petra & Kohl, 2010). Some of these interventions have been used and evaluated primarily with maltreating birth families and as an alternative to child placement, rather than directly with caregivers outside the birth family. Also, they were not developed to address the nature of complex trauma/ attachment/identity issues in some adopted children who also may have other coexisting developmental challenges. For example, trauma-focused CBT was developed for children whose primary presenting problems were related to a traumatic event and who display symptoms of PTSD. The clinical presentation of many adopted children involves a more complex layering of adaptations to trauma and loss with other longstanding emotional, behavioral, and developmental issues.

The applicability of these models in post-adoption services needs to be further explored and researched. Some model programs report using specific evidence-based practices such as PCIT techniques and TF-CBT. The intensive home- and community-based wraparound approach used in the Kinship Center's AFTER program in California stems from MST's intervention model.

Promising Practices

Several models for interventions focused on the types of challenges common among youth served through adoption preservation programs have begun to build a research base, although few, if any, rise to the level of established empirically based practices with randomized control studies. The first noteworthy intervention, <u>ARC: Attachment, Self-Regulation, & Competency</u>, 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, the attachment field, and developmental psychology. ARC includes a range of therapeutic procedures including psychoeducation, relationship strengthening, parent training, building regulatory capacities through sensory and body-based strategies, 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 a preliminary evaluation of its use reported a 50% reduction in PTSD symptoms (Kinniburgh & Blaustein, 2006). A workshop describing this interventive model is available online (Kinniburgh, 2008), and in a recent book outlining the therapeutic approach (Blaustein & Kinniburgh, 2010).

ARC was implemented in the ADOPTS post-adoption program of Bethany Christian Services, beginning in Grand Rapids, MI, in 2004, and after two years at eight other sites, through the support of a four-year grant from the U.S. Department of Health and Human Services. It was used with both pre- and post-adoptive 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 six-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; it focuses on enhancing parent-child attachment and is based in attachment theory, developmental psychology, and pre-school educational practices (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 sessions 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, and therapists trained in its techniques can incorporate them in many facets of their work with families, whether or not it is the overarching modality for treatment.

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 children gain emotional access to the most painful and difficult feelings and perceptions stemming from their early traumatic experiences, and supporting them in being able to think and talk about these experiences in a manner that detoxifies them and leads to a coherent narrative. The Kinship Center offers a three-part series of DVDs presenting the DDP model being used in family therapy sessions with children and adolescents (Kinship Center, 2010).

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 four years after treatment was 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, and these gains were sustained four years after treatment, while the 30 subjects in the comparison group receiving other forms of treatment did not demonstrate sustained gains on any subscales.

Therapeutic Lifebook Work is an intervention that focuses primarily on processing loss and trauma experiences and facilitating continuity in identity. Although lifebooks have been used with foster and adopted children for many years, unfortunately there is little research on the efficacy of this intervention. One preliminary study, using matched pairs of eight foster children who received lifebook work and eight others who did not, showed a statistically significant treatment effect on placement stability for the lifebook group. (The intervention involved 30 45-minute sessions with experienced therapists.) In addition, case studies presented on four children showed a marked decline in ratings of behavioral symptoms for all of them. The authors observed that lifebook work was particularly effective in breaking through children's defenses against thinking or talking about difficult experiences and in facilitating communication about them (Kliman & Zelman, 1996). 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).

<u>Video-Feedback Intervention to Promote Positive Parenting (VIPP)</u> involves home-based interventions with video feedback for adoptive parents of infants and young children, as well as training on accurate interpretation of the children's cues and sensitive responsiveness in parenting; it was developed by researchers at Leiden University in the Netherlands (Juffer, et al., 2008). The rationale for this treatment is based on the higher risk of disorganized attachment (which predicts higher externalizing behaviors) in children who experienced early adverse care, particularly those who were adopted after 1 year of age.[12] A randomized study of 130 Dutch adoptive families with 6-month-old infants – involving three home-based interventions with video feedback (VIPP) and a book with the treatment group of mothers – found that this approach lowered the rate of disorganized attachment from 22% in the no-treatment group to 6% in the treatment group (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2005). As a result of the work of these researchers, for the past 10 years the Netherlands has offered video feedback training to parents for each new adopted child (Juffer, 2010). A later randomized control trial using six sessions of VIPP-SD (VIPP plus instruction on Sensitive Discipline) with parents of 1-3 year olds with high levels of externalizing behaviors found the intervention was effective in reducing cortisol levels for some of these children[13] (Bakermans-Kranenburg, van IJzendoorn, Mesman, Alink, & Juffer, 2008). These findings indicate that some children are genetically predisposed to respond to attachment interventions more than others.

CURRENT MODELS OF POST-ADOPTION SERVICES

C hild welfare systems and private agencies vary considerably in the extent to which they have developed post-adoption programs that contain a broad array of services. Some service models are described below; this summary does not cover the array of all well-established or noteworthy post-adoption programs nationwide, but describes a range of types of services and programs.

Statewide Adoption Resource Centers and Adoption Preservation Programs

A number of child welfare agencies seek to provide some post-adoption programs throughout their states by contracting with private agencies to deliver a specific package of services. Some state-funded programs are open to any type of adoptive family, while others help only families adopting from foster care. They range from programs that primarily provide information, referral, and linkage (such as Oregon's) to others that offer a more comprehensive continuum of services. The Oregon Post-Adoption Resource Center (ORPARC) offers information and referral services (I&R) and some parent trainings across the state, a lending library and phone consultation. Support workers at ORPARC also provide limited advocacy to assist families in obtaining needed services, either on the phone or through attending meetings with families).

Most statewide programs have regional centers to serve specific geographic areas. For example, Wisconsin's PARC program has five regional offices, which offer I&R, a lending library, and some training events or parent conferences; Pennsylvania's Statewide Adoption and Permanency Network (SWAN) offers assessment, case advocacy, respite, and support groups to any type of adoptive

---

[12] A meta-analysis of studies on the rates of disorganized attachment in different groups of children reported it was 73% among institutionalized children, 31% among adopted children (based on 17 studies), and 15% in the general population (van den Dries, Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2009).

[13] Children with a specific genetic profile (having the dopamine receptor D4 (DRD4) gene) showed decreased daily cortisol production in response to therapy, but those without this allele did not show lower cortisol levels.

family throughout the state. There is a six-month timeframe for services. Georgia's Center for Resources and Support offers a similar array of services.

New Jersey was the first state to develop a statewide program in the mid-1980s. The state contracts with Children's Aid and Family Services to operate an adoption resource clearinghouse, NJARCH (2010), which provides phone and web-based services – a warmline, I&R, chat rooms, a lending library, and other educational opportunities. It also contracts with nine agencies to provide pre- and post-adoption counseling services (PACS). The pre-adoption counseling is provided to families of foster children referred by the NJ Division of Youth and Family Services, while the post-adoption counseling is provided free of charge to any type of adoptive family (Kathy Russo, personal communication, March 11, 2010).

Texas developed a statewide program in 1990 by contracting with private agencies to serve the 11 regions of the state. This program, which cost $3.7 million in 2009, serves only children who were in the custody of Texas at the time of their adoptions. The primary supports provided are counseling and case management. Other services include 24-hour crisis response, respite care, support groups, and assisting families in accessing residential treatment. The program contracts cover the first 60-90 days of residential care, after which the state would take custody of the child and pay for this care (Audrey Jackson, personal communication, March 16, 2010; Pat Sims, personal communication, March 12, 2010).

Massachusetts' statewide program delivers a range of services, including some I&R, training, support groups, and crisis or therapeutic interventions. The Adoption Journeys program in Massachusetts (formerly Adoption Crossroads) serves only families who have adopted through the state and has response teams in five regions that provide brief intervention to families (averaging about 4.5 office or home visits per family in one evaluation) as well as linkage with adoption-competent therapists (Hudson, et al., 2002). The program is administered by Child and Family Service of New Bedford, which also coordinates monthly parent support groups in each region as well as monthly social/recreational activities for adoptive families.

Alabama's Post-Adoption Connections (APAC, 2010; Kathy Hummel, personal communication, March 8, 2010) has centers in three regions of the state and offers a continuum of services including a warmline, resource library, parent trainings, and brief crisis counseling, as well as a statewide system of monthly support groups (18 around the state). Each of the regions has one or two professionals available to provide brief therapy at no cost to families, and these therapists also lead specialized therapeutic groups. These services are available to any type of adoptive family throughout the state. In addition, there is a summer camp that is open to up to 150 adopted youth and their siblings.

Adoption preservation programs encompass therapeutic and other services focused primarily on families who are struggling. The Illinois Adoption & Guardianship Preservation Program, initiated in 1991, was mandated in the state's family preservation statute to serve adoptive families with children at risk of dissolution or out-of-home placement. In reality, it serves any type of adoptive family experiencing significant difficulties, providing a range of services that include: intensive therapeutic counseling, support groups for parents and children, 24-hour crisis-call response, advocacy, limited cash assistance, and some respite services. This program has a 12-month service period, after which permission must be received from the state Department of Children and Family Services to extend the services for up to another year. The program is funded by DCFS through contracts with private agencies totaling over $6 million, and services are delivered at 18 sites throughout the state. In FY09, the program served over 1,200 adoptive families. Research findings based on evaluations of this program were described earlier in this report.

Virginia's Adoption Family Preservation Program (AFP) includes an array of services: crisis intervention, case management and advocacy, I&R, support groups, and parent training. The program serves any type of adoptive family (approximately 300 per year) through contracts with four private agencies at nine sites. The services are described as more of a case management approach than "therapy" (Rosemary Liberti, personal communication, March 5, 2010). It has been challenging to make services accessible throughout the state on a modest budget (approximately $1 million annually), since program demand continues to increase. The program employs both therapists and adoptive parent liaisons who provide support to families. An evaluation based on phone interviews with 460 families found that 63% included children adopted from foster care, and families sought assistance from AFP an average of six years after children were placed, typically when they entered adolescence. Families who received services for a longer time period were more likely to rate their progress as substantial, and the evaluators reported that the most significant changes described "were not in the children but in the capacity of parents to understand, love, and cope with their children" (Atkinson & Gonet, 2007, p. 98). Based on the evaluation, the authors concluded that the most helpful model includes an array of services that allows families to receive help at different times over a period of years.

Tennessee began a statewide Adoption Support and Preservation program (ASAP) in 2004 through a contract with Harmony Adoption Services, which subcontracts with two other private agencies to deliver services throughout the state, including in-home therapeutic counseling, monthly support groups, and educational opportunities for families. This program is funded at approximately $2.4 million and serves over 750 families annually. While families of children who were wards of the state are served at no charge, other types of adoptive families can get help for a sliding scale fee. Some of the families served are pre-adoptive (32%), and ASAP requires that therapists have a face-to-face visit with adoptive families in crisis (about 40%) within 48 hours of their initial phone call. Part of their approach involves helping the families develop a relief team to provide a natural support network for all family members, and stipends are available to assist families in obtaining respite. In addition, the program sponsors an annual Cycles of Healing Conference for adoptive families and clinicians (Michael Yates, personal communication, April 16, 2010).

County-Based Adoption Support and Preservation Programs

In county-administered child welfare states, some model programs receive funding to serve child welfare adoptive families in specific counties, but they do not exist for families around the state. UCLA's TIES program (Training, Intervention, Education, and Services) and the Kinship Center's Adoptive Family Therapeutic and Educational Resources (AFTER) program are such model programs. TIES provides a continuum of services – from pre-placement consultation to post-placement and post-adoption education, support, and therapy – for families adopting children with special needs from the Los Angeles foster care system. They specialize in assessing and treating children with prenatal drug exposure, but also address other types of special needs. This multi-disciplinary service is a collaboration between UCLA, the L.A. County D.C.F.S., and the L.A. Department of Mental Health. Families participating in services complete nine hours of training classes that review a range of medical, behavioral, and adoption issues. TIES's services include child and family therapy, ongoing monthly support groups for parents and children, an infant mental health program with home visiting, psychiatric services, pediatric and educational consultation, and others. The professionals incorporate several evidence-based practice models into their work, including weekly behavior-management groups for parents and children using the Incredible Years and trauma-focused cognitive behavioral treatment. Five-year longitudinal data shows decreases in parenting stress and increases in adoption satisfaction, as well as significant cognitive gains and lower internalizing behaviors for the children (Jill Waterman & Susan Edelstein, personal communication, March 25, 2010).

The Kinship Center's AFTER program offers supportive services to all types of adoptive families, including phone support by adoptive parents, educational opportunities, and support groups in collaboration with FAIR, an adoptive parent organization. It also offers a community-based wraparound program for child welfare adoptive/guardianship families placed by specific California counties. Since its start-up in 2001, the program has expanded to additional counties, and other agencies have replicated it to serve even more California counties. The strengths-based and family-driven wraparound services are for an 18-month period (some have a second round) and begin with a thorough assessment using an Adoptive Family Development Matrix that rates functioning across many domains. Services are funded by diverting the dollars that would otherwise be spent if the child were placed in a group home.

The wraparound services involve several types of helpers assisting the entire family to develop and work with a team in addressing the needs of the entire family. The team meets at least monthly, and sometimes several times a month, to work with the family in developing new resources and solutions. In addition to family members, the team includes community members who play an important role in the family, as well as the Kinship Center's staff (a Master's level social worker is the team facilitator, a family assistant works with the family on an ongoing basis in their home, and a parent partner, who is an experienced adoptive parent, serves as an advocate and support to the family). When a family is stuck in addressing behavioral issues, the program staffs the case with a Behavioral Assessment Team, including a psychologist and other wrap team members. Many of the families are involved with adoption-competent therapists who may come to the team meetings or consult with the facilitator by phone. (The Kinship Center has a 48-hour Adoption Clinical Training program for clinicians, who serve as referral resources for this program.)

Another model for post-adoption services delivered through the Kinship Center includes specialized mental health clinics for adoptive families of children with mental health issues who have been adopted or placed for adoption and children with relative caregivers. It is completely funded under Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/Medicaid and operates in three California counties – Orange, Monterey, and San Luis Obispo. Services are delivered through a multidisciplinary team (social workers, psychologists, psychiatrists, other mental health therapists, and occupational therapists) and include a wide range of treatment modalities, therapeutic camps and several interventions described earlier, such as Dyadic Developmental Psychotherapy, Theraplay and therapeutic parenting curricula (Ornelas, Silverstein, & Tan, 2007). The three clinics currently serve approximately 550 youth and work with the entire family unit for an average service period of 16.5 months (Laura Ornelas, personal communication, September 30, 2010).

Private Adoption Agency Post-Adoption Programs

Adoption agencies vary in the kinds of adoptions they facilitate, with some offering all three types (child welfare, domestic infant, and intercountry) and others focusing on one or two of these. They also vary greatly in the extent to which they offer post-adoption services. For many years, the term post-adoption services in infant adoptions denoted help with search and reunion. Inquiries related to other needs typically were handled informally by phone or through brief consultations. It is difficult to know the extent to which private adoption programs provide post-adoption services outside of those funded by state child welfare agencies. In 2006, CWLA conducted an internet survey of its private agency members to assess their provision of post-adoption services, receiving 95 responses from approximately 650 private agency members (Mack, 2006). The most common post-adoption services provided were support groups, crisis intervention, therapy, advocacy, and adoption search. Over one-third of the respondents contracted with state or county child welfare agencies to provide these services. Some agencies charged a sliding scale fee to families, but most supported post-adoption services independently.

Some larger adoption agencies today have substantial post-adoption programs, offering support groups, cultural heritage events, workshops, and either counseling or linkage with adoption-competent therapists. However, many other agencies offer few if any such services. Some large agencies that provide varied models of post-adoption programs include Spence-Chapin in New York (founded in 1908), Children's Home Society & Family Services of St. Paul (1889), The Cradle in Evanston, Illinois (1923), and Adoptions Together in the D.C. area (1993). Exploring these agencies' websites yields a wealth of creative services for adoptive families.

All of these agencies provide a wide array of educational opportunities for adoptive parents, including in-person classes and webinars. For example, Children's Home Society & Family Services offers classes on such subjects as adoption camps and identity, sibling group adoption, strategies for promoting self-regulation in traumatized children, and what adopted adults want their parents to know. This agency also offers a post-adoption helpline and is affiliated with the Resource Committee of Adopted Adults (RCAA), which is the first national group of adult adopted persons from various adoptee communities. The Cradle offers regular workshops on many specialized topics and its affiliate, Adoption Learning Partners, offers an array of online training courses described below under Education & Training. Most of the educational programs charge modest fees (such as $20-25 for a workshop or webinar).

These agencies also offer adoption-competent counseling programs. Adoptions Together has a Center for Adoptive Families that provides traditional counseling, as well as parent coaching, therapeutic groups for children, mediation related to open adoption relationships, and other services. Counseling fees in most agencies are approximately $100+/hour, although some may provide brief phone assistance or consultation and services to birthparents at no cost. Spence-Chapin charges a sliding scale fee for counseling and heavily utilizes Theraplay and Hughes' Developmental Dyadic Psychotherapy in its services (Rita Taddonio, personal communication, March 19, 2010).

Private Post-Adoption Agencies

There are two unique organizations that have provided leadership and innovative programming for post-adoption services. These agencies do not facilitate adoptions but, rather, specialize in providing services to members of the triad and their families. They both have developed myriad therapeutic strategies and resources that are widely disseminated around the country. Center for Family Connections (CFFC) in Cambridge, Massachusetts, founded in 1982 by Joyce Maguire Pavao, offers pre- and post-adoption consulting, counseling, and a range of other therapies including groups, clinical mediation, and an Adoption Wellness Institute. CFFC offers monthly trainings, intensive summer training institutes and biennial international conferences on post-adoption services, and collaborates with Hunter College in running a post-graduate certificate program in adoption therapy. The Center for Adoption Support and Education (CASE), founded in 1998 by Debbie Riley, provides pre- and post-adoption mental health services, specialized groups for children and teens, educational advocacy, and training for families, educators, and professionals in Maryland, Northern Virginia, and D.C., as well as offering training and other resources for the development of post-adoption services nationally. Currently, CASE is piloting a national Adoption Competency Certificate Training Program for Mental Health Professionals with the University of Maryland's School of Social Work.

Education and Training

Many adoptive families educate themselves about adoption issues by seeking out information in books, magazines, websites and blogs, and/or by participating in organizations or parent groups. In addition, many public and private agencies offer training and other educational opportunities for adoptive parents, including utilizing existing training offered to foster parents. For example, ORPARC's website lists a range of workshops around the state on a variety of subjects, such as

advocating for your child in the schools or understanding specific types of disorders. Most states with post-adoption resource centers have lending libraries containing books, videos, and other materials.

Some states contract with foster and adoptive parent associations to provide educational opportunities to families. For example, Connecticut's Association of Foster and Adoptive Parents (2010) offers a range of training opportunities based predominantly on the post-PRIDE curriculum on topics such as promoting healthy racial identity, dealing with oppositional defiant children, sibling relationships, and many others.

There also are web-based training opportunities, including webinars and online courses, such as those offered by Adoption Learning Partners. ALP offers over 15 interactive courses for all types of adoptive families, including a "Hague package" of five courses that meet the training requirements for families adopting internationally, as well as many other courses on topics such as lifebooks, attachment, adopting an older child, talking with children about adoption, and transracial adoption.

Many publicly funded post-adoption programs offer behavioral management or therapeutic parenting classes, and some specific therapeutic models contain parent training groups. Many different curricula and training models are used in these classes, including *Becoming a Love and Logic Parent* (Fay, Fay, & Cline, 2010; identified by four programs), *Positive Parenting* (three-course series at Foster Parent College, 2010), and *The Incredible Years* (2008) at UCLA TIES.

Parent and Adoptee Support Models

Support resources for parents and adopted individuals in the well-established private adoption agencies described earlier include many types of services. Adoptions Together offers many parents' and children's groups, including a Saturday program for school-age children that also provides respite for parents, a teen adoptee group, and a super-parenting group for parents of children with special needs. The support systems provided by The Cradle have evolved to incorporate social networking and web-based forms of communication through an online adoption community forum. Children's Home Society offers a day camp program for any adopted child and, like several other agencies, provides birthland travel opportunities for internationally adopted children and their families. Spence-Chapin has programs for adopted teens that include forums on adoption-related topics and a group mentorship program facilitating monthly interactions between 15 adopted teens and adult adoptee facilitators. Other unique offerings at Spence-Chapin include playshops for children and their parents to explore adoption through tools such as lifebooks and mask-making and a playshop for children up to age 5 to facilitate child assessment by developmental specialists.

The most common types of services offered through child welfare systems are support groups or mentoring programs for parents, typically funded through contracts with parent organizations, private agencies, or individual therapists. For example, Iowa contracts with the Iowa Foster and Adoptive Parents Association to provide peer support and I&R to foster and adoptive families. There are 18 peer liaison positions, with some held by couples, and each position is contracted to work from home for 15-20 hours per week serving a specific geographic area; there are training positions in addition to the peer liaisons (NACAC, 2009). Adoption Journeys in Massachusetts has parent liaisons and young adult adoptee liaisons who have been trained to provide support to adoptive families.

Two other examples of model support programs are Minnesota's ASAP Parent Support Network and Adoption Support for Kentucky (ASK). In collaboration with NACAC, Minnesota provides a statewide program that includes a large network of support groups and a mentoring program with 11 parent liaisons who assist parents in crisis. NACAC provides assistance and coordination to this program (NACAC, 2009). ASK in Kentucky was modeled after Minnesota's support program and employs 16 regional adoptive parent liaisons who work 50 hours monthly providing two support group meetings and two trainings each month, as well as informal support to both foster and adoptive families. An

evaluation of this program found that most parents attended to receive emotional support and information, were highly satisfied with the program, and some credited it for stabilizing their families (Bryan, Flaherty, & Saunders, 2010).

Services for adopted youth include support groups, mentoring programs, and adoption camps that provide opportunities to interact with other adopted youth as well as activities related to adoption themes. Among publicly supported post-adoption services, there are far fewer programs for adopted youth than for parents. Some state resource centers facilitate support groups for children simultaneously with ones for parents. A few states offer weekends and camp opportunities for adopted youth; for example, Alabama sponsors a summer camp for 150 adopted children and their siblings. Georgia offers a program called Adopted Teen Empowerment and Mentoring (ATEAM) that meets monthly on Saturdays for seven hours in each of the 12 regions of the state, and also offers two weekend retreats each year (capacity=360 youth). A unique program sponsored by the Minnesota Adoption Resource Network and funded by the state's Department of Human Services was launched this spring – an organization run by and for adopted persons called Adoptees Have Answers (AHA). This program provides a variety of opportunities for adopted individuals to connect with each other, including a virtual community of discussion boards and networking opportunities, a 12-part webinar series featuring adoptee presenters, support groups, and other events/activities.

There also are supportive services designed for families with various types of adoptions, such as open adoptions or transracial adoptions.

Supportive Services for Transracial Adoptive Families
A number of private adoption agencies offer post-adoption services for transracially adopted children and their parents. Some utilize transracially adopted young adults to help staff these programs and to serve as mentors for their younger counterparts. For example, Lutheran Social Services of New England offers several support groups organized around teens completing an educational project to teach others about adoption. One group made a series of DVDs and presentations in schools, addressing questions that fellow students often ask them about adoption. Another group for transracially adopted girls worked with young adult adoptees to develop a show for a local public access television channel to educate others on issues involved in transracial adoption (Lynn Gabbard, personal communication, September 22, 2010).

An agency specializing in serving adopted children of color (adopted both transracially and in-race) is Pact, an Adoption Alliance, headquartered in Oakland, California. Pact offers a wide range of programming, including training on transracial adoptive parenting, a monthly teen club, family camps, conferences, and other educational and supportive services.

Camps are a common service for transracially and transculturally adopted youth; they often include educational activities related to specific cultures, as well as therapeutic activities related to adoption and support from peers. One program that sponsors summer camps in five states across the country is operated by Holt International Children's Services, an agency that has operated internationally for over 50 years. Holt, like some other agencies, also sponsors heritage tours, on which adoptees of various ages visit their home countries, often with their adoptive families.

Services to Support Contact between Birth and Adoptive Families
For decades, agencies and other organizations have provided a range of post-adoption services to assist both birth and adoptive family members in searching and reuniting with each other, as well as to provide them with other identifying and non-identifying information; these are described more fully in "For the Records II," a publication by the Adoption Institute (Howard, Smith, & Deoudes, 2010). With the increase in ongoing contact between birth and adoptive family members that has occurred in recent decades, a growing number of programs have been offering services to help families develop and maintain successful open adoption relationships. Many agencies' infant adoption

programs offer families in open adoptions the opportunity to return for counseling or mediation if needed, and a smaller number offer ongoing supports.

For over 20 years, the Kinship Center, for example, has operated an open adoption support group that brings together birth and adoptive family members. The group meets one evening a month and typically has 30-50 attendees. The current leader, Melissa Dodson (personal communication, September 23, 2010), reported that it is common for adoptive parents and birthparents to attend together in the early stages of an adoption, and families enter and leave the group as challenges arise and relationships evolve.

The Independent Adoption Center, an agency that operates infant adoption programs in five states, offers in-person and online support groups, separately for adoptive parents and birthparents. The online groups are particularly popular due to their easy accessibility and the ready availability of peer support. While professionals may post responses on the online groups, members do a lot of sharing and supporting of each other (Kathleen Silber, personal communication, September 28, 2010).

Additional services to support open adoptions will be described in a publication on openness in infant adoptions that the Adoption Institute will publish in the coming year.

Respite Program Models

Respite often has been identified as a service that is highly effective but difficult to obtain; yet, when respite programs are offered, families are sometimes reluctant to use them, often because they worry that others cannot adequately care for or manage their children (Festinger, 2006; U.S. Children's Bureau, 2007; Child Welfare Information Gateway, 2002). Services need to be matched to families' needs and should address issues such as the parents' comfort with and confidence in the provider's ability to handle their children. In some states, respite is included as part of the adoption assistance agreement, although often this is tied to an assessment of clear need, such as having a medically fragile child. Also, some of the statewide post-adoption programs include respite as a core service; however, it may be very limited, such as paying for one week of camp.

There are many types of respite, including in- or out-of-home care, short- and long-term stays, camps for children and families, and therapeutic programs. Two states providing statewide respite opportunities for sizeable numbers of adoptive families are Arizona and Oklahoma. Arizona's approach is unique in that it was established as a benefit in state law – i.e., each child receiving adoption assistance is allotted up to 288 hours, or 12 days, of respite per year. The rationale for supporting this entitlement was that it would prevent out-of-home placements and adoption instability, thus saving the state money. When the legislation was passed in the early 90s, the state monitored its impact, and none of the families receiving respite had children placed outside their homes during the project period, so the funding was continued (Howard & Smith, 1997). The first 100 hours of respite are fairly easy to obtain; however additional hours require greater justification that the service cannot be obtained from another source. Some parents hire their own respite providers and are reimbursed, while other families receive care from trained caregivers through Aid to Adoption of Special Kids (Shelly Davidson, personal communication, March 10, 2010).

Oklahoma's Respite Resource Network (ORRN), funded in FY08 at $2.2 million from nine major funding sources, provides respite to 20,000 families throughout the state; these include adoptive families and others who have been identified as needing such help. Adoptive families must apply to ORRN and meet specified criteria to be issued a voucher for respite. They can apply for a $200-$400 voucher every three months until the budget is depleted. Usually families receive three vouchers a year, and they employ and train their own providers (NACAC, 2008b).

There also are a host of other creative respite programs, including camps and other recreational opportunities for adopted children, cooperative respite groups of adoptive parents, mentoring experiences for children on a regular basis, and others. The U.S. Children's Bureau through AdoptUsKids, provides 33 small ($5,000) grants each year to start new respite programs. As a condition of the grants, parent groups or associations must have public agency partners, and they must include an initial assessment of parents' needs. AdoptUsKids also provides training to assist with planning and start-up.

Advocacy

Advocacy is an essential component of the service continuum, particularly for families in need of costly and difficult-to-obtain resources. Intensive assistance and guidance may be needed to negotiate the maze of procedures and bureaucracies required to obtain such services. The type of response needed for many families with intense needs goes beyond what is typically provided by an office-based private therapist. For example, in NACAC's (2002) parent survey on mental health services, one respondent reported frustration that her child's therapist refused to come to a meeting at the school. Families need professionals who are willing to go with them to an I.E.P. meeting at school, to send a letter justifying a needed service, or to be available beyond weekly counseling sessions to provide support during crises. Few states have programs specifically designed for advocacy, but many of them specify advocacy as a component of case management or therapeutic intervention programs, and sometimes for I&R or support programs.

One area in which advocacy is especially needed is in the educational system, such as for getting a child into the appropriate academic placement or facilitating the school's supportive treatment of a child. A unique educational advocacy program for foster and child welfare adoptive parents in Illinois is provided through a partnership with Northern Illinois University, the Educational Access Project. This initiative assists over 3,000 foster or adoptive parents annually on a range of educational issues, and also provides trainings on educational advocacy, special education, and other topics. In each region of the state, this program provides access to an educational advisor, an educational assistant, and a volunteer educational liaison to help families work with schools to meet their children's needs.

Looking to the Future

Many public and private child welfare agencies clearly are working to address some of the needs of families after adoption, but much more remains to be done if families are to receive a full continuum of the supports they need. Along with the services described above, other necessary components of the continuum include mediation, information and search resources, and effective residential treatment. In addition, the multi-disciplinary knowledge base that informs post-adoption services needs to be further developed in order to determine what types of services are most effective, particularly for meeting the therapeutic needs of families who are really struggling.

BARRIERS TO RECEIVING NEEDED SERVICES

Limited Adoption Competence among Mental Health and Other Professionals

Adopted children and their families are involved with a range of service systems and professionals, all of whom need sensitivity and basic understanding of adoption issues; that is especially the case for those who are involved in addressing children's developmental issues, such as pediatricians, teachers, school psychologists, and counselors. It is these front-line professionals who first assess the children, determine whether additional services are required, and engage parents in searching for the appropriate solutions. Efforts to educate school personnel about adoption issues have begun but, to date, they are fairly isolated and informal.

Since the 1980s there has been greater recognition among medical professionals of the need for specialized knowledge related to adoption and foster care, resulting in the American Academy of Pediatrics providing an opportunity for members and affiliates to join the Section on Adoption and Foster Care. Only about 100 physicians are currently listed as members of the adoption section across the U.S., but there are many states with no members on the list (American Academy of Pediatrics, 2010). It is clear that much broader educational efforts are needed to reach the large numbers of pediatricians serving adopted children.

A primary barrier to receiving effective post-adoption services is the scarcity of mental health professionals who understand adoption issues and the experiences of adoptive families. Numerous adoptive parent surveys have documented their difficulty in finding mental health professionals who are knowledgeable about adoption or the range of issues affecting adopted children who experienced deprivation and maltreatment (Nelson, 1985; Massachusetts Department of Mental Health, 1994; Festinger, 2006).

In addition, surveys of counseling professionals further document their lack of adoption competence. For example, about two-thirds of respondents in a national survey of licensed psychologists reported having no graduate coursework that dealt with adoption issues; fewer than one-third rated themselves as very well prepared or well prepared to treat adoption issues, and 90% believed psychologists need more education regarding adoption (Sass & Henderson, 2000). Another survey, of clinical psychology professors, reported that the average time they spent teaching about adoption at the graduate level was eight minutes per semester, as compared to almost three to 10 times that amount on subjects that impact far fewer people, such as autism, which effects .05% of all children (Post, 2000; Henderson, 2002). Another study interviewed family therapists and had them assess a simulated case study of an adoptive family that explicitly involved adoption issues; it found that only 16% of the respondents focused aspects of their interventions on adoption-related issues (McDaniel & Jennings, 1997).

One critical perspective that is essential for mental health professionals who work with adoptive families whose children come from early adverse situations is an understanding of the impact of maltreatment and interrupted attachments on children, as well as the adaptations that children make to these experiences and bring to their adoptive families. This knowledge base dictates a paradigm shift from the traditional approach of mental health professionals, in which a child's problems are thought to have evolved largely from the family system. In the paradigm that is needed to help many adoptive families, the child – as a result of damaging experiences – brings problems to the family system that add significant stresses to even the most functional family (Howe & Fearnley, 2003; Delaney & Kunstal, 1993). Without this understanding, therapists often respond in ways that lead to adoptive parents feeling blamed for their children's difficulties.

The negative experiences of some adoptive families in seeking help underscore the reality that therapists lacking adoption competence can do more harm than good in some of their work. Some of the "unhelpful" help that has been reported by adoptive parents includes (Linville & Lyness, 2007; Smith & Howard, 1999; NACAC, 2002):

- failing to validate or believe their experiences

- conveying blame to parents for their children's problems

- pathologizing adoption and viewing the family as pathological

- questioning the parents' motives for adoption

- advising parents not to talk about adoption with the child because it will "stir things up"

- seeing children with attachment problems without parental presence or input

- telling parents to just give their child back to the state

- failing to gather information about the child's history or to address the impact of previous maltreatment on the child

It is difficult to find a therapist with basic adoption competency, and harder still to find one with advanced knowledge of intervention models that are most likely to be effective with high-end cases. For example, the director of an agency's post-adoption program in New York City reported that there are therapists everywhere in New York, but it is almost impossible to find one who has training in attachment-based therapies (Rita Taddonio, personal communication, March 19, 2010).
Many families seek help again and again without significant improvement (Smith & Howard, 1999); an early Massachusetts study found that some families had sought help from up to 10 different practitioners before locating one who understood their circumstances (Frey, 1986). A recent study of adoptive families seeking mental health treatment for their children found that over 80% had previously received treatment, with an average of 3.2 prior treatment episodes (Becker-Weidman & Hughes, 2008). The failure to find genuinely helpful assistance can lead some families to grow desperate and to grasp at alternative treatments on the fringes of acceptable mental health practice.

Some states have funded adoption-focused education for mental health professionals, which have included both brief trainings to sensitize therapists to relevant issues and more comprehensive courses over a period of many months. There are currently at least 10 adoption-related certification programs for therapists, offered primarily through universities,[14] with a few delivered through private agencies (the Education Institute at the Kinship Center, Hillside Family of Agencies, New York, and Center for Adoption Support and Education). The Kinship Center's adoption competency training curriculum was the first to be developed (1993) and has been delivered to over 7,000 professionals in at least six states, including staff members in some residential treatment centers (Carol Bishop, personal communication, September 15, 2010); however, most of these programs train a single class of professionals each year. The 64-hour course currently developed by CASE, with the assistance of a national advisory board, was piloted at the University of Maryland and involves clinical consultation after course completion. It is the only program with a manualized protocol and rigorous evaluation, and it is being replicated in four sites in 2011.

Inadequacies in Knowledge about a Range of Problems and Interventions

The range of conditions contributing to developmental challenges in adopted children is very broad, and often there is sparse, if any, information available on their genetic histories and prenatal or early-life experiences. While research has made progress in the past few decades in uncovering the impact of various risk factors on child development, there is still a lot more to learn on this front. When trying to assess individual children, it is very hard to unravel the specific nature and causes of problems, since the child may have experienced multiple known risk factors as well as suspected or unknown ones. For example, a single child may have experienced prenatal alcohol exposure, early malnutrition and sensory deprivation, lead poisoning, and brain deficits from inappropriately prescribed psychotropic medications. Thus, diagnosing the causes of a child's and family's problems can be extremely complex.

Also, knowledge about how to help children who have experienced a range of adverse early life experiences is still in the early stages of development. Over the past 25 years, experts have investigated the impact of trauma on children's social, emotional, neurological, physical, and sensory development; they use the term "complex trauma" to describe the experience of multiple or chronic traumatic events occurring in a child's early care (Cook, Blaustein, Spinazzola, & van der Kolk, 2003;

---

[14] Rutgers University, Hunter College and City University of New York (not refunded in 2010), Portland State University, Louisiana State University, Southern Connecticut State University and University of Connecticut, University of Maryland, and University of Denver.

Cook, et al, 2005). Much more is known about the impact of complex trauma than about how to effectively treat children who have had such experiences. Furthermore, we are just beginning to understand some aspects of trauma impact and treatment, such as the biochemical neuroendocrine imbalances common to many victims. Some children experience multiple types of adverse experiences, such as prenatal substance exposure, severe neglect and abuse, and multiple moves in care, so one specific type of treatment may only partially address their problems. A few empirically based treatment models have been developed that are applicable to post-adoption services; they were discussed earlier in this paper. However, many of these interventions are not widely used by mental health professionals, nor do they typically address the full range of issues being confronted. Much more research is needed on the efficacy of relevant treatment models with adoptive families.

Post-adoption services have developed primarily without an integrated theoretical base, and most therapeutic programs rely on the eclectic body of general counseling and family therapy techniques that practitioners have gleaned from their own training. In assessing the area of post-adoption services – as commissioned by the U.S. Department of Health and Human Services – Barth and colleagues (2001) concluded that there was a lack of systematic evaluation of such services. They could find only five evaluations of post-adoption programs, most of which had served 50 or fewer families, and they reported a critical need for more rigorous clinical research in this field.

Failure to Access Interventions That Are Most Likely to Be Effective

Identifying children's challenges and getting to the right kind of help in a timely way is extremely difficult for adoptive families whose children have complex special needs. For example, two experts in intercountry adoption noted that adoptive parents typically go to their local pediatrician and are told not to worry about children's delays – because their nurture will help these improve in time. When some of these foreign-born children start school, their parents are told they should not be evaluated until they are proficient in English, even when they were adopted several years earlier. Most pediatricians and school psychologists have not been trained to understand post-institutionalized children, so early identification of foundational "holes" in their development may not take place (Gunnar & Pollak, 2007). Often, developmental delays or disabilities are not accurately diagnosed until the end of third grade or later and so, unfortunately, the period when remediation could have been most helpful has often passed for these children. Expert assessments and interventions need to occur at very young ages in order to maximize children's development to their fullest potential.

A recent follow-up study assessing school readiness for a group of 37 children adopted internationally before age 2 (mean age=12 months) showed that at age 4-5, these children had made surprising gains in some areas of development, particularly those related to expressive and receptive language – where they scored well above the norm – but many of them scored in the problem range in other areas of development, such as oppositional traits, inattention, hyperactivity, and atypical sensory-seeking behaviors.[15] The authors observed that specific parent training and provision of sensory-focused occupational therapy for those children with developmental deficits would likely reduce later school performance problems, preserve children's self-esteem, and reduce family stress (Jacobs, Miller, & Tirella, 2010). Another longitudinal study of intercountry adoptees found that children who received professional help after adoption had improved significantly more (decreased behavior problems) than those who did not (Rijk, Hoksbergen, & ter Laak, 2010); yet many adoptees and their families do not find their way to such services in a timely way, if at all.

---

[15] This study was based at an international adoption clinic where children had received a sophisticated battery of medical and developmental assessments very soon after arrival, and whose parents were oriented toward seeking expert help. This follow-up study also excluded children with formal diagnoses of a broad range of developmental disorders, so developmental scores on a more inclusive group of internationally adopted children would most likely have been lower.

It is important to point out that the post-placement supervision period, during which adoption professionals "check in" with families, is brief (usually 6-12 months). Many of the children are infants or preschoolers at this stage, so the challenges that may later emerge are often not yet apparent. Parents therefore need to be educated early on about the issues that may arise for their children, as well as about effective resources for assistance. Often adoptive parents feel that seeking help is a sign of weakness or failure on their parts, and they may be particularly reluctant to acknowledge problems if they want to adopt additional children from the agency. Preparing them to reframe help-seeking as a strength in meeting the needs of their children could encourage more of them to reach out sooner, rather than waiting until problems have become pronounced or even entrenched.

Inadequate Funding and Accessibility of Services

As described above, an ideal system of post-adoption programs is composed of a range of services, from education and support to therapeutic counseling and preservation of families in crisis. Some states have developed some of the elements along this continuum, but hardly any make a full range of services available to all the families who need them.

Since there is no dedicated federal funding stream for post-adoption services, states struggle to pay for them, and those that are developed become easy targets for budget cuts during economic downturns. For example, all funding of Michigan's regional post-adoption support services centers (PASS) was eliminated in 2008. Also adoption subsidies, which are funded through a combination of federal, state, and sometimes county dollars, have become vulnerable to state budget cuts. Several states, including Ohio, Arizona, Iowa, and Indiana, have recently reduced their adoption subsidies. (Indiana currently is under an injunction to reinstate full subsidies pending the outcome of an ACLU suit). In Oregon, a successful class action lawsuit required the state to pay back $1.7 million to adoptive families whose subsidies were reduced in 2003 (McCowan, 2008). Still other states have frozen scheduled subsidy increases that were supposed to come as children reached older ages or are considering other means to reduce both foster care and adoption subsidies (Josh Kroll, personal communication, March 5, 1010).

Many operating post-adoption programs have been unable to increase funding to meet the growing demands for services. For example, Tennessee's program reported a 50% increase in referred families over the past year, while its budget was cut, and many others have been funded at the same level for many years despite increases in the number of families served.[16] ORPARC in Oregon (which has a staff of four to serve adoptive families across the state) is among the programs to have reported recent funding reductions. An adoption expert who works with a foundation-funded initiative at NACAC, which partners with U.S. states and Canadian provinces in developing post-adoption services, reported hearing from professionals in several states that they did not want to advertise their services because the demand would far outstrip their capacity (Kim Stevens, personal communication, January 29, 2010).

For child welfare adoptive families, a primary resource for payment of basic services such as counseling or respite is through adoption subsidy agreements. In a recent survey of families' service needs in Illinois, the most common reason given for being unable to obtain a needed service was that a provision for it was not made in the subsidy agreement. Other frequently reported barriers included lack of information about post-adoption services, difficulties with Medicaid service coverage, and unavailable, unresponsive, or misinformed post-adoption workers (Fuller, et al., 2006). Many children's needs emerge over time and may be impossible to foresee at the time adoptions are finalized and subsidy agreements written. Often it may require mountains of red tape and advocacy to obtain a service that can be purchased, but was not included in the original subsidy agreement.

---

[16] As noted by program administrators or evaluators in Massachusetts, Tennessee, Texas, and Virginia.

Another funding issue is that for many complex needs, the financing for programs drives the services that can be provided and limits access to them. For example, the AFTER (Adoptive Family Therapeutic & Educational Resources) post-adoption program operated by the Kinship Center in several California counties provides intensive wraparound services for child welfare adoptive families of children at imminent risk of out-of-home placement. While any adoptive family may receive information and referral services and access to support groups, the more extensive therapeutic services supported through adoption assistance funds are available only to children placed by these counties who are at risk of placement. This program's administrator reported that so much more could be done with referred families if they were eligible for the program at an earlier stage, before problems became so severe (Graham Wright, personal communication, November 20, 2009).

Some state-supported services are available only to families adopting from foster care and not to other types of adoptive families. Costly services such as residential treatment may be covered for a child adopted from foster care (in some states, though not all) but not for an internationally adopted child. Even for those adopted from foster care, the state may require that the child become a ward of the state, an extremely detrimental occurrence for many adoptive families. Being forced to relinquish custody to child welfare agencies in order to obtain necessary mental health services has been reported as a problem in at least half the states (NACAC, 2007).

The Adoption Institute regularly receives e-mails from adoptive parents who have struggled for years to obtain costly mental health services. Some have mortgaged their homes and run out of financial resources to pay for care. After losing appeals to insurance companies and school boards, they are faced with having to place their children in foster care to receive needed services – a move that they see as adversely affecting their children's mental health as well as their other adopted children and the rest of their families. One adoptive father wrote recently:

> *We were forced into relinquishing our adoptive son back to the state … because he came to us with a severe case of PTSD. It has been a traumatizing experience for him and us. The federal government pours millions into states for the purpose of increasing adoptions, but they won't offer any money to preserve adoptions for mentally and emotionally ill children. The states insist they become a ward so that they can get more money from federal [government]…when our son became too unsafe to remain home, our only option was to let them take him back. They traded his permanency for federal funding. We traded custody rights for mental healthcare… We are living a nightmare. Is there anything your organization can do to help abolish custody relinquishment for the sake of mental healthcare?*

Some Problems Cannot Be Remediated and Require Ongoing Support

In some adoptive families, children's special needs are not conditions that can be "cured," and they will need ongoing support for a long time. Some have developmental disabilities, such as fetal alcohol syndrome or severe physical impairments, and their parents need to be able to access services as their situations change and as they need assistance in coping.

Some families whose children have severe emotional and behavioral problems may have sought help repeatedly for their children. Their desperation can sometimes lead to their turning to nontraditional approaches that may not be sound. They need state-of-the-art, comprehensive, specialized services that help them to understand their children's needs and to find the most effective strategies for creating a supportive environment for healing. For example, a parent served through an adoption preservation program in Illinois described this kind of help:

> *I had gone everywhere I could think of for help. No one had proper help for us until the adoption support services. Our whole family had become dysfunctional. Our marriage was coming apart. We did not know how to cope with our daughter. No one had ever told us about*

> *any of what she was going through. We had this fantasy that adoption was the same as forming a family biologically. We were not prepared to help our children, especially our daughter, with the grieving process, the guilt, the anger. We have all grown to understand adoption and ourselves better. We've learned it's OK that we can't always take away our children's pain – but we can help them cope with it. We have become more open with our inner thoughts. We've learned to share as a family – to be supportive. It saved our family from totally splitting up (Smith, 2006, p. 160).*

It is hard for even the best-trained professionals to predict the extent to which severe behavioral and emotional problems can be remediated. Some may result from genetically based mental illness that develops over the course of childhood and will be a chronic issue into adulthood. Other reactions to trauma and attachment issues may result in extreme behaviors that eventually respond to a healing environment and, with maturity, the youth or young adult is able to stabilize and flourish. There are many examples of such successes among young people who survived horrendous early lives and, through the support of parents and others, were able to heal and become very productive adults. One of the most amazing of these is Beth Thomas (2008) who at age 6 was featured in an HBO Documentary, *Child of Rage.* Beth appeared to be the poster child for reactive attachment disorder – having been severely abused and neglected as an infant and placed for adoption before age 2. Her adoption dissolved due to her severe, rage-filled behaviors, which included making homicidal threats, killing animals, and abusing her younger brother. After a second adoption by the Thomas family and then receiving treatment, Beth was able to heal and is now a pediatric nurse and adoption trainer.

Other Issues Related to the Development of Post-Adoption Services

Controversy Surrounding 'Attachment Therapy'
Knowledge related to child attachment has an extensive research base, and maladaptive attachment patterns have been shown to interfere with children's ability to develop secure attachments; they also can interfere with other key developmental capacities, including self-regulation. Attachment therapy is a diverse field that includes a range of treatments, some of which have begun to build an empirical base. However, beginning in the late 1980s, an approach to treating reactive attachment disorder was developed that utilized forced holding and coercive techniques to induce rage in children, with the goal of getting them to vent and break down their resistance to accepting adult control and nurturance. Some related approaches – including "rebirthing" therapy, "compression holding" therapy, and parenting advice involving forced excessive intake of fluids – have resulted in several children's deaths. These controversial coercive attachment therapies have been repudiated by professional associations such as the American Psychological Association and a task force of the American Professional Society on the Abuse of Children (Chaffin, et al., 2006), as well as the organization ATTACH (2007), whose members are predominately attachment therapists. Some in the mental health and child welfare fields, as well as in the general public, are critical of virtually all attachment therapy – associating the term with the specific, coercive techniques that have been rejected by the vast majority of professionals as unsafe and unethical. Differentiation of responsible attachment therapies from the ones that have raised legitimate concerns is important in order for this field to move forward and for parents to be able to find sound treatment for children with severe attachment problems.

Addressing Physiological Effects in Deprived and Traumatized Children
As discussed earlier, experiences of prolonged, severe, or unpredictable stress resulting from early deprivation, neglect, and maltreatment can alter children's neuroendocrine stress system and brain development. Certain regions of the brain involved in anxiety and fear responses become overdeveloped, while other higher structures in the brain needed for self-regulation and learning remain underdeveloped, with consequences for physical, cognitive, and socio-emotional development. For example, children may be unable to control their emotions and may have frequent outbursts or learning and attention difficulties. Research is only now revealing the extent to which

these effects can be altered, and has generally established that the earlier these children can be placed in positive environments and receive interventions, the greater their chances of recovery (Mehta, et al., 2009; Rutter, 2005).

Discovering how to best treat the neurological and chemical impact of early maltreatment is the new frontier of adoption treatment and research. Purvis and Cross at Texas Christian University have conducted research in this area and emphasize creating an environment of "felt safety" for the child. Their study of adopted children involved in a five-week therapeutic day camp program documented a reduction in cortisol levels over the course of the camp, although these were not sustained after the camp ended (Purvis & Cross, 2006). Their book, *The Connected Child*, offers many strategies for promoting "felt safety" in children and normalizing brain chemistry (Purvis, et al., 2007). Other researchers have studied the effects of brief attachment-based interventions with parents of infants and toddlers both in foster care and adoption, finding some reduction in cortisol levels for children in the treatment group (Dozier, et al., 2008; Bakermans-Kranenburg, et al., 2008). As mentioned previously the latter Dutch study found positive improvements for children with a specific genetic profile, but not for others.

Transition to Adulthood
Adopted children with special needs may have difficulty in transitioning to adulthood, and their families may have intensified needs for support at an age when financial assistance and other supports from the child welfare system may be ending. This is an area of need that has received little attention in the adoption field, although assisting youth with transitioning from foster care is a current focus nationally.

Should State-Supported Services Be Open to All Types of Adoptive Families?
In their 2002 review of the field of post-adoption services, which was commissioned by the federal government, Gibbs, Siebenaler, and Barth reported:

> At the December 2000 National Conference on Post Adoption Services, there were repeated affirmations of the concept that post-adoption services should be universally available to all adopted children regardless of any past involvement with the U.S. foster care system. Article 9 of the recently ratified Hague Convention on International Adoption requires participating countries to 'promote the development of adoption counseling and post-adoption services in their States.'... New Child Welfare League of America standards will include provision of post-adoption services among its criteria for accreditation of private adoption agencies (including those providing international adoptions).

Recent news events have made only too clear the need for specialized post-adoption services for some families adopting internationally. In recent months, stories of two Tennessee families have made national news – the single mother who "returned" her son to Russia, and the pediatrician indicted for abuse and murder of her adopted daughter. (Similarly distressing situations have occurred in other states over the past decade.) In Tennessee, a model post-adoption program is operated statewide by Harmony Adoption Services, and although it was created and is free of charge for families adopting from foster care, other types of adoptive families may access the program for a sliding scale fee. It is likely that few Tennessee families adopting privately or internationally know these services are available, however.

While some state-supported post-adoption programs do indeed serve any type of adoptive family – for example, in Illinois, Pennsylvania, New Jersey, Virginia, Wisconsin, and Alabama – most are available only to those adopting children from that state's foster care system. It is important to point out that, when problems rise to a very severe level, other types of adopted children enter foster care; it seems apparent that in such cases, earlier intervention to stabilize these families would be the more humane and cost-effective solution.

An Ounce of Prevention

As recognized earlier in this paper, only a small percentage of adoptive families encounter situations that are severe enough to threaten the adoption's stability; however, for these families and others with significant difficulties, timely intervention to prevent the compounding of problems is very important. Studies of adoptive families seeking help indicate that the child has been in their home for six to eight years, on average, before they are referred for assistance. (Smith, 2006; Atkinson & Gonet, 2007). Finding ways of reaching them sooner is vitally important to achieving positive outcomes for many of these families.

Many supportive services for adoptive families build parental strengths that can promote resilience in their adopted children. These interventions seek to enhance the protective factors identified in this report, such as communicative openness or maternal responsiveness to promote secure attachments. Examples of these are the brief attachment intervention in the Netherlands described earlier and a program in Michigan, Inquisitive Minds, which seeks to create communicative openness in parents' communication about adoption with their preschool children (Freeark & Rosenblum, 2010). Also, the U.S. Children's Bureau has funded approximately 15 healthy marriage programs through Adoption Opportunities grants to strengthen the marriages of adoptive couples. Some of these programs have developed training curricula, including Adoption Resources of Wisconsin and Michigan State University.

'Adoption Is a Lifelong Process'

This basic tenet of adoption – that it is an ongoing, evolving experience and not a one-time occurrence – has major implications for the field of post-adoption services. A range of services should be available throughout the life cycles of adopted individuals and their families to educate and support parents to meet the needs of their children and to provide adoption-sensitive therapeutic interventions if difficulties arise. The field of specialized post-adoption services is relatively young; practitioners have struggled to know what services best meet families' needs and to make these services available to the many families who want them. The recommendations below address critical needs for the continued development of post-adoption services and for the reshaping of law, policy and practice to enable children and families who need assistance to receive it in a timely manner in order to maximize successful adoptions.

RECOMMENDATIONS

The range of services needed to sustain adoptive families includes preventive, supportive, and therapeutic services. Preventive services such as education and information assist families in understanding their child and family situation and in learning the most effective strategies for parenting. Supportive services such as information and referral, support groups, respite care, and advocacy help to normalize their view of their situation, relieve ongoing stress, strengthen their coping abilities, and assist them in obtaining needed resources for their family. Finally, a minority of adoptive families need clinical interventions to address specific difficulties, including specialized assessment services, crisis intervention, a variety of therapeutic interventions, and, for some, residential treatment services that include the adoptive family in treatment efforts.

Not all adoptive families will need or desire post-adoption services, and some will avail themselves of educational opportunities through books, adoption magazines, or the internet; however, many of them will struggle and would benefit from adoption-competent services. Development of knowledge on post-adoption practice and development of services for these families is the primary challenge to assure permanency for children removed from their birth families and to help them develop to their fullest potential. In order to promote progress in these areas, we make the following recommendations.

Convene a National Task Force to Develop a Strategic Plan

A national task force needs to provide strategic planning and legislative leadership for the development of post-adoption services; the body should include representatives from the Children's Bureau of the U,S. Department of Health and Human Services and the Department of State, as well as post-adoption experts, practitioners, and researchers. The task force should collect information, discuss key issues, and draft proposals/legislation to promote additional funding, policy changes, and practice improvements. This needs to be a long-term, sustained initiative to ensure that the effort is not ephemeral, but brings about continuing progress.

Minimize Damage to Children in the Child Welfare System or Other Settings

Many children placed from foster care or institutions here or abroad have negative past experiences that pose risks to ongoing healthy development. To truly promote successful adoptions, we need to minimize the damage that children experience on their paths to adoption, both in the U.S. and in orphanages abroad. Providing responsive and sensitive nurturance to children after separation from birth families, minimizing their moves in care or their number of caretakers, finding the right homes early in their journeys, and supporting them through transitions in care are all aspects of this goal. Some international efforts have already begun to move children from orphanages into foster homes and to provide better care for those remaining in institutions. Within the U.S. foster care system, it is important to use best practices to identify responsible relatives before children are removed, to utilize concurrent planning to place them into families that could become permanent resources if they are unable to return to their original homes, and to maximize placements with all their siblings in order to reduce traumatic losses. Assisting children to address loss and trauma issues includes supporting them through moves that must occur, maintaining their connections to significant attachment figures to the extent possible, and providing therapeutic opportunities for them to make sense of and cope with the events in their lives, including therapeutic lifebook work.

Prepare Parents to Expect Challenges and Understand the Benefits of Services

Families seeking to adopt, as well as those who already have adopted, need meaningful educational opportunities to understand the risk and protective factors in adoptive families, as well as the issues that may emerge over their child's development. An earlier project of the Institute on preparing adoptive parents can be accessed on our website (Brodzinsky, 2008). Individual preparation of families includes helping them to understand the specific child whom they are adopting and to forecast potential needs of the child in light of his/her history and known issues. These efforts help parents to have realistic expectations of their child and themselves. It also is important to assist adoptive families in identifying both informal and formal support systems to address their needs and link them with supports that are not readily available.

Another vital aspect of preparation is educating parents about the range and benefits of post-adoption services and normalizing help-seeking, reframing this as a parental strength and not a weakness. It also is important to stress their need for contact with other adoptive families, not only for their own support, but also for their children to have these supportive relationships. This is a particularly valuable resource for children adopted transracially who may have few connections to others from their same race/ethnicity.

Increase Research to Develop Knowledge and Disseminate to Practitioners

Knowledge about post-adoption services continues to be the most underdeveloped area of adoption research. Real progress on this front requires a clear strategy for incremental development of an integrated evidence base for post-adoption services, as well as the resources to fund research and disseminate practice knowledge. Whittaker's (2009) suggestions for further development of evidence-based interventions for high-risk youth seem apropos to these challenges, beginning with identifying the common elements across successful model programs and a common body of foundational knowledge and skill or core competencies. A subsequent task may involve aggregating selected EBT protocols and identifying discrete practice elements and clinical strategies matched with client factors (Chorpita & Daleiden, 2009). Through the development of strategic researcher-agency staff partnerships, possibly involving multiple agency partners, research can focus on investigating both the effectiveness of interventions delivered by post-adoption programs and the application and effectiveness of EBTs to real-world practice with adoptive families.

The federal government needs to take the lead in promoting and funding post-adoption research, possibly through the creation of a multi-agency workgroup with fiscal and intellectual support from multiple federal research entities such as NICHHD, NIMH, NCTSN and the Children's Bureau. There need to be specific program announcements on post-adoption services that fund intervention studies with rigorous research designs.

Dissemination of knowledge to practitioners in programs providing post-adoption services also requires a long-term strategy. Potential steps may include: 1) bringing together clinicians with extensive expertise in this area as well as knowledge of EBTs to collaborate in the identification of core competencies and delineation of model interventions for further development and research; 2) production of a manual/book with core competencies, practice principles and techniques; and 3) sponsoring a series of conferences for post-adoption service providers that would include workshops on selected EBTs, linked with possibilities for continued training on these, as well as workshops on other post-adoption interventive models and programs.

Educate Professionals to Understand Adoption and How to Support Families

Teachers, school counselors, school psychologists, medical professionals, social workers and other mental health professionals need to be provided with adoption-related training that will sensitize them to critical issues adopted children and adoptive parents confront in interacting with these systems. They are the frontline of helpers to whom parents go for advice and guidance in addressing the needs of their children, and they need greater awareness of the range of risk factors that impact the adjustment of some adopted children as well as normative challenges these youth face.

Efforts to educate these professionals need to target their university-based educational programs as well as in-service and continuing education programs and conferences. It would be helpful if post-adoption programs, websites, or warmlines could offer brief information for teachers and other professionals who do not know where to find materials specific to adoption.

Identify High-Risk Children, then Provide Services and Resources

Although professionals cannot always predict the children who are high risk for later adjustment difficulties, there are definitely indicators evidenced through research. Some of these include children with high levels of oppositional, defiant behaviors, difficulty giving and receiving affection, histories of severe maltreatment, many moves in care, diagnosed effects of substance exposure, or significant mental illness in their family histories. Providing preventive and early intervention services to families adopting these children is extremely important in stabilizing these adoptions. The means for accomplishing this goal is more readily available for state agencies placing children from foster care;

however, families adopting internationally also need to be able to access such services for high-risk children, perhaps on a fee basis.

Preventive and early intervention services to families adopting these children are extremely important in helping these adoptions be successful. Providing a time-limited intervention, such as the 18-week program, ARC (Attachment, Self-Regulation, & Competency), would help new adoptive families gain a firm foundation to address their children's needs. Hopefully, provision of such services would mean that problems do not intensify and patterns do not become entrenched for a period of years before families seek help.

Stop Cutbacks in Subsidies and Post-Adoption Services

In a 2009 article on funding post-adoption services, Kroll reported an item from Oregon's proposed human services budget that year – "Adoptions: Eliminate Post-Adoption Services Program" and his observation that such cuts would only serve to discourage more families from adopting, resulting in higher costs in foster care, court systems, and other public revenues. It is imperative for legislators to recognize that cutbacks in subsidies and post-adoption services yield disastrous consequences for children and families and, most likely, higher costs to the state in other areas. Beyond considerations of cost effectiveness, such cuts are a violation of the commitment that the state made at the time families adopted – the commitment to support them in meeting these children's needs until they reach adulthood.

End Forced Custody Relinquishments to Obtain Services

Being forced to relinquish custody of their children to child welfare agencies in order to obtain necessary mental health services has been reported as a problem in at least half the states (NACAC, 2007). Child welfare policies which require adoptive parents who want to continue their parental role to relinquish custody of their adopted children in order to receive help are not in the best interest of these children or their families. States in which these policies operate need to find other means of addressing this issue.

Develop Funding Partnerships, Including from the Federal Level

Currently, there is no dedicated federal funding stream for post-adoption services other than the dollars that assist states in providing adoption subsidies. There are a few federal sources that states have sometimes used to fund post-adoption services, including Adoption Incentive funds, Title IV-B, parts 1 and 2, Medicaid, TANF, Social Service Block Grants and others; however, none of these are designated exclusively for post-adoption services and they often get rerouted to other activities. Casey Family Services (2003) issued a report on the array of federal funding sources that could be utilized to help fund post-adoption services and strategies for states to use in their development. An updated analysis of funding sources for such services that incorporates recent legislative initiatives is contained in the Annie E. Casey Foundation's 2010 paper on strategic funding sources for maximizing use of federal dollars and is contained in Appendix II.

Recent changes in federal funding of child welfare legislated in the "Fostering Connections" Act will gradually increase foster children's eligibility for federal adoption assistance funding, as well as revising the adoption incentive program, making it easier for states to earn and spend incentive funds. States will save money from what they have had to allocate to adoption subsidies, and these funds – as well as incentive funds – could be reinvested in post-adoption services; however, there is no requirement of states to do so (NACAC, 2009). Joe Kroll (2009), Director of NACAC, recommends that states pass laws requiring that adoption incentive funds be designated for post-adoption services. State legislation mandating the provision of post-adoption services, which exists only in a few states, also would provide more stability for such funding.

Having a dedicated federal funding stream for post-adoption services that is continuous and stable would provide a federal mandate to provide these services, and would maintain a stable funding base for them. Title IV-B, subpart 2 of the Social Security Act contains a requirement that 20 percent of these funds go toward adoption promotion and support[17]. A report from the National Conference of State Legislatures (Christian, 2002), citing a review by James Bell and Associates (2002), reported that 1% of total child welfare spending from federal and state sources went to "adoption promotion and support." The most commonly specified activities reported by states for this category were adoptive parent recruitment and training, home studies, and worker training. The report recognizes that state funds primarily have been used for post-adoption services, but with budget shortfalls, there will be greater reliance on federal funds. **Having a funding stream dedicated specifically to *post-adoption* services would more readily encourage their development.**

Post-adoption services are often conceptualized and advocated on the justification of preventing dissolution. While this is a realistic basis for serving some families, it is important to recognize that dissolutions are rare, and the basis for the bulk of these services is the commitment of the state to assisting these families with the extraordinary needs of some children, as well as the human toll and compounding of problems when post-adoption services are not provided. Cost savings are popular platforms for human services programs, and while it seems apparent that efforts to improve child and family functioning will prevent the provision of higher cost services down the road, research documenting this has not yet been done.

Develop a Continuum of Services and Educate Mental Health Professionals

States need to take a leadership role in assessing the current continuum of post-adoption services and working with stakeholders to create a strategic plan for development of a comprehensive continuum of services. In strengthening adoption-competent counseling services, a range of strategies are needed. While specialized post-adoption services have grown in many states, it is unlikely that these programs will ever be sufficient to meet the counseling needs of all adoptive families. Many programs only serve child welfare adoptive families, and in no state are these programs comprehensive enough or accessible enough to meet the ongoing counseling needs of all adoptive families. We need to find innovative ways to provide training to the range of mental health professionals, both within their educational programs and afterwards. These professionals work in an array of community settings, including family counseling agencies, private practices, mental health clinics, child welfare agencies, and others. There are now about 10 adoption certification programs that train 20-30 professionals, on average, a year. These programs, even if doubled, cannot reach the hundreds of thousands of mental health professionals who work with adoptive families. Additional strategies are needed, such as web-based training linked with CEUs or other innovations.

A strategic plan involving collaboration among state human services systems and public and private agencies seems most likely to result in a continuum of services that can be accessed by families statewide. There also needs to be a framework through which adoptive families of all types can be fully informed of available services and how to access them.

Families with serious needs require therapeutic interventions from highly skilled professionals with in-depth knowledge about adoption and the complexity of issues and interventions related to these problem situations. States must develop their capacity to provide such services to all types of adoptive families at this level of severe need, even if some services are offered on a sliding-scale payment basis. These families need flexible service delivery that can work in a manner that goes beyond the typical one-hour weekly office session, so they can respond quickly in crisis situations,

---

[17] Adoption promotion and support services are defined as "services and activities designed to encourage more adoptions out of the foster care system, when adoptions promote the best interests of children, including such activities as pre- and post-adoptive services and activities designed to expedite the adoption process and support adoptive families." 42 U.S.C. §629a(8).

work collaboratively with multiple systems, provide advocacy as needed, and match the intensity of services to family needs. For any family with children at risk of maltreatment, placement outside the home, or dissolution, accessible state-supported services are clearly in the child's best interests.

This paper's title, **"Keeping the Promise,"** reflects the covenant that is made between parents and children when adoptions take place – to be a permanent family. But the covenant is also between agencies and families and between state or federal governments and adoptive families whom they help create. In domestic infant and intercountry adoptions, adoption professionals have assisted the families in their adoptions, approved them as meeting certain standards through a home study process, and committed to locating, arranging or providing whatever post-adoption supports the families needs. For intercountry adopters, the U.S. Citizens and Immigration Services has reviewed the families' documents, including their home studies, to determine that they are suitable to adopt and has approved all U.S. families adopting from foreign countries.

In adoptions from foster care, the state child welfare authority has removed these children from their original families, cared for them for a period of years (sometimes compounding the harm to them), and ultimately selected the families who adopts them with an agreement to provide needed supports over the course of childhood. When families struggle to address the developmental consequences of children's early adversity, they should be entitled to receive the types of services that truly meet their needs and sustain them.

Finally, through a number of laws, the federal government has aggressively supported adoptions from foster care, even providing financial incentives to states to increase their adoptions. The federal government has a role in creating these families and needs to act just as forcefully to sustain them. Only with federal, state, and local partnerships can we truly fulfill the three-fold mission of child welfare: promoting the safety, permanency, and well-being of children.

REFERENCES

Adoption Learning Partners. (2010). Website can be accessed at:
http://www.adoptionlearningpartners.org/

Annie E. Casey Foundation (2010). Funding permanency services: A guide to leveraging federal, state, and local dollars. Baltimore: Annie E. Casey Foundation.

American Academy of Pediatrics. (2010). Section on Adoption and Foster Care. Adoption Directory Membership List. Retrieved on May 10, 2010 at:
http://www.aap.org/sections/adoption/SOAFCAdoptionDirectory2.pdf

APAC – Alabama Post-Adoption Connections (2010). Retrieved March 1, 2010 from:
http://www.casapac.org/index.shtml

Armstrong, M. I., Birnie-Lefcovitch, S., & Ungar, M. T. (2005). Pathways between social support, family well being, quality of parenting, and child resilience: What we know. *Journal of Child and Family Studies, 14* (2), 269-281.

Aronson, J. (2000). Alcohol-related disorders and children adopted from abroad. In R.P. Barth, D. Brodzinsky, & M. Freundlich (Eds.), Adoption and prenatal drug exposure: *The research, policy and practice challenges,* pp. 147-170*.* Washington, DC: CWLA & Evan B. Donaldson Adoption Institute.

Atkinson, A., & Gonet, P. (2007). Strengthening adoption practice, listening to adoptive families. *Child Welfare, 86* (2), 87-104.

ATTACH (Association for Treatment and Training in the Attachment of Children). (2007). White paper on coercion in treatment. Available at: http://www.attach.org/WhitePaper.pdf

Avery, R. J. (1997). *Public agency adoption in New York state. Phase III report: Subsidized adoptions in New York state: 1989-1993*. Ithaca, NY: Cornell University, Dept. of Policy Analysis and Management.

Avery, R. J. (1999). Identifying obstacles to adoptions in the New York State's out-of-home care system. *Child Welfare, 78* (5), 653-671.

Bada, H. S., Das, A., Bauer, C. R., Shankaran, S., Lester, B. M., Gard, C. C., Wright, L. L., LaGasse, L., & Higgins, R. (2005). Low birth weight and preterm births: Etiologic fraction attributable to prenatal drug exposure. *Journal of Perinatology, 25*, 631-637.

Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Mesman, J., Alink, L. R. A., & Juffer, F. (2008). Effects of an attachment-based intervention on daily cortisol moderated by dopamine receptor D4: A randomized control trial on 1- to 3-year-olds screened for externalizing behavior. *Development and Psychopathology, 20*, 805-820.

Barth, R. P. (1993). Fiscal issues and stability in special-needs adoption. *Public Welfare, 51* (3), 21-28.

Barth R. P., & Berry, M. (1988). *Adoption and disruption: Rates, risks and resources.* New York: Aldine.

Barth, R. P. & Brooks, D. (2000). Outcomes for drug-exposed children eight years post-adoption. In R. P. Barth, D. Brodzinsky, & M. Freundlich (Eds.), Adoption and prenatal drug exposure: *The research, policy and practice challenges*, pp. 23-58. Washington, DC: CWLA & Evan B. Donaldson Adoption Institute.

Barth, R. P., Lee, C. K., Wildfire, J., & Guo, S. (2006). A comparison of the governmental costs of long-term foster care and adoption. *Social Service Review,80* (1), 127-158.

Barth, R. P., & Needell, B. (1996). Outcomes for drug-exposed children four years post-adoption. *Children & Youth Services Review, 18* (1-2), 37-56.

Barth, R. P., Gibbs, D. A., & Siebenaler, K. (2001). Assessing the field of post-adoption service: Family needs, program models, and evaluation isues: Literature review. Washington, DC: Department of Health and Human Services. Retrieved December 1, 2009 from: http://aspe.hhs.gov/hsp/PASS/lit-rev-01.htm

Barth, R.P., Wildfire, J., Lee, C.K., & Gibbs, D. (2003). Adoption subsidy dynamics. *Adoption Quarterly, 7*(2), 3-27.

Becker-Weidman, A. (2006). Treatment for children with trauma-attachment disorders: Dyadic developmental psychotherapy. *Child and Adolescent Social Work Journal, 23* (2), 147-171.

Becker-Weidman, A., & Hughes, D. (2008). Dyadic developmental psychotherapy: An evidence-based treatment for children with complex trauma and disorders of attachment. *Child and Family Social Work, 13*, 329-337.

Beckett, C., Maughan, B., Rutter, M., Castle, J., Colvert, E., Groothues, C., Kreppner, J., Stevens, S., O'Connor, T. G., Sonuga-Barke, E. J. S. (2006). Do the effects of early severe deprivation on cognition persist into early adolescence? Findings from the English and Romanian adoptees study. *Child Development, 77* (3), 696-711.

Beckett, C., Hawkins, A., Castle, J., Groothues, C., Sonuga-Barke, E., Colvert, E., Kreppner, J., Stevens, S., & Rutter, M. (2008). The experience of adoption II: The association between communicative openness and self esteem in adoption. *Adoption & Fostering, 32*, 29-39.

Bennett, L., Shiner, S. K., & Ryan, S. (2006). Using Theraplay in shelter settings with mothers and children who have experienced violence in the home. *Journal of Psychosocial Nursing and Mental Health Services, 44*(10), 38-48.

Benzies, K., & Mychasiuk, R. (2009). Fostering family resiliency: A review of the key protective factors. *Child & Family Social Work, 14* (1), 103-114.

Berry, M., & Barth, R. P. (1989). Behavior problems of children adopted when older. *Children and Youth Services Review, 11*, 221-228.

Berry, M., & Barth, R. P. (1990). A study of disrupted adoptive placements of adolescents. *Child Welfare, 69* (3), 209-225.

Berry, M., Barth, R., & Needell, B., (1996). Preparation, support, and satisfaction of adoptive families in agency and independent adoptions. *Child and Adolescent Social Work Journal, 13* (2), 157-183.

Bishop, C. (September 15, 2010). Personal communication.

Booth, P. B., & Jernberg, A. M. (2010). *Theraplay: Helping parents and children build better relationships through attachment-based play, 3rd edition.* San Francisco: John Wiley.

Blaustein, M., & Kinniburgh, K. (2010). Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency. New York: Guilford Press.

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R., Ernst, V. (2001). The trauma symptom checklist for young children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect, 25*, 1001-1014.

Briere, J., Kaltman, S., & Green, B. L. (2008). Accumulated childhood trauma and symptom complexity. *Journal of Traumatic Stress, 21* (2), 223-226.

Brodzinsky, D. M. (1987). Adjustment to adoption: A psychosocial perspective. *Clinical Psychology Review, 7* (1), 25-47.

Brodzinsky, D. (2006). Family structural openness and communication openness as predictors in the adjustment of adopted children. *Adoption Quarterly, 9* (4), 1-18.

Brodzinsky, D. (2008). Adoptive parent preparation: Meeting the mental health and developmental needs of adopted children. New York: Evan B. Donaldson Adoption Institute. Retrieved October 21, 2009 from: http://www.adoptioninstitute.org/policy/2008_02_parent_prep.php

Brodzinsky, D. M., Schechter, M. D., & Henig, R. M. (1992). *Being adopted: The lifelong search for self.* New York: Anchor Books.

Brodzinsky, D. M., & Steiger, C. (1991). Prevalence of adoptees among special education populations. *Journal of Learning Disabilities, 24* (8), 484-489.

Brodzinsky, D. M., Smith, D. W., & Brodzinsky, A. B. (1998). *Children's adjustment to adoption: Developmental and clinical issues.* Thousand Oaks, CA: Sage.

Brodzinsky, D. M., & Pinderhughes, E. (2002). Parenting and child development in adoptive families. In M. H. Borstein (Ed.), *Handbook of parenting* (pp. 279-311). Hillsdale, NJ: Lawrence Erlbaum Associates.

Brooks, D., Allen, J., & Barth, R. P. (2002). Adoption services use, helpfulness, and need: A comparison of public and private agency and independent adoptive families. *Children & Youth Services Review, 24*, 213-218.

Bruce, J., Fisher, P. A., Pears, K. C., & Levine, S. (2009). Morning cortisol levels in preschool-aged foster children: Differential effects of maltreatment type. *Developmental Psychobiology, 51* (1), 14-23.

Bryan, V., Flaherty, C., & Saunders, C. (2010). Supporting adoptive families: Participant perceptions of a statewide peer mentoring and support program. *Journal of Public Child Welfare, 4* (1), 91-112.

Bruns, E., & Burchard, J. (2000). Impact of respite care services for families with children experiencing emotional and behavioral problems. *Children's Services: Social Policy, Research, and Practice, 3* (1), 39-61.

Casey Family Services. (2002). Strengthening families and communities: An approach to post-adoption services. Casey Family Services & Annie E. Casey Foundation, Casey Center for Effective Child Welfare Practice.

Casey Family Services. (2003). Creative strategies for financing post-adoption services: A white paper. Retrieved on June 15, 2010 from:
http://www.caseyfamilyservices.org/index.php/resources/pubdetail/272/

Casey Family Services. (2009). Bibliography, A Casey Family Services compilation: Lifebooks for children and youth in foster care. Retrieved on January 25, 2010 from:
http://www.caseyfamilyservices.org/userfiles/pdf/bib-2009-lifebooks.pdf

Center for Adoption Studies. (2005). An evaluation of respite care services to adopted or guardianship children with severe medical or behavioral problems. (Evaluation of Adoption Opportunities Grant No. 90-CO-0978 received by Illinois Department of Children and Family Services).

Cermak, S. A., & Daunhauer, L. A. (1997). Sensory processing in the post-institutionalized child. *American Journal of Occupational Therapy, 51*, 500-507.

Cermak, S., & Groza, V. (1998). Sensory processing problems in post-institutionalized children: Implications for social work. *Child & Adolescent Social Work Journal, 15* (1), 5-37.

Chaffin, M., Hanson, R., Saunders, B. E., Nichols, T., Barnett, D., Zeanah, C., Berliner, L., Egeland, B., Newman, E., Lyon, T., LeTourneau, E., Miller-Perrin, C. (2006). Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems. *Child Maltreatment, 11* (1), 76-89.

Chambers, R., & Potter, C. (2009). A typology of family needs in child neglect cases. *Families in Society, 89*(5), 18-27.

Child Welfare Information Gateway. (2002). *Respite care services for families who adopt children with special needs: Synthesis of demonstration program final reports.* Washington, DC: U.S. Department of Health and Human Services.

Children's Rights. (2006). *Ending the foster care life sentence: The critical need for adoption subsidies.* New York, NY: Children's Rights.

Chorpita, B. F., Becker, K. D., & Daleiden, E. L. (2007). Understanding the common elements of evidence-based practice: Misconceptions and clinical examples. *Journal of American Academcy of Child and Adolescent Psychiatry, 46* (5), 647-652.

Chorpita, B. F., & Daleiden, E. L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology, 77* (3), 566-579.

Christian, S. (2002). Post-Adoption Services: Issues for Legislators. *NCSL State Legislative Report, 27* (17). Retrieved June 1, 2010 from: http://beta.ncsl.org/Home/SearchResults/tabid/702/Default.aspx?zoom_query=post-adoption%20services

Clark, P., Thigpen, S., & Yates, A. (2007). Integrating the older/special needs adoptive child into the family. *Journal of Marital and Family Therapy, 32* (2), 181-194.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents.* New York: Guilford Press.

Cohen, N. J., Coyne, J., & Duvall, J. (1993). Adopted and biological children in the clinic: Family, parental and child characteristics. *Journal of Child Psychology and Psychiatry, 34* (4), 545-562.

Connecticut Association of Foster and Adoptive Parents. (2010). Training calendar. Retrieved March 15, 2010 from: http://www.cafap.com/documents/training.pdf

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2003). Complex trauma in children and adolescents: White paper from the National Child Traumatic Stress Network Complex Trauma Task Force. Retrieved January 30, 2010 from: http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/ComplexTrauma_All.pdf

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagain, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in chidren and adolescents. *Psychiatric Annals, 35* (5), 390-398.

Coon, H., Carey, G., Corley, R., & Fulker, D.W. (1992). Identifying children in the Colorado adoption project at risk for conduct disorder. *Journal of American Academy of Child and Adolescent Psychiatry, 31*(3), 503-511.

Cradle (2010). Website on Post-Adoption Services. Retrieved March 16, 2010 from: http://www.cradle.org/postadopt_home.html

Craven, P. A., & Lee, R. E. (2006). Therapeutic interventions for foster children: A systematic research synthesis. *Research on Social Work Practice, 16* (3), 287-304.

Crea, T. M., Barth, R. P., Guo, S., and Brooks, D. (2008). Externalizing behaviors of substance-exposed adopted children: 14 years postadoption. *American Journal of Orthopsychiatry, 78*, 11-19.

Criss, M.M., Pettit, G.S., Bates, J.E., Dodge, K.A., & Lapp, A.L. (2002). Family adversity, positive peer relationships and children's externalizing behavior: A longitudinal perspective on risk and resilience. *Child Development, 73* (4), 1220-1237.

Dalberth, B., Gibbs, D., & Berkman, N. (2005). Understanding adoption subsidies: An analysis of AFCARS data: Final report. *Office of ASPE, US DHHS.* Retrieved June 15, 2010, from: http://aspe.hhs.gov/hsp/05/adoption-subsidies/index.htm.

Dance, C., & Rushton, A. (2005). Predictors of outcome for unrelated adoptive placements made during middle childhood. *Child & Family Social Work. 10*(4), 269-280.

Davidson, S. (March 10, 2010). Personal communication.

Delaney, R. J., & Kunstal, F. R. (1993). *Troubled transplants: Unconventional strategies for helping disturbed foster and adopted children.* Portland, ME: National Child Welfare Resource Center for Management and Administration.

Deutsch, D. K., Swanson, J. M., Bruell, J. H., Cantwell, D. P., Weinberg, F., & Baren, M. (1982). Overrepresentation of adoptees in children with the attention deficit disorder. *Behavior Genetics, 12,* 231-238.

Dhami, M. K., Mandel, D. R., & Sothmann, K. (2007). An evaluation of post-adoption services. Children and Youth Services Review, 29 (2), 162-179.

Dodson, M. (September 23, 2010). Personal communication.

Dozier, M., Peloso, E., Lewis, E., Laurenceau, J. P., & Levine, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. *Development and Psychopathology, 20*, 845-859.

Dunbar, N., & Grotevant, H. D. (2004). Adoption narratives: The construction of adoptive identity during adolescence. In M. W. Pratt & B. H. Fiese (Eds.), *Family stories and the life course: Across time and generations* (pp. 135-161). Mahwah, NJ: Erlbaum.

Elmund, A., Lindblad, F., Vinnerljung, B., Hjern, A. (2007). Intercountry adoptees in out-of-home care: A national cohort study. *Acta Paediatrica*, *96* (3), 437-442.

Evan B. Donaldson Adoption Institute (2002). International adoption facts. Retrieved January 16, 2009 from: http://www.adoptioninstitute.org/FactOverview/international.html

Fay, J., Fay, C., & Cline, F. (2010). *Becoming a Love and Logic Parent Curriculum.* Golden, CO: Love and Logic Institute. May be accessed at: http://www.loveandlogic.com/training-curricula.html#Becoming

Feigelman, W. (1997). Adopted results: comparisons with persons raised in conventional families. *Marriage and Family Review*, 25**,** 199–223.

Festinger, T. (1986). *Necessary risk: A study of adoptions and disrupted adoptive placements.* Washington, DC: Child Welfare League of America.

Festinger, T. (2002). After adoption: Dissolution or permanence? *Child Welfare, 81* (3)*,* 525-533.

Festinger, T. (2006). Adoption and after: Adoptive parents' service needs. In M. M. Dore (Ed.), *The postadoption experience: Adoptive families' service needs and service outcomes.* Washington, DC: Child Welfare League of America & Casey Family Services.

Festinger, T., & Maza, P. (2009). Displacement or post-adoption placement? A research note. *Journal of Public Child Welfare, 3* (3), 275-286.

Fine, D. (2000). *Adoptive family needs assessment: Final report.* Salem, OR: Oregon Department of Human Resources State Office of Services to Children and Families.

Fine, D., Doran, L., Berliner, L., & Lieb, R. (2006). Factors affecting recent adoption support levels in the Washington state adoption support program. In M. M. Dore (Ed.), *The postadoption experience: Adoptive families' service needs and service outcomes.* Washington, DC: Child Welfare League of America & Casey Family Services.

Finkelhor, D., & Browne, A. (1986). Initial and long-term effects: A conceptual framework. In D. Finkelhor (Ed.), *A sourcebook on child sexual abuse* (pp. 180-198). Beverly Hills, CA: Sage.

Flores, E., Cicchetti, D., & Rogosch, F. A. (2005). Predictors of resilience in maltreated and nonmaltreated Latino children. *Developmental Psychology, 41* (2), 338-351.

Flynn, C., Welch, W., Paget, K. & Wright, L. (2004). Field-Initiated Research on Successful Adolescent Adoption. Columbia, SC: Center for Child and Family Studies, University of South Carolina. Retrieved October 20, 2009 from:
http://www.sc.edu/ccfs/research/fullfinalreport.pdf

Ford, J. D., Racussin, R., Ellis, C. G., Daviss, W. B., Reiser, J., Fleischer, A., & Thomas. J. (2000). Child maltreatment, other trauma exposure, and posttraumatic symptomatology among children with oppositional defiant and attention deficit hyperactivity disorders. *Child Maltreatment, 5* (3), 205-217.

Foster Parent College. (2010). Training for Adoptive, Kinship, and Foster Parents. May be accessed at: http://www.fosterparentcollege.com/

Frank, D. A., Augustyn, M., Knight, W. G., Pell, T., & Zuckerman, B. (2001). Growth, development, and behavior in early childhood following prenatal cocaine exposure: A systematic review. *Journal of the American Medical Association, 285* (12), 1613-1625.

Fravel, D. L. (1995). Boundary ambiguity perceptions of adoptive parents experiencing various levels of openness in adoption. Unpublished Doctoral Dissertation, University of Minnesota, St. Paul.

Fravel, D. L., McRoy, R. G., & Grotevant, H. D. (2000). Birthmother perceptions of the psychologically present adopted child: Adoption openness and boundary ambiguity. *Family Relations, 49* (4)*,* 425-433.

Freeark, K., & Rosenblum, K. L. (2010). The Inquisitive Minds workshop: A psychoeducational curriculum to foster communicative openness in adoptive families. Workshop presented at the 3rd International Conference on Adoption Research, Leiden, Netherlands, July 13, 2010.

Freundlich, M. (2000). The impact of prenatal substance exposure: Research findings and their implications for adoption. In R.P. Barth, M. Freundlich, & D. Brodzinsky (Eds.), *Adoption & prenatal alcohol and drug exposure* (pp.1-21). Washington, DC: Child Welfare League of America & Evan B. Donaldson Adoption Institute.

Frey, L. (1986). Preserving permanence: A study of post adoption services in Massachusetts. Boston, MA: Department of Social Services.

Fuller, T. L., Bruhn, C., Cohen, L., Lis, M., Rolock, N., & Sheridan, K. (2006). *Supporting adoptions and guardianships in Illinois: An analysis of subsidies, services and spending.* Urbana-Champaign: University of Illinois. Retrieved October 20, 2009 from:
http://www.cfrc.illinois.edu/pubs/Pdf.files/AdoptionReport9.06.pdf

Fullerton, C. S., Goodrich, W., & Berman, L. B. (1986). Adoption predicts psychiatric treatment resistances in hospitalized adolescents. *Journal of the American Academy of Child Psychiatry, 25* (4), 542-551.

Gibbs, D., Barth, R. P., & Houts, R. (2005). Family characteristics and dynamics among families receiving post-adoption services. *Families in Society, 86*, 520-532.

Gibbs, D., Siebenaler, K., & Barth, R. P. (2002). *Assessing the field of post-adoption services: Family needs, program models, and evaluation issues. Summary report.* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved May 30, 2010 from:
http://aspe.hhs.gov/hsp/post-adoption01/summary/report.pdf

Goldschmidt, L., Day, N. L., & Richardson, G. A. (2000). Effects of prenatal marijuana exposure on child behavior problems at age 10. *Neurotoxicology and Teratology, 22* (3), 325-336.

Goldsmith, H. H., Buss, A. H., Plomin, R., Rothbart, M. K., Thomas, A., Chess, S., Hindle, R. A., McCall, R. B. (1987). Roundtable: What is temperament? Four approaches. *Child Development, 58* (2), 505-529.

Groark, C. J., Muhamedrahimov, R. J., Palmov, O. I., Nikiforova, N. V., & McCall, R. B. (2005). Improvements in early care in Russian orphanages and their relationship to observed behaviors. Infant Mental Health Journal, 26, 96–109.

Grotevant, H. D. (2009). Emotional distance regulation over the life course in adoptive kinship networks. In G. M. Wrobel & E. Neil (Eds.). *International advances in adoption research for practice* (pp. 295-316). London: Wiley-Blackwell.

Grotevant, H. D., & McRoy, R. G. (1998). *Openness in adoption: Exploring family connections.* Thousand Oaks, CA: Sage Publications.

Grotevant, H. D., Dunbar, N., Kohler, J. K., Lash Esau, A. M. (2007). Adoptive identity. In R. A. Javier, A. L. Baden, F. A. Biafora, & A. Camach-Gingerich (Eds.) *Handbook of adoption: Implication for researchers, practitioners, and families* (pp. 77-89). Thousand Oaks, CA: Sage Publications.

Grotevant, H. D., Ross, N. M., Marchel, M. A., & McRoy, R. G. (1999). Adaptive behavior in adopted children: Predictors from early risk, collaboration in relationships within the adoptive kinship network, and openness arrangements. *Journal of Adolescent Research, 14*, 231-247.

Groza, V., & Ileana, D. (1999). International adoption and adoption services. In T. Tepper & L. Hannon (Eds.). *International Adoption: Challenges and Opportunities* (pp. 42-61). Pittsburgh: Parent Support Network for the Post Institutionalized Child.

Groza, V., & Ryan, S. D. (2002). Pre-adoption stress and its association with child behavior in domestic special needs and international adoptions. *Psychoneuroendocrinology, 27,* 181-197.

Groze, V., & Gruenewald, A. (1991). PARTNERS: A model program for special-needs adoptive families in stress. *Child Welfare, 70*(5), 581-589.

Groze, V. (1995). A 1 and 2 year follow-up study of adoptive families and special needs children. *Children and Youth Services Review, 18*, 57-82.

Groze, V. (1996). *Successful adoptive families A longitudinal study of special needs adoption.* NewYork: Praeger.

Groze, V., Basista, M., & Persse, L. (1993). Strengthening resources and decreasing stressors in adoptive families: The post-legal special needs adoption family preservation treatment team project (Project Evaluation of Adoption Opportunities Grant #90C00551).

Groze, V., Young, J., and Corcran-Rumppe, K. (1991). *Post Adoption Resources for Training, Networking and Evaluation Services (PARTNERS): Working with special needs adoptive families in stress.* Washington, DC: Prepared with Four Oaks, Inc., Cedar Rapids, Iowa, for the Department of Health & Human Services, Adoption Opportunities.

Gunnar, M. R., Morison, S. J., Chisholm, K., & Schuder, M. (2001). Salivary cortisol levels in children adopted from Romanian orphanages. *Development and Psychopathology, 13*, 611-628.

Gunnar, M., & Pollak, S. D. (2007). Supporting parents so that they can support their internationally adopted children: The larger challenge lurking behind the fatality statistics. *Child Maltreatment, 12* (4), 381-382.

Gunnar, M. R., & Vazquez, D. M. (2001). Low cortisol and a flattening of expected daytime rhythm: Potential indices of risk in human development. *Development and Psychopathology, 13*, 515-538.

Gunnar, M. R., & Kertes, D. A. (2005). Prenatal and postnatal risks to neurobiological development in internationally adopted children. In D.B. Brodzinsky & J. Palacios (Eds.), *Psychological issues in adoption: Research & practice,* pp. 47-65). Westport, CT: Praeger.

Hamilton, B. E., Martin, J. A., & Ventura, S. J. (2010). Births: Preliminary Data for 2008. *National Vital Statistics Reports*; *58* (16). Hyattsville, MD: National Center for Health Statistics.

Hansen, M. E. (2005). Using subsidies to promote the adoption of children from foster care. American University Department of Economics Working Paper Serices No. 2005-15. Retrieved November 2, 2009 from: http://www1.american.edu/academic.depts/cas/econ/workingpapers/2005-15.pdf

Hansen, B., & Hansen, M. E. (2006). An economic analysis of the adoption of children from foster care. *Child Welfare, 85* (3), 559-583.

Hansen, M. E. (2007). Using subsidies to promote the adoption of children from foster care. *Journal of Family and Economic Issues, 28* (3), 377-393.

Hart, A., & Luckock, B. (2004). *Developing adoption support and therapy: New approaches for practice.* London: Jessica Kingsley Publishers.

Hart, A., & Luckock, B. (2006). Core principles and therapeutic objectives for therapy with adoptive and permanent foster families. *Adoption & Fostering, 30* (2), 29-42.

Hawkins, A., Beckett, C., Rutter, M., Castle, J., Colvert, E., Groothues, C., Kreppner, J., Stevens, S., & Sonuga-Barke, E. (2007). Communicative openness about adoption and interest in contact in a sample of domestic and intercountry adolescent adoptees. *Adoption Quarterly, 10* (3-4), 131-156.

Henderson, D. B. (2002). Challenging the silence of the mental health community on adoption issues. *Journal of Social Distress and the Homeless, 11* (2), 131-141.

Heneggeler, S. W., & Lee, T. (2003). Multisystemic treatment of serious clinical problems. *N A. E. Kazdin & J. R. Weisz (Eds.), Evidence-based psychotherapies for children and adolescents.* New York: Guilford Press.

Hoksbergen, R. A. C. (1997). Turmoil for adoptees during their adolescence? *International Journal of Behavioral Development, 20* (1), 33-46.

Hoksbergen, R. A. C. (1999). The importance of adoption for nurturing and enhancing the emotional and intellectual potential of children. *Adoption Quarterly, 3*(1), 29-42.

Houston, D. M., & Kramer, L. (2008). Meeting the long-term needs of families who adopt children out of foster care: A three-year follow-up study. *Child Welfare, 87* (4), 145-170.

Howard, J. A., & Smith, S. L. (1997). *Strengthening adoptive families: A synthesis of post-legal adoption opportunities grants.* Normal, IL: Illinois State University.

Howard, J. A., & Smith, S. L. (2003). *After adoption: The needs of adopted youth.* Washington, DC: Child Welfare League of America.

Howard, J. A., Smith, S. L., & Deoudes, G. (2010). For the records II: An examination of history and impact of adult adoptee access to original birth certificates. New York: Evan B. Donaldson Adoption Institute. Retrieved September 30, 2010 from:
http://www.adoptioninstitute.org/research/2010_07_for_records.php

Howard, J. A., Smith, S. L., & Oppenheim, E. (2002). *Sustaining adoptive families: A qualitative study of post-adoption services.* Washington, DC: American Public Human Services Association.

Howard, J. A., Smith, S. L., Ryan, S. (2003). Respite care needs of parents of children with severe behavior problems. Normal, IL: Center for Adoption Studies, Illinois State University.

Howard, J. A., Smith, S. L., & Ryan, S. D. (2004). A comparative study of child welfare adoptions with other types of adopted children and birth children. *Adoption Quarterly, 7* (3), 1-30.

Howe, D. (1997). Parent-reported problems in 211 adopted children: Some risk and protective factors. *Journal of Child Psychology and Psychiatry, 38*(4), 401-411.

Howe, D., & Fearnley, S. (2003). Disorders of attachment in adopted and fostered children: Recognition and treatment. *Clinical Child Psychology and Psychiatry, 8* (3), 369-387.

Hudson, C. G., Cedeno-Zamor, P., Rosenthal, M., Springer, C., & Hudson, B. (2002). Adoption crossroads the first five years: Summary report. Salem, MA: Salem State College School of Social Work. Retrieved January 21, 2010 from:
http://www.salemstate.edu/~chudson/ac_first5_report.pdf

Hughes, D. (2007). *Attachment-focused family therapy.* New York: W. W. Norton.

Hummel, K. (March 8, 2010). Personal communication.

Incredible Years Parent Training Programs. (2008). May be accessed at:
http://www.incredibleyears.com/Program/parent.asp

Jackson, A. (March 16, 2010). Personal communication.

Jacobs, E., Miller, L. C., & Tirella, L. G. (2010). Developmental and behavioral performance of internationally adopted preschoolers : A pilot study. *Child Psychiatry & Human Development, 41* (1), 15-29.

James Bell and Associates, Analysis of States' Annual Progress and Services Reports and Child and Family Services Plans (1999-2001) (Arlington, Va.: James Bell and Associates, 2002).

Ji, J., Brooks, D., Barth, R. P., & Kim, H. (2010). Beyond preadoptive risk: The impact of adoptive family environment on adopted youth's psychosocial adjustment. *American Journal of Orthopsychiatry, 80* (3), 432-442.

Johnson, D. E., Guthrie, D., Smyke, A. T., Koga, S. F., Fox, N. A., Zeanah, C. H., & Nelson, C. A. (2010). Growth and associations between auxology, caregiving environment, and cognition in socially deprived Romanian children randomized to foster vs ongoing institutional care. *Archives of Pediatric and Adolescent Medicine, 164* (6), 507-16.

Johnson, M., & Howard, J. (2008). *Putting the pieces together: Lifebook work with children* (DVD). Rock Island, IL: Lutheran Social Services of Illinois.

Johnson, E. O., Kamilaris, T. C., Chrousos, G. P., & Gold, P. P. (1992). Mechanisms of stress: A dynamic overview of hormonal and behavioral homeostasis. *Neuroscience and Biobehavioral Reviews, 16,* 115-130.

Jones J. (2009). Who Adopts? Characteristics of Women and Men Who Have Adopted Children, NCHS Data Brief, No. 12. Center for Disease Control and Prevention, National Center for Health Statistics. Retrieved January 16, 2009 from:
http://www.cdc.gov/nchs/data/databriefs/db12.pdf

Judge, S. (2004). The impact of early institutionalization on child and family outcomes. *Adoption Quarterly, 7* (3), 31-48.

Juffer, F., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H. (2005). The importance of parenting in the development of disorganized attachment: Evidence from a preventive intervention study in adoptive families. *Journal of Child Psychology and Psychiatry, 46* (3), 263-274.

Juffer, F. (2006). Children's awareness of adoption and their problem behavior in families with 7-year-old internationally adopted children. *Adoption Quarterly, 9* (2/3), 1-22.

Juffer, F., Bakermans-Kranenburg, M. J., & Van IJzendoorn, M. H. (2008). *Promoting positive parenting: An attachment-based intervention.* New York: Taylor & Francis.

Juffer, F. (2010). Attachment, adoptive parenting, and intervention. Presented at 3rd International Conference on Adoption Research, Leiden, Netherlands, July 13, 2010.

Juffer, F., & van IJzendoorn, M. H. (2005). Behavior problems and mental health referrals of international adoptees: A meta-analysis. *Journal of the American Medical Association, 293* (20), 2501- 2515.

Kaniuk, J., Steele, M., & Hodges, J. (2004). Research on a longitudinal research project, exploring the development of attachments between older, hard-to-place children and their adopters over the first two years of placement. *Adoption and Fostering, 28*, 61-67.

Kaye, K. (1990). Acknowledgement or rejection of differences. In D. Brodzinsky & M. Schechter (Eds.) *The psychology of adoption* (pp. 121-143). New York: Oxford University Press.

Kazdin, A.E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice.* New York: Oxford University Press.

Keyes, M. A., Sharma, A., Elkins, I. J., Iacono, W. G., & McGue, M. (2008). The mental health of U.S. adolescents adopted in infancy. *Archives of Pediatric Adolescent Medicine, 162* (5), 419-425.

Kinniburgh, K., & Blaustein, M. (2006). A. R. C.: Attachment, self-regulation and competency. A comprehensive framework for intervention with complexly traumatized youth. Unpublished manuscript.

Kinniburgh, K. (2008). ARC: Attachment, self-regulation and competency. A comprehensive framework for intervention with complexly traumatized youth. Complex Trauma Speaker Series. National Child Traumatic Stress Network website. Retrieved January 25, 2010 at: http://mediasite.nctsn.org/NCTSN/Viewer/?peid=14c17788-d0f4-4ad9-9cf0-e392073c46d7

Kinship Center, Education Institute. (2010). *Developing attachment: Family therapy examples with Dr. Daniel A. Hughes.* Practice Tool Series. May be accessed at: http://www.kinshipcenter.org/education-institute/education-store/family-therapy-examples-part-1-adolescents.html

Kirk, H. D. (1964). *Shared fate: A theory and method of adoptive relationships.* Port Angeles, WA: Ben-Simon.

Kirk, H. D. (1981). *Adoptive kinship: A modern institution in need of reform.* Toronto: Butterworths.

Kirschner, D., & Nagel, L. S. (1988). Antisocial behavior in adoptees: Patterns and dynamics. *Child and Adolescent Social Work, 5* (4), 300-314.

Kliman, G. W., & Zelman, A. B. (1996). Use of a personal life history book in the treatment of foster children – An attempt to enhance stability of foster care placements. In A.B. Zelman (Ed.), *Early intervention with high-risk children: Freeing prisoners of circumstance.* Northvale, NJ: Jason Aronson, Inc.

Kohler, J. K., Grotevant, H. D., & McRoy, R. G. (2002). Adopted adolescents' preoccupation with adoption: The impact on adoptive family relationships. *Journal of Marriage and Family, 64* (1), 93-104.

Kotch, J. B., Lewis, T., Hussey, J. M., English, D., Thompson, R., Litrownike, A. J., Runyan, D. K., Bangdiwala, S. I., Margolis, B., & Dubowitz, H. (2008). Importance of early neglect for childhood aggression. *Pediatrics, 121* (4), 725-731.

Kotsopolous, S., Cote, A., Joseph, L., Pentland, N., Chryssoula, S., Sheahan, P., & Oke, L. (1988). Psychiatric disorders in adopted children. *American Journal of Orthopsychiatry, 58*, 608-612.

Kramer, L., & Houston, D. (1998). Supporting families as they adopt children with special needs. *Family Relations, 47* (4), 423-432.

Kreider, R. M. (2003). Adopted children and stepchildren: 2000. Census 2000 special reports. U.S. Department of Commerce, U.S. Census Bureau.

Kreider, R. M., & Cohen, P. N. (2009). Disability among internationally adopted children in the United States. *Pediatrics, 124* (5), 1311-1318.

Kroll, J. (Summer, 2009). Fund post-adoption services with adoption incentive awards. *Adoptalk.* North American Council on Adoptable Children.

Kroll, Josh. (March 5, 2010). Personal communication.

Lahti, M. F. (Winter, 2005). Maine adoption guides: Making the case for family-driven post-adoption services. *Adoptalk.* North American Council on Adoptable Children. Retrieved January 20, 2010 from: http://www.nacac.org/adoptalk/Maine.html

Lahti, M. F. (2006). Maine adoption guides: A study of postlegalization services. In M. M. Dore (Ed.), *The postadoption experience: Adoptive families' service needs and service outcomes* (pp. 111-134). Washington, DC: Child Welfare League of America.

Landers, S., Forsythe, L., & Nickman, S. (1996). *Massachusetts Department of Mental Health training and adoptive family stabilization project final report.* Boston: Massachusetts Department of Mental Health.

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.

Lee, R. M., Seol, K. O., Sung, M., & Miller, M. J. (2010). The behavioral development of Korean children in institutional care and international adoptive families. *Developmental Psychology, 46* (2), 468-478.

LeMare, L. L., Audet, K., & Kurytnik, K. (2007). A longitudinal study of service use in families of children adopted from Romanian orphanages. *International Journal of Behavioral Development, 31* (3), 242-251.

Lenerz, K., Gibbs, D., & Barth, R. P. (2006). Postadoption services: A study of program participants, services, and outcomes. In M. M. Dore (Ed.), *The postadoption experience: Adoptive families' service needs and service outcomes* (pp. 95-110). Washington, DC: Child Welfare League of America.

Leung, P., & Erich, S. (2002). Family functioning of adoptive children with special needs: Implications of familial supports and child characteristics. *Children and Youth Services Review, 24* (11), 799-816.

Lewis, E. E., Dozier, M., Ackerman, J., & Sepulveda-Kozakowski, S. (2007). The effect of placement instability on adopted children's inhibitory control abilities and oppositional behavior. *Developmental Psychology,* 43 (6), 1415-1427.

Liberti, R. (March 5, 2010). Personal communication.

Lieberman, A. F., Ghosh, C., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 45* (8), 913-918.

Linville, D., & Lyness, A. P. (2007). Twenty American families' stories of adaptation: Adoption of children from Russian and Romanian institutions. *Journal of Marital and Family Therapy, 33* (1), 77-93.

Mack, K. (2006). Survey examines postadoption services among private agencies. *Children's Voice.* Child Welfare League of America. Retrieved March 15, 2010 from: http://www.cwla.org/programs/adoption/adoptionsurvey.pdf

Marshall, M. J., Marshall, S., & Heer, M. (1994). Characteristics of adolescent substance abusers who first sought treatment in adolescence. *The Journal of Drug Education, 24,* 151-162.

Massachusetts Department of Mental Health. (1994). *Training and adoptive family stabilization project quarterly report.* Boston: author.

Maza, P. L. (February, 2007). Adoption Data Update. Presented at the National Advisory Committee on Adoption, Washington, DC.

McCarty, C., Waterman, J., Burge, D., & Edelstein, S. B. (1999). Experiences, concerns, and service needs of families adopting children with prenatal substance exposure: Summary and recommendations. *Child Welfare, 78* (5), 561-577.

McCowan, K. (July 29, 2008). Families who adopted foster kids to share $1.7 million settlement. The *Register Guard.* Eugene, OR.

McDaniel, K., & Jennings, G. (1997). Therapists' choice of treatment for adoptive families. *Journal of Family Psychotherapy, 8* (4), 47-68.

McDonald, T., Propp, J., & Murphy, K. (2001). The postadoption experience: Child, parent, and family adjustment to adoption. *Child Welfare, 80* (1), 71-94.

McGuinness, T., & Pallansch, L. (2000). Competence of children adopted from the former Soviet Union. *Family Relations, 49* (4), 457-464.

McGuinness, T., & Pallansch, L. (2007). Problem behavior of children adopted from the former Soviet Union. *Journal of Pediatric Health Care, 21,* 171-179*.*

McRoy, R., Grotevant, H., & Zurcher, S. (1988). *Emotional disturbance in adopted adolescents.* New York: Praeger.

McRoy, R.G. (1999). *Special needs adoptions: Practice issues.* New York: Garland Publishing.

Meese, R.L. (2005). A few new children: Postinstitutionalized children of intercountry adoption. *Journal of Special Education, 39* (3), 157-167.

Mehta, M. A., Golembo, N. I., Nosarti, C., Colvert, E., Mota, A., Williams, S. C., Rutter, M., Sonuga-Barke, E. J. (2009).Amygdala, hippocampal and corpus callosum size following severe early institutional deprivation: the English and Romanian Adoptees study pilot.

Merz, E. C., & McCall, R. B. (2010). Behavior problems in children adopted from psychosocially depriving institutions. *Journal of Abnormal Child Psychology, 38* (4), 459-470.

Miller, B. C., Fan, X., Grotevant, H. D., Christensen, M., Coyle, D., & van Dulmen, M. (2000). Adopted adolescents' overrepresentation in mental health counseling: Adoptee's problems or parents' lower threshold for referral? *Journal of the American Academy of Child & Adolescent Psychiatry, 39*(12), 1504-1511.

Miller, B. C., Fan X., Christensen, M., Grotevant, H. D., & van Dulmen, M. (2000). Comparisons of adopted and nonadopted adolescents in a large, nationally representative sample. *Child Development, 71* (5), 1458-1473.

Miller, L. C., Chan, W., Litvinova, A., Rubin, A., Comfort, K., Tirella, L., Cermak, S., Morse, B., & Kovalev, I. (2006). Fetal alcohol spectrum disorders in children resideng in Russian orphanages: A phenotypic survey. *Alcoholism: Clinical and Experimental Research, 30* (3), 531-538.

Miller, L. C., Chan, W., Reece, R. A, Tirella, L., & Pertman, A. (2007). Child abuse fatalities among internationally adopted children. *Child Maltreatment, 12* (4), 385-386.

NACAC—North American Council on Adoptable Children. (July, 2009). *Providing federal adoption assistance to more children with special needs: A welcome change.* Retrieved July 20, 2010 from: http://www.nacac.org/policy/MoEBriefJuly09.pdf

NACAC—North American Council on Adoptable Children. (2002). Therapy survey results in. *Adoptalk*, Fall, St. Paul, MN: NACAC.

NACAC—North American Council on Adoptable Children. (2007). Summary of State Adoption Assistance Programs. Retrieved November 3, 2009 from: http://www.nacac.org/adoptionsubsidy/summary.html

NACAC—North American Council on Adoptable Children. (2008a). *The value of adoption subsidies: Helping children find permanent families.* Retrieved June 20, 2009 from: http://www.nacac.org/adoptionsubsidy/valueofsubsidies.pdf

NACAC—North American Council on Adoptable Children. (2008b). *Answering the call. Taking a break: Creating foster, adoptive and kinship respite care in your community.* (With National Foster Parent Association & Collaboration to AdoptUsKids.) Retrieved March 5, 2010 from: http://www.adoptuskids.org/images/resourceCenter/TakingABreak.pdf

NACAC—North American Council on Adoptable Children. (2009). *Developing a parent-to-parent support network.* Retrieved March 14, 2010 from: http://www.nacac.org/adoptalk/parent2parentnetwork.pdf

Nalavany, B. A., Ryan, S. D., Howard, J. A., Smith, S. L. (2008). Preadoptive child sexual abuse as a predictor of moves in care, adoption disruptions, and inconsistent parent commitment. *Child Abuse & Neglect, 32*, 1084-1088.

National Consortium for Post Legal Adoption Services. (1996). Adoption support and preservation. Retrieved November 3, 2009 from: http://www.childwelfare.gov/pubs/conceptmodel.pdf.

National Survey of Children's Health (2007). Health care access & utilization: Use of mental health services. Retrieved January 19, 2010 from: http://nschdata.org/DataQuery/DataQueryResults.aspx?q=5518&r1=0&r2=-1

Newton, R. R., Litrownik, A. J., Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect, 24* (10), 1363-1374.

Nelson, K. A. (1985). *On the frontier of adoption: A study of special needs adoptive families.* New York: Child Welfare League of America.

NJARCH. (2010). Website operated by Children's Aid & Family Services, Inc. at: http://www.njarch.org/

Ogden, T., & Hagen, K. A. (2006). Multisystemic treatment of serious behaviour problems in youth: Sustainability of effectiveness two years after intake. *Child and Adolescent Mental Health, 11* (3), 142-149.

Ornelas, L. (September 30, 2010). Personal communication.

Ornelas, L. A., Silverstein, D. N., & Tan, S. (2007). Effectively addressing mental health issues in permanency-focused child welfare practice. *Child Welfare, 86* (5), 93-112.

Palacios, J. (2009). The ecology of adoption. In G. M. Wrobel, & E. Neil (Eds.), *International advances in adoption research for practice* (pp. 71-94). Oxford: Wiley-Blackwell.

Patterson, G. R., Reid, J. B., & Dishion, T. J. (1992). *Antisocial boys.* Eugene, OR: Castalia.

Paulsen, C., & Merighi, J. (2009). Adoption preparedness, cultural engagement, and parental satisfaction in intercountry adoption. *Adoption Quarterly,12* (1), 1-18.

Pavao, J. M. (1998). *The family of adoption.* Boston: Beacon Press.

Pears, K. C., & Fisher, P. A. (2005). Emotion understanding and theory of mind among maltreated children in foster care: Evidence of deficits. *Development and Psychopathology, 17,* 47-65.

Perry, B. (1998). Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America, 7* (1), 33-51.

Peterson, M. (January 22, 2010). Personal communication.

Petra, M., & Kohl, P. (2010). Pathways Triple P and the child welfare system: A promising fit. *Children and Youth Services Review, 32*, 611-618.

Pinderhughes, E. E. (1996). Toward understanding family readjustment following older child adoptions: The interplay between theory generation and empirical research. *Children and Youth Services Review, 18* (1/2), 115-138.

Placek, P. (2007). National adoption data. *Adoption Factbook IV* (pp. 3-70. (Alexandria, VA: National Council for Adoption).

Post, D. E. (2000). Adoption in clinical psychology: A review of the absence, ramifications, and recommendations for change. *Journal of Social Distress and the Homeless, 9* (4), 361-372.

Prew, C., Suter, S., & Carrington, J. (1990). *Post adoption family therapy: A practice manual.* Salem: Oregon Department of Human Resources.

Prinz, R. (2009). Dissemination of a multilevel evidence-based system of parenting interventions with broad application to child welfare populations. *Child Welfare, 88* (1), 127-132.

Purvis, K. B., Cross, D. R., & Sunshine, W. L. (2007). *The connected child.* New York: McGraw Hill.

Randall, J. (2009). Towards a better understanding of the needs of children currently adopted from care: An analysis of placements 2003-2005. *Adoption & Fostering, 33* (1), 44-55.

Reilly, T., & Platz, L. (2003). Characteristics and challenges of families who adopt children with special needs: An empirical study. *Children and Youth Services Review, 25,* 781-803.

Reilly, T., & Platz, L. (2004). Post-adoption service needs of families with special needs children: Use, helpfulness, and unmet needs. *Journal of Social Service Research, 30* (4), 51- 67.

Reynolds, J., & Medina, S. (2008). Challenges and resiliency factors of families with internationally adopted children. In G. R. Walz, J. C. Bleuer, & R. K. Yep (Eds.). *Compelling counseling interventions: Celebrating VISTAS' fifth anniversary.* (pp. 81-90). Ann Arbor, MI: Counseling Outfitters.

Richardson, G. A., Ryan, C., Willford, J., Day, N. L., & Goldschmidt, L. Prenatal alcohol and marijuana exposure: Effects on neuropsychological outcomes at 10 years. *Neurotoxicology and Teratology, 24* (3), 309-320.

Rijk, C., Hoksbergen, R., & ter Laak, J. (2010). Development of behavioural problems in children adopted from Romania to the Netherlands, after a period of deprivation. *European Journal of Developmental Psychology, 7* (2), 233-248.

Robison, M., Lindaman, S. L., Clemmons, M. P., Doyle-Buckwalter, K., & Ryan, M. (2009). "I deserve a family": The evolution of an adolescent's behavior and beliefs about himself and others when treated with theraplay in residential care. *Child and Adolescent Social Work Journal, 26* (4), 291-306.

Rogeness, G. A., Hoppe, S. K., Macedo, C. A., Fischer, C., & Harris, W. R. (1988). Psychopathology in hospitalized, adopted children. *Journal of American Academy of Child and Adolescent Psychiatry, 27,* 628-31.

Rogosch, F. A., Cicchetti, D., & Aber, J. L. (1995). The role of child maltreatment in early deviations in cognitive and affective processing abilities and later peer relationship problems. *Development and Psychopathology, 7,* 591-609.

Rosenberg, E. B. (1992). The adoptive family life cycle: The children and their families through the years. New York: Simon & Schuster.

Rosenthal, J. A. (1993). Outcomes of adoption of children with special needs. *The Future of Children, 3* (1)*,* 77-88.

Rosenthal, J. A., & Groze, V. K. (1992). *Special needs adoptions: A study of intact families.* Westport, CT: Praeger.

Rosenthal, J. A., & Groze, V.K. (1994). A longitudinal study of special-needs adoptive families. *Child Welfare, 73* (6), 689-706.

Rosenthal, J. A., Groze, V. K., & Morgan, J. (1996). Services for families adopting children via public child welfare agencies: Use, helpfulness, and need. *Children and Youth Services Review, 18* (1/2), 163-182.

Rueter, M. A., & Koerner, A. F. (2008). The effect of family communication patterns on adopted adolescent adjustment. *Journal of Marriage and Family, 70*, 715-727.

Rushton, A., & Dance, C. (2003). Preferentially rejected children and their development in permanent family placements. *Child and Family Social Work, 8,* 257-267.

Rushton, A., Mayes, D., Dance, C., & Quinton, D. (2003). Parenting late-placed children: The development of new relationships and the challenge of behavioral problems. *Clinical Child Psychology and Psychiatry, 8* (3), 389-400.

Rushton, A., & Monck, E. (2009). Adopters' experiences of preparation to parent children with serious difficulties. *Adoption & Fostering, 33* (2), 4-12.

Russo, K. (March 11, 2010). Personal communication.

Rutter, M. (2005). Adverse preadoption experiences and psychological outcomes. In D. Brodzinsky & Jesus Palacios (Eds.), *Psychological issues in adoption* (pp.67-92). Santa Barbara, CA: Greenwood Publishing Group.

Rutter, M., Colvert, E., Kreppner, J., Beckett, C., Castle, J., Groothues, C., Hawkins, A., O'Connor, T. G., Stevens, S. E., & Sonuga-Barke, E. J. S. (2007). Early adolescent outcomes for institutionally-deprived and non-deprived adoptees. I: Disinhibited attachment. *Journal of Child Psychology and Psychiatry, 48* (1), 17-30.

Rutter, M., O'Connor, T. G., & English and Romanian Adoptees (ERA) Study Team. (2004). Are there biological programming effects for psychological development?: Findings from a study of Romanian adoptees. *Developmental Psychology, 40* (1), 81-94.

Ryan, J. P., & Testa, M. F. (2005). Child maltreatment and juvenile delinquency: Investigating the role of placement and placement instability. *Children and Youth Services Review. 27*(3), 227-249.

Sass, D. A., & Henderson, D. B. (2000). Adoption issues: Preparation of psychologists and an evaluation of the need for continuing education. *Journal of Social Distress and the Homeless, 9* (4), 349-359.

Schooler, J. E., & Norris, B. L. (2002). *Journeys after adoption: Understanding lifelong issues.* Westport, CT: Bergin & Garvey.

Sedlak, A. J. (1991). Study of adoption assistance impact and outcomes: Phase II report. Submitted to the Administration for Children, Youth, and Families, DHHS, Contract No. 105-89-1607. Rockville, MD: Westat.

Selman, P. (2009). The rise and fall of intercountry adoption in the 21st century. *International Social Work, 52* (5), 575-594.

Selwyn, J., & Quinton, D. (2004). Stability, permanence, outcomes and support: Foster care and adoption compared. *Adoption & Fostering, 28* (4), 6-15.

Sharma, A. R., McGue, M. K., & Benson, P. L. (1996a). The emotional and behavioral adjustment of United States adopted adolescents: Part II. Age at adoption. *Children and Youth Services Review, 18* (1/2), 101-114.

Sharma, A. R., McGue, M. K., & Benson, P. L. (1996b). The emotional and behavioral adjustment of United States adopted adolescents: Part I. An overview. *Children and Youth Services Review, 18* (1/2), 83-100.

Sharma, A. R., McGue, M. K., & Benson, P. L. (1998). The psychological adjustment of United States adopted adolescents and their nonadopted siblings. *Child Development, 69* (3), 791-802.

Silber, K. (September 28, 2010). Personal communication.

Silverstein, D., & Kaplan Roszia, S. (1988). Lifelong issues in adoption. In L. Coleman, K. Tilbor, H. Hornby, & C. Baggis (Eds.), *Working with older adoptees* (pp. 45-53). Portland, ME: University of Southern Maine.

Simmel, C. (2007). Risk and protective factors contributing to the longitudinal psychosocial well-being of adopted foster children. *Journal of Emotional and Behavioral Disorders, 15* (4), 237-249.

Simmel, C. Brooks, D., Barth, R. P., & Hinshaw, S. P. (2001). Externalizing symptomatology among adoptive youth: Prevalence and preadoption risk factors. *Journal of Abnormal Psychology, 29(1)*, 57-69.

Simmel, C., Barth, R. P., & Brooks, D. (2007). Adopted foster youths' psychosocial functioning: A longitudinal perspective. *Child and Family Social Work, 12*, 336-348.

Sims, P. (March 12, 2010). Personal communication.

Smith, D. W., & Brodzinsky, D. M. (2002). Coping with birthparent loss in adopted children. *Journal of Child Psychology and Psychiatry. 43*(2), 213-223.

Smith, S. L. (2006). The nature of effective adoption preservation services: A qualitative study. In M. M. Dore (Ed.), *The postadoption experience: Adoptive families' service needs and service outcomes* (pp. 159-196). Washington, DC: Child Welfare League of America.

Smith, S. L. (2006). A study of the Illinois adoption/guardianship preservation program. In M. M. Dore (Ed.), *The postadoption experience: Adoptive families' service needs and service outcomes* (pp. 67-94). Washington, DC: Child Welfare League of America.

Smith, S. L., & Howard, J. A. (1991). A comparative study of successful and disrupted adoptions. *Journal of Social Service Review, 65*,248-265.

Smith, S. L., & Howard, J. A. (1994). The impact of previous sexual abuse on children's adjustment in adoptive placement. *Social Work, 39* (5), 491-501.

Smith, S. L., & Howard, J. A. (1999). *Promoting successful adoptions: Practice with troubled families.* Thousand Oaks, CA: Sage.

Smith, S. L., Howard, J. A., & Monroe, A. D. (1998). An analysis of child behavior problems in adoptions in difficulty. *Journal of Social Service Research, 24* (1/2), 61-84.

Smith, S. L., Howard, J. A., & Monroe, A. D. (2000). Issues underlying behavior problems in at-risk adopted children. *Children and Youth Services Review, 22* (7), 539-562.

Smith, S. L., Howard, J. A., Garnier, P. C., & Ryan, S. D. (2006). Where are we now?: A post-ASFA examination of adoption disruption. *Adoption Quarterly, 9* (4), 19-44.

Smith-McKeever, T. C. (2005). Child behavioral outcomes in African American adoptive families. *Adoption Quarterly, 7* (4), 29-56.

Smyke, A. T., Koga, S. F., Johnson, D. E., Fox, N. A., Marshall, P. J., Nelson, C. A., Zeanah, C. H., & the BEIP Core Group. (2007). The caregiving context in institution-reared and family-reared infants and toddlers in Romania. *Journal of Child Psychology and Psychiatry, 48* (2), 210-218.

Sokol, R. J., Delaney-Black, V., & Nordstrom, B. (2003). Fetal alcohol spectrum disorder. *Journal of the American Medical Association, 290* (22), 2996-2999.

Spangler, G., Johann, M., Ronai, Z., & Zimmermann, P. (2009). Genetic and environmental influence on attachment disorganization. *Journal of Child Psychology and Psychiatry, 50* (8), 952-961.

Spence-Chapin Adoption Services. (2010). Post-Adoption Services. Retrieved 3/16/10 from: http://www.spence-chapin.org/post-adoption-services/c0_post_adoption_services.php

Steele, M., Hodges, J., Kaniuk, J., Hillman, S., & Henderson, K. (2003). Attachment representations and adoption: Associations between maternal states of mind and emotion narratives in previously maltreated children. *Journal of Child Psychotherapy, 29* (2), 187-205.

Steinberg, L. (2001). We know some things: Parent-adolescent relationships in retrospect and prospect. *Journal of Research on Adolescence, 11*, 1-19.

Stevens, K. (January 29, 2010). Personal communication.

Taddonio, R., Spence-Chapin. (March 19, 2010). Personal communication.

Tan, T. X. (2006). History of early neglect and middle childhood social competence: An adoption study. *Adoption Quarterly, 9* (4), 59-72.

Tan, T.X., & Marfo, K. (2006). Parental ratings of behavioral adjustment in two samples of adopted Chinese girls: Age-related versus socio-emotional correlates and predictors. *Applied Developmental Psychology, 27* (1), 14-30.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148* (1), 10-20.

Thomas, B. (2008). *More than a thread of hope. 2 DVD Set.* Available at: https://www.attachment.org/mm5/merchant.mvc?Screen=PROD&Store_Code=attachment&Product_Code=189&Attributes=Yes&Quantity=1

Tieman, W., van der Ende, J., & Verhulst, F. C. (2005). Psychiatric disorders in young adult intercountry adoptees : An epidemiological study. *American Journal of Psychiatry, 162* (3), 592-598.

Tieman, W., van der Ende, J., & Verhulst, F. C. (2006). Social functioning of young adult intercountry adoptees compared to nonadoptees. *Social Psychiatry and Psychiatric Epidemiology*, *41*, 68-74.

Timmer, S. G., Urquiza, A. J., Zebell, N. (2006). Challenging foster caregiver-maltreated child relationships : The effectiveness of parent-child interaction therapy. *Children and Youth Services Review, 28* (1), 1-19.

Triseliotis, J. (2002). Long-term foster care or adoption? The evidence examined. *Child & Family Social Work, 7* (1), 23-33.

Urban Systems Research & Engineering. (1985). *Evaluation of state activities with regard to adoption disruption.* Washington, DC: USR&E.

U.S. Children's Bureau. (2007). *Barriers and success factors in adoptions from foster care: Perspectives of families & staff.* Collaboration to AdoptUSKids. Retrieved March 8, 2010 from: http://www.adoptuskids.org/images/resourceCenter/BarrierSuccessFactors.pdf

U.S. Department of Health and Human Services (2007). *Child Maltreatment 2007*. Retrieved July 20, 2009 from: http://www.acf.hhs.gov/programs/cb/pubs/cm07/table5_5.htm

U.S. Department of Health and Human Services Administration for Children and Families. (2008). Adoptions of children with public child welfare agency involvement by state, FY 1995--FY 2006. Retrieved January 13, 2010 from: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/adoptchild06.pdf

U.S. Department of Health and Human Services Administration for Children and Families (2010). The AFCARS report: Preliminary FY2009 estimates as of July, 2010. Retrieved September 22, 2010 at: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.pdf

U.S. Department of State. (2009). Intercountry adoption: Total adoptions to the United States. Retrieved January 15, 2010 from: http://adoption.state.gov/news/total_chart.html

U.S. House Committee on Ways and Means. (2008). *The Green Book, Section 11-Child Welfare.* Retrieved July 30, 2010 from: http://waysandmeans.house.gov/media/pdf/111/s11cw.pdf
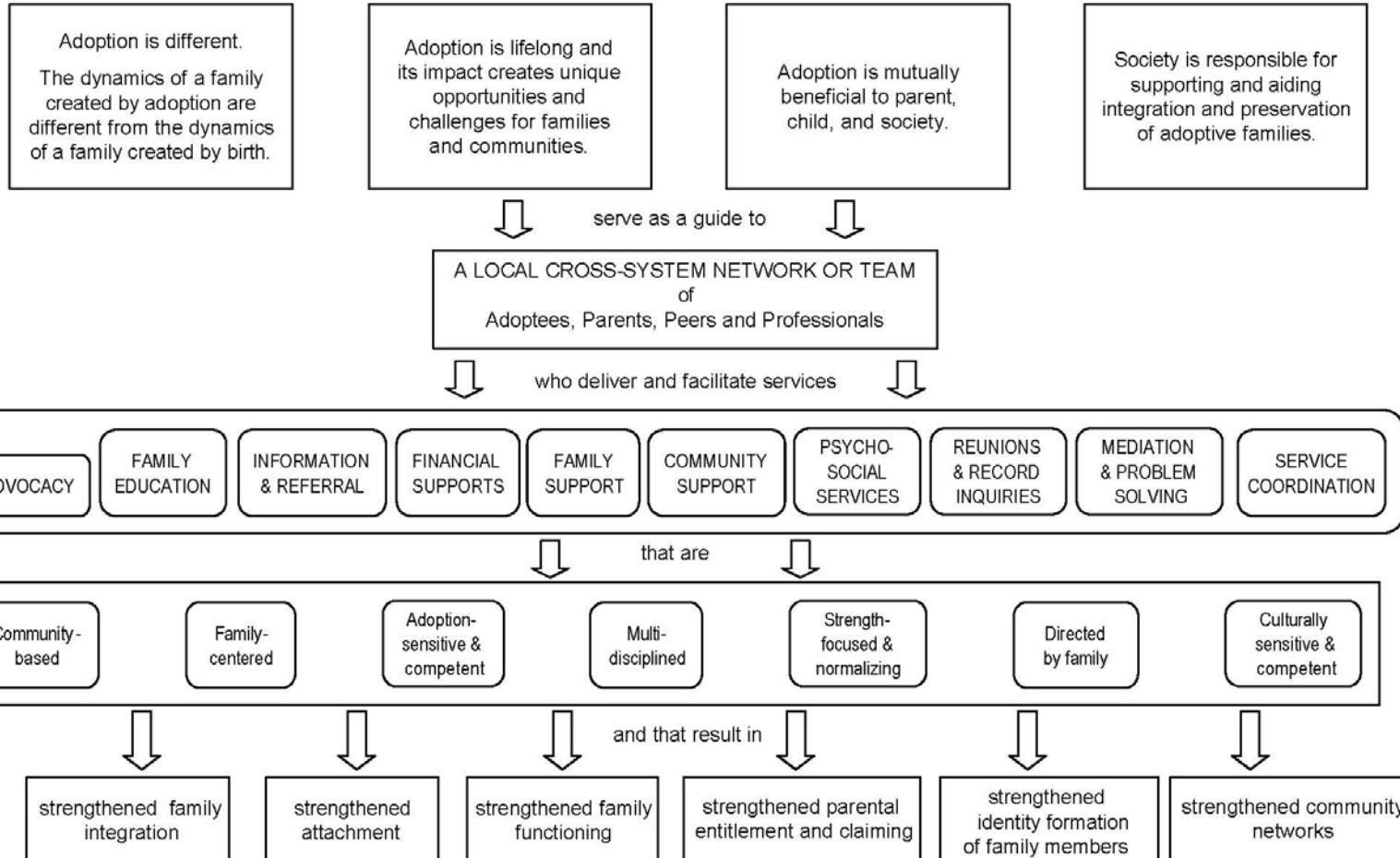
van den Dries, L., Juffer, F., van IJzendoorn, M. H., Bakermans-Kranenburg, M. J. (2009). Fostering security? A meta-analysis of attachment in adopted children. *Children and Youth Services Review, 31* (3)*,* 410-421.

van der Vegt, E. J. M., van der Ende, J., Kirschbaum, C., Verhulst, F. C., Tiemeier, H. (2009). Early neglect and abuse predict diurnal cortisol patterns in adults : A study of international adoptees. *Psychoneuroendocrinology, 34* (5), 660-669.

van der Vegt, E. J. M., van der Ende, J., Ferdinand, R. F., Verhulst, F. C. Tiemeier, H. (2009). Early childhood adversities and trajectories of psychiatric problems in adoptees: Evidence for long lasting effects. *Journal of Abnormal Child Psychology, 37* (2), 239-249.

Vandivere, S., Malm, K., & Radel, L. (2009). *Adoption USA: A Chartbook Based on the 2007 National Survey of Adoptive Parents*. U.S. Department of Health and Human Services. Retrieved November 23, 2009 from:
http://aspe.hhs.gov/hsp/09/NSAP/chartbook/index.pdf

van IJzendoorn, M. H., & Juffer, F. (2005). Adoption is a successful natural intervention enhancing adopted children's IQ and school performance. *Current Directions in Psychological Science, 14* (6), 326-330.

van Zeijl, J., Mesman, J., Stolk, M. N., Alink, L. R. A., van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Juffer, F., Koot, H. M. (2007). Differential susceptibility to discipline: The moderating effect of child temperament on the association between maternal discipline and early childhood externalizing problems. *Journal of Family Psychology, 21* (4), 626-636.

Verhulst, F. C. (2000). Internationally adopted children: The Dutch longitudinal adoption study. *Adoption Quarterly, 4* (1), 27- 44.

Verhulst, F. C., Althaus, M., Bieman, H. J. (1990). Problem behavior in international adoptees: II. Age at placement. *Journal of the American Academy of Child and Adolescent Psychiatry, 29,* 104-111.

Verhulst, F. C., Althaus, M., Versluis-den Bieman, H. J. M. (1992). Damaging backgrounds: Later adjustment of international adoptees. *Journal of the American Academy of Child and Adolescent Psychiatry, 31* (3), 518-24.

Versluis-den Bieman, H. J. M., & Verhulst, F. C. (1995). Self-reported and parent reported problems in adolescent international adoptees. *Journal of Child Psychology and Psychiatry, 36* (8), 1411-1428.

Warren, S. (1992). Lower threshold for referral for psychiatric treatment for adopted adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 31* (3), 512-517.

Waterman, J., & Edelstein, S., TIES. (Mar. 25, 2010). Personal communication.

Watson, K. (1991). *The role of the public agency: Delivering post adoption services.* Springfield, IL: Illinois Department of Children and Family Services.

Weiss, A., (1985). Symptomatology of adopted and nonadopted adolescents in a psychiatric hospital. *Adolescence, 20,* 763-774.

Weisz, J. R., & Gray, J. S. (2008). Evidence-based psychotherapy for children and adolescents: Data from the present and a model for the future. *Child and Adolescent Mental Health, 13* (2), 54-65.

Whittaker, J. K. (2009). Evidence-based intervention and services for high-risk youth: A North American perspective on the challenges of integration for policy, practice and research. *Child & Family Social Work, 14,* 166-177.

Wolf, P. (May 8, 2009). Personal communication.

Wong, B. Y. L. (2003). General and specific issues for researchers' considerations in applying the risk and resilience framework to the social domain of learning disabilities. *Learning Disabilities Research & Practice, 18* (2), 68-76.

Woody, S. R., Weisz, J. R., & McLean, C. (2005). Empirically supported treatments: Ten years later. *The Clinical Psychologist, 58*, 5-11.

Wright, G. (November 20, 2009). Personal communication.

Wright, L., & Flynn, C. C. (2006). Adolescent adoption: Success despite challenges. *Children and Youth Services Review, 28* (5), 487-510.

Wrobel, G., Kohler, J., Grotevant, H., & McRoy, R. (1998). Factors related to patterns of information exchange between adoptive parents and children in mediated adoptions. *Journal of Applied Developmental Psychology, 19*, 641-657.

Wrobel, G., Grotevant, H., Mendenhall, T., & McRoy, R. (2003). Contact in adoption: The experience of adoptive families in the USA. *Adoption & Fostering, 27,* 57-67.

Yates, M. (April 16, 2010). Personal communication.

Zosky, D. L., Howard, J. A., Smith, S. L., Howard, A. M., & Shelvin, K. H. (2005). Investing in adoptive families: What adoptive families tell us regarding the benefits of adoption preservation services. *Adoption Quarterly, 8* (3), 1-23.

APPENDIX I

NATIONAL CONSORTIUM FOR POST LEGAL ADOPTION SERVICES
ADOPTION SUPPORT AND PRESERVATION

The following principles

Adoption is different. The dynamics of a family created by adoption are different from the dynamics of a family created by birth.	Adoption is lifelong and its impact creates unique opportunities and challenges for families and communities.	Adoption is mutually beneficial to parent, child, and society.	Society is responsible for supporting and aiding integration and preservation of adoptive families.

serve as a guide to

A LOCAL CROSS-SYSTEM NETWORK OR TEAM
of
Adoptees, Parents, Peers and Professionals

who deliver and facilitate services

ADVOCACY | FAMILY EDUCATION | INFORMATION & REFERRAL | FINANCIAL SUPPORTS | FAMILY SUPPORT | COMMUNITY SUPPORT | PSYCHO-SOCIAL SERVICES | REUNIONS & RECORD INQUIRIES | MEDIATION & PROBLEM SOLVING | SERVICE COORDINATION

that are

Community-based | Family-centered | Adoption-sensitive & competent | Multi-disciplined | Strength-focused & normalizing | Directed by family | Culturally sensitive & competent

and that result in

strengthened family integration | strengthened attachment | strengthened family functioning | strengthened parental entitlement and claiming | strengthened identity formation of family members | strengthened community networks

Appendix II

Casey Family Services/The Casey Center for Effective Child Welfare Practice											
FINANCING ADOPTION AND POST-ADOPTION SERVICES											
Developed by Donald L. Schmid, Financing Consultant											
ADOPTION AND POST-ADOPTION SERVICES	**FEDERAL FUNDING SOURCES**										
	IV-B-1	**IV-B-2**	**IV - E Main.**	**IV-E Admin**	**IV-E Train.g**	**XIX**	**XX**	**Adop. Incen-tive**	**TANF/ EA**	**Chafee IL/ETV**	**CAPTA/ CBCAP**
ADMINISTRATION, CASE MANAGEMENT & SERVICES/TREATMENT											
Adoption Search	•	•		•			•	•	•		
Adoption Assistance Payment	•		•					•			
Adoption Resource Centers	•	•		•		•	•	•	•		•
Case Management	•	•		•			•	•	•	•	•
Case Plan/Review	•	•		•			•	•	•	•	•
Child/Family Advocacy	•	•		•		•	•	•	•	•	•
Crisis Intervention	•	•				•	•	•	•	•	•
Day Treatment	•	•				•	•	•	•		
Information & Referral to Adoptive Family	•	•		•			•	•			
Educational Advocacy	•	•				•	•	•			•
Eligibility Determination - IV-E & XIX				•		•					
Family Therapy	•	•				•	•	•			
Family Group Decision-Making/Team Meetings	•	•		•			•	•	•		•
Flexible Funding for Families		•						•			
Group Therapy	•	•				•	•	•	•		
Independent Living Services	•						•	•		•	
Individual Therapy	•	•				•	•	•	•		
Intensive In-Home Supervision	•	•					•	•	•		•

	1	2	3	4	5	6	7	8	9	10	11
Medical/Physical Health Services						•		•			
Medical/Behavioral Health Services	•	•				•	•	•	•		•
Mental Health Treatment	•	•				•	•	•	•		
Parent Aide	•	•					•	•	•		•
Parenting Education	•	•					•	•	•		•
Recreation Therapy	•	•				•	•	•	•		
Residential Treatment	•					•		•	•		
Respite Care	•	•					•	•	•		•
Social Skills Training	•	•					•	•	•		
Special Camps	•	•				•		•	•		
Substance Abuse Treatment	•	•				•	•	•	•		•
Supplies and Equipment	•	•				•		•			
Support Groups	•	•		•			•	•	•	•	•
Targeted Case Management (TCM)						•					
Wrap Around Services	•	•					•	•	•		•
TRAINING											
Adoptive Parents: Current/Prospective	•	•			•		•	•	•		
Community Education Regarding Needs of Adopted Children	•	•		•			•	•	•		
Private Agency Adoption/Case Management Staff	•	•			•		•	•	•		
Public Agency Adoption/Case Management Staff	•	•			•		•	•	•		
Court & Legal System re: IV-E Adoption Req.	•	•			•		•	•	•		

Explanation of Chart - This chart includes federal funding resources which are wholly or partially administered by the state/local child welfare agency to support a comprehensive array of allowable adoption and post-adoption services. It includes adoption-related services authorized in the Fostering Connections to Success and Increasing Adoptions Act of 2008 as well as other authorizing federal child welfare-related legislation, regulations and policies.

APPENDIX III

Risk Factors Influencing Adjustment in Adopted 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, and these are described in the paper. **For most children, adoption itself is a huge protective factor, bringing permanency, safety 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. This Appendix contains additional research findings on risk factors experienced by some adopted children.

Range of Resiliency
While risk factors are associated with lower levels of functioning, they do not necessarily predict problems for everyone who experiences 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).

Many children may also come from very different background situations yet be diagnosed with the same conditions, with some having no identified risk factors. For example, while domestic infant adoptees generally have been assumed to have the fewest risk factors for developmental problems, some recent studies have not corroborated this assumption. A University of Minnesota study of the mental health of U.S. adolescents adopted in infancy (placed by age 2) and using community-based samples, found that relative to nonadopted adolescents, domestic adoptees had 3.25 greater odds of having an externalizing disorder, while intercountry adoptees had 1.7 greater odds. The 178 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 problems, 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, and healthy brain development, and can increase other health and developmental risks as well. Low birth weight in itself poses some long-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, their average birth weight was 5.8 pounds, and low birth weight (defined as less than 5.5 pounds) had a large negative impact on the 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 -- the other two were the ages at which children entered orphanages and the length of their stays) – that significantly predicted higher behavior problem scores. Also, those who were premature had lower school competence scores (McGuiness & Pallansch, 2000; 2007). Another study found that infants coming to Russian orphanages had much higher rates of low birth weight and birth complications than were the norms for other infants in the country (Groark, Muhamedrahimov, Palmov, Nikifororova, & McCall, 2005).

A very recent study following the growth of institutionalized children remaining in institutions or placed in foster homes found that low-birth-weight children are particularly vulnerable to social deprivation, and the sensitive period for growth recovery is under 12 months of age (Johnson, Guthrie, Smyke, Koga, Fox, Zeanah, & Nelson, 2010).

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 low birth weight are common consequences for the children of parents who use 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 these risks escalate exponentially with exposure to multiple drugs (Bada & colleagues, 2005).

The chronic impact of heavy alcohol consumption during pregnancy results in some of the most devastating long-term challenges, which are described as fetal alcohol spectrum disorders. The most severe form, fetal alcohol syndrome, is characterized by irreversible neurological and physical abnormalities. 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 other Eastern European countries, where alcohol consumption is common, have a higher than average rate of fetal alcohol exposure (Aronson, 2000; Miller, et al., 2006). For example, a study of 105 children adopted from the former Soviet Union found that despite unknown prenatal histories for over half the children, 41% were known to have mothers who abused alcohol during pregnancy (McGuiness & Pallansch, 2000). Another study, of 234 residents of a baby home in Russia, assessed more than half of residents as having intermediate to high scores that indicated prenatal alcohol exposure (Miller, et al., 2006).

Longitudinal studies have been conducted that collect 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 exposure 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 have been exposed prenatally to   drugs (cocaine, marijuana, or heroin) with those known to not have been exposed at two, four, eight 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 four-year follow-up the two groups were alike on most measures, including parental satisfaction with the 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 a study by this report's author of outcomes in over 1300 foster care adoptions (Howard & Smith, 2003), 60% 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 their 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 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 the children's 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 the 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 that 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, et al., 1996b; Merz & McCall, 2010). For example, the latter study by Sharma and colleagues compared adopted teens in four groups by age at adoption: 0-1, 2-5, 6-10, and older than 10; the researchers found that infant-adopted youth were most similar to the non-adopted peers and those adopted after age 10 had the worst adjustment levels. The behavior of the teens in the middle two groups generally ranked between the early- and late-placed groups.

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 do report differences among some groups. For example, the Dutch longitudinal study described in the full paper in the section on adoption outcome research 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 adoptees 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 the adverse experiences 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 a Dutch longitudinal study of internationally adopted children, the older the age of the child at placement, the greater the probability of experiencing early maltreatment and multiple placements. 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 Chronic Neglect
Adequate nurture 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 six 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 3½ years, and has 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 two years or more. Also, there was marked heterogeneity in children's cognitive functioning that 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 six months were more likely to show a pattern of "disinhibited attachment," characterized by the relative failure to develop a normal attachment relationship rather than insecurity in an established attachment. (Children would act silly, seek attention, and 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 (a part of the brain involved in basic emotional processing and guiding social behaviors). They concluded 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 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 adoptions and to provide their basis for this assessment. For the girls known to have been neglected, 42% scored below average on a social competence scale, as compared to only 14% of girls not known to have experienced neglect. Not every study of intercountry adoptees has found a long-term impact of institutionalization on child behavioral adjustment; for example, one study of 695 girls 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).

One problem frequently found 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 (Cermak & Groza, 1998). For example, a study of 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 atypical behaviors, including oversensitivity to tactile sensations such as shirt labels rubbing their necks or defensiveness to being touched, hypersensitivity to noises, an aversion to many tastes or food textures, being distractible or whiny, clumsiness, and others (Purvis, et al., 2007). This condition among adopted children has been researched primarily among those coming from institutions abroad, and while children experiencing chronic neglect in the U.S. also are likely to experience sensory integration difficulties, this is an area that needs further research.

Neuroendocrine imbalances, such as abnormally high or low cortisol levels (a hormone produced by the adrenal glands), also 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 6½ years on average after their adoptions, children who spent eight months or more in Romanian orphanages showed higher cortisol levels than did two comparison groups of children. Cortisol is one of two major stress-related hormones, and having too much or too little of it for an extended period can cause a range of developmental problems.[18] The Dutch longitudinal study

---

[18] 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).

described earlier assessed cortisol levels in 623 young adult intercountry adoptees, finding that those who had experienced severe neglect or abuse had lower morning cortisol levels than did 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). There is a broad range of conditions classified under neglect, however, 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% of these cases pose a high level of risk to the child (Chambers & Potter, 2009).[19] Severely neglectful mothers interact minimally with their children, provide less affection, 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 that hampers normal child development in all its domains.

Neglect is sometimes erroneously perceived as less serious than physical or sexual abuse; however, a longitudinal study of at-risk children in the U.S. found that neglect in infancy was a significant predictor of aggression at ages 4, 6, and 8; whereas early abuse or later neglect or abuse were not significant predictors of later aggression for this group of children (Kotch, et al., 2010).

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/or emotional abuse, as well as witnessing violence. 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. In addition, some children experience multiple types of maltreatment as well as other types of trauma, such as witnessing violence and/or traumatic loss. Research indicates 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 come to light. A minority of substantiated child abuse and neglect cases involve physical abuse (10%), sexual abuse (7%), psychological maltreatment (4%), or multiple maltreatments (13%) (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 various types of maltreatment, including an "unsure" category. The incidence of various types of maltreatment reported were: serious neglect (63%), physical abuse (33%), and sexual abuse (17%), with another one-quarter of the parents stating they were unsure whether their children 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 trauma histories. One study reported that children diagnosed with externalizing disorders had experienced more trauma than had those with other diagnoses. In fact, 91% of children dually diagnosed with both ADHD and ODD were assessed as having a traumatic history, primarily physical or sexual abuse (Ford, Racussin, Ellis, Daviss, Reiser, Fleischer, &

---

[19] 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).

Thomas, 2000). The causal pathways for understanding the relationship of trauma to behavior is complex and needs further theory development and research.

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 related 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). The maltreatment of children also puts them at increased risk for depression (Ji, Barth, Brooks, & Kim, 2010) – and can affect their adjustment into adulthood, especially when the 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, including among adopted children. 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 eight times greater odds of their adoptive 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, anxiety, depression, low self-esteem, difficulties in self-regulation of feelings and behaviors, and PTSD-related symptoms such as hyperarousal, intrusive thoughts, and avoidance responses ranging from avoiding stressful situations and numbing of feelings to dissociation. Trauma experts have coined the term "complex trauma" to describe the cumulative effects of prolonged exposure to traumatic experiences. 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). Hart and Luckock (2004) suggest that the main legacy of previous maltreatment is in "the way children have organized, or have tried to organize, survival and coping strategies in the face of risk and adversity…" (p. 43). Trauma experts have identified seven domains of impairment in children exposed to complex trauma – attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept (Cook, et al., 2005).

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). There is a certain amount of plasticity or malleability in the neural systems involved in early life trauma, both in stimulating development of underdeveloped neural cells and the potential for other brain cells to take over functions carried out by damaged cells, particularly at very young ages (Fisher & Gunnar, 2010).

An additional area of functioning challenged by 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). Overall, trauma experts have identified seven domains of impairment in children exposed to complex trauma – attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept (Cook, et al., 2005).

Number of Placements Prior to Adoption

An additional factor in the pre-adoption history of children that has been linked with greater risk for ongoing adjustment problems is their number of placements prior to 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 high levels 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 single event of removal from family and placement into foster care. For example, one study evidenced that adopted children with histories 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 three or more moves had a much higher rate of delinquency (Ryan & Testa, 2005).

Placement instability undermines the development of a secure parent-child attachment, which is essential for building emotionally strong and psychologically healthy children. Children need adults who are invested in them and understand their nuances of temperament, behaviors, and needs. Without the reciprocal emotional investment of the parent-child relationship, children do not receive the emotional support they need from a caring adult whom they can count on to be there for them in the future.

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 identities. It is common for adopted children to struggle at times with their feelings about 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). Also, loss is a central issue in adoption, and becomes particularly salient for children placed at older ages who have experienced many traumatic separations. These children typically have not been helped to mourn previous losses, which can contribute to ongoing emotional problems.

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. 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 with significantly higher levels of alienation and lower levels of trust for their adoptive parents (Kohler, Grotevant, & McRoy, 2002).

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 White Dutch families. She found 55% of these children had expressed the wish to be White and/or to have been 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 children's country of origin; i.e., those with dark skin reported the greatest concern about difference.

A study by this report's author 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 five of the six 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.

Finally, an English study of children placed from care in middle childhood found that the minority of those (27%) who had not yet developed an attached relationship to at least one parent by one year after placement were much more likely to have serious behavior problems than those who had formed such a relationship (Rushton, Mayes, Dance, & Quinton, 2003). It is not clear whether the problems negatively affected development of an attachment relationship or the lack of an attachment relationship contributed to problem expression.