

Article 18

Post-Adoption Counseling: Clinical Efficacy and Potential Benefits

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Adoption is defined as the social and legal placement of a child or children into a home other than with birth parents (Sharma, McGue, & Benson, 1996a; Sharma, McGue, & Benson, 1996b). Over the last forty years an increasing number of Americans have pursued adoption as a method for fulfilling the desire to have a family life with children (Nickman et al., 2005). Further, International adoptions in the United States have more than doubled between 1991 and 2003 (Mohanty & Newhill, 2006). Yet, despite the increased willingness to adopt, many people are frustrated by an ever increasingly complex adoption process. Fewer healthy Caucasian children available for adoption (Reilly & Platz, 2003; Wright & Flynn, 2006); adoption legal reform (Egbert & LaMont, 2004; Reilly & Platz, 2003); and the growth in acceptance of transracial, transcultural, and international adoptions (Groe, 1996) are some of the issues identified as contributing factors to the increased biological, psychological, and social complexity of adoption.

Adoption Disruption

Unfortunately, despite the wider social acceptance of transracial, transcultural, and international adoptions, the biopsychosocial complexities of these adoptions may also be related to the increasing number of adoption disruptions (failures; Rosenthal & Groe, 1994). Adoption disruption rates have been reported with wide variance from 2.9% to 31% (Poertner, McDonald, & Murray, 2000). Many factors have been reported as influencing adoption disruption. Egbert and LaMont (2004) noted that the parents who reported feeling more prepared for the adoption fared better in terms of the duration of the adoption. One recent study reported additional factors that could be related to adoption disruptions including age at placement, behavioral problems, parental

preferential rejection, time spent by a child in foster care before adoption, and attachment issues between the adoptee and the adoptive parents (Dance & Rushton, 2005). Rosenthal (1993) reported in a literature review that disruption rates were higher when the child was older at adoptive placement; inadequate background information or unrealistic parental expectations existed; family functioning patterns were rigid, especially if the father was absent in parenting tasks; little support came from relatives or friends; the child's history included prior physical and sexual abuse or a history of psychiatric hospitalization; the child had externalized behavioral problems including sexual acting-out; and the adoptive placement was with new adoptive parents, not by foster parents. When combining some of these characteristics for analyses, the disruption rates ranged from 20-75% for an adolescent population (Berry & Barth, 1990). The adoption disruption rate in 1988 for this sample was 24.2% for adolescents ages 12 to 17 from several counties in California (Berry & Barth, 1990).

Common adjustment problems, which are the focus of treatment for adopted children, include fighting, difficulty in becoming emotionally attached to the adoptive parents, substance abuse, and school failure (Brooks, Allen, & Barth, 2002; Wilson, 2004). In addition to adjustment issues many adopted children also have special needs such as medical problems, behavioral or mental health problems, and developmental disability (Reilly & Platz, 2003).

Often adoptive parents are not given full disclosure of the child's history or their problems are minimized (Lightburn & Pine, 1996). Thoburn (2002) indicates that many children who were older at the age of adoption and displaying problem behaviors and emotional difficulties may have had difficult or traumatic experiences in their past history. Another issue highlighted in the literature is that adopted children may have been previously reared in various (Groze, 1996) or stressful environments and then may present for treatment with a variety of issues, disorders, diagnoses, or experiences. Some may have experienced prenatal (Barth & Needell, 1996) or at-home substance abuse, physical and/or sexual abuse, residential housing and/or psychiatric hospitalization (Brooks et al., 2002; Staff & Fein, 1995). For some adoptive families, a child's history may have included abuse that was not discovered until after the adoption (Lightburn & Pine, 1996).

Evidence of the difficulties that adoptive families with special-needs children often face includes higher rates of these families being reported to child protection authorities (Lightburn & Pine, 1996). Of the community services requested for special-needs children, Lightburn and Pine reported that adoptive families needed counseling 59.6% of the time for children with developmental disabilities. Disparagingly, it has been estimated that 10-15% of adoptions of special-needs children ended in disruption (Rosenthal, 1993).

Post-Adoption Counseling: Normalization Model

In response to the high levels of adoption disruptions, it has been suggested that post-adoption counseling services be provided to assist the newly constituted families. The focus of these services is to assist the families in coping with the potentially complex biopsychosocial issues that the adoption creates (Egbert & LaMont, 2004). Currently there are many different adoption counseling approaches used in clinical settings,

although to date most have not been empirically studied or supported (Rosenthal, 1993). The present study was conducted at an adoption counseling agency in a large Midwestern city for the purpose of evaluating the efficacy of the treatment provided. The goal of the treatment was to lessen the severity of the adopted child's problem behaviors. The agency treatment philosophy was to use "Normalization Therapy for Adoptive Families" (Dupre-Clark, 2002).

The Normalization Therapy model was developed by the "Post-Adoption Program" staff. The agency staff participated in several yearly training sessions and followed a Normalization Therapy treatment manual describing treatment theory/protocols, and group and individual counseling. The model focuses on how adopted children develop symptoms and problem behaviors and how parents can address those issues. Counseling is viewed as an opportunity for adopted children and their parents to explore the possibility that pre-adoptive influences from breaks with previous early environments are the root of current adjustment problems (A. Dupre-Clark, personal communication, February 19, 2007). It was theorized in the treatment manual that many behavioral and emotional issues for adopted children are in some cases "driven" by a child's early experiences.

Dupre-Clark (2002) asserted that Normalization Therapy consisted of creating a safe environment and a working alliance in the counseling session coupled with helping the children to work through the causes of their difficulties through the use of therapy occurring in three stages. The first stage was called the intentional treatment stage. The intentional treatment stage occurred after an initial diagnostic interview. The processes of this stage were empathetic engagement, living in triangles and rebuilding relationships, consolidating gains, and termination.

The focus in the empathetic engagement process was to help the children identify their concerns, realize they were not the cause of their attachment problems, and share their experiences with their therapist. The "living in triangles and rebuilding relationships" component involved educating children about the different relationship triangles in which they have lived (Dupre-Clark, 2002). One sub-goal of this stage was to assist the children in becoming aware of, accepting, and evaluating their feelings about their birth families (Dupre-Clark). This phase integrated cognitive, behavioral, and reality therapies (Dupre-Clark). One important aspect of treatment in these first two stages was engaging the adoptive parents in consultation with the therapist, thus helping the parents to form the consolidating gains stage of Normalization Therapy. Each clinician was directed to teach parents how to address such things as loss of birth origins and adoption in their children (e.g., control, identity, rejection and abandonment issues). According to Dupre-Clark (2002), the purpose is to aid parents in developing a "parenting repertoire". Communication, cognitive, and emotional techniques are used during family therapy sessions. Children at this stage are being given tools to help them develop an awareness of their difficulties/issues.

The termination stage included summarization of the children's progress and the family's continuing in support and psycho-education groups (Dupre-Clark, 2002). Also, the children may have received respite care, and the families may have been offered retreat opportunities throughout the treatment process.

Method

This study sought to examine the effectiveness of post-adoption counseling treatments by using a pre- and post-test evaluation design intended to measure the behavior of the adopted children as they adjusted to their new family environment.

Procedure

Families of children who were adopted, experienced a problem, and sought counseling comprised the sample participants in this study. The post-adoption counseling services that all participants received were those regularly provided by the agency under the Normalization Therapy model. Parents and participants willingly signed informed consent forms after the purpose of the study was explained to them during the intake interview by the treatment staff. Fifty participants were enrolled in the study. Nine of the participants were eliminated from the study due to lack of a post-RBPC score. Three of the participants were omitted from the study due to scoring discrepancies (different people scored the children) therefore 38 participant scores were calculated for the study results. The study was conducted by having the parent or legal guardian fill out a Revised Behavior Problem Checklists (RBPC, Quay & Peterson, 1987) during the initial interview with the family and at three month intervals during the course of treatment. The mean time duration from the pre-test to the post-test administration was 11.45 months (SD 8.74) with a range of 3 to 39 months.

Sample

Demographic data, dates and types of treatment, and other pertinent information were collected in a chart review. The research team did not have any contact with the clients. The sample consisted of 22 female and 16 male children, adolescents, and teenagers ages 5 to 17. The mean age of the children and adolescents at the time of their adoption was 3.48 (SD 3.56) with a range from 3 days to 17 years of age. The sample consisted of 18 Caucasian (43.9%), 10 African American (26.8%), 5 Asian or Pacific Islander (12.2%), 1 Hispanic (2.4%), 3 Biracial (7.3%), and 1 other (2.4%). The mean age of the sample at the time they came to treatment was 10.8 years (SD 3.49), and the mean age at discharge was 11.09 years (SD 3.83). Five participants had been hospitalized in a psychiatric unit once, and two were currently living in residential treatment situations during their time in counseling.

Most of the children and adolescents (85.4%) did not have any history of substance abuse or use although 17 (41.5%) had been exposed in utero to some type of illicit drug. Two of the children had prenatal exposure to cocaine, and one child had been given alcohol during infancy.

The Axis III diagnoses of the participants varied somewhat. During treatment, nine of the participants had emotional problems relating to adoption adjustment issues, eight had conflicts with adoptive parents, and six had academic problems. This differs from the literature in that school problems were reported as the most prevalent problem (Barth, Gibbs, & Siebenaler, 2001). Another five had diagnoses of peer relationship problems, and five had histories of sexual abuse with two of these children touching others inappropriately and one being labeled as a sexual abuse perpetrator.

Sixty percent of the participants came into the study having been prescribed a wide range of psychotropic or other medication(s). Ten participants were prescribed medications such as Adderall®, Concerta®, Clonidine®, or Strattera® for diagnoses of Attention Deficit Hyperactivity Disorder. Seven participants were taking one or two anti-depressant medications (Effexor®, Imipramine®, Lexipro®, Prozac®, Paxil®, Zoloft®, and/or Wellbutrin®). Four participants were prescribed major tranquilizers and three participants were taking anti-seizure medications. Thirty of the participants did not experience any change in their medications during their time in the study.

The parental structure of the homes varied. Twenty-two of the adoptive couples were mother/father dyads. Twelve homes were headed by single mothers. One adoptive couple consisted of two females, one household was headed by a widow, one couple was divorced and remarried to different spouses, and another couple was divorced. The mean age of the mothers ($n = 38$) was 45.92 (SD 6.38). The mean age of the fathers ($n = 23$) was 46.86 (SD 7.38). Although these ages are older than the ages of parents in the general population of all families, these ages were similar to the Lightburn and Pine (1996) convenience sample study results wherein the mean age of the mothers was 46 and that of the fathers was 47. The adoptive parents' income ranged from \$20,000 to \$150,000 with a mean income of \$74,052.63. This sample's family income greatly differed from other studies that reported a substantial proportion had relatively low income (Barth et al., 2001). The children, adolescents, and teenagers received a mean total of 25.66 treatment days (SD 24.01).

Instrument

The Revised Behavior Problem Checklist (RBPC, Quay & Peterson, 1987) is an instrument that parents, guardians, and teachers use to rate problem behaviors observed in children ages 5-18. The six RBPC subscales are Conduct Disorder, Socialized Aggression, Attention Problems-Immaturity, Anxiety-Withdrawal, Psychotic Behavior, and Motor Tension-Excess. The adults who fill out the RBPC record one of three choices that include the child does not have a problem, exhibits somewhat of a problem, or displays a severe problem for each symptoms by circling a 0, +1, or +2 on the form. According to the test manual, the mean internal consistency reliabilities, based on teacher ratings of students, ranged from .73 - .94 for the six subscales (Quay & Peterson, 1987).

Results

These children, adolescents, and teenagers received different levels of counseling treatment in a private counseling agency. The counseling levels included individual counseling, group therapy, and parent support groups. Thirty-six of these participants received individual counseling while two received group counseling only. Eighteen participants received all three levels of counseling. The individual counseling was provided by Master's level trained and licensed clinical counselors, independently licensed Social Workers, or a Clinical Director with a Clinical Counseling license. Group counseling consisted of a group that was formed and led by licensed social workers. The number for all levels of treatment sessions ranged from 3 to 129 sessions.

Paired sample *t* tests were conducted on the pre-and post-test RBPC scores. Table one represents the mean and standard deviations of both pre- and post- test RBPC subscales. While all the post-test mean scores on the RBPC were lower than the pre-test

score means, only one subscale, Conduct Disorder, was found to be statistically significant ($M = 3.97$, $SD = 8.77$) $df = 37$, $t = 2.79$, $p > .008$).

Table 1: Means and Standard Deviations of the pretest and posttest scores of the Revised Behavior Problem Checklist subscales (Quay & Peterson, 1987).

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	pcpreCD	67.4474	38	12.14707	1.97051
	pcpostCD	63.4737	38	11.46731	1.86024
Pair 2	pcpreSA	61.9474	38	11.03789	1.79058
	pcpostSA	60.6316	38	11.57915	1.87839
Pair 3	pcpreAP	64.4211	38	10.64572	1.72696
	pcpostAP	62.7632	38	10.41681	1.68983
Pair 4	pcpreAW	64.1842	38	10.86491	1.76252
	pcpostAW	62.7632	38	10.99984	1.78441
Pair 5	pcprePB	60.5526	38	10.99065	1.78292
	pcpostPB	58.5000	38	11.60324	1.88229
Pair 6	pcpreME	60.2895	38	10.83016	1.75688
	pcpostME	57.7368	38	9.83563	1.59555

Discussion

The results of this study are to be interpreted with caution. This effectiveness study was intended as the initial groundwork to better understand whether or not post-adoption counseling had lessened the symptoms of the children and teenagers who had been adopted. It should be noted that participants were rated as having fewer symptoms on their post-tests than during their initial intake into counseling. According to the treatment records, many developed different symptoms in new behavioral problem eruptions, possibly accounting for the overall small differences in the RBPC treatment results. Another possible cause for the lack of significance was that of the 38 cases, only 20 were successful terminations and the remaining 18 cases were still receiving treatment at the end of the study.

Another possibility was that some of the parents may have over-rated the participants' symptoms and their severity on the RBPC. This has been explained by Barth et al. (2001) and Barth and Miller (2000) as the adoptive parents' tendency to over-assess their children because of their high expectations. Upon review of the RBPC scores, it was noticed that some parents rated their children, adolescents, or teenagers as experiencing anxiety-withdrawal symptoms as well as having severe motor excess symptoms. This dyad of symptoms is not typically matched and may indicate the parents may have viewed their children more severely than others may rate them (Quay & Peterson, 1987).

One of the most important reasons for families to enter into counseling is saving the adoption. Thirty-five of the participants' thirty-eight adoptions, according to the agencies' treatment staff, were reported as saved (the family unit remained intact) and three were revoked (permanently disrupted adoption). This high number of intact

adoptions could be considered clinically significant, given some of the characteristics and past history of the participants (i.e., the range of age at adoption, psychiatric hospitalization history, exposure to prenatal drug abuse, and the large percentage of participants taking psychotropic medications).

Limitations

This study had several methodological issues. One issue was this study's sample consisted of a small number of children ages 5 to 18. Children under the age of five were not studied as the RBPC is an instrument designed with that limitation. The adopted sample's home/school/social lives and their current adoptive parental influences were diverse as well. Further, other factors such as age at adoption and prenatal influences were wide-ranging (from shortly after birth to teenagers). Another confounding factor was that the treatments received by the participants ranged from 3 individual counseling sessions to 129 sessions that included child, parent, support group, and family sessions. The income levels of the families were higher than the average American family, although the numbers were comparable to other adoptive families (Freundlich, 2002; O'Brien & Zamostny, 2003).

Future Research Directions

Due to a variety of biopsychosocial problem areas, some of the children, adolescents, and teenagers who have been adopted need access to post-adoption counseling services (Barth et al., 2001; Pierce, Sarason, Sarason, Joseph, & Henderson, 1996, cited in Brooks, Allen, & Barth, 2002). These services usually have not been evaluated or researched as recommended in the literature (Barth et al., 2001; Rapp & Poertner, 1992; as cited in Brooks, Allen, & Barth, 2002). Studies on the effects of international, transracial, open, and sibling adoptions and their multiple variables hopefully will be forthcoming. One example of a research gap is the level of racism and discrimination (Freundlich, 2002) and its impacts upon this population and their counseling treatment.

The need for continued research in order to better understand this population is warranted (Nickman et al., 2005). Children, adolescents, and teenagers may experience adoption disruption, but most importantly, may have a need to address some of their prior experiences if they lived in a home with chaotic circumstances and other family members with problem behaviors (Wright & Flynn, 2006). Due to these special circumstances, some of those who have been adopted need counseling along with their adoptive parents. As for the adoptions where diverse cultures and races exist, very little information is known or has been researched about how to help these children resolve problems relating to acclimating with their new community or family (Alexander & Curtis, 1996; Kapp, McDonald, & Diamond, 2001; Pinderhughes, 1996).

There are overall recommendations about the research for the adopted population. First, a method of classifying the types of treatment given to this population should be established (Barth et al., 2001). Important questions to be investigated will be what type/theory, methods, and level of counseling lead to positive outcomes for this population. Critical to this understanding will be the exploration of appropriate

assessment instruments that measure the differing characteristics and not just the negative behavioral symptoms of the adopted population (Alexander & Curtis, 1996; Kleist, 1998). Additionally, the assessment methods of studying adoption counseling outcomes should be defined (there is not another study using the RBPC with this population) and assessment tools refined to reliably measure the diverse characteristics of adoptees and their family constellations. Especially lacking are assessment tools written to reliably measure symptoms of members in transracial, transcultural, and international adoptions.

In future studies, the positive effects (e.g., increase in social support) and outcomes (e.g., improved self esteem) of participating in counseling could be measured. Further, there is a need to define and understand how recently asserted terms, coined to characterize this population, such as “birth parent rejection,” “preferential rejection,” and “false affection” could affect the adoptees’ acclimation to a new family (Dance, Rushton, & Quinton, 2002). Further, qualitative studies could examine parent and child attachment and different responses a child has to a father or mother. As the diversity in adoptive families evolves, the need for new ways to counsel and gain therapeutic alliance with this population will grow exponentially. Also, different treatment approaches merit review (Barth et al. 2001) and the utilization of treatment manuals would enhance the assessment integrity of counseling methods (Sexton, 1996). Lastly, replication and longitudinal studies are recommended to build upon this study and the literature. Children, adolescents, and teenagers who have been adopted and require counseling services are growing in number and diversity. The adopted children, adolescents, and teenagers in counseling and their families need tools and techniques to help them identify and alleviate their diverse issues and problems.

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