ABSTRACT

Title of Document: DOES ADOPTION THERAPY WORK?: EVALUATING A THERAPY PROGRAM FOR ADOPTED CHILDREN AND THEIR FAMILIES.

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The purpose of this study was to evaluate the extent to which participation in an integrated therapeutic intervention for adopted children and their families related to positive psychological outcomes. Fifty children and their parents receiving adoption-competent therapy at a community mental health center specializing in the treatment of adoptive families were assessed prior to and at the conclusion of treatment on indices of child and family functioning. At post-test, children exhibited fewer emotional and behavioral problems than they did at pre-test. No differences in family functioning were found. Higher levels of therapist adherence to the treatment model were associated with fewer emotional problems, greater parental satisfaction with adoption, and greater satisfaction with treatment. Implications for practitioners, directions for future research, and the limitations of this study are discussed.

DOES ADOPTION THERAPY WORK?: EVALUATING A THERAPY PROGRAM FOR ADOPTED CHILDREN AND THEIR FAMILIES.

By

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Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2013

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Acknowledgements

I thank my committee members, Dr. Karen O'Brien, Dr. Ellen Fabian, Dr. Paul Hanges, Dr. Dennis Kivlighan, and Dr. Matt Miller for their support and guidance. Their thoughtful comments improved this project on many levels.

I also thank The Center for Adoption Support and Education as an agency as well the following individuals at CASE: Cynthia Cubbage, Sean Delahant, Lisa Dominguez, Mari Itzkowtiz, Madeleine Krebs, Valerie Kunsman, Susan LaVigna, Debbie Riley, Allyson Shaffer, Ann Roth, and Hannah Worthington. I would especially like to thank Valerie Kunsman. Without her support, diligence, and graciousness this project would not have been possible. Very special thanks is also due to the participating families for whom I feel great appreciation and gratitude. My research assistants Janice Castro, Alex Hammer, and Jared Utley contributed much to the successful completion of this study through their dedicated efforts in data entry.

To my advisor Dr. Karen O'Brien I would like to extend my deep gratitude for her enduring support, guidance, and mentorship. Karen has been an important role model in my life who has helped me believe in myself and expect excellence from myself. Her blend of appropriate challenge, constructive feedback, warmth, encouragement, and caring supported me and guided me through even most difficult and challenging periods of my training.

The support and love of my friends and family has been an essential component of not only this project but my success in graduate school. I want to thank my friends David Simmons and Valerie Tracy, whose many hours rechecking and cleaning the data made the timely completion of this project possible. I would like to thank my dear friend

John and my wonderful community of friends for their unconditional love and support during my graduate career. Finally, and most importantly, are the thanks owed to my parents John and Ellen Wydra. It is to them this project is dedicated. Though my dad passed away during my first year of my doctoral program, his wonderful sense of humor, unconditional love, and affection has continued to sustain and inspire me. My mother told me countless times throughout my formative years that there was nothing more important to a woman's success than a good education. So, I thank you mom and dad, for your unfailing love and support that have made it possible for me to attain this achievement.

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CHAPTER 1

Introduction

Adopted children and adults comprise about 2.5% of the U.S. population (Brooks, Simmel, Wind, & Barth, 2005) or roughly 7.6 million persons. However, when compared to their rates in the general population, adoptees are overrepresented in the clinical population (Miller, Fan, Grotevant et al., 2000), constituting 5 to 17% of those seeking mental health services (Haugaard, 1998; Ingersoll, 1997). Studies of the adjustment of adopted persons have found that while the majority function well (Borders, Penny, & Portnoy, 2000; Burrow, Tubman, & Finley, 2004), many adoptive families need assistance throughout the life cycle with normative developmental issues related to adoption (O'Brien & Zamostny, 2003). Moreover, a substantial minority experience serious emotional and behavioral problems (Juffer & van IJzendoorn, 2005; Keyes, Sharma, Elkins, Iacono, & McGue, 2008; Nickman et al., 2005) and need intensive therapeutic interventions.

Despite the unique mental health needs of adopted children and their families, therapists historically have worked with this population without adequate training related to adoption (Henderson, 2000). This is problematic because when the mental health needs of adoptive families are not fully addressed, adopted children and their families are at further risk for long-term maladjustment (Rycus, Freundlich, Hughes, Keefer, & Oakes, 2006). A model of adoption-competent therapy recently has been developed by the Center for Adoption Support and Education (CASE), Burtonsville, MD, to educate therapists regarding issues that have been identified as salient in the lives of adopted persons and their families. The purpose of the study was to investigate the extent to

which participation in an integrated therapeutic intervention for adoptive families relates to positive socioemotional outcomes for adopted children and their families.

The need for adoption focused therapy

Within the past 40 years, a large body of literature examining the outcomes associated with adoption has been amassed. The majority of studies investigated the physical and psychological health and development of adopted children and adolescents compared with either non-adopted peers or children living in institutions (Wilson, 2009). Recent meta-analyses (Juffer & van IJzendoorn, 2007; Juffer & van IJzendoorn, 2005; Keyes et al., 2008; van IJzendoorn, Juffer, & Klein Poelhuis, 2005), literature reviews (Nickman et al., 2005), and national survey data (Miller, Fan, Christensen, Grotevant, & van Dulmen, 2000) have supported the cumulative wisdom of the research: while the majority of adoptees are well within the range of normal functioning, there is a substantial minority who experience psychological and behavioral problems which require intervention.

Specifically, a subset of adopted children have high rates of emotional and behavioral problems, and disturbed patterns of attachment to caregivers (Juffer & van IJzendoorn, 2005, Keyes et al., 2008; Nickman et al., 2005). These problems are believed to be the result of experiences specific to adoption such as grief and loss, missing information about family background, the mismanagement of racial, cultural, and temperamental differences between adopted children and their parents, challenges to identity development, and trauma related to pre-adoption adversity (such as institutional deprivation, multiple caregivers, abuse, and neglect) (Smith & Howard, 1991). These experiences place adoptive families, particularly those whose children are adopted from

foster care, impoverished environments, or institutional settings, at risk for maladjustment (McDonald, Propp, & Murphy, 2001).

In addition, several areas of family functioning have been identified as important contributors to child functioning and outcomes, including parent-child communication, family cohesion, and the degree to which family members are emotionally responsive to one another. These aspects of family functioning relate positively to healthy functioning of adoptive children and negatively to problematic behaviors (Brodzinsky, 2006; McGuinness, Ryan, & Robinson, 2005; Vuchinich, Ozretich, Pratt, & Kneedler, 2002).

Adoptive families, researchers, and scholars frequently cite a need for adoption-sensitive counseling (Atkinson & Gonet, 2007; Baden & Wiley, 2007; Festinger, 2006). Unfortunately, it is difficult for adoptive families to find professionals who are sensitive and knowledgeable about adoption (Howard & Smith, 1997). This is problematic in part because adoptive families differ from birth families, and they need help managing those differences. When seen by professionals who lack adoption competence, adoptive parents feel inadequately served (Atkinson & Gonet, 2007).

Adoption competence, which will be described in detail below, is a relatively new term that has been used to refer to the knowledge and skills that counselors need to possess to work with adoptive families (Baden & Wiley, 2007; Riley & Meeks, 2006). As of yet, however, there are no clear guidelines established by the mental health profession or training programs regarding what type of training is necessary to ensure the competency and expertise of clinicians who work with adoptive families (Singer, 2004). Studies indicate that most professionals are underprepared to work with adoptive families (e.g., Henderson, 2000; McDaniel & Jennings, 1997; McRoy, Grotevant, & Zurcher,

1988; Sass & Henderson, 2002). Given that many adoptees and their families seek counseling, it is important for therapists to be sensitive to adoption status and its relevance when making diagnoses that accurately reflect the issues that are unique to adoptive families (Miller et al., 2000).

Practitioners have begun to respond to calls for the establishment of adoption-competent therapy models, and several programs can be found in disparate locations in the U.S. However, research on the effectiveness of such programs continues to lag. The few studies that have been conducted mostly have evaluated post-adoption services that provide financial resources, parent training, and case management services aimed at the prevention of adoption disruptions and dissolutions. These studies have been criticized for their small sample sizes (Barth & Miller, 2000), use of measures without established psychometric properties, and the absence of a theoretical rationale (O'Brien & Zamostny, 2003). However, the limited research available has suggested that existing post-adoption services are related to a reduction in adoption disruptions and improvements in child and family functioning (Anderson, 2005; Groze, Basista, & Persse, 1993; Smith & Howard, 1991).

A model of adoption-competent therapy

The Center for Adoption Support and Education (CASE) developed a model of adoption-competent therapy, in the form of an integrated therapeutic intervention, (Riley & Meeks, 2006) for therapists to use when working with adoptees and their families. The CASE model was based on the theoretical foundations of attachment theory (Ainsworth, 1989; Bowlby, 1982) and family systems theory (Bowen, 1978; S. Minuchin, 1974; Satir, 1964). Viewing the experiences of adoption from the lens of these theories, the model

stresses the important role that healthy parent-child bonds play in the facilitation of optimal adoptee adjustment. It recognizes the importance of the interactions between family members and how those interactions shape and change family and individual functioning.

The CASE model and attachment theory. Attachment to parents is the affective bond between parent and child that ensures the child's security, helps the child to regulate her or his emotions, and forms the basis for the individual's ability to form future relationships (Bowlby, 1978). Attachment theory asserts that for healthy emotional development to occur, infants must form an attachment, or a bond, with a caregiver who is consistently available to provide security and care for the child's needs (Bowlby, 1982). The formation of a secure attachment relationship between parent and child is a key developmental task with implications for the future psychological well-being of the child. Adopted persons, particularly those who were institutionalized, had multiple caregivers, were adopted at later ages, or were subject to pre-adoption maltreatment and neglect, may have difficulty bonding with adoptive parents (Feeney, Passmore, & Peterson, 2007; O'Connor & Rutter, 2000; Steele, Hodges, Kaniuk, & Steele, 2010). When secure attachments are not developed, adopted children may suffer future emotional and behavioral maladjustment, and impaired social relationships (Bretherton & Munholland, 1999; Lyons-Ruth, Easterbrooks, & Cibelli, 1997; van IJzendoorn, Schuengel, & Bakermans-Kranenberg, 1999). The CASE model of adoption-competent therapy promotes the development of parenting behaviors that are facilitative of secure attachments for adoptees (Riley & Meeks, 2006).

Consistent with an attachment perspective, CASE's integrated therapeutic intervention aims to educate adoptive parents about the importance of consistent and loving caregiving as a means of facilitating secure attachments of children to parents. Parents are encouraged to repeatedly and lovingly demonstrate their care and concern in overt ways, to show sensitivity to their child's emotions and not react with rejection or withdrawing behaviors when children reject or push parents away. Therapists provide opportunities for corrective attachment experiences that encourage the development of healthy relationships with caregivers. They do this by sensitively responding to the child's emotions with tenderness and compassion (Riley & Meeks, 2006).

The CASE model and family systems theory. Family systems theory views child functioning within the context of the entire family and recognizes the reciprocal nature of family member interactions (Minuchin, P., 1985). When the family system functions effectively, it provides, just as individual attachments do, a secure base that contributes to greater security in the family as a whole. This security contributes to family cohesiveness in the face of the challenges to family stability and identity that can be presented by adoption (Byng-Hall, 1999).

Consistent with a family systems perspective, CASE's model emphasizes the importance family therapy. By including the parents in the therapeutic relationship from the outset, therapists help parents develop a greater understanding of the adoption issues relevant to their child's experiences and problems. Therapists facilitate parent's ability to use newfound understanding to support their child's coping with adoption-related issues. Therapists also emphasize open communication between parents and children and facilitate this during sessions. CASE reports that the majority (98%) of their clients

indicated that the most helpful aspect of their family therapy was gaining a better understanding of how adoption-related issues are affecting the behavioral and emotional problems of the child (Riley & Meeks, 2006).

Outcomes of adoption-competent therapy

This study sought to investigate the extent to which an integrated therapeutic intervention designed for adoptive families relates to salient child and family outcomes. Selection of the outcomes was guided by a review of the adoption literature as well as consideration of attachment and family systems theory as they pertain to adoption (see Figure 1). Two categories of outcome variables were investigated: child functioning and family functioning. Because we were interested in child and family functioning within the family system, attachment-related and family system outcome variables were investigated in this study. Child functioning was defined as the child's attachment to parents and her or his overall mental health as operationalized by internalizing behaviors (i.e., emotional distress) and externalizing behaviors (i.e., behavioral or conduct problems). Family functioning was comprised of adoption-related parent-child communication, family cohesion, emotional responsiveness, and satisfaction with adoption.

Child functioning. This study evaluated the degree to which participation in an integrated therapeutic intervention for adoptive families related to child functioning as adopted individuals are at risk for insecure attachments to parents, psychological distress, and behavioral problems (Feigelman, 1997; Juffer & van IJzendoorn, 2005; Keyes et al., 2008; Nickman et al., 2005; Sharma, McGue, & Benson, 1998). There has been inadequate investigation of the effectiveness of therapeutic services in addressing adoptee

maladjustment. Child functioning was operationalized as attachment to parents, internalizing behaviors, and externalizing behaviors.

Attachment is defined as the affectional bond between children and their caregivers that, when the bond is secure, promotes a sense of safety and comfort for the child (Feeney et al., 2007). Security of attachment in adopted children may be undermined because of the normative issues of grief, loss, and separation faced by adoptees (Smith, Howard, & Monroe, 2000; Feeney et al., 2007) and the risk of pre-adoption maltreatment and neglect (Groze, 1992). As such, attachment is a construct that is frequently examined and deemed important in study of adoptee adjustment. Adoption-competent therapy promotes sensitive parenting to facilitate the healthy attachment of adoptees to their adoptive parents (Riley & Meeks, 2006). However, the impact of this type of therapy on parent-child attachment has not been empirically investigated.

Internalizing behaviors include depression, anxiety, and social withdrawal. Externalizing behaviors include aggressive behavior, rule-breaking, and conduct problems. Both internalizing and externalizing behaviors have received a significant amount of attention in the empirical literature as important outcome variables for adopted children. While adoptees are at risk for higher rates of these problems that their non-adopted peers (Burrow et al., 2004; Keyes et al., 2008; Miller et al., 2000; von Borczyskowski, Hjern, Lindblad, & Vinnerljung, 2006) very little research has examined the degree to which mental health treatment reduces risk and improves outcomes on these variables.

Family functioning. In addition to child functioning, the relationship between participation in an integrated intervention for adoptive families and family functioning

also was examined because family interactions are related to children's adjustment (Steinberg, 2001). Specifically, family cohesion (Uruk, Sayger, & Cogdal, 2007), emotional responsiveness (Denham, Mitchell-Copeland, Strandberg, Auerbach, & Blair, 1997; Stams, Juffer, van IJzendoorn, & Hoksbergen, 2001), and communication (Brodzinsky, 2006) have been correlated with important child outcomes and the adjustment of adoptive families. The impact of adoption-competent therapy on enhancing family functioning is unknown but is hypothesized to have a positive effect on these outcomes (Riley & Meeks, 2006). Family functioning was operationalized as communication, the family environment, and satisfaction with adoption.

Communication has been studied as an important predictor of positive outcomes for adopted children. General and adoption-related, parent-child communication are related positively to children's adjustment and attachment (Amato & Fowler, 2002; Brodzinsky, 2006; Byng-Hall, 1999; Hawkins et al., 2007; Lanz, Iafrate, Rosnati, & Scabini, 1999). It is thought that therapy can have a positive effect on family communication (Nichols & Everett, 1986), but this has not been empirically investigated with adoptive families. Moreover, family communication about adoption is an important focus of adoption-competent therapy (Riley & Meeks, 2006. The family environment includes the cohesiveness and the emotional responsiveness of family members. These factors have been associated negatively with emotional and behavioral problems, delinquency, and negative affect in children (Matherne & Thomas, 2007; Vuchinich et al., 2002; Warren & Johnson, 1989), and positively with infant-parent attachment (de Wolff & van IJzendoorn, 1997). There is a need for research to investigate the effects of therapy on improving the family environment in adoptive families.

Satisfaction with adoption is defined as the degree to which parent's and children's expectations for their adoption have been met, the level of happiness with the adoption, and the degree to which the involved parties accept the adoption as adequate (Nalavany, Glidden, & Ryan, 2009; Raynor, 1980). Satisfaction with adoption relates positively to family preservation and healthy family functioning, and negatively to emotional and behavioral maladjustment in adoptees (Martin, Kelly, & Towner-Thyrum, 1999; Nalavany et al., 2009; Rijk, Hoksbergen, ter Laak, Dijkum, & Robbroeckx, 2006; Smith-McKeever, 2006). A qualitative study of post-adoption services has suggested that they may improve satisfaction (Zosky, Howard, Smith, Howard, & Shelvin, 2005), but the extent to which adoption-competent therapy relates to improved satisfaction with adoption has yet to be empirically investigated.

To summarize, it is important to investigate the degree to which adoption-competent therapy relates to improvements in child and family functioning because adoptive children and families are at risk for maladjustment (Juffer & van IJzendoorn, 2005; Nickman et al., 2005; Rueter, Keyes, Iacono, & McGue, 2009) and adoption disruption (Smith & Howard, 1991). To date there have been a small number of studies that have evaluated therapies for adoptive families, and those that have been conducted have been limited by failures to use psychometrically reliable and valid measures, the absence of a theoretical foundation, and small sample sizes (Barth & Miller, 2000; O'Brien & Zamostny, 2003). The present study examined the degree to which involvement in an integrated therapeutic intervention for adoptive families related to improvements in child functioning (i.e., enhanced attachment to parents, fewer internalizing and externalizing behaviors) and family functioning (i.e., enhanced family

cohesion, emotional responsiveness, general and adoption-related communication, and satisfaction with adoption). It was hypothesized that participation in the intervention would be related to reduction of emotional and behavioral problems in children, improvements in attachment quality with adoptive parents, and increases in family cohesiveness, emotional responsiveness, communication, and satisfaction with the family from pre-test to post-test. The findings contribute to our understanding of adoption-competent therapy and inform future research and clinical work with adoptive families.

CHAPTER II

Review of the Literature

United States Adoption Statistics

In recent years, adoption has becomes a more common means of creating a family. In fact, the prevalence of adoption in our society is such that one out of every two people in the United States has been personally affected by adoption, either by being an adopted person, having adopted a child, having placed a child for adoption, or knowing someone who was adopted (Evan B. Donaldson Adoption Institute, 1997). As of 2001, there were 1.5 million adopted children in the U.S. (Kreider & Fields, 2005), and each year an estimated 135,000 children are adopted (Evan B. Donaldson, 2007). Adopted children and adults comprise between 2 and 4 percent of the U.S. population (Brooks et al., 2005) or 6 to 12 million persons. However, adoptees are overrepresented in clinical populations at a rate of 2 to 6 times their number in the general population (Miller, Fan, Grotevant et al., 2000). Depending on the setting (e.g., inpatient or private outpatient treatment), adoptees comprise 5 to 17 percent of those receiving mental health services (Haugaard, 1998; Ingersoll, 1997).

Within the blanket term of adoption, there are different subtypes of adoption including private domestic, public domestic (i.e., foster care), and international. In 2002, there were more than half a million foster children in the United States, and 23% were available for adoption (U.S. Department of Health and Human Services, 2002). Although the majority of these children are reunited with their birth families, about 17% are placed for adoption. Children adopted from foster care are more likely than those adopted domestically to have experienced early adversity (such as neglect, abuse, and

maltreatment from caregivers) that place them at risk for developing insecure attachments, and emotional and behavioral problems (Barth & Miller, 2000). The number of private, domestic adoptions has been declining in the United States due to increased access to contraception, the legalization of abortion, and changing social norms with regard to single motherhood (Evan B. Donaldson Adoption Institute, 2007), however, the rates of international adoption are rising. Between 1991 and 2001 international adoptions have more than doubled, jumping from just over 9,000 to nearly 20,000 a year. Within the last 30 years, a quarter of a million children were adopted internationally into the U.S. Between 2004 and 2008 there were 103,353 international adoptions recorded in the U.S. with the largest percentages coming from Asian nations such as China (30%) and South Korea (7%), and Russia (approximately 20%) (U.S. Department of State, 2009). Internationally adopted children are at risk for attachment, emotional, and behavioral problems, particularly those who were placed after age 5 or who experienced deprivation prior to adoption (Welsh, Viana, Petrill, & Mathias, 2007).

As the above statistics demonstrate, adoptive families are not a homogeneous group. Each type of adoption has specific characteristics and differences that represent unique needs of adoptive families (Freundlich, 2002). This reality, combined with the increasing numbers of families affected by adoption indicates that the question of how to best serve adopted children and their families is critically important.

Adoptee mental health and adjustment

Although the majority of adopted persons function well (Juffer & van IJzendoorn, 2005; Nickman et al., 2005; O'Brien & Zamostny, 2003), a substantial minority experience significant problems (Nickman et al., 2005). A subset of adopted children

have high rates of emotional and behavioral problems and disturbed patterns of attachment to caregivers that require intervention (Feigelman, 1997; Juffer & van IJzendoorn, 2005, Keyes et al., 2008; Sharma et al., 1998), and adoptive families are at risk for adoption disruption and maladjustment over the lifespan (McDonald et al.; Smith & Howard, 1991).

Studies have found that compared to non-adopted peers, adoptees are more than twice as likely to have emotional and behavioral problems such as depression, anxiety, conduct problems, and aggression (Brodzinsky, Radice, Huffman, & Merkler, 1987). They also have higher rates of juvenile delinquency and use of drugs and alcohol (Feigelman, 1987). A large-scale study with a nationally representative sample found that adoptees have lower self-esteem and more hopelessness, and engage in lying to parents, skipping school, and fighting more frequently than their non-adopted peers (Miller et al., 2000). In a two-year longitudinal study of 133 special needs adoptive families (families adopting from foster care) researchers found that a minority of families reported problems (Groze, 1992). Specifically, there were more ups and downs in their adoptions than they expected (27.9% in year 1 and 31.5 % in year two), children's problems were greater than they expected (32%), and the impact of the adoption on the family was mixed or mostly negative (21%, 3.9 to 5.4% respectively). Family cohesion decreased from year 1 to year 2, and relationships became less positive.

To summarize, across the lifespan adoptive families face challenges related to child and family functioning. Specifically, these issues place children at risk for attachment problems, and emotional and behavioral problems. These challenges,

combined with adoptees' overrepresentation in the clinical population point to the need for adoption-competent mental health services.

The need for adoption-competent therapy

Adoption professionals as well as adoptive families report that one of the most common post-placement needs is access to qualified mental health professionals who are sensitive to adoption-related issues and concerns (Atkinson & Gonet, 2007; Festinger, 2006; Smith & Howard, 1999). Unfortunately, it can be very difficult for adoptive families to find satisfactory mental health treatment. Adoptive families often are unable to access professionals who are knowledgeable about adoption (Howard & Smith, 1997). They report that mental health professionals lack understanding of the issues they face (Nickman & Lewis, 1994) and that they have to provide therapists with basic information about the needs and experiences of adoptive families (Smith & Howard, 1999). Some parents have reported encountering prejudice and stigma from mental health professionals about their status as an adoptive family, and criticize the tendency of practitioners to pathologize normative adoption issues (Reynolds & Medina, 2008). In one study, adoptive parents expressed the belief that their families fundamentally differ from birth families and that they need help managing those differences. These parents reported that when seen by professionals who lack adoption competence, they feel inadequately served, and that mental health services would be more helpful if clinicians were versed in adoption and the unique ways it impacts family members (Atkinson & Gonet, 2007).

A relatively new term, adoption competence, has been used to describe the knowledge and skills that counselors need to possess to work with adoptive families

(Riley & Meeks, 2006). Various adoption scholars and professionals have discussed the components of adoption-competent therapy. Included in these descriptions are specific knowledge about adoption history, adoption laws, the process of adoption, and as societal attitudes and stigma about adoption (Riley, 2009; Baden & Wiley, 2007). In addition, adoption-competent therapists should be aware of the unique and potentially lifelong developmental and psychological needs of adoptees (Riley, 2009; Riley & Meeks, 2006). Adoption competency requires an understanding of how child functioning (i.e., attachment to parents and behavioral and emotional problems) and family functioning (i.e., adoption-related family communication, family cohesion, emotional responsiveness, and satisfaction with the adoption) are affected by the complexities of adoption and the unique challenges faced by adoptive families (Hart & Luckock, 2004; Nickman et al., 2005; Reitz & Watson, 1992; Riley & Meeks, 2006; Watson, 1997). Adoption-specific challenges include grief and loss issues, challenges of identity development, management of parent-child differences, and missing information about children's backgrounds (Riley & Meeks, 2006).

Adoption-competent mental health professionals view the psychological and behavioral functioning of adopted children and their families within a family systems context (Riley & Meeks, 2006). They must demonstrate an understanding of the impact that adoption has on all members of the adoptive family and their relationships with one another. Therapists should consider family members in relation to their adoptive kinship network including the nuclear and extended adoptive family and the birth family (Watson, 1997). Adoptive families should be treated in family therapy in combination with individual and group modalities (Riley & Meeks, 2006; Watson, 1997).

In addition to preventing adoption disruption and/or dissolution, there are a number of important goals of adoption-competent therapy. These goals include the following: help families understand and accept that they are part of an adoptive kinship network; improve family communication (including communication about adoption); increase the emotional availability of parents to their children; help families recognize that adoption issues may become salient at different times in the family's life; and educate families about how their adjustment can be facilitated by addressing the recurring adoption themes as they arise (Riley & Meeks, 2006; Watson, 19967).

To date, there are no clear guidelines established by the mental health profession or training programs regarding what constitutes competency and expertise for clinicians who work with adoptive families (Singer, 2004). One unfortunate consequence of this is that the vast majority of professionals receive little or no training on the development of adoptive children, the adoptive family life cycle, and the mental health needs of adoptive families (Baden & Wiley, 2007; Taymans et al., 2008). The silence of the mental health community on adoption is striking when one considers the prevalence of other clinical populations relative to the emphasis of their needs in the field of psychology. For example, although the prevalence of adopted individuals (i.e., 2.5% of the population) is far greater than that of individuals with autism (i.e., .05% of the population), adopted persons receive far less attention in the mental health community (Henderson, 2000).

Several studies indicated that most professionals are underprepared to work with adoptive families. In a survey by Sass and Henderson (2000), 90% of clinicians reported that they needed more education in adoption and a quarter replied that they were "not very prepared" to treat members of the adoption triad. Other studies have found that

many clinicians downplay or are completely unaware of clients' adoption status (McRoy et al., 1988). In a study examining how well clinicians address the issue of adoption in case vignettes, only a minority identified adoption as an issue to be included in their treatment plan. The majority made no mention of it at all or merely noted that it was a relevant demographic variable without including it in the treatment plan (McDaniel & Jennings, 1997). When therapists have inquired about or address adoption with their clients, they were seen as being more prepared and helpful than therapists who do neither (Sass & Henderson, 2002). Finally, only 25% of graduate students said they were adequately trained to treat members of the adoption triad (Henderson, 2000).

Existing mental services for adopted children and their families

Despite the established need of adoptive families for adoption competent mental health care, there have been few therapy programs developed to date and little empirical investigation of their effectiveness. Existing programs largely focus on prevention of adoption disruption and remediating attachment disorders rather than focusing on the broader range of needs and concerns of adoptive families (Barth & Miller, 2000). The few studies that have been conducted have mostly evaluated post-adoption services programs (i.e., programs that provide financial resources, parent training, and case management services aimed at prevention adoption disruptions and dissolutions for families who adopt children with special needs; Wind, Brooks, & Barth, 2007). Special-needs adoptions have been variously defined in the literature, but most adoption researchers and scholars agree that they include the following: late age of adoption (i.e., the child is age 3 or older at the time of adoption), multiple foster care placements, a pre-adoption history of neglect or abuse, learning disabilities, physical disabilities or other

medical needs, and the presence of emotional or behavioral problems (Anderson, 2005; Dore, 2006).

A number of studies have examined treatment programs designed to remediate attachment problems in adopted children. One such study conducted in the Netherlands examined the effects of attachment-based interventions with 130 families who adopted infant internationally (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2005). The adoptees consisted of 66 boys and 64 girls adopted from Sri Lanka, Columbia, and South Korea prior to 6 months of age. Other than the interventions examined in the study, the families received no post-adoption services. Treatment was intended to increase parental sensitivity and responsiveness to infants' needs to improve children's attachment to parents (i.e., to foster secure attachment and reduce frequency of insecure attachments).

In this study, three levels of interventions were used: 1) video feedback sessions using recorded footage of the participants' mother-child interactions plus a book that contained suggestions for sensitive parenting and ideas for playful interactions; 2) the parenting book alone with no video feedback sessions; and 3) a control group intervention which consisted of a "dummy" book with no information related to parenting or parent-child interactions. Video feedback sessions consisted of researchers commentating on videos of participants' interactions with their infants, vocalizing the baby's needs and encouraging mothers to sensitively and appropriately respond to their children's signals (Juffer et al., 2005).

Children's attachments to their mothers were assessed pre-treatment and at 6- and 12-month follow-ups using the Strange Situation procedure (Ainsworth, Blehar, Waters, & Wall, 1978). Children were classified as secure, insecure-avoidant, or insecure-

ambivalent at the 6- and 12-month assessments, and as disorganized or organized at the 12-month assessment. The video-feedback plus book intervention was moderately successful in increasing maternal responsiveness (d = .65) and decreasing the frequency of disorganized attachment classifications from pre-test to follow-up. No such effect was found for the book-only or control groups (Juffer et al., 2005).

Other studies (e.g., Wimmer, Simmons, & Dews, 2003; Wimmer, Vonk, & Bordnick, 2009; Wimmer, Vonk, & Reeves, 2010) have been conducted to examine the effectiveness of attachment therapy (i.e., holding therapy) for adopted children diagnosed with reactive attachment disorder. This form of therapy is regarded with skepticism, as it is potentially harmful, and it is considered to be controversial and lacking in scientific or theoretical merit (Mercer, 2005). Therefore, these studies will not be reviewed here.

The majority of the other studies of interventions with adopted children and their families have investigated the perceived helpfulness of post-adoption services. The primary goal of post-adoption services is to increase family preservation for families who adopted special-needs or high-risk children (Barth & Miller, 2000). Preservation means that families remain intact and the numbers of disruptions they experience are reduced. PAS also aim to enhance adoptive families' quality of life (Anderson, 2005), increase parents' ability to manage the needs of their adopted children (Haugaard, 2006), and improve child and family functioning (Barth & Miller, 2000). One such study (Lenerz, Gibbs, & Barth, 2006) evaluated the effectiveness of a post-adoptive services program that provided families with individual and family counseling, support groups, education workshops, and advocacy. The study evaluated the treatment outcomes of 293 families via social-worker rated improvements of child and family functioning. Most of the

children in the sample were adopted from public care (62%), experienced neglect (92%), and were physically abused (53%). A minority (30%) had been sexually abused. The greatest improvements were found for child behaviors, parents' understanding of the impact of adoption on children's behavior, and family communication. All measures of child and family functioning were developed by the service providers.

A two-year study of an adoption preservation program evaluated the perceived effectiveness of services at preventing adoption disruptions and dissolutions, and improving child and family functioning (Smith, 2006a). The sample included 912 families and 1,162 children, 78% of whom were adopted form from public care. Seventy-one percent of the children had history of neglect, including physical (43%) and sexual (27%) abuse. Services provided to families included crisis intervention, intensive therapeutic services, support groups, advocacy, and financial support. In the majority of families (87%), adopted children were still living in the home when treatment concluded. Social workers rated 74% of families' overall functioning as somewhat or significantly improved. Social workers also rated specific areas of child and family functioning, reporting improvements in children's behaviors (70% of cases), parents' abilities to manage children's behavioral problems (70% of cases), parents' abilities to tolerate behavioral problems (76% of cases), and children's abilities to discuss and tolerate their feelings (71% and 63% of cases respectively).

Another study (Groze et al., 1993) evaluated the perceived effectiveness of a post-adoptive family preservation project with 19 families who had adopted children with special needs. The adopted children in the sample were labeled special needs because they possessed one or more of the following characteristics: adopted from foster care, late

age adoption (age 5 or older), pre-adoptive history of sexual abuse or physical abuse, learning disability, developmental delay. The program provided information to treatment group parents on coping strategies and resources, assisted families with crisis planning, and educated parents about the importance of understanding their children's pre-adoption placement history. At post-test, parents reported less stress and improvements in their perceptions of children's internalizing and externalizing behaviors. Fathers' perceptions of family cohesion increased, and children's interpersonal and social skills improved.

In one qualitative study, parent's perceptions of the helpfulness of time-limited post-adoption preservation services for families adopting special needs children were examined (Zosky et al., 2005). Other than indicating that the adoptees' in their sample had significant emotional or behavioral problems, the researchers did not indicate on what basis the children were characterized as having special needs. This study evaluated open-ended responses from a small subset (up to 32 responders depending on the question) of 838 parents who completed parent feedback forms subsequent to receiving services. The services included a home-based therapeutic intervention, support groups, and case management. In their responses, some parents reported benefits of services received including improved communication skills (17 endorsements), better understanding of children's feelings and behaviors (32 endorsements), improved understanding of grief and identity issues (8 endorsements), and increased awareness of children's attachment issues (9 endorsements). Twenty-one parents reported that it was helpful to have a social worker who listened in an empathic manner.

Another qualitative study was conducted with 500 families who participated in post-adoption services as part of a family preservation program (Atkinson & Gonet,

2007). The services were assessed by retrospective parental self-report. Services included counseling, crisis intervention, support groups, parent training, and case-management. Sixty percent of the families had adopted children from foster care, and of those 90% were considered special needs adoptions, 20% were private adoptions, and 15% were international. The majority of families reported benefiting from the services with 60% reporting substantial or moderate progress; 78% of those families attributed that progress directly to the services they received. Improvements that parents noted included the following: learning to cope better with children's emotional and behavioral problems, a greater understanding of the ways adoption affected their child and their family, better parenting skills, an improvement in children behaviors, and improved family climate. Parents named support as the most helpful service followed closely by counseling.

A case study of 8 families who received adoption preservation services examined what kinds of outcomes parents reported for their families and adopted children (Smith, 2006b). Parents reported numerous benefits including a better understanding of their child's special needs related to adoption; improvements in their ability to support children through their emotional struggles with adoption; and improved strategies for managing children's behavioral problems. Parents also reported improvements in the rates of children's behavioral and emotional problems that they attributed to the services they received. Improvements in family functioning (such as better communication and increased affective involvement with and responsiveness to one another) were noted as well. A study of another post-adoption services provider demonstrated improvements including reductions in disruptions as well as reductions in child behavior problems, improvement in family communication, and greater understanding of adoption issues

(Gibbs, Siebenaler, & Barth, 2002). In a study conducted on an agency that provided individual and family counseling, psychoeducational resources, and case management, gains were greatest for those who received the highest number of counseling sessions (Gibbs, Barth, & Lenerz, 2000).

The studies have been criticized for their use of measures without established psychometric properties, absence of a theoretical rationale, (O'Brien & Zamostny, 2003), and small sample sizes (Barth & Miller, 2000). Furthermore, as the majority of them investigated the services aimed at special needs adoption, it may be that the effectiveness of such programs would be different for the wide and diverse range of adoptive families seen in clinical practice. Despite these limitations, preliminary research has suggested that the post-adoption services were related to a reduction in adoption disruptions and improvements in child and family functioning (Anderson, 2005; Groze et al., 1993; Smith & Howard, 1991).

The CASE Model of adoption-competent therapy

In 2006, the Center for Adoption Support and Education (CASE) developed a model of adoption-competent therapy, in the form of an integrated therapeutic intervention, in order to serve the complex and unique needs of adopted children and their families. The model was derived from the application of family systems therapy and attachment theory to the concerns faced by adoptive families. It also incorporates components of trauma therapy and developmental theories as they relate to the issues faced by adopted children and their parents throughout the lifespan.

The CASE model of therapy adheres to a set of 14 principles that guide treatment goals and interventions. The first seven principles are the following: 1) Adoption is a

circumstance of emotional importance that impacts all members of the adoptive family; 2) Adoption is not pathological, and there are predictable developmental stages through which adoptees progress, albeit in individualized ways; 3) Adoptive families have unique challenges that differentiate them from other kinds of families; 4) Adoption is a lifelong process; 5) Adoptive loss is unique and pervasive in all areas of adoption adjustment, and it is ambiguous and often misunderstood; 6) Individual differences in temperament, personality, resiliency, and vulnerability ensure that no two adoption experiences are the same; and 7) There are specific issues unique to and inherent in adoption (such as missing or difficult information, difference, permanence, identity, and loyalty) that can create emotional stressors for members of the adoptive family. The remaining seven principles are as follows: 8) Adoption issues must be treated in a family systems context; 9) Information empowers the adoptee and reduces uncertainty; 10) Children frequently and intently think about their birth families; 11) Children need help integrating their history prior to adoption; 12) Pre-adoption factors (such as environmental, relationship, and organic stressors) can impact physical and brain development, adjustment, and attachment; 13) Adoptees have two sets of parents to separate from in adolescence; and 14) Talking about adoption is positive and promotes healthy adjustment.

CASE therapists apply these principles when working with adoptive families to help family members explore and understand the way adoption affects their lives, development, and relationships with one another. Therapists assist families in resolving children's behavioral and emotional difficulties by applying their understanding of how adoption affects each individual member of the family as well as the family as a whole. Within the context of individual and family therapy, therapists explore and discuss family

members' feelings and concerns, normalize their experiences, and model alternative means of family member interaction. Group therapy provides additional means for children and parents to explore their feelings and concerns related to adoption, and share common experiences with other adoptees and adoptive parents respectively. Parent workshops educate parents about the common challenges faced by adoptive families and children and offer new strategies and alternative for coping with those challenges.

There has been an unpublished, private program evaluation of the CASE model. The results suggested that use of the CASE model with adopted children and their families may be associated with increases in parent-child attachment, decreases in parental stress, a reduction in children's depressive and anxiety symptoms, and improvements in the quality of the family environment and in parent-child relationships (Klayman, 2009).

Theoretical foundation for a model of adoption-competent therapy

As noted above, theoretically guided research and empirically-tested models of therapy are needed for adoptive families (Brooks et al., 2005; O'Brien & Zamostny, 2003). The CASE model) was developed using the foundations of attachment theory and family systems theory. Attachment theory stresses the effects that pre- and post-adoption experiences may have on the security of children's attachment to caregivers. It also provides a context to consider interventions aimed at strengthening children's attachments to adoptive parents. Family systems theory recognizes the importance of family members' interactions and how those interactions shape individual and family functioning.

Attachment theory. "Intimate attachments to other human beings are the hub around which a person's life revolves" (Bowlby, 1980, p. 441). Early relationship with caregivers (the child's primary attachment figures) help the child regulate her or his emotions in the present, facilitate adaptive emotional regulation throughout the lifespan, and serve as the primary models for the child's future relationships (Bowlby, 1978; Gunnar, 2000). Parents who are available and responsive to children's needs (including emotional needs as well as physical ones) enable children to feel secure that parents will be there to protect and comfort them (Ainsworth, 1989; Bowlby, 1982). This provides the child with what has been called a "secure base" from which to explore the world around them and to engage in social play and relationships with others. The secure base ideally remains available for the children to return to in times of fear, threat, or uncertainty (Cassidy, 2008).

Secure attachment has been associated with positive outcomes for children, such as social competence (e.g., Stams et al., 2002; Weinfield et al., 2008) and positive relationships with parents and peers (e.g., Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2008; Sroufe, Egeland, Carlson, & Collins, 2005). When caregivers are inconsistent, unavailable, neglectful, or abusive, children can develop insecure or disorganized patterns of attachment that place them at risk for psychological and behavioral problems (Weinfield et al., 1999).

Children who lack access to consistent, loving, available caregivers can exhibit a host of problems including the inability to regulate their emotions, the inability to experience and express a full range of emotions, difficulty understanding the emotions, trouble forming close relationships, inattention, learning disabilities, impaired cognitive

functioning, behavioral problems, impaired decision making, and poor impulse control (Groza, Ryan, & Nelson, 2008; Shapiro & Shapiro, 2006). Adult attachment insecurity has been associated with psychiatric symptomatology, particularly for those individuals experiencing concomitantly high levels of life stress (Fortuna & Roisman, 2008). Individuals who were classified as anxiously attached in infancy were twice as likely to develop anxiety disorders in childhood and late adolescence than those who were more securely attached (Warren, Huston, Egeland, & Sroufe, 1997). Carlson (1998) found, in the same sample, that infant attachment disorganization predicted childhood and adolescent behavioral problems, total psychopathology, and dissociative symptomatology in late adolescence.

Attachment theory provides a model to understand the issues of grief, loss, and separation faced by adoptees. Being adopted is thought to be associated with a sense of having being rejected by birth parents (Feeney et al., 2007). This may be true in all types of adoption, but certain subtypes of adoption are linked to event greater risk for attachment problems in children, such as adoption from foster care, international adoption, and late-age adoptions (Becker-Weidman, 2009; van IJzendoorn, Schuengel & Bakermans-Kranenburg, 1999). It has been suggested that children adopted at later ages must mourn their lost attachments to birth parents to establish new attachments with adoptive families and that they must develop positive working models of their caregivers as being available and safe to be healthfully adjusted and attached to new parents (Smith et al., 2000).

In addition to the grief and loss issues that many adoptees experience as a result of their separation from birth parents, exposure to pre-adoption adversity for a subset of

adoptees can profoundly impact the security of the child's attachment to caregivers (Groze, 1992). Attachment theory is helpful in understanding the adjustment of adopted persons who were institutionalized, had multiple caregivers, were adopted at later ages, or were subject to pre-adoptive maltreatment and neglect. There is a substantial amount of evidence suggesting that children who have experienced this kind of pre-adoption adversity and those who have been adopted from institutional or foster care have higher incidences of insecure attachments to caregivers (Prather & Golden, 2009; van IJzendoorn et al., 1999).

When not addressed, problematic attachments to adoptive parents can threaten the stability of the adoption placement. For example, attachment problems are the most commonly reported problems among adoptees whose adoptions are deemed at risk for dissolution (Smith et al., 2000). Sometimes placement in a stable home with readily available and consistent caregivers is enough to help adopted children form secure attachments (Wilson, 2009). In cases where children already have disturbed attachment patterns or a history of pre-adoption adversity, children's behaviors toward caregivers may be confusing, contradictory, and difficult for parents to manage. In these cases, parents can be taught how to interpret and respond to children's subtle or conflicting cues sensitively and appropriately (Stams et al., 2001). Emotionally sensitive and responsive caregiving has been shown to be facilitative of greater security in attachments for adoptees (Juffer et al., 2008).

Family systems theory. Family systems theory views the functioning of the individuals within the context of the entire family and points out the reciprocal nature of family member interactions (P. Minuchin, 1985). Family systems theory grew out of

Bertalanffy's (1968) general systems theory which attempts to understand the individual elements in context and explores the interrelationships among all elements in physical, biological, and symbolic systems (e.g., family systems). Family systems theory proposes that the interpersonal processes within a family contribute to dysfunction and need to be examined. The behaviors of parents, siblings, and children all affect one another and cause changes in one another (Byng-Hall, 1999). Interventions are designed to affect the interaction among family members.

Some family systems theorists view attachment of children to caregivers as a key dyadic relationship within the larger system. From this perspective, children do not form attachments with just one family member (i.e., the mother) but rather with all family members (Kozlowska & Hanney, 2002). The primary caregivers have the most profound influences on the child, but all family members can shape the child's models of what to expect from close relationships in the future. This concept is very important in understanding the importance of the adoptive family environment on adopted children. This affords them the opportunity to have either corrective attachment relationships with caregivers or potentially to have dysfunctional ones that continue to reinforce attachment insecurity. When parents can respond to children with emotional sensitivity, children are at lower risk for emotional and behavioral problems, and adoptions are at reduced risk for disruption. In turn, when adopted children have special needs such as attachment problems, or emotional or behavioral issues, the establishment of healthy bonds and the facilitation of positive family relationships is impaired (Brodzinsky & Pinderhughes, 2002).

The family system influences the felt security of its members (Byng-Hall, 1999) and provides, just as individual attachments do, a secure base that contributes to greater security in the family as a whole. A secure family base is a defined by Byng-Hall (1999) as a consistently available network of attachment relationships with caregivers that provide a base from which family members feel secure in exploring their potential. The security allows family to experience conflict and express negative emotions such anger and yet remain cohesive. Normative threats to the family security (e.g., the loss or threatened loss of an attachment figure, the monopolization of a family's member's attention by another member, overprotective parenting, and parents' turning to children to care for them and fulfill their needs that cause difficulties for many families; Byng-Hall, 1999), may be especially problematic for adoptive families. These problems can cause corollary difficulties in the adoptive family, including higher parental stress, adoption disruption, and lower levels of parent satisfaction (Welsh et al., 2007).

Outcomes of adoption-competent therapy

Over time the adoption literature has diversified, and scholars have begun to consider the various risk and protective factors that may predict outcomes for adoptees and their families over the lifespan. The predictors that have received the most attention are age of child at time of adoption placement, number of years in institutional care, multiple pre-adoptive placements, and pre-adoption adversity (such as maltreatment, malnutrition, and neglect) (Colvert et al., 2008; Juffer & van IJzendoorn, 2005; Wind et al., 2007). More recently, post-adoption factors have begun to receive attention in the literature. These factors, such as family communication (Rueter & Koerner, 2008), parenting behaviors (Passmore, Feeney, Peterson, & Shimmaki, 2006), availability of

post-adoption services (Reilly & Platz, 2004), and children's attachment to parents (Juffer et al., 2008), are interesting constructs to investigate in part because they are amenable to intervention.

In this study, the CASE model of adoption-competent therapy was evaluated by the degree to which it relates to specific child and family outcomes. Selection of the outcomes was guided by a review of the adoption literature as well as consideration of attachment and family systems theory (see Figure 1). Child functioning and family functioning were the two categories of outcome variables investigated.

Child functioning. Child functioning was defined as the child's attachment to parents and overall psychological health (i.e., internalizing behaviors (i.e., emotional distress), and externalizing behaviors (i.e., behavioral or conduct problems)).

Attachment. There is some evidence to suggest that parent training programs aimed at promoting sensitive parental responsiveness to the adopted child's needs can promote the development of secure attachments to adoptive parents. For example, programs that work with parents on improving their emotional availability to children show a relationship between parental sensitivity and quality of adoptive child attachment (Stams et al., 2001). However, this research has focused on parent training programs as opposed to child and family therapy, and on children with severe attachment disorders. There has been very little empirical investigation of the effect of adoption-competent therapy on strengthening adopted children's attachment to their parents for the broad range of adoptive families who seek mental health services. Positive adoptee self-esteem also was related to positive affectional bonds between parents and children (Passmore, Fogarty, Bourke, & Baker-Evans, 2005).

Internalizing behaviors. Internalizing behaviors have received a significant amount of attention in the empirical literature investigating the adjustment of adopted persons. Adopted individuals are more likely to have high levels of emotional distress (Miller et al., 2000), specifically anxiety (Keyes et al., 2008), depression (Burrow et al., 2004), and increased risk of suicide (von Borczyskowski et al., 2006). In a study of adopted individuals and a matched group of their friends, adoptees had higher depression than friends (Borders et al., 2000). While a few studies of post-adoption services have suggested that adoption-competent therapy can reduce the risk of emotional problems and help to decrease levels of depression and anxiety (Anderson, 2005; Groze et al., 1993; Smith & Howard, 1994), this claim has yet to be empirically tested with a model of adoption-competent therapy.

Externalizing behaviors. Externalizing behaviors also have received a significant amount of attention in the empirical literature investigating the adjustment of adopted persons. As with internalizing behaviors, adoptees are at greater risk for behavioral problems than their non-adopted peers (Miller et al., 2000). Adoptees are more likely than their non-adopted peers to be diagnosed with ADHD, conduct disorder, and oppositional defiant disorder (Keyes et al., 2008), and to exhibit delinquent and antisocial behaviors such as running away from home, stealing, fighting, skipping school, and drug and alcohol use (Feigelman, 1997; Simmel, Barth & Brooks, 2007). As is true for externalizing behaviors, a few studies of post-adoption services have suggested that adoption-competent therapy can reduce these risks and help to reduce children's behavioral problems (Anderson, 2005; Groze et al., 1993; Smith & Howard, 1991),

though the claim has yet to be empirically tested with a model of adoption-competent therapy.

Family functioning. It has been said that "life in a well-functioning family is the best cure" for adoptive children who may have suffered trauma or maltreatment prior to adoption (Watson, 1997, p. 532). Though there has been little empirical research examining the functioning of adoptive families, a recent study found that they are at risk for problematic functioning and impaired family relationships (Rueter et al., 2009). Parents who adopt special needs children specifically report high stress, inadequate self care, low confidence in their ability to effectively parent, need for social support, and high need to adequate support services and mental health care (Reynolds & Medina, 2008). Theoretically, life in an adoptive family is thought to be remedial and facilitative of healthy functioning (Watson, 1997). In fact, the emotional and behavioral adjustment of adopted children is related positively to the quality of family relationships (Hill, Fonagy, Safier, & Sargent, 2003).

In this study, family functioning was comprised of parent-child communication about adoption, family cohesion, emotional responsiveness and satisfaction with the adoption. It is important to consider family functioning when examining child outcomes because, as the family systems perspective states, each person affects all others members of the family, and the family whole affects the person. The way parents respond to a child's behaviors and behavioral problems will influence the child's future behaviors by maintaining, exacerbating, or ameliorating problems. For example, parent variables and affectional bonds between parents and children are more important than adoptive status alone in predicting levels of depression in adoptees (Passmore et al., 2005; Passmore et

al., 2006). Furthermore, an understanding of children's pre-adoption history, awareness of how adoption affects family life, and positive parental coping skills are related positively to family cohesion and family relationships (Groze et al., 1993). Therefore, family patterns of interaction should be examined as potential targets for intervention (Gabbard, 2009). Interventions aimed at strengthening families are thought to be able to prevent or alleviate adoptees' adjustment problems and improve family functioning (Passmore et al., 2006). However, this remains to be empirically validated.

Communication about adoption. For adoptive families, communication about adoption between parents and children is related to positive adoptee adjustment. Most adoptive children are curious about their backgrounds and desire more information about their adoptions from their parents (Morgan, 2006). However, some adopted children may find initiating conversation about adoption with their adoptive parents difficult (Triseliotis, Feast, & Kyle, 2005). In adoptive families, more positive general communication related to self-esteem in adopted children (Lanz et al., 1999).

Children who are happy with the amount of adoption-specific communication in their homes have higher level of self-esteem and more satisfied with their adoptions (Brodzinsky, 2006; Hawkins et al., 2007). Those who are unhappy with the amount of discussion are less satisfied with being adopted and unhappier about being placed for adoption by birth parents (Hawkins et al., 2007). Among children adopted from Romania, those who found it harder to talk to their parents about adoption were found to have more emotional and behavioral problems that those adoptees who did not find communication difficult (Hawkins et al., 2007).

One study revealed that adoptive parents underestimate how difficult it is for their children to talk to them about adoption (Beckett et al., 2008). Furthermore, adopted children who had difficulty talking openly with parents felt different from their parents and children who felt different were more likely to have low self-esteem. Brodzinsky (2006) found that communication openness was a predictor of children's adjustment in that openness in communication was predictive of self-esteem as reported by adopted children and fewer child behavioral problems as rated by parents.

Family environment. Family environment was operationalized as degree of cohesiveness and emotional responsiveness that family members experience with one another. Demonstrations of emotional warmth, positive affect, intimacy, and cohesion are associated with low levels of emotional and behavioral problems in children (Vuchinich et al., 2002).

Cohesion is defined as the emotional bonds that members of a family have to one another (Olson, Portner, & Bell, 1982). Family cohesion is important determinant of successful family functioning (Hill et al., 2003). Furthermore, family cohesion was a protective factor in adoptive families (McGuinness et al., 2005), as it was associated with low levels of negative affect (Warren & Johnson, 1989), high levels of psychological well-being (Uruk et al., 2007), and low rates of juvenile delinquency (Matherene & Thomas, 2007). For example, self-esteem has been examined in the adoption literature, and has been related positively to cohesiveness in the adopted family, family communication levels, and expressed affection; in other words, healthy adoptive family functioning can promote positive self-esteem for adoptees (Brodzinsky, 2006; Groze, 1992).

Family emotional expressivity is related positively to adoptees' sense of self-approval; those whose families were expressive of emotions were less likely to have negative view of their self-control and moral self-approval (Kelly et al., 1998). Also, parents' level of emotional sensitivity and responsiveness has been associated with infant-parent attachment in meta-analyses (de Wolff & van IJzendoorn, 1997).

Satisfaction with adoption. Satisfaction with adoption has been examined in the adoption literature (Zosky et al., 2005). Adoption satisfaction is related to decreased rates of adoption disruption and dissolution (Smith-McKeever, 2006). Low levels of parent satisfaction with adoption have been associated with high levels of emotional and behavioral problems, poor quality of parent-child communication, insecurity of children's attachment to parents, and low levels of family cohesion (Nalavany et al., 2009; Rijk et al., 2006; Smith-McKeever, 2006). Satisfaction with family life and adoption are strong predictors of the quality of the family environment, and high satisfaction was related positively to emotional expressiveness and involvement (Martin et al., 1999).

Assessing treatment models

When evaluating a therapy model, it is important to assess factors related to the treatment quality. These include therapist treatment fidelity (Heppner, Wampold, & Kivlighan, 2007), therapist effects (Corrigan & Schmidt, 1983), and treatment satisfaction (Carroll & Rounsaville, 2003).

Treatment fidelity ensures that the treatment was delivered as intended, and measures of it have become an important part of therapy outcome research (Lambert & Bergin, 1994). One aspect of treatment fidelity is treatment adherence which is an evaluation of how well a therapist has used the specific ingredients called for by the

given therapy model they are practicing (Hogue et al., 1998). A measure of adherence to the treatment model should be used to check for fidelity (Stern, Alaggia, Watson, & Morton, 2008). Because adherence is an assessment of how much therapists employ techniques and follow components dictated by the specific treatment approach they are using (Hill, O'Grady, & Elkin, 1992), it is important that the measure of adherence be specific to the treatment model so that one can evaluate therapist fidelity to each of the unique components of the treatment (Waltz, Addis, Koerner, & Jacobson, 1993). It is recommended that assessment of adherence include therapist behaviors that are prescribed by the therapy model and that are unique to that model (Waltz et al., 1993). This allows not only for one to check to see if the treatment was faithfully replicated but also allows one to compare it to treatments with which it is presumed/intended to differ. Assessment of adherence is important in that is impacts the validity of the inferences that can be drawn from the results of treatment outcome research (Perepletchikova, Treat, & Kazdin, 2007). Treatment fidelity increases our confidence that outcomes are attributable to the treatment rather than other factors (Borrelli et al., 2005).

Therapist effects are qualities inherent in the therapist that may affect outcomes above and beyond the effects of treatment that is being delivered. Empirical evidence suggests that a small to moderate amount of the variance in client outcomes can be accounted for by individual characteristics of different therapists (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). One type of therapist effect is the therapists' behavior as perceived by the client. For example, clients' attributions of counselors' expertness, attractiveness, and trustworthiness have the potential to influence their perceptions of a counselor's ability to help them (Barak & LaCrosse, 1975; LaCrosse,

1977). In the present study, expertness, attractiveness, and trustworthiness were examined as they have the potential to influence clients' perceptions of the therapist and treatment outcomes (Kazdin, 1986).

Treatment satisfaction is defined as an interaction of client expectations about and subsequent experiences with treatment (Dearing, Barrick, Dermen, & Walitzer, 2005). It has been increasingly emphasized in recent years as an important outcome in treatment effectiveness studies (Carroll & Rounsaville, 2003), and client satisfaction questionnaires are widely used in community mental health settings to assess quality of services (Fischer & Valley, 2000; Lebow, 1982). Satisfaction is seen as an important indicator of how a treatment program was received by a community of clients. For example, even if a treatment has shown to be very effective, it will be of limited benefit if clients find it unacceptable (Dudley, Melvin, Williams, Tonge, & King, 2005). In the evaluation of therapy quality, client satisfaction surveys are viewed as professionally useful despite some of their methodological drawbacks (e.g., client self-report bias; Barker, Pistrang, & Elliott, 1994). This is because they offer mental health agencies one way to monitor the degree to which their clients are benefitting from the services they provide (Lebow, 1982). Client satisfaction data can be used to improve services, aid with staff recruitment and retention, support fundraising endeavors (Fischer & Valley, 2000). Treatment satisfaction is related positively to a client's engagement with therapy in that it correlates with treatment acceptability, compliance, and retention (Kia-Keating, Brown, Schulte, & Monreal, 2009; Rosenheck, Wilson, & Meterko, 1997). It also is related positively to treatment outcome (Dearing et al., 2005).

Statement of the problem

Adopted persons are at risk for social, emotional, and behavioral problems that require intervention (Juffer & van IJzendoorn, 2005; Nickman et al., 2005). Adoptive families also are at risk for impaired functioning (Rueter et al., 2009) and adoption disruption (Smith & Howard, 1991). Of the nearly 8 million adopted persons in this country, an estimated 400,000 to 1.4 million of them at any one time are receiving mental health services for emotional and/or behavioral problems (Miller et al., 2000). However, adoption-competent mental health services are scarcely available, and there limited empirical validation of existing programs (Bath & Miller, 2000). Given the unique needs of this population and their prevalence in the clinical population, the paucity of empirically-supported adoption-competent therapy models and adoption-competent mental health professionals is problematic. Families who do not receive adequate services are at risk for continued distress and dysfunction throughout the lifespan (Rycus et al., 2006).

An adoption-focused, integrated therapeutic intervention has been developed by the Center for Adoption Support and Education (CASE) to train professionals to deliver adoption-competent therapy to families. This study evaluated the extent to which participation in this therapy program for adopted children and their families related to psychological outcomes for children and families. Families receiving adoption-competent therapy at CASE were assessed pre-treatment on indices of child and family functioning to establish a baseline against which they were compared at the conclusion of their treatment. The purpose of the comparison was to study whether families demonstrated improvement on measures of child and family functioning at the conclusion of their treatment.

This study contributed to the literature in a number of important ways. First and foremost, it answered recent calls for empirical investigations to evaluate models of adoption-competent therapy using adequate sample size, appropriate measures, and a theoretical rationale. Furthermore, it advanced knowledge regarding the specific outcomes that may be related to the provision of one model of adoption-focused therapy. The findings from this study inform the work of counseling psychologists in their roles as researchers, therapists, and advocates by providing information about the relationships between one model of adoption-focused therapy for adoptive families and child and family functioning outcomes. Specifically, the results may contribute to counseling psychologists' work in individual and family therapy with adoptive families. Finally, the findings of this study can be used to guide the development, implementation, and empirical evaluation of adoption-competent therapy programs (and related training programs for therapists and counselors) throughout the country.

Hypotheses

Prior to testing hypotheses, therapists' adherence to treatment and equivalence of therapists were assessed and descriptive statistics on all measured variables were calculated.

Treatment adherence. Therapists were expected to adhere to the CASE model of adoption-competent therapy such that there would be no differences among therapists on parent and child rating ratings on the Treatment Adherence Questionnaire, a measure of the degree to which therapists adhered to the treatment model.

Equivalence of therapists. Therapists were expected to be perceived by parents and children as equivalent on the Counselor Rating Form - Short Form, a measure of

therapists' expertness, attractiveness, and trustworthiness as perceived by participants. Therapists were expected be equivalent such that there would be no main effects of therapists on perceived expertness, attractiveness, or trustworthiness.

Hypothesis 1. Participation in an integrated therapeutic intervention for adoptive families was expected to be related to improvements in child functioning from pre-test to post-test.

Hypothesis 1a. Participation in an integrated therapeutic intervention for adoptive families was proposed to be related to higher scores on a measure of attachment to parents from pre-test to post-test.

Hypothesis 1b. Participation in an integrated therapeutic intervention for adoptive families was proposed be related to lower scores on a measure of internalizing behaviors from pre-test to post-test.

Hypothesis 1c. Participation in an integrated therapeutic intervention for adoptive families was proposed to be related to lower scores on a measure of externalizing behaviors from pre-test to post-test.

Hypothesis 2. Participation in an integrated therapeutic intervention for adoptive families was proposed to be related to improvements in family functioning from pre-test to post-test.

Hypothesis 2a. Participation in an integrated therapeutic intervention for adoptive families was proposed to be related to higher post-test scores on a measure of adoption-related communication.

Hypothesis 2b. Participation in an integrated therapeutic intervention for adoptive families was proposed to be related to higher post-test scores on family cohesion.

Hypothesis 2c. Participation in an integrated therapeutic intervention for adoptive families was proposed to be related to higher post-test scores on emotional responsiveness.

Hypothesis 2d. Participation in an integrated therapeutic intervention for adoptive families was proposed to be related to higher post-test scores on measures of parent satisfaction with adoption.

Hypothesis 2e. Participation in an integrated therapeutic intervention for adoptive families was proposed to be related to higher post-test scores on measures of child satisfaction with the adoptive family.

Hypothesis 3. Therapists scoring higher on a measure of adherence to the integrative intervention for adoptive families were expected to receive higher scores on the treatment satisfaction questionnaire from parents than those therapists scoring lower on a measure of treatment adherence.

CHAPTER III

Method

Participants

The sample included 50 adoptive families who were clients of a community mental health agency specializing in the treatment of families formed through adoption and foster care. Several criteria were established for inclusion in the study. The child's adoption must have been finalized by the start of treatment. Children were required to be between the ages of 8 to 18 years old. A minimum of 8 sessions must have been completed for eligibility in the study. Fifty-nine families were identified as eligible and invited to participate. Of that number, 51 families agreed to participate. One family terminated treatment after four sessions, reportedly due to time conflicts, and therefore was not included in the sample for analysis. A total of 50 families completed the treatment, corresponding to an 85% response rate.

The final sample consisted of 50 children and 50 parents. See Tables 1 to 3 for the demographic characteristics of the sample. The child participants were 15 boys (30%) and 35 girls (70%) between the ages of 8 and 18 (M = 12.86, SD = 2.86). The sample included children from the following racial groups: 40% White/European American (N = 20), 30% Asian/Pacific Islander (N = 15), 14% Black/African-American (N = 7), 8% multiracial (N = 4), 6% Hispanic/Latino/a (N = 3), and 2% Native American/Indigenous (N = 1). The majority of children in the sample had been adopted internationally (66%, N = 33), 20% (N = 10) were adopted within the United States through public agencies, and the remaining 14% (N = 7) were adopted through private, domestic adoption agencies. Ages of adoption ranged from 0 months to 16 years. See Table 1. Fifty percent (N = 25)

of the children in the sample were adopted between the ages of 0 and 23 months, 30% (*N* = 15) were adopted between ages 2 and 4, 18% (*N* = 9) were adopted between 5 to 7 years old, and the remaining 10% (*N* = 5) were adopted between 8 to 16 years old. The majority of pre-adoption placements were institutional care (46%, *N* = 23) and foster care (42%, *N* = 21). Other pre-adoption placements included adoptive parents (6%, *N* = 3), birth parents (4%, *N* = 2), and birth relatives (2%, *N* = 1). Most children in the sample had no contact with birth parents (78%, *N* = 39). Others ranged in frequency of contact. Four percent (*N* = 2) rarely had contact (one to several times in child's life), 6% had infrequent contact (one time every few years), 8% had yearly contact (two to four times per year) with birth parents, and 4% (*N* = 2) had monthly contact (one to two times per month).

Participating families resided in the greater metropolitan area of Baltimore and Washington, D.C., and south-central Pennsylvania. See Table 2. Participating parents were mostly female (80%, *N* = 40) and White (88%, *N* = 44). Other racial/ethnic groups represented among parents were Black/African American (8%, *N* = 4), Asian/Pacific Islander (4%, *N* = 2), and Other (2%, *N* = 1). Most of the parents were married (80%, *N* = 40). Ten percent were single (*N* = 5), 4% (*N* = 2) were widowed, 4% (*N* = 2) were divorced/separated, and 2% (*N* = 1) were cohabitating. Two percent (*N* = 1) of the sample identified as homosexual. Parents were largely highly educated with 72% (*N* = 36) of the sample holding bachelor's and graduate degrees. The majority of families (48%, *N* = 24) earned incomes of $100,000 or more; 22% earned between $50,000-99,999; 6% (*N* = 3) reported incomes of under $49,999; 24% of families (*N* = 12) chose not to disclose their income.

Participants received individual (for the child) and family therapy, with an average number of 16.04 sessions (*SD* = 5.45, range = 8-27). See Table 4. Nearly half (48.8%) of the total sessions were labeled as individual sessions with the child (*M* = 7.96, *SD* = 6.16, range = 0-23) and almost half (49.4%) were labeled as family sessions (*M* = 8.06, *SD* = 6.06, range = 0-21). However, therapists reported that sessions described as "family" sessions sometimes included time spent with children alone and parents alone. Therefore, no analyses could be run with respect to child and family sessions. Children from two families participated in group therapy as well, averaging 7 group sessions (*SD* = 5.66, range = 3-11). Group sessions comprised 2% of the total number of sessions received by participants in the study.

Procedure

Participants were families who either learned of CASE services on their own or who were referred to CASE by adoption agencies, social workers, or others. When an eligible family called CASE to make an appointment, the person scheduling the appointment read a script describing the study and invited the family to participate (see Appendix A for recruitment materials).

Prior to commencing therapy, the child client and one of her or his parents completed a pre-test. Upon completion of treatment, these same individuals completed a post-test. The pre-test occurred during the family's intake session with a CASE therapist. When families arrived for the appointment, the primary investigator briefly described the study to the family, reviewed the informed consent document, and obtained parents' consent and children's assent.

While the therapist conducted a one-hour intake session with the parents, the investigator took the child into a private room for the pre-test. The measures administered to child participants were the Adoption Communication Openness Scale (ACOS), Family Adaptability and Cohesion Evaluation Scales II (FACES II), McMaster Family Assessment Device (FAD), Inventory of Parent Peer Attachment, Revised for Children (IPPA-R), and Satisfaction with Family Scale (SWFS). See Appendix B for a table summarizing the measures. Children ages 10 and up completed paper-and-pencil versions of the measures. Children ages 9 and under were read the measures by the investigator. Children independently selected the answers.

The researcher took one of the parents into a private room for the parent pre-test while the therapist conducted an intake assessment with the child. A paper-and-pencil administration of the Child Behavior Checklist (CBCL), Family Adaptability and Cohesion Evaluation Scales II (FACES II), McMaster Family Assessment Device (FAD), Parental Adoption Satisfaction Scale (PASS), and a demographics questionnaire was conducted with the parents. See Appendix A for a table summarizing the measures.

Participants were thanked for their time and given a $5 gift certificate to Target. Copies of the CBCL, FACES, and FAD were directly given to the family's therapist and placed in the family's clinical file.

Parents and children were then seen for weekly therapy by therapists employed by CASE at one of its offices in the greater metropolitan area of Baltimore and Washington, D.C. A minimum of 8 sessions of therapy had to be completed to be eligible for participation in the research. Therapists documented the number of sessions/services, types of sessions/services, and family members participating. The types of services

provided in this study were individual and family therapy. A small minority of the child participants were treated in group therapy in addition to individual and family therapy. See Table 4.

The post-test occurred at the termination of therapy upon completion of at least 8 sessions. If families continued in treatment beyond six months, the post-test occurred 6 months after beginning treatment. The primary investigator kept track of the 6-month post-assessment date and coordinated with the therapist and/or family to schedule the post-test at the CASE office after their appointment.

The post-test was conducted by the primary investigator. She administered paper-and-pencil versions of the measures to the same parent who completed the pre-test. The parent measures included the Child Behavior Checklist (CBCL), Counselor Rating Form, short version (CRF-S), Family Adaptability and Cohesion Evaluation Scales II (FACES II), McMaster Family Assessment Device (FAD), Parental Adoption Satisfaction Scale (PASS), a treatment adherence questionnaire (TAQ), and a treatment satisfaction questionnaire (TSQ). See Appendix A for a table summarizing the measures. While the parent was completing the parent measures, the investigator took the child into a separate room to complete the child measures which included the Adoption Communication Openness Scale (ACOS), Counselor Rating Form, Short Form (CRF-S), Family Adaptability and Cohesion Evaluation Scales II (FACES II), McMaster Family Assessment Device (FAD), Inventory of Parent Peer Attachment, Revised for Children (IPPA-R), Satisfaction with Family Scale (SWFS), and a treatment adherence questionnaire (TAQ). See Appendix A for a table summarizing the measures. Children 10

and up (provided the child is able to read) independently read and completed paper-and pencil versions of the measures. Children 9 and under were read the measures.

Parents and children were thanked for their participation, and each was given a $5 gift certificate to Target.

Therapist procedures. Therapists completed a demographics questionnaire prior to their treating the families enrolled in the study.

Therapist demographics. See Tables 5 and 6 for complete therapist demographics. The therapists were 10 females and two males whose ages ranged from 38 to 68 years old (*M* = 51.08, *SD* = 9.73). All therapists possessed master's degrees. The majority, 58.3%, possessed a master's of social work and included six licensed clinical social workers and one licensed graduate social worker. Six therapists (33.3%) possessed master's degrees in psychology and were credentialed as licensed clinical professional counselors. One therapist (8.3%) was a licensed graduate marriage and family therapist. Therapists ranged in years of experience between 2 and 38 years (*M* = 15, *SD* = 10.27). All therapists had some training in providing adoption-competent therapy, with an average number of 206.33 training hours (*SD* = 115.62, range = 45-469). Given the large range in training hours, the Shapiro-Wilk test of normality was performed; the test was non-significant (*p* = .57) indicating that the data were normally distributed. Training consisted of a combination of continuing education classes on adoption-focused therapy and adoption-competency focused supervision. On average, each therapist treated 4.17 families (*SD* = 2.27, range = 1-7). The majority (58.3%) of therapists had some personal connection to adoption, either as an adoptive parent (33.3%, *N* = 4), adopted person (16.7%, *N* = 2), or having family members who have adopted (8.3%, *N* = 1). Therapists

identified having the following theoretical orientations (note that therapists could select more than one option, and therefore percentages total more than 100): behavioral/cognitive-behavioral (41.7%, *N* = 5), family systems (66.7, *N* = 8), eclectic/integrative (33.3%, *N* = 4), interpersonal (16.6%, *N* = 2), person-centered (33.3%, *N* = 4), psychodynamic (41.7%, *N* = 5), and solution-focused (8.3%, *N* = 1).

Measures

Child Functioning

Child functioning was measured with two different scales, which together assessed three important aspects of adopted child functioning: attachment and emotional and behavioral problems (i.e., internalizing and externalizing behaviors). The scales used included the Inventory of Parent Peer Attachment (IPPA) and the Child Behavior Checklist (CBCL).

Attachment. The Inventory of Parent Peer Attachment, Revised for Children (IPPA-R; Gullone & Robinson, 2005; see Appendix C) is a 75-item measure of a child's attachment parents and peers. It consists of three subscales, each containing 25 items Attachment to Mother, Attachment to Father, and Attachment to Peers. For the purposes of this study, only the Attachment to Mother and Attachment to Father subscales were used.

Participants read each item and indicate, on a five-point Likert-type scale, the degree to which each item was true for them, from 1 (*almost never or never true*) to 5 (*almost always or always true*). Example items from the Attachment to Mother subscale included "my mother respects my feelings." Examples of items from the attachment to father subscale include "my father trusts my judgment." Ratings for items on each

subscale were summed, and higher total scores indicated better attachment to the parent. Previous research demonstrates Cronbach alphas ranging from .72 to .91 on its subscales (Gullone & Robinson, 2005). In the present study, Cronbach alphas on pre- and post-test administrations were .94 and .96 for Attachment to Mother and .95 and .96 for Attachment to father. Test–retest reliability was found to range from .86 for peer attachment to .93 for parent attachment (Armsden & Greenberg, 1987). Moderate correlations were found between the IPPA and other measures, such as the Family Self-Concept subscale of the Tennessee Self-Concept Scale and the Social Self-Concept subscale, with $r = .78$ and $r = .46$, respectively, for parent attachment (Gullone & Robinson, 2005).

Emotional and behavioral problems. The Child Behavior Checklist for Ages 6-18 (CBCL, 6-18; Achenbach & Rescorla, 2001; see Appendix D) is a widely used 113-item parent rating scale that assesses internalizing (emotional) and externalizing (behavioral) problems in children. The measure produces a Total Problems score as well as scores on two broadband subscales (Internalizing Problems and Externalizing Problems), and eight empirically based subscales. The empirically based subscales are Anxious/Depressed (13 items), Withdrawn/Depressed (8 items), Somatic Complaints (11 items), Social Problems (11 items), Thought Problems (15 items), Attention Problems (10 items), Rule-Breaking Behavior (17 items), and Aggressive Behavior (18 items). The Internalizing Problems score is formed by combining Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints, and the Externalizing Problems score is formed by combining Rule-Breaking Behavior and Aggressive Behavior. The two

broadband subscales, Internalizing Problems and Externalizing Problems, were used in this study.

Each of the CBCL's 113 items is a description of a symptom. Parents rated each item on a 3-point scale ranging from 0 (*not true*) to 2 (*very/often true*) indicating how true the description was for their child in the past six months. Example items from each subscale included the following: "Too fearful or anxious," "Feels worthless or inferior," "Nausea, feels sick," "Gets teased a lot," "Hears sound or voices that aren't there," "Can't concentrate, can't pay attention for long," "Truancy, skips school," and "Physically attacks people." Scores from each of the subscale's items were summed, and higher total scores indicated more emotional and behavioral problems. Summed subscale scores were categorized as falling in the normal, borderline clinical and clinical ranges by using the cut-off scores provided in the CBCL manual (Achenbach & Rescorla, 2001). Raw scores were used in the repeated measures analyses for the present study instead of standard scores because they provide an indicator of change over time (Hartman, Stage, & Webster-Stratton, 2003).

Internal consistency estimates for the CBCL ranged from .78 to .94 across the empirically based subscales. Cronbach alphas for Internalizing, Externalizing, and Total Problems were .90, .94, and .97 respectively. The range of eight-day test-retest values across the empirically based subscales were .82 to .92. For the Internalizing and Externalizing subscales, test-retest reliabilities were .91 and .94 respectively, and test-retest for Total Problems was .94. In the present study, Cronbach alphas for Internalizing Problems subscale were .86 for the pre-test and .86 for the post-test. For the Externalizing Problems subscale, Cronbach alphas were .91, pre-test, and .90 post-test. The CBCL has

been shown to correlate in the expected direction with other measures of child functioning and to accurately discriminate between youth in clinical and community samples (Achenbach & Rescorla, 2001).

Family functioning

Family functioning was measured with five different scales which assessed five important aspects of adoptive family functioning: adoption-related communication, cohesion, affective responsiveness, the child's satisfaction with the family, and the parent's satisfaction with adoption. The scales used included the Adoption Communication Openness Scale (ACOS), the Family Adaptability and Cohesion Evaluations Scales II (FACES II), the McMaster Family Assessment Device (FAD), the Satisfaction with Family Scale (SWF), and the Parental Adoption Satisfaction Scale (PASS).

Communication about adoption. The Adoption Communication Openness Scale (ACOS; Brodzinsky, 2006; see Appendix E) is a 28-item self-report scale that measures the extent to which adoptive children feel comfortable talking to their parents about adoption and perceive their parents as open and sensitive about adoption-related communication. The scale was adapted from the Parent-Adolescent Communication Scale (Barnes & Olson, 1985). The first 14 items in the ACOS assess adoptees' perceptions of communication with their adoptive mothers, and the last 14 items assess perceptions of communication with adoptive fathers. Participants endorsed the degree to which they agree with each item on a 5-point Likert-type ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Examples of items included "I am very satisfied with how my mother and I talk together concerning my feelings about being adopted" and "I

feel very uncomfortable discussing my birth parents with my father." Problematic communication items were reversed scored. Scores from each item were summed, and high total scores indicated better communication about adoption as perceived by the adoptee.

Reliability data was available for only the original measure which consisted of 14 items assessing communication with both parents versus the current version which included 14 items for each parent. The Cronbach alpha for the original version of the scale was .79, and test-retest over a one-week period was .70. Cronbach alphas for the mother subscale of ACOS were .90 for the pre-test and .91. For the father subscale, alphas were .93 for the pre-test and .92 for the post-test.

Cohesion. The Family Adaptability and Cohesion Evaluation Scale, II (FACES II; Olson et al., 1982; see Appendix F) is a 30-item scale assessing two dimensions of family functioning: cohesion and adaptability. There two subscales are Cohesion (16 items) and Adaptability (14 items). For the purpose of this study, only the Cohesion subscale was used.

Participants rated the extent to which they agree with each on a 5-pt Likert scale ranging from 1 (*almost never*) to 5 (*almost always*). Example items from Cohesion subscale included "Family members are supportive of each other during difficult times" and "Family members feel very close to each other." To obtain an average score for the scale, scores on each item in a subscale were summed and divided by the number of items in that subscale. Negatively worded items were reverse scored. Despite Olson's (1991) claims that results are curvilinear with midrange sores representing optimal family functioning, large-scale studies have consistently demonstrated that high score represent

high levels of family functioning (Green, Harris, Forte, & Robinson, 1991). Scores ranged from 16 to 80 and are classified into the following categories: "disengaged" (scores of 16 to 50), "separated" (scores of 51 to 59), "connected" (scores of 60 to 70), and "very connected" (scores of 71 to 80).

Cronbach alphas for the Cohesion subscale ranged from .71 to .89. In the present study, alphas on the pre-test were .90 for the parent-completed scale and .86 for the child-completed scale. For the post-test, Cronbach alpha for the parents was .84 and .92 for the children. FACES four- to five-week test-retest reliability subscale was.83. FACES II correlated in the expected direction with other measures of family functioning including Family Environment Scale (FES; Moos & Moos, 1991), the Family Assessment Measure (FAM; Skinner, Steinhauer, & Santa-Barbara, 1983), and the Dallas Self Report Family Inventory (SFI; Beavers, Hampson, & Hulgus, 1985; Gondoli & Jacob, 1993; Hampson, Hulgus, & Beavers, 1991). Furthermore, scores distinguished between high- and low-functioning families as rated by mental health professionals (Altiere & von Kluge, 2009) and discriminated clinically different patterns of family functioning (Place, Hulsmeier, Brownrigg, & Soulsby, 2005).

Emotional responsiveness. The Family Assessment Device (FAD; Epstein, Baldwin, & Bishop, 1983; see Appendix G) is a 60-item measure that assesses family functioning and consists of six subscales, each measuring a different dimension of family functioning. The subscale used in this study was the Affective Responsiveness scale. Example items from the Affective Responsiveness subscale included "We express tenderness" and "We do not show our love for each other."

Participants rated the degree to which they endorsed each item using a 4-point Likert-type scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Items that were negatively worded are reverse scored. Scores from the items on each scale were summed and averaged to provide an indicator of functioning for the scale. Low scores indicated high levels of family functioning (1 = best functioning, and 4 = worst functioning) (Miller, Ryan, Keitner, Bishop, & Epstein, 2000). Cronbach alphas for the Affective Responsiveness subscale ranged from .73 to .75 (Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990). Alphas for the present study were .76 and .86 for the parent-completed measures at pre- and post-test, respectively and .63 and .76 for the child-completed measures at pre- and post-test. The FAD correlated in the expected direction with the FACES and other measures of family functioning (Miller et al., 2000). Scores on the FAD have been shown to correctly differentiate families with a member with a psychiatric disorder from families in medical and nonclinical samples (Kabacoff et al., 1990).

Satisfaction with adoptive family. For the purpose of this study, the Satisfaction with Life Scale, a measure of global life satisfaction (Diener, Emmons, Larson, & Griffin, 1985; see Appendix H), was adapted by the researchers to measure child participants' satisfaction with their adoptive families. The scale consists of five items. Example items included "In most ways my life is close to my ideal" and "I am satisfied with my life." For the purpose of this study, items were reworded so that the phrase "my life" was replaced with "my family." Children rated the degree to which they endorse each item using a 7-point Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Scores from individual items were summed with high scores

representing strong levels of family satisfaction. The Cronbach alpha for the Satisfaction with Life Scale was .87 (Diener et al., 1985). In the present study, the Cronbach alpha for the SWF pre-test was .92, and for the post-test alpha was .90. The scale correlated in the expected direction with other measures of life satisfaction (Diener et al., 1985).

Satisfaction with adoption. The Parental Adoption Satisfaction Scale (PASS; see Appendix I) was developed for the purpose of this study to assess the degree to which adoptive parent participants were satisfied with their decision to adopt. Previously, most studies assessed the construct with up to a few yes or no questions inquiring if parent's are satisfied with the adoption of their child and if they would make the decision to adopt again based on their experience. A more extensive scale using a Likert-type response format was developed by Pinderhughes (1998) to assess satisfaction with foster care adoptions. For this study, a measure was needed to assess satisfactions with all types of adoptions as CASE serves families who adopt domestically and internationally from both foster care and private agencies. An initial set of items was written by the researcher after examining the means by which the construct has been assessed in the adoption literature. After the initial construction, items on the measure were edited by a psychologist and then reviewed by two adoption services professionals. The reviewers made suggestions for rewording the item to improve their clarity, and the items were revised based on the suggestions. The revised items were reviewed by the psychologist and primary investigator, and the final version was approved by the adoption services professionals.

The PASS consisted of 10 items that were rated on a 7-point Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Example items included "Knowing what I know now, I believe the adoption of my child was a good decision" and

"Raising an adopted child was harder than I anticipated." Negatively worded items were reverse scored. Scores were averaged across all items, and high mean scores represented strong levels of satisfaction with adoption. Cronbach alphas for this study were .93 for the pre-test and .92 for the post-test.

Family demographics questionnaire. The demographics questionnaire was developed by the researcher (see Appendix J). It asked adoptive parents to complete questions about themselves and their children. Parents indicated their age, gender, race, ethnicity, education, marital status, sexual orientation, and state of residence. They provided the following information about their adoptive children: age, gender, race, country of origin, age at adoption placement, number of month/years since adoption placement, type of adoption, amount of contact with birth parents, number of criminal offenses committed, and number of times their child was the victim of a crime. Parents were asked about any foster children living in their home and were asked to indicate the children's' age, gender, race, age at initial placement, time since placement, number of placement disruption, amount of contact with birth families, and the parents' plan to adopt the foster children. Finally, parents were asked to indicate the age, gender race, ethnicity, and country of birth of their biological children.

Treatment effects

Therapist equivalence. The Counselor Rating Form, Short Form (CRF-S; Corrigan & Schmidt, 1983; see Appendix K) is a 12-item scale that assesses clients' perceptions of their therapists' characteristics on three subscales: Expertness, Attractiveness, and Trustworthiness. Each item is an adjective representing a characteristic that a therapist may have to varying degrees. On a Likert-type scale ranging

from 1 (*not very*) to 7 (*very*), participants rated their therapists on the how well they believed each characteristic accurately describes the therapist. Examples of items included "friendly," "warm," "experienced," "skillful," "reliable," and "sincere." Estimates of internal consistency were .85, .94, and .89 for Expertness, Attractiveness, and Trustworthiness, respectively. In the present study, Cronbach alphas for the child-completed CRF-S were .91, .78, and .91 for Expertness, Attractiveness, and Trustworthiness, respectively. For the parent-completed CRF-S, alphas were .92 for Expertness, .94 for Attractiveness, and .97 for Trustworthiness. A factor structure equivalent to Barak and LaCrosse's (1975) original version of the CRF has been demonstrated for the short form of the scale (Corrigan & Schmidt, 1983).

Adherence. The Therapist Adherence Questionnaire (TAQ; see Appendix L) was developed for this study to assess how well therapists adhered to the adoption-competent therapy model developed by the Center for Adoption Support and Education (CASE). In accordance with the recommendation that adherence measures be written to check the specific components of a therapy model (Waltz et al., 1993), the TAQ items were written to correspond with the core principles and competencies of CASE's model of adoption-competent therapy. An initial set of items was developed by the primary investigator and was edited by a psychologist. Two adoption services professionals reviewed the items to ensure the items adequately reflected the components of the model. The reviewers' suggestions for revisions to improve correspondence to the model components, readability, and clarity were incorporated, and the revisions were edited by the psychologist. The revisions were resubmitted to the reviewers who gave their approval.

The final version of TAQ included a parent and child version each consisting of 20 items. Participants rated how well each item described their therapist on a 7-point Likert-type scale with answers ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). High scores indicated therapist adherence to the treatment model. Example items from the parent scale included: "We talked about the importance of my child's understanding of her/his identity" and "My therapist encouraged me to provide my child with as much information about her/his background as we can, in an age-appropriate manner." Examples of items from the child version included "My therapist understood that having information about my adoption is helpful to me" and "My therapist believed that it is normal for me to have an interest in my birth parents." Cronbach alphas were .94 for the parent version of the scale and .94 for the child version.

Treatment satisfaction. Treatment Satisfaction Questionnaire (TSQ; see Appendix M) is a nine-item measure developed for use in this study to assess how satisfied parents were with the therapy they received. A number of client satisfaction measures are available, including the Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) and the Client Satisfaction Inventory (McMurtry & Hudson, 2000). However, they were written to assess client satisfaction with a broad range of mental health and medical services. The present study was interested in capturing parental satisfaction with adoption-competent therapy compared to treatment as usual. For this reason it was important that the satisfaction measure be specifically written for the therapy being delivered. This measure was developed in a fashion similar to that the TAQ. The primary investigator developed an initial set of items that assessed parental satisfaction with the treatment related to outcomes that CASE

expects from a successful course of therapy. These outcomes included improvement in child behavior, family communication related to adoption, and parental understanding of children's feelings about adoption. The items were edited by a psychologist and then were reviewed by two adoption services professionals. The reviewers suggested minor changes to improve the clarity of the items. The changes were incorporated, and the revisions edited by the psychologist. The revised version was approved by the adoption services professionals, resulting in the final scale.

Parent participants rated how well each of the nine items describes their experience in therapy on a 7-point Likert-type scale with answers ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). High scores indicated satisfaction with therapy. Example items included "Therapy led to improvements in my child's behavior" and "I better understand my son/daughter's feelings about adoption as a result of therapy." Cronbach alpha for the treatment satisfaction scale was .95.

Therapist demographics questionnaire. The therapist demographics questionnaire was developed by the researcher (see Appendix N). It asked therapists to indicate their age, gender, race, ethnicity, credentials, amount of training, years of experience, theoretical orientation, and personal experience with adoption.

CHAPTER IV

Results

Missing values analysis

Prior to conducting formal statistical analyses, missing values analyses were conducted using SPSS 19.0. Missing values pattern analyses indicated that there was no pattern of missing data among participants. All but 7 participants had completed more than 96% of the questions. Seven participants did not complete 13% of the questions. These participants were children from single parent families. Therefore, questions pertaining to the second parent were not applicable. All cases were retained for subsequent analyses. On average, participants from dual-parent households missed less than one question (M = .63, SD = 3.66). All but one participant from the seven single-parent households in the sample missed the 78 questions (M = 78.14, SD = .38) pertaining to the second parent in the household. One participated missed an additional question from another measure. The number of items missing for any given participant, including children with single parents, was below 15%, allowing data to be imputed for all of the missing items. Data imputation was conducted using expectation maximization (EM) method for each scale at the individual level. The following analyses were performed using imputed data from SPSS.

Descriptive statistics

Descriptive statistics on all measured variables were calculated prior to testing the hypotheses. The sample characteristics as measured by the variables of interest are discussed below. See Table 7 for complete data regarding sample characteristics.

To assess child functioning, measures of attachment to parents were completed by

the child participants and measures of children's internalizing and externalizing problems were completed by parents. On average, children at pre-test reported medium-high quality attachments to their parents, scoring in the highest end of the middle third of the score range, reporting that it was "sometimes" to "often true" that their caregiver was accessible and responsive in the variety of ways assessed by the attachment inventory. At post-test, child participants indicated high quality attachment to their parents with scores in the top third of the score range.

Typically, parents at pre-test reported that children's internalizing problems (e.g., depression and anxiety) fell in the high end of the clinical level at pre-test and in the borderline clinical range at post-test. On average, parents report of children's externalizing problems (e.g., rule breaking and aggressive behaviors) were in the clinical range at pre-test and in the normal range at post-test.

To assess family functioning, measures of adoption-related communication, family cohesiveness, affective responsiveness, and satisfaction with the family were completed participants. On average at pre- and post-test, children reported a moderate degree of openness with respect to communication about adoption with their parents. Family cohesiveness (as measured by the Family Adaptability and Cohesiveness Evaluation Scales II) can fall into four categories, ordered here from lowest to highest with respect to levels of cohesiveness: "disengaged," "separated," "connected," and "very connected." On average, children rated their level of family cohesion as "separated" at pre- and post-test. Parents, on the other hand, reported they felt that their families were "connected" at both time points. On average, participants reported at pre- and post-test that "for the most part" their families displayed their emotions as well as their affection

for one another. At pre-test, parents indicated that they "somewhat agreed" that they felt satisfied having adopted their child and at post-test reported that they "agreed" they felt satisfied. On average, children indicated at pre-test that they "slightly agreed" and at post-test that they "agreed" that they felt satisfied with their adoptive families.

Therapists were rated by participants on the degree to which they adhered to a model of adoption-competent therapy, and on average, child participants judged therapists as adhering to the model in "most sessions," and parents indicated that therapists adhered to the model in "some sessions," corresponding to mean item scores of 2.63 (*SD* = 1.04) and 2.43 (*SD* = .98), respectively. Parent and child measures of adherence correlated positively with one another (*r* = .40). Parents and children also rated therapists on the degree to which they found them expert, attractive, and trustworthy. Therapists on average were judged by parents and children as being "very" expert, attractive, and trustworthy, with a mean item score of 6.43 (*SD* = 1.01) out of 7 on these characteristics. With respect to parental satisfaction with treatment, parents on average "somewhat agreed" to feeling satisfied with the treatment they received. The mean item score for the satisfaction measure was 5.44 (*SD* = 1.55) on a 7-point scale.

Preliminary analyses

Prior to conducting the primary analyses, preliminary analyses were run to determine if the data could be grouped for analysis.

Treatment adherence. First, a test of treatment adherence was conducted. Therapist adherence to an adoption-competent therapy model was assessed by participants' responses on a treatment adherence questionnaire. A MANOVA was conducted to determine if therapists differed on the degree to which parents and children

rated them as adhering to the treatment model. No differences were found on participants' ratings of therapists' adherence, $F(26,70) = 1.27$, $p > .05$. Therapists were judged to be equivalent on the degree to which they adhered to the treatment, and the data were grouped together for analysis of the treatment.

Equivalence of therapists. The degree to which therapists differed on participants' perceptions of their expertness, attractiveness, and trustworthiness, was examined using the Counselor Rating Form, Short Form. A multivariate analysis of variance was conducted to determine if therapists differed on participants' ratings of the three characteristics noted above. The MANOVA was computed using therapist as the independent variable and expertness, attractiveness, and trustworthiness as the dependent variables. The Wilk's lambda value for the overall MANOVA was not significant, $F(66,182.03) = 1.37$, $p > .05$. Therefore, it was determined that therapists were equivalent on expertness, attractiveness, and trustworthiness and that the data could be grouped together for further analyses.

Primary data analyses

Child and family functioning. To evaluate the degree to which participation in an integrated therapeutic intervention for adoptive families was related to changes in child functioning from pre-test to post-test, a mixed model repeated measures multivariate analyses of variance was conducted on four dependent measures to determine if children demonstrated improvement on child outcome variables at post-test compared to pre-test. The child outcomes included in the analyses were attachment to mother and father and internalizing and externalizing behaviors. These outcomes were assessed by comparing pre-test and post-test scores on the attachment to mother and

attachment to father subscales of Inventory of Parent Peer Attachment and the Externalizing and Internalizing problems subscales of the Child Behavior Checklist.

The comparison of the pre-and post-test scores on measures of child functioning yielded a significant multivariate *F* value of 7.794 (*df* = 4, 95; $p < .01$, partial $\eta_p^{2} = .24$). To further examine differences on pre- and post-test measures, univariate tests of significance using analysis of variance with repeated measures were conducted. There were differences for internalizing problems, $F(1, 98) = 26.26$, $p < .01$, $\eta_p^{2} = .21$, and externalizing problems, $F(1, 98) = 19.96$, $p < .01$, $\eta_p^{2} = .17$. No differences between pre- and post-test were found for the IPPA subscales. The means and standard deviations for the pre- and post-test administrations' of the child functioning outcome measures are provided in Table 7.

To evaluate the degree to which participation in an integrated therapeutic intervention for adoptive families was related to changes in family functioning from pre-test to post-test, a second MANOVA was conducted to determine if families demonstrated improvement on family outcome variables at post-test compared to pre-test. The family outcomes included in the analysis were adoption-related communication, family cohesion, emotional responsiveness, parent satisfaction with adoption, and child satisfaction with the adoptive family. The comparison of the pre-and post-test scores on measures of family functioning yielded a non-significant multivariate *F* value, $F(8, 91) = 1.1$, $p > .05$. Therefore, univariate F tests were not conducted.

Treatment satisfaction. It was hypothesized that therapists' adherence to the integrative intervention for adoptive families would be related positively to satisfaction with treatment. Pearson product-moment correlations were calculated to assess the

relationship between child and parent ratings of therapist adherence and parental ratings of treatment satisfaction. There was a positive correlation between parent and child ratings of therapist adherence to the treatment model and parents' ratings of treatment satisfaction. Correlations, means, and standard deviations can be found in Tables 7 and 8.

Additional analyses

Correlational analyses were conducted to examine relationships among the variables of interest in the current study. Based on the large number of correlations, only correlations where $p < .01$ are discussed. A correlation table showing the relationships between all measures can be found in Table 8.

A number of correlations emerged among child and family functioning variables. With respect to attachment, there were positive correlations among variables measuring children's attachment to parents and those evaluating the family environment. For example, attachment to mother as rated by child participants at pre-test was correlated positively with children's and parent's rating of family cohesiveness and with children's ratings of the degree to which adoption was discussed openly in the home. Attachment to mother and father was correlated in the expected direction with a child-report measure of affective responsiveness, a scale on which low ratings indicated greater displays of emotion and affection in the home. Child perceptions of attachment to parents also were correlated positively with their level of satisfaction with their adoptive families. Attachment to mother as measured at post-test was positively correlated with children's ratings of therapists on expertness, attractiveness, and trustworthiness. Negative correlations emerged between parents' ratings of children's emotional and behavioral problems and parental satisfaction with adoption.

Several notable correlations were found among the family functioning variables. For example, high levels of openness in adoption-related communication as rated by children were correlated with high levels of cohesion and emotional responsiveness in families, as rated by children and their parents. Adoption-related communication openness also correlated positively with children's satisfaction with their adoptive families. Family cohesiveness, as rated by children and parents, correlated positively with parent and child overall satisfaction with the family. A measure of emotional responsiveness (on which lower scores indicated greater affection and emotional expressiveness) was correlated negatively with children's satisfaction with their adoptive families.

There were a number of additional correlations of note with respect to parent's ratings of their satisfaction with treatment. Treatment satisfaction, as reported by parents, was correlated positively with post-test scores of family cohesiveness as rated by both parents and children. It also was correlated positively with children's post-test ratings of openness in adoption-related communications with mother as reported by children and with children's post-test ratings of satisfaction with their adoptive families. Treatment satisfaction scores also were correlated positively with child and parent ratings of therapists' expertness, attractiveness, and trustworthiness.

Post hoc analyses

After running the primary analyses, we examined whether four variables were possible covariates in the relationship between participation in the intervention and child and family outcomes. The potential covariates examined were number of sessions, therapist years of experience, amount of training in the CASE model of adoption-

competent therapy, and therapist adherence to the model. First, change scores were calculated between Time 1 and Time 2 measures for each of the dependent variables. We then examined the correlations between the potential covariates and the change scores. Only two were correlated with any of the outcome variables. Therapists' years of experience were correlated with parents' ratings of the family environment, and adherence was correlated with children's attachment to father at post-test. Therefore, we reran the MANOVAs examining the relationship between participation in treatment and child and family functioning outcomes with therapists' years of experience and adherence included as covariates. With respect to the relationship between participation in treatment and child functioning, it was significant when adherence was included as a covariate in the model. With respect to the relationship between family functioning and participation in treatment, we did not expect that it would change once the covariate was included given that no difference was found in the initial analysis. This was indeed the case, and the relationship remained non-significant.

We were also interested in examining if there were differences in child and family outcomes depending on degree to which therapists adhered to the treatment model. To examine this, adherence levels were divided into two categories ("higher adherence" and "lower adherence") using a median split, and ANCOVAS were conducted to examine the relationship between higher and lower adherence and post-test measures of the dependent variables controlling for pre-test scores. Only two differences were found. Parents who rated their therapists as higher in adherence to the treatment model reported higher satisfaction with the adoptions of their children ($F(1,47) = 11.71$, $p<.05$). Those higher in adherence to the treatment model had a mean score of 5.85 ($SD = .87$), while those

reporting less adherence had a mean score of 5.59 (*SD* = 1.17), Children who rated therapists as higher in adherence exhibited fewer emotional problems at post-test than those who rated therapists as lower in adherence ($F(1, 47) = 4.21$, $p < .05$). Those higher in adherence to the treatment model had a mean score of 6.42 (*SD* = 6.19), while those reporting less adherence had a mean score of 9.46 (*SD* = 6.16).

CHAPTER V

Discussion

Despite the unique mental health needs of adopted children and their families, therapists historically have worked with this population without adequate training related to adoption (Henderson, 2000). Given the unique needs of this population and their prevalence in the clinical population, the paucity of empirically-supported adoption-competent therapy models and adoption-competent mental health professionals is problematic. The present study utilized an adequate sample size and psychometrically validated measures to examine the degree to which involvement in an theoretically integrative therapeutic intervention for adoptive families related to improvements in child functioning (i.e., enhanced attachment to parents, fewer internalizing and externalizing behaviors) and family functioning (i.e., enhanced family cohesion, emotional responsiveness, general and adoption-related communication, and satisfaction with adoption). Fifty children and their parents receiving adoption-competent therapy at a community mental health center specializing in the treatment of adoptive families were assessed prior to and at the conclusion of treatment on indices of child and family functioning. At post-test, children exhibited fewer emotional and behavioral problems than they did at pre-test. No differences in family functioning were found.

Prior to testing the primary hypotheses, preliminary analyses were run to assess if differences among therapists might prevent the data to be grouped together for the analyses. Therapists can differ in a number of important ways that would have an impact on outcomes above and beyond the impact of the actual treatment. In this study, there were no differences in the degree to which therapists were adhering to the model of

adoption-competent therapy - therapists on average were moderately adherent. Therefore, it was judged that therapists were implementing the treatment at approximately the same level and that adherence would not need to be controlled for when examining the relationships between treatment participation and outcomes. Furthermore, no differences among therapists were found with respect to their expertness, attractiveness, and trustworthiness. In fact, on average therapists were judged to be high on all of these characteristics. Therefore the therapists were implementing the treatment at about the same level, and the data were grouped for the remaining analyses.

The CASE model of adoption-competent therapy was based on the theoretical foundations of attachment theory (Ainsworth, 1989; Bowlby, 1982) and family systems theory (Bowen, 1978; S. Minuchin, 1974; Satir, 1964). The model stresses the important role that healthy parent-child bonds play in the facilitation of optimal adoptee adjustment and asserts that interactions between family members contribute to family and individual functioning (Riley & Meeks, 2006). An important supposition of the CASE model is that its application would lead to improvements in children's behavior. Therefore, the study's first primary hypothesis was that participation in an integrated therapeutic intervention for adoptive families was expected to be related to improvements in child functioning from pre-test to post-test (i.e., fewer emotional and behavioral problems and increases in attachment quality with adoptive parents). The study found that at post-test children were judged by their parents as having fewer internalizing and externalizing problems than at pre-test with their average scores at Time 2 falling in the "normal range" compared to the Time 1 average scores which fell in the "clinical range" on the Child Behavior Checklist, a measure of children's socioemotional functioning. One explanation for this finding is

that the treatment was effective in reducing emotional and behavioral problems for the children in the sample. This is consistent with previous claims that participation in adoption-competent therapy may be associated with lower levels of children's emotional and behavioral problems (Anderson, 2005; Groze et al., 1993; Smith, 2006a; Smith & Howard, 1991). However, given the lack of control group and randomization, it cannot be concluded that the treatment itself produced the results, and further study is needed to investigate this supposition. It is possible that children's problematic behaviors decreased as a function of time, the therapeutic relationship, or other variables not measured in this study.

Another important focus of the CASE model is facilitating healthy bonds between adopted children and their parents, which was proposed to lead to higher quality parent-child attachment. Attachment theory stresses the effects that pre- and post-adoption experiences may have on the security of children's attachment to caregivers. It also provides a context to consider interventions aimed at strengthening children's attachments to adoptive parents. However, with respect to children's attachment to parents, no differences were found at post-test compared to pre-test. There may be a number of explanations for this finding. First, the literature on attachment suggests that attachment to parents is stable over time (Scharfe, 2003) and therefore may not be amenable to change in the span of a brief course of treatment. Another possible explanation is that the children in the sample, on average, reported medium-high quality attachment to parents at baseline and therefore had little room for improvement at post-test. Alternatively, because less than half of the sessions received were family ones, there may not have been sufficient opportunity to work on attachment-related issues with the

parents in the therapy. Finally, it could be argued that participation in the treatment may have prevented a decline in family functioning. Children's emotional and behavioral problems have been shown to negatively impact family functioning (Sikora et al., 2013). Left untreated, it is possible that children's internalizing and externalizing symptoms could have led to a decline in family cohesiveness, emotional responsiveness, and communication. In this light, the finding of no change in family functioning at post-test could be seen as the result of a protective effect of the treatment.

Family functioning also is addressed by the CASE model, which states that an important component for the healthy adjustment of adoptees is their family environment. It would be expected that adhering to the CASE model would be related to improvements in family functioning. Therefore, this study's second primary hypothesis was that participation in an integrated therapeutic intervention for adoptive families would be related to improvements in family functioning (i.e., increases in family cohesiveness, emotional responsiveness, adoption-related communication, and overall satisfaction with the family). However, no such differences in family functioning were found at post-test. One possible explanation for this is that, similar to attachment, family systems are hypothesized to be stable over time, favoring homeostasis or equilibrium (Cox & Paley, 1987; Minuchin, 1985). This may mean that a brief course of therapy (in the case of this study, 6 months or less) would not be sufficient to produce change in the family system. Furthermore, it is likely that very few of the sessions received were family ones. Therapists labeled sessions as either family or individual, and they designated 49% of the sessions to be family sessions. However, some unknown subset of these were likely individual sessions as therapists anecdotally reported that they sometimes labeled family

sessions as such even though the therapist met with the child and parents separately during the session. Perhaps a greater focus on family therapy within sessions with a larger percentage of family sessions overall may have produced different results. Increasing the number of family sessions could have afforded therapists the opportunity to view family interactions as they occurred and to implement interventions aimed at changed problematic patterns of communication.

Another explanation for the findings is that the sample on average was functioning moderately well at baseline with respect to family functioning variables, leaving little room for improvement. Family functioning was operationalized as adoption-related communication openness, cohesiveness, emotional responsiveness, and satisfaction with the family. On average, the sample indicated moderately open communication about adoption. This could be because parents who would seek out therapy specifically designed for adoptive families are more comfortable talking about adoption. Participating families, on average, also rated themselves as being moderately emotional responsive, and cohesive, and generally satisfied with their families, again leaving little room for improvement on each of these variables.

The family systems literature also offers another possible explanation for the non-significant findings with respect to family functioning. It has been suggested that for interventions to be effective at changing a family system, the timing of the intervention must occur during a transition for the family, when difficulties are more likely to arise and family-based interventions are most needed (Cox & Paley, 1997). This study did not assess if families were in a state of transition or disruption when they entered therapy, so it may be that the timing of the intervention, in its ability to impact the family system,

was not ideal. Furthermore, the family therapy literature suggests that these interventions must not only be well-timed but specifically aimed at the relationship systems within the family (Cox & Paley, 1997). It has already been noted above that the majority of the interventions in this study were aimed at the individuals rather than including the family as a whole.

It was hypothesized that families who reported that therapists more closely adhered to the integrated intervention model would report greater satisfaction with the treatment they received. Supporting this hypothesis, the results demonstrated a positive relationship between ratings of therapist adherence and satisfaction with treatment. In other words, the more closely therapists were judged to have adhered to the model of adoption-competent therapy the higher parents rated their satisfaction with treatment. This is consistent with previous literature that reports parents being unsatisfied when receiving therapy from professionals deemed to lack knowledge or competence in the issues salient to adoptive families (Atkinson & Gonet, 2007). There is also some evidence to suggest that adherence to the treatment model may relate to more favorable outcomes for children and families. Children who judged their therapists to be higher in adherence had fewer emotional problems at post-test, and parents who reported that their therapists were higher in adherence expressed greater satisfaction with adoption.

Finally, certain demographic variables, specifically number of therapy sessions, therapists' years of experience, and hours of adoption competency training completed by therapists may have accounted for some of the variance in the relationship between participation in the treatment and the child and family functioning outcomes variables. Therefore, post hoc analyses were conducted to explore these variables as potential

covariates. Therapists' years of experience was the only demographic variable that was correlated with the outcomes. However, when the multivariate analyses of variance were rerun controlling for years of experience, no changes were found in the relationship between participation in the treatment and family functioning. The finding that number of sessions did not qualify as a covariate seems consistent with the literature that suggests that the largest amount of change is accounted for in the first 5 to 13 sessions of therapy (Kopta, Howard, Lowry, & Beutler, 1994). The minimum number of session to qualify for inclusion in this study was 8. Furthermore, more recent research (Cuijpers, Huibers, Ebert, Koole, & Andersson, 2013) has suggested that number of sessions has only a small effect on outcome and that other factors, such as number of session per week, may better account for improvement. Finally, hours of adoption competent training may not have emerged as a covariate because therapists were judged as only moderately adhering to the model of adoption-competent therapy. In other words, it is possible that the hours of training did not matter because therapists were not implementing the training to a large degree in session with their clients.

The study was built on the existing literature in a number of ways. The authors of this study sought to address a number of the limitations for which past research on adoption-competent therapy was criticized. Specifically, a sound theoretical rationale for the therapeutic intervention was presented. The therapeutic intervention was evaluated on the basis of measurable outcomes at post-test whereas previous studies had investigated only parents' or therapists' general perceptions of improvement and parental satisfaction with services. Furthermore, measures with sound psychometric properties to were used to assess the outcome variables. Finally, both child and parent ratings of outcome

variables were included. Previous studies had assessed therapists' and parents' views of children's post-treatment improvement. However, there are a number of limitations to the present study that must be considered.

Limitations

There are a number of limitations to this study. First, it is important to note some limitations with respect to sample characteristics. As previously mentioned, families on average were functioning well at pre-test. Therefore, findings with respect to improvements in child functioning and satisfaction with treatment may not be generalizable to families reporting lower levels of communication, cohesion, emotional responsiveness, and satisfaction with their family. Furthermore, the majority of the parents in the sample were White, well-educated, and had high incomes. Findings may not generalize to adoptive families from different racial and socioeconomic backgrounds. The majority of child participants were White and female, and so it is not clear if the findings would equally apply to males or racially diverse adoptees. The majority of adoptions were private and international, so the results may not generalize to samples predominated by private and public domestic adoptions. Finally, while the overall sample size was adequate to detect medium effects, it may have been too small to detect small effects. Furthermore, the tests of therapist effects were underpowered to detect differences given that the number of families seen by each therapist ranged from 1 to 7. Perhaps these are explanations for why no differences between pre- and post-test were found for attachment and family functioning variables.

There also are a number of methodological limitations that must be considered. An important limitation is the lack of a control group. Without a comparison group that

either received no treatment or a different type of treatment, it cannot be concluded that it was indeed the treatment that was responsible for the reduction in emotional and behavioral problems among children in the sample. It is possible that children's problematic behaviors decreased as a function of time or other variables not measured in this study. For example, common factors (e.g., therapist effects and the therapeutic relationship) are said to account for up to 30% of the variance in therapy outcomes (Lambert & Barley, 2002).

Additional important limitations are the lack of clarity with respect to the labeling of family and individual sessions as well as lack of information about what interventions were used during the course of treatment. As noted above, therapists sometimes indicated that a session was a "family" session, but this may not have meant family members were seen together in the session. Therapists reported that they would sometimes label a session as a family session but would see parents separately for a portion of the time and then children separately for another portion of the time without working with members of the family together for any portion of a given session. This negates the ability to examine the relationship between the number of family sessions and family functioning outcome variables. Furthermore, little is known about what occurred during any given session. Measures of adherence were conducted at the end of treatment and not at periodic intervals throughout the duration of the study. This limits the ability to determine what accounts for the reductions in children's emotional and behavioral problems at post-test.

Another limitation is the possibility that participants responded to measures assessing child and family functioning in a socially desirable manner, over-reporting good behaviors and under-reporting problem behaviors. As detailed in the method section

above, participants completed the measures in the presence of an investigator. Children ages 9 and under were read the measures by the investigator. It is possible that the presence of the investigator increased the likelihood that participants provided socially desirable responses. This may be particularly true for the 10% of child participants who had the measures read to them by the investigator.

This study included child and parent ratings of a number of outcome variables, including family functioning, therapist adherence to the treatment model, and therapist personal characteristics. However, treatment satisfaction was assessed, as it had been in previous studies, by parent ratings only. Child satisfaction should have been assessed as well, particularly at least half of the sessions delivered were individual with the child. Another limitation with respect to measurement is that therapist adherence was rated by participants versus observers, and the accuracy of these ratings was not checked by independent raters.

Additional limitations are related to the degree to which therapists were rated by participants as adhering to the CASE model of adoption-competent therapy and the level of parental satisfaction with services. On average, therapists were judged by child participants as adhering to the model in "most sessions" and by parents as adhering to the model in "some sessions." It may be that more training is needed in order to improve adherence. Therapists may also need to learn ways to apply the knowledge gained from training in their sessions with client. Ideas for future directions with respect to model adherence are discussed below. With respect to parental satisfaction with treatment, parents on average "somewhat agreed" to feeling satisfied with the treatment they received. These rating may be related to ratings of therapists' adherence, and perhaps

parents may have reported greater satisfaction if therapists had more closely adhered to the CASE model of adoption-competent therapy. It is worth noting however, that adherence in this study was within the ranges reported in the therapy outcome literature which reports ranges of moderate to high adherence (Chandler, 2011; Goldman & Gregory, 2009).

A final limitation was that the participants in this study sought therapy for a range of presenting concerns, and diagnoses were neither assessed nor accounted for by this study. It is possible that some diagnoses are more amenable than others for improvement within the relatively short span of therapy that was examined in this study.

Future directions and implications

There are a number of future directions that could be taken to build on the contribution made by this study and address its limitations. The first recommendation is for the replication of this study with the addition of a wait-list control group and a comparison group which receives another treatment (e.g., family therapy that is not adoption specific). This replication would allow inferences about the effectiveness of adoption-competent therapy and its superiority to other treatments received by adoptive families.

Given that the literature has identified family systems variables as important predictors of adoptee adjustment, future research could examine to what extent the number of family sessions received correlates with improvements in family functioning. To do so, a definition of what constitutes a family session must be established, and the study should include a fidelity measure to assess if sessions were accurately labeled as family versus individual. It also would be interesting to examine the relationships

between outcomes and the issues that families identified as salient when presenting for treatment. It may be that salient issues change depending on stage of child's development. Additionally, because family systems may be fairly stable over short time periods, treatment of longer duration may be required for improvements on family outcome variables to be observed. Examining treatment that occurred over a span of 8 weeks to 6 months may not have afforded a long enough window to observe change in family systems. Future research could examine treatment conducted over a longer time period to examine the relationship between treatment duration and changes in the family system.

Some improvements in the way treatment was delivered may have improved family outcomes as well as satisfaction with treatment and are recommended for future research. First, a number of suggestions for the training of adoption competency and the measurement of adherence across sessions might improve adherence to the treatment model. With respect to training in adoption-competent therapy, more hours of training (than the average of 206 found in this study) may be required to improve adherence to the model. It also may be helpful for the training to address the application of the treatment model in session, outlining specific, behavioral recommendations for therapeutic interventions. A treatment manual could further clarify the way the treatment is to be delivered. Another suggestion would be to have therapists or supervisors periodically assess adherence to the model and use this assessment in supervision to address ways to better incorporate tenets of the model into therapy sessions.

With respect to satisfaction with treatment, parents brought their children to CASE because they were looking for adoption-specific therapy for their families. It may

be that parents felt less satisfied with services because therapists were only moderately adhering to this model. Therefore, therapists who improved their adherence may find that parents would be more satisfied with the treatment their families received.

Finally, future research could assess therapists' perceptions of the treatment model and their reasons for adherence or non-adherence to it. It is possible that therapists' non-adherence may have related to their clinical judgment, theoretical orientation, or presenting concerns of the clients. For example, therapists may have disagreed with the model and may have utilized clinical judgment when deciding which and much of any one model component to implement. It is also possible that the child and family were presenting with issues unrelated to adoption. Perhaps some participants were families for whom adoption-related concerns were not as salient as for others. Interviewing therapists regarding their perceptions of the treatment model could provide important feedback regarding the efficacy of the model and its usefulness in therapy.

Future research also could attend to the degree to which common factors could be responsible for improvements in child functioning. Outcome studies with adopted children and their parents could include measures of therapeutic relationship variables and examine how they relate to outcomes.

With respect to limitations regarding variability in treatment duration, a future study may address this by keeping the number of sessions constant for all participants or by assessing psychological functioning at every session to test the effect of therapy dose on psychological functioning. Also noted above was the limitation with respect to range of presenting concerns and diagnoses. Future studies could address this by either keeping diagnosis constant or examining differences between diagnoses.

The findings from this study may inform counseling psychologists' work in individual and family therapy with adoptive families. Adoptive families in this sample reported being moderately satisfied with the treatment they received, and high ratings on therapists' adherence to the adoption-competent model of therapy were associated with high treatment satisfaction. Therapists working with adoptive families should consider familiarizing themselves with the salient issues faced by and experiences of adoptees and adoptive families. The literature suggests that families are seeking mental health professionals who are knowledgeable about adoption processes (Howard & Smith, 1997), who understand the issues they face (Nickman & Lewis, 1994), and who have basic knowledge about the needs and experiences of adoptive families (Smith & Howard, 1999).

The CASE model of adoption-competent therapy stresses the importance of addressing the health of the family environment as well as the affectional bonds between parents and children as important factors contributing to the healthy adjustment of adopted individuals. However, at least as assessed in this study, participation in the treatment was related to improvements in child behaviors but not to improvements in family functioning. It may be that the way the model is actually practiced better addresses child behaviors than the family environment. There is some evidence to support this supposition as nearly half of the sessions delivered to participants were individual therapy with the child.

To better address attachment and family functioning, the following changes to the model are suggested. First, a greater proportion of sessions should incorporate the child and her/his parents to provide opportunities to assess parent-child interactions and

incorporate interventions that specifically address parent-child attachment and the family system. To have an impact on attachment, therapists should attend specifically to interventions facilitating attachment bonds. Therapists should be aware that in children with problematic attachment styles, parents can be taught how to interpret and respond to children's subtle or conflicting cues sensitively and appropriately (Stams et al., 2001). Emotionally sensitive and responsive caregiving has been shown to be facilitative of greater security in attachments for adoptees (Juffer et al., 2008). Programs that work with parents on improving their emotional availability to children show a relationship between parental sensitivity and quality of adoptive child attachment (Stams et al., 2001).

Family functioning variables in the model include communication about adoption, family cohesiveness, and emotional responsiveness. Interventions specifically targeting each of these outcome areas could be included to improve the model's ability to address these components of the family environment. Therapists could work specifically with adoption-related communication by assessing the need for improvement in this area, assessing barriers to communication, and working with family members to reduce those barriers and talk openly with one another about adoption in session.

Other components of family functioning measured in this study were cohesiveness and emotional responsiveness. These outcomes were chosen because the CASE model purported to improve the cohesion of family and the emotional availability of family members. In-session interventions directed at the family system as a whole with all members present could be emphasized to improve family functioning on these outcome variables. Cohesion could be addressed by helping the family identify common interests and values and increasing activities enjoyed together.

Interventions aimed at facilitating emotionally sensitive responding to one another also could be included. Therapists could educate families about the benefits that emotional expressivity has for their families and could facilitate such expressions in session. Emotional expressiveness has been considered an important facilitator of parent-child bonds (Juffer et al., 2008). Family emotional expressivity and responsiveness is related positively to adoptees' self-esteem (Kelly et al., 1998) and attachment to parents (Juffer et al., 2008). Attachment to parents in turn has been associated with positive emotional and social outcomes for children, (Juffer et al., 2008; Sroufe et al., 2005; Stams et al., 2002; Weinfield et al., 2008) and reduced risk or emotional problems (Carlson, 1998; Fortuna & Roisman, 2008). Moreover, family emotional expressivity and responsiveness has also been associated with a reduction in risk of adoption disruptions and dissolution (Smith et al., 2008).

It might be helpful for future researchers to know how we conducted this intervention study in a community agency. Field research is challenging, and there can be many obstacles to conducting studies with community-based mental health centers. There were a number of factors that contributed to the successful completion of this project. Perhaps the most important of these were the relationships built by the principal investigator with agency staff members and therapists. The agency, the Center for Adoption Support and Education, was interested in evaluating its treatment model and had been awarded grant money from the federal government to provide and evaluate services for adoptive families. The authors of this study proposed a method of evaluation to which the agency agreed.

Knowing that the evaluation would be a challenging undertaking, the principal investigator wished to be on-site to facilitate agency participation and data collection. To that end, she proposed and was granted a clinical training position with the agency which would allow her to be on-site several days a week. Working at the agency greatly facilitated recruitment and data collection. It allowed the principal investigator to be present when many of the families arrived for treatment. She also was able to form relationships with the therapists to enhance their motivation to participate and encourage them to refer families for the study. It was largely through the formation of such positive working relationships with agency staff and therapists that the data were collected from the families connected to this agency.

Conclusion

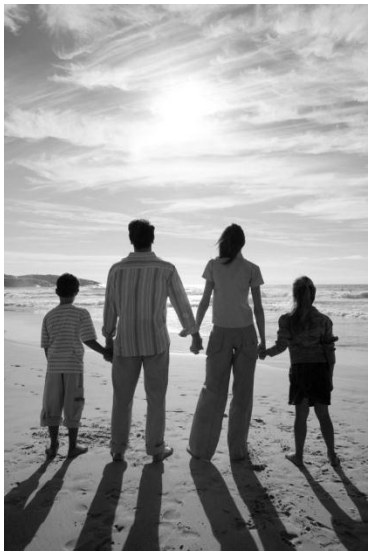
Adopted children and adoptive families have unique mental health needs. Unfortunately, they report that therapists lack adequate training related to adoption (Henderson, 2000). This study evaluated one model of adoption-competent therapy developed by The Center for Adoption Support and Education (CASE) that is an integrated therapeutic intervention for therapists to use when working with adoptees and their families. The present study utilized an adequate sample size and psychometrically validated measures to examine the degree to which this intervention related to improvements in child functioning and family functioning. The study found that children exhibited fewer emotional and behavioral problems at post-test than they did at pre-test. The study also found that higher ratings of therapists' adherence to the adoption competent model of therapy were related to greater treatment satisfaction, supporting the notion that adoptive families feel best served by mental health professionals who are

sensitive to their unique experiences, needs, and challenges. These findings elucidate our understanding of and provide ideas for further research is needed with adoptive families.

Appendix A

Study Advertisement for CASE Listserv

Adoptive Parents:
Please Help Us Learn About Therapy Effectiveness for Adoptive Families



Are you an adoptive parent who is about to begin or has recently begun receiving counseling for your family or your adopted child?

If so, you could be part of an exciting research project that could lead to improved services and resources for families like yours.

Participation would involve a total 2 hours of your family's time:

- one hour for you and your child to answer questionnaires prior to beginning counseling,
- and one hour for you and your child after completing counseling.

Participating families who complete the study will receive a total of $20 in gift certificates to Target.

Please consider helping the University of Maryland Department of Psychology and the Center for Adoption Support and Education (C.A.S.E.) with this important study. For information, contact Maria Wydra, M.A., at (443) 742-1041 or mwydra@psyc.umd.edu.

Recruitment Script

CASE is conducting an evaluation of the effectiveness of the services we provide to adoptive families, and we would like to invite you to participate. The study involves completing a set of questionnaires when you come in for your first appointment and your last appointment. As small thank you, we will give both you and your child a $5 gift card when you complete the first set and two more $5 gift cards when you complete the second set of questions.

If you want to participate, when you come in for your first appointment, you'll meet with an adoption researcher who will describe the research in more detail and give you a chance to ask questions before you participate. If the researcher is not able to attend your first session at CASE, she will schedule a time to come to your home prior to your second session at CASE so you may complete the questionnaires.

CONSENT FORM – PARENT

Project Title	**Adoption-Centered Therapy for Families**
Why is this research being done?	This is a research project being conducted by Dr. Karen O'Brien and Ms. Maria Wydra in the Department of Psychology at the University of Maryland, College Park, and Ms. Debbie Riley and Ms. Allison Stearns at the Center for Adoption Support and Education. We are inviting you to participate in this research project because you are an adoptive parent seeking therapy for your family and/or your adopted child. The purpose of this research project is to study the effectiveness of the treatment that you will be receiving.
What will I be asked to do?	There are three parts to this study. *Part 1:* Before you/your child begin your therapy program, you will be asked to complete questions related your child's and family's functioning. You will be asked about your child's mental health (including emotional problems and self-esteem) and behavior. You will also be asked questions about your family environment (e.g., levels of conflict and closeness), family communication, and your satisfaction with the adoption. In addition to answering questions about your child and your family, you also will be asked about your satisfaction with the services you received. Answering these items will take about 1 hour. *Part 2:* You will meet with a therapist who will talk with you about what mental health services will be best for your family. Depending on your therapist's assessment, you may be recommended for one or more of the following: weekly individual counseling for your adopted child, weekly family counseling, an 8-week group therapy program for your child (entitled the Kids Adoption Network), crisis intervention services, an adoptive parent support group, and/or monthly psychoeducational workshops for adoptive parents. If you decide to accept the treatment plan, you will begin the selected mode(s) of treatment with a mental health professional. *Part 3:* After you finish your treatment program (if you have had at least 8 sessions) or after you have been in treatment for six months, you and your child will once again be given a set of questions asking about your child's and your family's functioning. You also will be asked your opinion about the therapy you received. Answering these questions will take about 1 hour. *(Note that your family may continue therapy past 6 months).* Six months after completing this set of questionnaires, we will contact you for a follow-up and will to invite you to complete the questions one last time.
What about confidentiality?	We will do our best to keep your personal information confidential. Your name will not be included on the surveys and other collected data. Instead, a code will be placed on the survey and other

	collected data. Only the researchers will have access to the document linking your name with the identification number. This document, along with your signed consent form, will be stored in a locked file cabinet to which only the researchers will have access. The survey data that you provide online will be collected on a password-protected computer on secure website that encrypts your data. Once you have completed the online measures, we advise you to close Internet browser, and we will erase the web history to further protect confidentiality. Because the data you enter online will be collected on a laptop belonging to the investigators, there will be no way to trace your identity using the computer's IP address. All measures completed by you and your child will be shared with your therapist. And electronic copy will be retained in the research file and one paper copy will be kept in the therapist's file. The electronic copy will be stored on a password-protected computer. All paper copies of the data will be stored in a locked file cabinet. If we write a report or article about this research project, we will write about trends in responses, not individual participants. In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others.
What are the risks of this research?	There may be some risks associated with participating in this research study. You may feel uncomfortable with some of the questions you will be asked before and after beginning your therapy program because they are about your child's emotions and behaviors, your feelings about the adoption process, and how you parent. Throughout the course of therapy, you, your partner, or your child may feel uncomfortable discussing your feelings, thoughts, and behaviors with your therapist. If a question makes you uncomfortable, you do not have to answer it.
What are the benefits of this research?	This research is not designed to help you personally, but the results may help the investigator learn more about effective therapy for adoptive families. We hope that, in the future, other people might benefit from this study through improved understanding of interventions to improve the lives of adoptive families.
Do I have to be in this research? **May I stop participating at any time?**	Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits for which you otherwise qualify.

What if I have questions?	This research is being conducted by **Karen O'Brien, Ph.D., and Maria Wydra, M.A.,** in the Department of Psychology**,** at the University of Maryland, College Park, and Debbie Riley, M.S. and Allison Stearns, L.C.P.C., at the Center for Adoption Support and Education. If you have any questions about the research study itself, please contact **Dr. Karen O'Brien** at: **Department of Psychology, 1147 Biology/Psychology Building, University of Maryland, College Park, MD 20742, 301-405-5812, kobrien@psyc.umd.edu** You may also contact **co-investigator Ms. Maria Wydra** at: **Department of Psychology, 1147 Biology/Psychology Building, University of Maryland, College Park, MD 20742, 443-742-1041 mwydra@psyc.umd.edu** If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: **Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; (e-mail) irb@deans.umd.edu; (telephone) 301-405-0678.** This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.	
Statement of Age of Subject and Consent	Your signature indicates that: you are at least 18 years of age; the research has been explained to you; your questions have been fully answered; you freely and voluntarily choose to participate in this research project.	
Signature and Date	**NAME OF PARENT**	
	SIGNATURE OF PARENT	
	DATE	

PARENTAL PERMISSION FORM - for MINOR CHILD

Project Title	**Adoption-Centered Therapy for Families**
Why is this research being done?	This is a research project being conducted by Dr. Karen O'Brien and Ms. Maria Wydra in the Department of Psychology at the University of Maryland, College Park, and Ms. Debbie Riley and Ms. Allison Stearns at the Center for Adoption Support and Education. We are inviting your child to participate in this research project because he or she is an adopted person and you are seeking therapy for your family and/or your adopted child. The purpose of this research project is to study the effectiveness of the treatment that you and/or your child will be receiving.
What will I be asked to do?	There are three parts to this study. *Part 1:* Before child begins therapy, he or she will be asked to answer questions related his or her mental health, including questions about emotional distress and self esteem. Your child also will be asked questions about his or her relationship with you and his or her perceptions of your family functioning (e.g., levels of conflict and closeness) and family communication. Children 10 and older will read and answer the questions themselves. Children 9 and younger will be read the questions be the researcher and will indicate which answer they prefer. Answering these questions will take about 1 hour. *Part 2:* You will meet with a therapist who will talk with you about what mental health services will be best for your family and your child. Depending on your therapist's assessment, you may be recommended for one or more of the following: weekly individual counseling for your adopted child, weekly family counseling, an 8-week group therapy program for your child (entitled the Kids Adoption Network), crisis intervention services, an adoptive parent support group, and/or monthly psychoeducational workshops for adoptive parents. If you decide to accept the treatment plan, you and your child will begin the selected mode(s) of treatment with a mental health professional. *Part 3:* After you finish your treatment program (if you have had at least 8 sessions) or after you have been in treatment for six months, your child will once again be given a set of questions asking his or her mental health and perceptions of family's functioning and family communication. Answering these questions will take about 1 hour. *(Note that your family may continue therapy past 6 months).* Six months after completing this set of questionnaires, we will contact you for a follow-up and will to invite your child to complete the questions one last time.

What about confidentiality?	We will do our best to keep your child's personal information confidential. His or her name will not be included on the surveys and other collected data. Instead, a code will be placed on the survey and other collected data. Only the researchers will have access to the document linking your child's name with the identification number. This document, along with your signed Consent form, signed Parental Permission form, and child's Assent form will be stored in a locked filing cabinet to which only the researchers will have access. The survey data that your child provides online will be collected on a password-protected computer on secure website that encrypts his or her data. Once your child has completed the online measures, we will close the Internet browser and erase the web history to further protect confidentiality. Because the data your child enters online will be collected on a laptop belonging to the investigators, there will be no way to trace his or her identity using the computer's IP address. All measures completed by you and your child will be shared with his or her therapist. And electronic copy will be retained in the research file and one paper copy will be kept in the therapist's file. The electronic copy will be stored on a password-protected computer. All paper copies of the data will be stored in a locked file cabinet. If we write a report or article about this research project, we will write about trends in responses, not individual participants. In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to your child or others.
What are the risks of this research?	There may be some risks associated with participating in this research study. Your child may feel uncomfortable with some of the questions he or she will be asked because they are about his or her emotions, feelings toward you and your partner, and about your family environment and family communication. Throughout the course of your treatment program, your child may feel uncomfortable discussing his or her feelings, thoughts, and behaviors with his or her therapist. If a question makes you uncomfortable, you do not have to answer it.
What are the benefits of this research?	This research is not designed to help your child personally, but the results may help the investigator learn more about effective therapy for adoptive families. We hope that, in the future, other people might benefit from this study through improved understanding of interventions to improve the lives of adoptive families.
Do I have to be in this research? **May I stop participating at any time?**	Your child's participation in this research is completely voluntary. He or she may choose not to take part at all. If your child decides to participate in this research, he or she may stop participating at any time. If your child decides not to participate in this study or if he or she stops participating at any time, your

	child will not be penalized or lose any benefits for which he or she otherwise qualifies.	
What if I have questions?	This research is being conducted by **Karen O'Brien, Ph.D., and Maria Wydra, M.A.,** in the **Department of Psychology,** at the University of Maryland, College Park, and Debbie Riley, M.S. and Allison Stearns, L.C.P.C., at the Center for Adoption Support and Education. If you have any questions about the research study itself, please contact **Dr. Karen O'Brien** at: **Department of Psychology, 1147 Biology/Psychology Building, University of Maryland, College Park, MD 20742, 301-405-5812, kobrien@psyc.umd.edu** You may also contact **co-investigator Ms. Maria Wydra** at: **Department of Psychology, 1147 Biology/Psychology Building, University of Maryland, College Park, MD 20742, 443-742-1041** **mwydra@psyc.umd.edu** If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: **Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; (e-mail) irb@deans.umd.edu; (telephone) 301-405-0678.** This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.	
Statement of Age of Subject and Consent	Your signature indicates that: your child, who will be participating in this research, is under the age of 18 and is not legally able to give consent; the research and the expectations for your child's participation in it have been explained to you; the questions you have regarding your child's participation in this research have been fully answered; you freely and voluntarily give permission for your child to participate in this research project.	
Signature and Date	**NAME OF CHILD**	
	NAME OF PARENT	
	SIGNATURE OF PARENT	
	DATE	

ASSENT FORM - CHILD

Project Title	**Adoption-Centered Therapy for Families**
Why is this research being done?	This is a research project being conducted by Dr. Karen O'Brien and Ms. Maria Wydra in the Department of Psychology at the University of Maryland, College Park, and Ms. Debbie Riley, and Ms. Allison Stearns at the Center for Adoption Support and Education. We are inviting you to participate in this research project because you were adopted and you are coming to talk to a counselor. The purpose of this research project is to study the effectiveness of the counseling that you will be receiving.
What will I be asked to do?	There are three parts to this study. *Part 1:* Before you begin counseling, you will be asked to complete questions about how you feel about yourself and your family. You will be asked some questions about how you and your parents talk about your adoption. If you are 10 or older you may read and answer the questions on your own. If you are under 10 the researcher will read them to you, and you can point to answer you want to pick. The questions are not a test. There is no one right answer. You can pick whatever answer best describes you. An example of question you will be asked is: "Indicate how strongly you agree with the statement: I take a positive attitude toward myself." It will take about 1 hour to answer these questions. *Part 2:* You will meet with a therapist who will decide what services will be helpful for you and your family. The therapist might decide that it would be helpful if just the two of you met together once a week to talk. She or he might decide it would be helpful if you and your parents all met together once a week. Or the therapist might recommend that you join a group of other adopted kids who talk about what it's like to be adopted and help each other. You and your parents will work with the therapist to decide what is best for you. *Part 3:* When you're finished with all of your meetings with the therapist and/or attending the support group, we'll ask you again to answer more questions. If you and your family decide to keep meeting with the therapist for longer than 6 months, we'll have you answer the questions at 6 months. It will take about an hour to answer the questions. Six months after completing this set of questionnaires, we will contact your parents for a follow-up and will to invite you to complete the questions one last time.

What about confidentiality?	We will do our best to keep your personal information confidential so no one else can see it. Your name won't be on any of the answers you give to our questions. Instead we'll use a code. Only the researcher will have the key to unlock the code, and she will keep it locked in a file cabinet to which only she has access. We'll also keep this form (called an Assent form) that has your name and signature in the locked file cabinet too. The answers you give on the laptop will be entered onto a secure web site and will be stored on a password-protected computer. No one but the researcher will be able to know how you answered the questions. There are some things that we can't keep confidential. If we learn that you might hurt yourself or someone else or that someone else has hurt you, we will need to tell the appropriate individuals to protect you.
What are the risks of this research?	There may be some risks associated with participating in this research study. You may feel uncomfortable with some of the questions you will be asked because they are your feelings about yourself and your family. When you are in counseling, it is possible that you might sometimes feel uncomfortable discussing your feelings, thoughts, and behaviors with your therapist.
What are the benefits of this research?	This research is not designed to help you personally, but the results may help us learn more about effective therapy for adoptive families. We hope that, in the future, other people might benefit from this study through improved understanding of interventions to improve the lives of adoptive families.
Do I have to be in this research? **May I stop participating at any time?**	Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you can still get the services that you and your family choose.
What if I have questions?	This research is being conducted by **Karen O'Brien, Ph.D., and Maria Wydra, M.A.,** in the **Psychology Department,** at the University of Maryland, College Park, and Debbie Riley, M.S. and Allison Stearns, L.C.P.C., at the Center for Adoption Support and Education. If you have any questions about the research study itself, please contact **Dr. Karen O'Brien** at: **Department of Psychology, 1147 Biology/Psychology Building, University of Maryland, College Park, MD 20742, 301-405-5812, kobrien@psyc.umd.edu** You may also contact **co-investigator Ms. Maria Wydra** at: **Department of Psychology, 1147 Biology/Psychology Building, University of Maryland, College Park, MD 20742, 443-742-1041** **mwydra@psyc.umd.edu**

	If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: **Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; (e-mail) irb@deans.umd.edu; (telephone) 301-405-0678.** This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.	
Statement of Age of Subject and Assent	Your signature indicates that: • you are under 18 years of age; • the research has been explained to you; • your questions have been fully answered; • you freely and voluntarily choose to participate in this research project.	
Signature and Date	**NAME OF CHILD**	
	SIGNATURE OF CHILD	
	DATE	

Appendix B

Summary of Measures

Measure/ Construct	No. items	Child Completed	Parent Completed	Therapist Completed
Child Attachment				
Inventory of Parent Peer Attachment – R (IPPA-R) Measure of attachment to (revised for children)	**50**	✓		
Child Mental Health				
Child Behavior Checklist (CBCL) Affective, anxiety, and behavioral problems	**113**		✓	
Family Functioning				
Adoption Communication Openness Scale (ACOS) Communication (adoption-related)	**28**	✓		
Family Adaptability and Cohesion Scale, II (FACES-II) Cohesion	**16**	✓	✓	
McMaster Family Assessment Device (FAD) Communication (family), emotional involvement/responsiveness	**22**	✓	✓	
Parental Adoption Satisfaction Scale (PASS) Satisfaction with adoptive family (Parent version)	**10**		✓	
Satisfaction with Family Scale (SWFS) Satisfaction with Family (Child's perspective)	**5**	✓		
Treatment				
Counselor Rating Form, Short (CRF-S) Perceptions of counselors expertness, attractiveness, and trustworthiness	**12**	✓	✓	
Treatment adherence	**10**	✓	✓	
Satisfaction with treatment	**5**		✓	
Demographics				
Parent demographics questionnaire	**8**		✓	
Therapist demographics questionnaire	**9**			✓

Appendix C

Inventory of Parent and Peer Attachment (IPPA-R; Gullone & Robinson, 2005)

This questionnaire asks about your relationships with important people in your life (your mother and your father or persons who acted as your mother and father).

Part I

The following statements ask about your feelings about your adoptive mother.

Please read each statement and circle the ONE number that tells how true the statement is for you now.

	Almost Never/ Never True	Not Very Often True	Some-times True	Often True	Almost Always/ Always True
1. My mother respects my feelings.	1	2	3	4	5
2. I feel my mother does a good job as my mother.	1	2	3	4	5
3. I wish I had a different mother.	1	2	3	4	5
4. My mother accepts me as I am.	1	2	3	4	5
5. I like to get my mother's point of view on things I'm concerned about.	1	2	3	4	5
6. I feel it's no use letting my feelings show around my mother.	1	2	3	4	5
7. My mother can tell when I'm upset about something.	1	2	3	4	5
8. Talking over my problems with my mother makes me feel ashamed or foolish.	1	2	3	4	5
9. My mother expects too much from me.	1	2	3	4	5
10. I get upset easily around my mother.	1	2	3	4	5
11. I get upset a lot more than my mother knows about.	1	2	3	4	5
12.When we discuss things, my mother cares about my point of view.	1	2	3	4	5
13. My mother trusts my judgment.	1	2	3	4	5
14. My mother has her own problems so I don't bother her with mine.	1	2	3	4	5

	Almost Never/ Never True	Not Very Often True	Some-times True	Often True	Almost Always/ Always True
15. My mother helps me to understand myself better.	1	2	3	4	5
16. I tell my mother about my problems and my troubles.	1	2	3	4	5
17. I feel angry with my mother.	1	2	3	4	5
18. I don't get much attention from my mother.	1	2	3	4	5
19. My mother helps me to talk about my difficulties.	1	2	3	4	5
20. My mother understands me.	1	2	3	4	5
21. When I am angry about something, my mother tries to be understanding.	1	2	3	4	5
22. I trust my mother.	1	2	3	4	5
23. My mother doesn't understand what I'm going through these days.	1	2	3	4	5
24. I can count on my mother when I need to get something off my chest.	1	2	3	4	5
25. If my mother knows something is bothering me, she asks me about it.	1	2	3	4	5

Part II

This part asks about your feelings about your adoptive father.

Please read each statement and circle the ONE number that tells how true the statement is for you now

	Almost Never or Never True	Not Very Often True	Some-times True	Often True	Almost Always or Always True
1. My father respects my feelings.	1	2	3	4	5
2. I feel my father does a good job as my father.	1	2	3	4	5
3. I wish I had a different father.	1	2	3	4	5
4. My father accepts me as I am.	1	2	3	4	5
5. I like to get my father's point of view on things I'm concerned about.	1	2	3	4	5
6. I feel it's no use letting my feelings show around my father.	1	2	3	4	5
7. My father can tell when I'm upset about something.	1	2	3	4	5
8. Talking over my problems with my father makes me feel ashamed or foolish.	1	2	3	4	5
9. My father expects too much from me.	1	2	3	4	5
10. I get upset easily around my father.	1	2	3	4	5
11. I get upset a lot more than my father knows about.	1	2	3	4	5
12.When we discuss things, my father cares about my point of view.	1	2	3	4	5
13. My father trusts my judgment.	1	2	3	4	5
14. My father has his own problems so I don't bother him with mine.	1	2	3	4	5
15. My father helps me to understand myself better.	1	2	3	4	5
16. I tell my father about my problems and my troubles.	1	2	3	4	5

	Almost Never/ Never True	Not Very Often True	Some-times True	Often True	Almost Always/ Always True
17. I feel angry with my father.	1	2	3	4	5
18. I don't get much attention from my father.	1	2	3	4	5
19. My father helps me to talk about my difficulties.	1	2	3	4	5
20. My father understands me.	1	2	3	4	5
21. When I am angry about something, my father tries to be understanding.	1	2	3	4	5
22. I trust my father.	1	2	3	4	5
23. My father doesn't understand what I'm going through these days.	1	2	3	4	5
24. I can count on my father when I need to get something off my chest.	1	2	3	4	5
25. If my father knows something is bothering me, he asks me about it.	1	2	3	4	5

Appendix D

Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001)

Below is a list of items that describe children and youths. Please read each item and check the box that best describes your child now or within the past 6 months. Please answer all the items as well as you can even if some do not seem to apply to your child.

	(0) Not true	(1) Somewhat/ Sometimes True	(2) Very True or Often True
1. Acts too young for his/her age	☐	☐	☐
2. Drinks alcohol without parents' approval	☐	☐	☐
3. Argues a lot	☐	☐	☐
4. Fails to finish things he/she starts	☐	☐	☐
5. There is very little he/she enjoys	☐	☐	☐
6. Bowel movements outside toilet	☐	☐	☐
7. Bragging, boasting	☐	☐	☐
8. Can't concentrate, can't pay attention for long	☐	☐	☐
9. Can't get his/her mind of certain thoughts/obsessions	☐	☐	☐
10. Can't sit still, restless, or hyperactive	☐	☐	☐
11. Clings to adults, too dependent	☐	☐	☐
12. Complains of loneliness	☐	☐	☐
13. Confused or seems to be in a fog	☐	☐	☐
14. Cries a lot	☐	☐	☐
15. Cruel to animals	☐	☐	☐
16. Cruelty, bullying, or meanness to others	☐	☐	☐
17. Daydreams or gets lost in his/her thoughts	☐	☐	☐
18. Deliberately harms self or attempts suicide	☐	☐	☐
19. Demands a lot of attention	☐	☐	☐
20. Destroys his/her own things	☐	☐	☐

	(0) Not true	(1) Somewhat/ Sometimes True	(2) Very True or Often True
21. Destroys things belonging to his/her family or others	☐	☐	☐
22. Disobedient at home	☐	☐	☐
23. Disobedient at school	☐	☐	☐
24. Doesn't eat well	☐	☐	☐
25. Doesn't get along with other kids	☐	☐	☐
26. Doesn't seem to feel guilty after misbehaving	☐	☐	☐
27. Easily jealous	☐	☐	☐
28. Breaks rules at home, school, or elsewhere	☐	☐	☐
29. Fears certain animals, situations, or places other than school	☐	☐	☐
30. Fear going to school	☐	☐	☐
31. Fears he/she might do something bad	☐	☐	☐
32. Feels he/she has to be perfect	☐	☐	☐
33. Feels or complains no one loves him/her	☐	☐	☐
34. Feels others are out to get him/her	☐	☐	☐
35. Feels worthless or inferior	☐	☐	☐
36. Gets hurt a lot, accident prone	☐	☐	☐
37. Gets in many fights	☐	☐	☐
38. Gets teased a lot	☐	☐	☐
39. Hangs around with others who get in trouble	☐	☐	☐
40. Hears sound or voices that aren't there.	☐	☐	☐
41. Impulsive or acts without thinking	☐	☐	☐
42. Would rather be alone than with others	☐	☐	☐
43. Lying or cheating	☐	☐	☐
44. Bites fingernails	☐	☐	☐
45. Nervous, highstrung, or tense	☐	☐	☐
46. Nervous movements or twitching	☐	☐	☐

	(0) Not true	(1) Somewhat/ Sometimes True	(2) Very True or Often True
47. Nightmares	☐	☐	☐
48. Not likes by kids at school	☐	☐	☐
49. Constipated, doesn't move bowels	☐	☐	☐
50. Too fearful or anxious	☐	☐	☐
51. Feels dizzy or lightheaded	☐	☐	☐
52. Feels too guilty	☐	☐	☐
53. Overeating	☐	☐	☐
54. Overtired without good reason	☐	☐	☐
55. Overweight	☐	☐	☐
56. Physical problems without known medical cause:			
a. aches or pains (not stomach or headaches)	☐	☐	☐
b. Headaches	☐	☐	☐
c. Nausea, feels sick	☐	☐	☐
d. Problem with eyes (NOT if corrected by glasses)	☐	☐	☐
e. Rashes or other skin problems	☐	☐	☐
f. Stomachaches	☐	☐	☐
g. Vomiting, throwing up	☐	☐	☐
57. Physically attacks people	☐	☐	☐
58. Picks nose, skin, or other parts of body	☐	☐	☐
59. Plays with own sex parts in public	☐	☐	☐
60. Plays with own sex parts too much	☐	☐	☐
61. Poor school work	☐	☐	☐
62. Poorly coordinated or clumsy	☐	☐	☐
63. Prefers being with older kids	☐	☐	☐
64. Prefers being with younger kids	☐	☐	☐
65. Refuses to talk	☐	☐	☐
66. Repeats certain acts over and over; compulsions	☐	☐	☐
67. Runs away from home	☐	☐	☐
68. Screams a lot	☐	☐	☐

	(0) Not true	(1) Somewhat/ Sometimes True	(2) Very True or Often True
69. Secretive, keeps things to self	☐	☐	☐
70. Sees things that aren't there	☐	☐	☐
71. Self-conscious or easily embarrassed	☐	☐	☐
72. Sets fires	☐	☐	☐
73. Sexual problems	☐	☐	☐
74. Showing off or clowning	☐	☐	☐
75. Too shy or timid	☐	☐	☐
76. Sleeps less than most kids	☐	☐	☐
77. Sleeps more than most kids during day and/or night	☐	☐	☐
78. Inattentive or easily distracted	☐	☐	☐
79. Speech problem	☐	☐	☐
80. Stares blankly	☐	☐	☐
81. Steals at home	☐	☐	☐
82. Steals outside the home	☐	☐	☐
83. Stores up too many things he/she doesn't need	☐	☐	☐
84. Strange behaviors	☐	☐	☐
85. Strange ideas	☐	☐	☐
86. Stubborn, sullen, or irritable	☐	☐	☐
87. Sudden changes in mood or feelings	☐	☐	☐
88. Sulks a lot	☐	☐	☐
89. Suspicious	☐	☐	☐
90. Swearing or obscene language	☐	☐	☐
91. Talks about killing self	☐	☐	☐
92. Talks or walks in sleep	☐	☐	☐
93. Talks too much	☐	☐	☐
94. Teases a lot	☐	☐	☐
95. Temper tantrums or hot temper	☐	☐	☐
96. Thinks about sex too much	☐	☐	☐
97. Threatens people	☐	☐	☐
98. Thumb-sucking	☐	☐	☐
99. Smokes, chews or sniff tobacco	☐	☐	☐
100. Trouble sleeping	☐	☐	☐

	(0) Not true	(1) Somewhat/ Sometimes True	(2) Very True or Often True
101. Truancy, skips school	☐	☐	☐
102. Underactive, slow moving, or lacks energy	☐	☐	☐
103. Unhappy, sad, or depressed	☐	☐	☐
104. Unusually loud	☐	☐	☐
105. Uses drugs for nonmedical purposes (don't include alcohol or tobacco)	☐	☐	☐
106. Vandalism	☐	☐	☐
107. Wets self during day	☐	☐	☐
108. Wets the bed	☐	☐	☐
109. Whining	☐	☐	☐
110. Wishes to be of opposite sex	☐	☐	☐
111. Withdrawn, doesn't get involved with others	☐	☐	☐
112. Worries	☐	☐	☐

Appendix E

Adoption-related Communication

Adoption Communication Openness Scale (ACOS; Brodzinsky, 2006)

Questions about your mother and father refer to your parents who adopted you. Please answer each question as honestly as you can. Check the appropriate box.

Adoptive Mother

	1 Strongly Disagree	2 Moderately Disagree	3 Neither Agree nor Disagree	4 Moderately Agree	5 Strongly Agree
1. My mother is a good listener when it comes to my thoughts and feelings about being adopted.	☐	☐	☐	☐	☐
2. My mother has difficulty in understanding adoption from my point of view	☐	☐	☐	☐	☐
3. I am very satisfied with how my mother and I talk together concerning my feelings about being adopted.	☐	☐	☐	☐	☐
4. If I have problems or concerns related to being adopted, I find it easy to discuss them with my mother.	☐	☐	☐	☐	☐
5. My mother is uncomfortable when I ask questions about my birth parents.	☐	☐	☐	☐	☐
6. I can discuss my true thoughts and feelings about being adopted or about my birth parents with my mother without feeling uncomfortable or embarrassed.	☐	☐	☐	☐	☐
7. When I ask questions about my adoption or about my birth parents, I get honest answers from my mother.	☐	☐	☐	☐	☐
8. My mother understands what I am feeling about being adopted without having to ask me.	☐	☐	☐	☐	☐
9. I feel very uncomfortable discussing my birth parents with my mother.	☐	☐	☐	☐	☐

	1 Strongly Disagree	2 Moderately Disagree	3 Neither Agree nor Disagree	4 Moderately Agree	5 Strongly Agree
10. It is easy for me to express my thoughts and feelings about being adopted to my mother.	☐	☐	☐	☐	☐
11. If there is something I need to know about my adoption, my mother is always there for me trying to answer my questions.	☐	☐	☐	☐	☐
12. My mother has told me all she knows about the reasons why I was placed for adoption.	☐	☐	☐	☐	☐
13. I have many thoughts and feelings about being adopted or about my birth parents which I cannot share with my mother.	☐	☐	☐	☐	☐
14. My mother makes it very easy for me to ask questions about my adoption or about my birth parents.	☐	☐	☐	☐	☐

Adoptive Father

	1 Strongly Disagree	2 Moderately Disagree	3 Neither Agree nor Disagree	4 Moderately Agree	5 Strongly Agree
15. My father is a good listener when it comes to my thoughts and feelings about being adopted.	☐	☐	☐	☐	☐
16. My father has difficulty in understanding adoption from my point of view.	☐	☐	☐	☐	☐
17. I am very satisfied with how my father and I talk together concerning my feelings about being adopted.	☐	☐	☐	☐	☐
18. If I have problems or concerns related to being adopted, I find it easy to discuss them with my father.	☐	☐	☐	☐	☐
19. My father is uncomfortable when I ask questions about my birth parents.	☐	☐	☐	☐	☐

	1 Strongly Disagree	2 Moderately Disagree	3 Neither Agree nor Disagree	4 Moderately Agree	5 Strongly Agree
20. I can discuss my true thoughts and feelings about being adopted or about my birth parents with my father without feeling uncomfortable or embarrassed.	☐	☐	☐	☐	☐
21. When I ask questions about my adoption or about my birth parents, I get honest answers from my father.	☐	☐	☐	☐	☐
22. My father understands what I am feeling about being adopted without having to ask me.	☐	☐	☐	☐	☐
23. I feel very uncomfortable discussing my birth parents with my father.	☐	☐	☐	☐	☐
24. It is easy for me to express my thoughts and feelings about being adopted to my father.	☐	☐	☐	☐	☐
25. If there is something I need to know about my adoption, my father is always there for me trying to answer my questions.	☐	☐	☐	☐	☐
26. My father has told me all that he knows about the reasons why I was placed for adoption.	☐	☐	☐	☐	☐
27. I have many thoughts and feelings about being adopted or about my birth parents which I cannot share with my father.	☐	☐	☐	☐	☐
28. My father makes it very easy for me to ask questions about my adoption or about my birth parents.	☐	☐	☐	☐	☐

Appendix F

Family Adaptability and Cohesion Evaluation Scales II, Cohesion Subscale
(FACES II; Olson, Bell, & Portner, year)

Directions: Read each statement and rate the degree each statement applies to your family. Check the appropriate box to indicate your response.

	1 Almost Never	2 Once in a while	3 Sometimes	4 Frequently	5 Almost Always
1. Family members are supportive of each other during difficult times.	☐	☐	☐	☐	☐
2. In our family, it is easy for everyone to express her/his opinion.	☐	☐	☐	☐	☐
3. It is easier to discuss problems with people outside the family than with other family members.	☐	☐	☐	☐	☐
4. Our family does things together.	☐	☐	☐	☐	☐
5. In our family, everyone goes her/his own way.	☐	☐	☐	☐	☐
6. Family members know each other's close friends.	☐	☐	☐	☐	☐
7. Family members consult other family members on personal decisions.	☐	☐	☐	☐	☐
8. We have difficulty thinking of things to do as a family.	☐	☐	☐	☐	☐
9. Family members feel very close to each other.	☐	☐	☐	☐	☐
10. Family members feel closer to people outside the family than to other family members.	☐	☐	☐	☐	☐
11. Family members go along with what the family decides to do.	☐	☐	☐	☐	☐
12. Family members like to spend their free time with each other.	☐	☐	☐	☐	☐
13. Family members avoid each other at home.	☐	☐	☐	☐	☐
14. We approve of each other's friends.	☐	☐	☐	☐	☐
15. Family members tend to pair up rather than do things as a total family.	☐	☐	☐	☐	☐
16. Family members share interests and hobbies with each other.	☐	☐	☐	☐	☐

Appendix G

McMaster Family Assessment Device (FAD; Epstein et al., 1983)

Following are a number of statements about families. Please read each statement carefully, and decide how well it describes your family.

	(1) Strongly Agree	(2) Agree	(3) Disagree	(4) Strongly Disagree
1. We are reluctant to show our affection for each other.	☐	☐	☐	☐
2. Some of us just don't respond emotionally.	☐	☐	☐	☐
3. We do not show our love for each other.	☐	☐	☐	☐
4. Tenderness takes second place to other things in our family.	☐	☐	☐	☐
5. We express tenderness.	☐	☐	☐	☐
6. We cry openly.	☐	☐	☐	☐

Appendix H

The Satisfaction with Adoptive Family Scale,
adapted from the Satisfaction with Life Scale (SWL; Diener et al., 1985)

Below are 5 statements with which you may agree or disagree. Using the 1 to 7 scale below, indicate your agreement with each item.

	Strongly Disagree (1)	Disagree (2)	Slightly Disagree (3)	Neither Agree or Disagree (4)	Slightly Agree (5)	Agree (6)	Strongly Agree (7)
1. In most ways my family is close to my ideal.	☐	☐	☐	☐	☐	☐	☐
2. The conditions of my family are excellent.	☐	☐	☐	☐	☐	☐	☐
3. I am satisfied with my family.	☐	☐	☐	☐	☐	☐	☐
4. So far I have gotten the important things I want in family.	☐	☐	☐	☐	☐	☐	☐
5. I would change almost nothing about my family.	☐	☐	☐	☐	☐	☐	☐

Appendix I

Parental Adoption Satisfaction Scale (PASS; Developed for this study)

Please read the following items and indicate how much you agree with each statement according to the 7 –point scale described below.

	Strongly agree (7)	Agree (6)	Somewhat agree (5)	Neutral (4)	Somewhat disagree (3)	Disagree (2)	Strongly disagree (1)
1. I am satisfied with the adoption of my child.	☐	☐	☐	☐	☐	☐	☐
2. I never question my decision to adopt my daughter/son.	☐	☐	☐	☐	☐	☐	☐
3. I feel capable of handling issues related to my child's adoption.	☐	☐	☐	☐	☐	☐	☐
4. The adoption of my daughter/son never feels more stressful for our family than we anticipated.	☐	☐	☐	☐	☐	☐	☐
5. Knowing what I know now, I believe the adoption of my child was a good decision.	☐	☐	☐	☐	☐	☐	☐
6. I am happy with my adoptive daughter/son.	☐	☐	☐	☐	☐	☐	☐
7. Raising an adopted child was harder than I anticipated.	☐	☐	☐	☐	☐	☐	☐
8. I am happy with how well my adopted daughter/son fits into our family.	☐	☐	☐	☐	☐	☐	☐
9. If I had to do it all over again, I would make the same decision to adopt my child.	☐	☐	☐	☐	☐	☐	☐

	Strongly agree (7)	Agree (6)	Somewhat agree (5)	Neutral (4)	Somewhat disagree (3)	Disagree (2)	Strongly disagree (1)
10. Raising my adopted daughter/son has been a very positive experience for me.	☐	☐	☐	☐	☐	☐	☐

Appendix J

Demographic Questionnaire – Pre-test

1.) Parents:

Parent 1						
Age:	Gender:	Race:	Ethnicity:	Education:	Marital Status:	Sexual Orientation:
	__ Female __ Male	__ White __Black (African-American) __ Asian/ Pacific Islander __Native American/ Indigenous __ Other		__ Didn't complete high school __ Completed high school __ Some college __ Completed 2-year college __ Degree from trade/technical school __ Completed 4-year college __ Completed graduate education (Masters' or PhD level)	__ Single __ Cohabiting __ Married __ Separated __ Divorced __ Widowed	__ heterosexual __ gay/lesbian __ bisexual
Parent 2						
Age:	Gender:	Race:	Ethnicity:	Education:	Marital Status:	Sexual Orientation:
	__ Female __ Male	__ White __Black (African-American) __ Asian/ Pacific Islander __Native American/ Indigenous __ Other		__ Didn't complete high school __ Completed high school __ Some college __ Completed 2-year college __ Degree from trade/technical school __ Completed 4-year college __ Completed graduate education (Masters' or PhD level)	__ Single __ Cohabiting __ Married __ Separated __ Divorced __ Widowed	__ heterosexual __ gay/lesbian __ bisexual

2.) Family Income: _____

3.) State of residence: _____

4.) Adoptive children:

Adoptive child	Age	Gender	Race	Pre-adoption placement	No. of months/ yrs in pre-adoption placement	Age at time of adoption place-ment	No.of months/ years since placement	Type of adoption	Country of origin	Contact w/ Birth Parent(s)	Freq. of contact:
Child in study				__ Foster care __ Institutional care ___Birth-parents ___Birth-relatives				__ Domestic __ Private __ Domestic Public __ International		__Yes __No	
2				__ Foster care __ Institutional care ___Birth-parents ___Birth-relatives				__ Domestic __ Private __ Domestic Public __ International		__Yes __No	
3				__ Foster care __ Institutional care ___Birth-parents ___Birth-relatives				__ Domestic __ Private __ Domestic Public __ International		__Yes __No	
4				__ Foster care __ Institutional care ___Birth-parents ___Birth-relatives				__ Domestic __ Private __ Domestic Public __ International		__Yes __No	
5				__ Foster care __ Institutional care ___Birth-parents ___Birth-relatives				__ Domestic __ Private __ Domestic Public __ International		__Yes __No	

5.) Foster children:

Foster child	Age	Gender	Race	Age at time of initial foster-care placement	No.of months/ years since initial placement	No. of placement disruptions	Plan to adopt?	Contact w/ Birth Parent(s)	Freq. of contact:
1						_____	__ Yes __ No	__ Yes __ No	
2						_____	__ Yes __ No	__ Yes __ No	
3						_____	__ Yes __ No	__ Yes __ No	
4						_____	__ Yes __ No	__ Yes __ No	
5						_____	__ Yes __ No	__ Yes __ No	
6						_____	__ Yes __ No	__ Yes __ No	

5.) Biological children:

Biological child	Age	Gender	Race	Ethnicity	Country of birth
1					
2					
3					
4					
5					
6					

7.) Has the adoptee (who is enrolled in this study) committed any criminal offenses prior to beginning the study?

Yes: _____
No: _____

7a.) If yes, how many? ____

8.) Has the adoptee (who is enrolled in this study) ever been victimized prior to beginning the study?

Yes: _____
No: _____

8a.) If yes, number of times? ____

Demographics Questionnaire – Post-test

1.) Has the adoptee (who is enrolled in this study) committed any criminal offenses during the course of the study?

Yes: _____
No: _____

1a.) If yes, how many? ____

2.) Has the adoptee (who is enrolled in this study) been victimized during the course of the study?

Yes: _____
No: _____

2a.) If yes, number of times? ____

Appendix K

Counselor Rating Form, Short (CRF-S; Corrigan & Schmidt, 1983)

On the following pages, each characteristic is followed by a seven-point scale that ranges from "not very" to "very". Please check the box that best represents how you viewed the therapist.

	NOT VERY (1)	**(2)**	**(3)**	**NEUTRAL (4)**	**(5)**	**(6)**	**VERY (7)**
1. Friendly	☐	☐	☐	☐	☐	☐	☐
2. Likeable	☐	☐	☐	☐	☐	☐	☐
3. Sociable	☐	☐	☐	☐	☐	☐	☐
4. Warm	☐	☐	☐	☐	☐	☐	☐
5. Experienced	☐	☐	☐	☐	☐	☐	☐
6. Expert	☐	☐	☐	☐	☐	☐	☐
7. Prepared	☐	☐	☐	☐	☐	☐	☐
8. Skillful	☐	☐	☐	☐	☐	☐	☐
9. Honest	☐	☐	☐	☐	☐	☐	☐
10. Reliable	☐	☐	☐	☐	☐	☐	☐
11. Sincere	☐	☐	☐	☐	☐	☐	☐

Appendix L

Therapist Adherence Questionnaire (TAQ; Developed for this study)

For Parents. Please provide your responses to each of the following questions.

	Every Session	Most Sessions	Some Sessions	Very Few Sessions
1. My therapist discussed emotions connected to being part of an adoptive family.	☐	☐	☐	☐
2. My therapist talked about positive aspects of adoption.	☐	☐	☐	☐
3. Our therapist educated us about common experiences faced by adoptees and adoptive parents at different times in their lives.	☐	☐	☐	☐
4. My therapist discussed the unique challenges that adoptive families face.	☐	☐	☐	☐
5. My therapist talked about adoption being an important part of our family for our entire lives.	☐	☐	☐	☐
6. My therapist helped me to talk about feelings of loss I have related to being an adoptive parent.	☐	☐	☐	☐
7. Time in sessions was devoted to talking about my strengths.	☐	☐	☐	☐
8. My therapist helped me resolve feelings about aspects of my child's adoption that are emotionally stressful.	☐	☐	☐	☐
9. We talked about the importance of my child's understanding of her/his identity.	☐	☐	☐	☐
10. My therapist talked with members of my family in addition to me.	☐	☐	☐	☐
11. My therapist encouraged me to provide my child with as much information about her/his background as we can, in an age-appropriate manner.	☐	☐	☐	☐
12. My therapist educated us that it is normal to have interest in one's birth parents.	☐	☐	☐	☐
13. My therapist helped us talk about life experiences before adoption.	☐	☐	☐	☐
14. My therapist educated us about the way pre-adoption and prenatal experiences can impact a child's physical development, adjustment, and attachment.	☐	☐	☐	☐
15. My therapist helped me understand that in adolescence, adoptees develop identities that are both connected to and separate from adoptive and birth parents.	☐	☐	☐	☐
16. My therapist encouraged us to talk about adoption.	☐	☐	☐	☐
17. Time in therapy was devoted to understanding the emotional issues related to adoption.	☐	☐	☐	☐
18. My therapist helped us cope with the stressors related to being part of an adoptive family.	☐	☐	☐	☐
19. When needed, my therapist worked other professionals in our lives (for example, teachers, and doctors).	☐	☐	☐	☐
20. My therapist connected us to helpful resources.	☐	☐	☐	☐

For Children. Read each item below and indicate whether or not your therapist did the things described. If yes, please indicate how often by selecting the appropriate response in the third column.

	Every Session	Most Sessions	Some Sessions	Very Few Sessions
1. My therapist discussed emotions connected to being part of an adoptive family.	☐	☐	☐	☐
2. My therapist talked about positive aspects of adoption.	☐	☐	☐	☐
3. Our therapist educated us about common experiences faced by adoptees and adoptive parents at different times in their lives.	☐	☐	☐	☐
4. We discussed the unique challenges that adoptive families face.	☐	☐	☐	☐
5. My therapist talked about adoption being an important part of our family for our entire lives.	☐	☐	☐	☐
6. My therapist helped me talk about the feelings of loss that I have related to my adoption.	☐	☐	☐	☐
7. Time in sessions was devoted to talking about my strengths.	☐	☐	☐	☐
8. My therapist helped me resolve feelings about aspects of my adoption that are emotionally stressful.	☐	☐	☐	☐
9. We talked about issues related to who I am.	☐	☐	☐	☐
10. My therapist talked with members of my family in addition to me.	☐	☐	☐	☐
11. My therapist helped my parent(s) talk to me about my adoption.	☐	☐	☐	☐
12. My therapist told me it was OK to talk about and be interested in my birth parents.	☐	☐	☐	☐
13. My therapist helped me talk about my life experiences before adoption.	☐	☐	☐	☐
14. My therapist educated me about the way pre-adoption and prenatal experiences can impact a child's physical development, adjustment, and attachment.	☐	☐	☐	☐
15. My therapist helped me understand that in adolescence, adoptees develop identities that are both connected to and separate from adoptive and birth parents.	☐	☐	☐	☐
16. My therapist helped my parent(s) and me talk about adoption.	☐	☐	☐	☐
17. Time in therapy was devoted to understanding the emotional issues related to adoption.	☐	☐	☐	☐
18. My therapist helped us cope with the stressors related to being part of an adoptive family.	☐	☐	☐	☐
19. When needed, my therapist worked with other professionals in our lives (for example, teachers, and doctors).	☐	☐	☐	☐
20. My therapist connected us to helpful resources.	☐	☐	☐	☐

Appendix M

Treatment Satisfaction Questionnaire (TSQ; Developed for this study)

Please provide your responses to each of the following questions.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree not Disagree	Somewhat Agree	Agree	Strongly Agree
1. I am satisfied with the treatment my family received.	☐	☐	☐	☐	☐	☐	☐
2. Therapy led to improvements in my child's behavior.	☐	☐	☐	☐	☐	☐	☐
3. Our family talks more openly about adoption after receiving therapy.	☐	☐	☐	☐	☐	☐	☐
4. Because of our therapy, we feel closer as a family.	☐	☐	☐	☐	☐	☐	☐
5. My daughter/son was able to explore feelings about her/his adoption in therapy.	☐	☐	☐	☐	☐	☐	☐
6. The therapy resulted in improvements in my child's emotional well-being.	☐	☐	☐	☐	☐	☐	☐
7. I better understand my son/daughter's feelings about adoption as a result of therapy.	☐	☐	☐	☐	☐	☐	☐
8. I am now more comfortable talking about my feelings about our family's adoption.	☐	☐	☐	☐	☐	☐	☐
9. My therapist helped us meet the goals we had for therapy.	☐	☐	☐	☐	☐	☐	☐

Appendix N

Therapist Demographics

Age:	Gender:	Race:	Ethnicity:	Personal experience with adoption?	Credentials (check all that apply)	Months/ yrs of exp. as a therapist:	Theoretical orientation	Describe the amt. of training you have in adoption-focused therapy:
___	__ Female __ Male	__ White __ Black (African-American) __ Asian/ Pacific Islander __ Native American/ Indigenous __ Other:		__ Adoptive parent __ Adopted person __ Other:	__ EdD __ LCSW __ LCPC __ LGSW __ MA/MS Psychology __ MFT __ MD __ MPH __ MSW __ PhD __ PsyD Other: _____ _____ _____		__ Cognitive-behavioral __ Family Systems __ Eclectic __ Interpersonal __ Person-centered __ Psycho-dynamic Other: _____ _____ _____ _____	

Table 1. Demographic characteristics of sample: Children

Variable	N	%
Gender		
Female	35	70
Male	15	30
Race/ethnicity		
White/European-American	20	40
Black/African-American	7	14
Asian/Pacific Islander	15	30
Hispanic/Latina/o	3	6
Native American/Indigenous	1	2
Multiracial	4	8
Age adopted		
0-11 months	16	32
12-23 months	9	18
2-4 years	15	30
5-7 years	9	18
8-10 years	2	4
11-13 years	2	4
14-16 years	1	2
Type of adoption		
Domestic, private	7	14
Domestic, public	10	20
International	33	66
Pre-adoption placement		
Foster care	21	42
Institutional care	23	46
Birth parents	2	4
Birth relatives	1	2
Adoptive parents	3	6
Birth parent contact		
None	39	78
Rarely (1 to several times in child's life)	2	4
Infrequently (1 time every few years)	3	6
Yearly (2-4 times per year)	4	8
Monthly (1-2 times per month)	2	4

Continent/country of origin		
Africa (N=1, %=2)		
Ethiopia	1	2
Americas (N=22; %=44)		
Ecuador	1	2
El Salvador	1	2
Guatemala	1	2
Haiti	2	4
Peru	1	2
United States	16	32
Asia (N=13; %=26)		
China	6	12
India	2	4
Korea	4	8
Vietnam	1	2
Eastern Europe (N=15; %=30)		
Bulgaria	1	2
Kazakhstan	2	4
Moldova	1	2
Russia	10	20
Ukraine	1	2

Table 2. Demographic characteristics of sample: Parents

Variable	N	%
Gender		
Female	40	80
Male	10	20
Sexual orientation		
Heterosexual	49	98
Homosexual	1	2
Marital status		
Married	40	80
Single	5	10
Widowed	2	4
Cohabitating	1	2
Divorced/separated	2	4
Race/ethnicity		
White/European-American	44	88
Black/African-American	4	8
Asian/Pacific Islander	1	2
Hispanic/Latina/o	1	2
Native American/Indigenous	0	0
Multiracial	0	0
Family income		
$20,000-29,999	2	4
$30,000-39,999	1	2
$40,000-49,999	0	0
$50,000-59,999	1	2
$60,000-69,999	4	8
$70,000-79,999	0	0
$80,000-89,999	5	10
$90,000-99,999	1	2
$100,000-$124,999	6	12
$125,000-149,999	3	6
$150,000 plus	15	30

Variable	N	%
Parent's educational level		
Did not complete high school	1	2
High school/GED	3	6
Trade school	1	2
Some college	4	8
Associate's degree	5	10
Bachelor's degree	14	28
Graduate degree	22	44
State of residence		
Maryland	30	60
Virginia	13	26
District of Columbia	4	8
Pennsylvania	3	6

Table 3. Demographic characteristics of sample continued: Children and parents

Measure	Min	Max	Mean	SD
Parent age	38	74	52.72	7.11
Child age	8	18	12.86	2.86
Number of total therapy sessions	8	30	16.32	5.78
Number of group therapy sessions	3	11	7	5.66
Number of individual therapy sessions	8	27	16.04	5.45

Table 4. Types of therapy received

	Number of sessions	Percentage of total	Mean	SD	Range
Individual sessions	398	48.83%	7.96	6.16	0-23
Family sessions	403	49.45%	8.08	6.06	0-21
Group sessions	14	1.72%	.28	1.60	0-11
Total sessions	815	100%	16.30	5.77	8-27

Table 5. Demographic characteristics of therapists

Variable	N	%
Gender		
Female	10	83.3
Male	2	16.7
Race/ethnicity		
White/European American	12	100
Therapist credentials		
LCPC	4	33.3
LCSW	6	50
LGMFT	1	8.3
LGSW	1	8.3
Connection to adoption		
Adopted person	2	16.7
Adoptive parent	4	33.3
Family members are/have adopted	1	8.3
None	5	41.7
Theoretical orientation*		
Behavioral/cognitive-behavioral	5	41.7
Family systems	8	66.7
Eclectic/integrative	4	33.3
Interpersonal	2	16.7
Person-centered	4	33.3
Psychodynamic	5	41.7
Solution-focused	1	8.3

* - Percentages total > 100% because therapists could select more than one orientation

Table 6. Demographic characteristics of therapists continued

Measure	Min	Max	Mean	SD
Therapist age	38	68	51.08	9.73
Years of experience	2	38	15.00	10.27
Hours of training in adoption-focused therapy	45	469	206.33	115.62
Number of families seen by each therapist	1	7	4.17	2.37

Table 7. Means, standard deviations, internal consistencies, and ranges for measures used

Measure	Pre-test mean	Pre-test SD	Pre-test avg. item score	Pre-test alpha	Pre-test range	Post-test mean	Post-test SD	Post-test avg. item score	Post-test alpha	Post-test range	Possible range
IPPA-Mother	91.04	19.58	3.64	.94	41-125	96.86	19.79	3.87	.96	47-125	25-125
IPPA-Father	90.52	21.26	3.62	.95	36-125	96.81	18.93	3.87	.96	35-125	25-125
CBCL-Internalizing	15.80	8.93	.25	.86	2-49	7.88	6.30	.12	.86	0-25	0-64
CBCL-Externalizing	17.18	10.15	.25	.91	0-47	9.20	7.50	.13	.90	0-29	0-70
ACOS-Mom	3.60	.86	3.60	.90	1.57-5.00	3.97	.76	3.97	.91	1.64-5.00	1-4
ACOS-Dad	3.29	.97	3.29	.93	1.14-5.00	3.69	.78	3.69	.92	1.57-5.00	1-4
FACES: Child	56.32	11.15	3.52	.86	25-80	58.76	12.09	3.67	.92	25-80	16-80
FACES: Parent	62.88	8.71	3.93	.90	42.77	65.00	7.17	4.06	.84	47-78	16-80
FAD: Child	2.18	.54	2.18	.63	1.00-3.67	1.99	.55	1.99	.76	1.00-3.17	1-4
FAD: Parent	1.8	.52	1.80	.76	1.00-3.00	1.67	.55	1.67	.86	1.00-3.17	1-4
SWF	25.64	8.13	5.13	.93	8-35	28.12	6.61	5.64	.90	11-35	5-35
PASS	5.44	1.22	5.44	.93	2-7	5.71	1.04	5.71	.92	2.80-7.00	1-7
CRF-S: Trustworthiness (Child completed)	-	-	-	-	-	25.90	3.38	6.48	.91	14-28	4-28
CRF-S: Trustworthiness (Parent completed)	-	-	-	-	-	27.06	2.11	6.77	.97	19-28	4-28
CRF-S: Attractiveness (Child completed)	-	-	-	-	-	24.76	4.31	6.19	.78	9-28	4-28
CRF-S: Attractiveness (Parent completed)	-	-	-	-	-	26.12	3.00	6.53	.94	16-28	4-28
CRF-S: Expertness (Child completed)	-	-	-	-	-	25.16	3.51	6.29	.91	15-28	4-28
CRF-S: Expertness (Parent completed)	-	-	-	-	-	25.18	4.22	6.30	.92	10-28	4-28
TAQ: Child	-	-	-	-	-	52.54	13.32	2.63	.94	33-78	20-80
TAQ: Parent	-	-	-	-	-	48.62	12.43	2.43	.94	22-70	20-80
TSQ	-	-	-	-	-	49.00	11.60	5.44	.95	17-63	9-63

Table 8. Correlations among variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. IPPA-T1-Mother	1																	
2. IPPA-T2-Mother	.61*	1																
3. IPPA-T1-Father	.66*	.37*	1															
4. IPPA-T2-Father	.48*	.55*	.73*	1														
5. CBCL-T1-Internalizing	-.04	.07	-.11	.06	1													
6. CBCL-T2-Internalizing	-.05	-.19	-.05	-.04	.49*	1												
7. CBCL-T1-Externalizing	-.22	-.16	-.27	-.02	.41*	.24	1											
8. CBCL-T2-Externalizing	-.14	-.29	-.19	-.05	.23	.61*	.71*	1										
9. ACOS-T1-Mom	.54*	.26	.32	.10	-.20	-.16	-.03	.01	1									
10. ACOS-T2-Mom	.47*	.71*	.17	.34	-.02	-.27	.01	-.07	.62*	1								
11. ACOS-T1-Dad	.51*	.23	.80*	.53*	-.11	.02	-.14	-.05	.32	.8	1							
12. ACOS-T2-Dad	.50*	.46*	.78*	.91*	.05	.04	.05	.08	.24	.37*	.63*	1						
13. FACES-T1: Child	.72*	.45*	.48*	.33	-.04	-.09	-.21	-.19	.50*	.48*	.35*	.30	1					
14. FACES-T2: Child	.43*	.60*	.35	.50*	.03	-.14	-.09	-.14	.20	.64*	.21	.45*	.62*	1				
15. FACES-T1: Parent	.19	-.01	.26	.01	-.04	-.04	-.10	-.00	.28	.19	.32	.09	.29*	.14	1			
16. FACES-T2: Parent	.31*	.36*	.31	.23	.01	-.27	-.06	-.20	.25	.40*	.12	.17	.41*	.38*	.68*	1		
17. FAD-T1: Child	-.47*	-.36	-.38*	-.26	-.14	.07	.06	.14	.41	.40*	-.26	-.28	-.55*	-.47*	-.29	-.48*	1	
18. FAD-T2: Child	-.34*	-.69*	-.29*	-.44*	-.15	.18	.07	.18	-.25	.62*	-.12	-.40*	-.42*	-.69*	-.14	-.42*	.62*	1
19. FAD-T1: Parent	-.11	.01	-.07	.01	-.20	-.29*	.04	-.11	-.14	-.09	-.11	-.09	.01	-.07	-.45*	-.21	.24	.20
20. FAD-T2: Parent	-.16	-.22	-.14	-.11	-.08	.03	.06	.06	-.09	-.27	.04	-.12	-.22	-.22	-.39*	-.58*	.24	.32
21. SWF-T1	.72*	.54*	.54*	.45*	-.17	-.19	-.27	-.20	.52*	.49*	.37*	.44*	-62*	.43*	.26	.46*	-.48*	-.39*
22.SWF-T12	.49*	.77*	.27	.50*	-.11	-.33	-.04	-.11	.30	.78*	.19	.48*	.37*	.71*	.05	.29	-.30	-.62*
23. PASS-T1	.14	.04	.21	-.03	-.08	-.07	-.38*	-.34	.27	.11	.05	.02	.03	.01	.28*	.23	-.20	-.14
24. PASS-T2	.27	.28	.30	-.25	-.09	-.29	-.27	-.40*	.28	.36	.02	.20	.20	.32	.27	.53*	-.38*	-.34
25. CRF-S: Trustworthiness (Child completed)	.34	.59*	.14	.31	-.04	.34	-.05	-.17	.15	.62*	-.05	.20	.34	.57*	.09	.32	-.25	-.48*
26. CRF-S: Trustworthiness (Parent completed)	.08	.36	-.06	.24	.08	.01	.18	.00	.07	.39*	-.11	.10	.23	.37*	-.03	.32	-.21	-.29*
27. CRF-S: Attractiveness (Child completed)	.32	.47*	.02	.21	-.06	-.18	-.11	-.18	.25	.54*	-.12	.04	.37*	.39*	-.13	.10	-.20	-.35
28. CRF-S: Attractiveness (Parent completed)	.13	.28	-.04	.16	-.00	.01	.11	.06	.05	.25	-.10	.06	.23	.23	-.32	.03	-.19	-.17

Correlation matrix continued

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
29. CRF-S: Expertness (Child completed)	.14	.48*	.15	.35	.06	-.14	-.05	-.10	.01	.52*	-.02	.23	.27	.54*	.16	.30	-.23	-.54*
30. CRF-S: Expertness (Parent completed)	.13	.29*	-.23	-.44	.06	-.15	.17	.03	.11	.37*	-.18	-.13	.28	.31	.02	.19	-.11	-.06
31. TAQ: Child	.08	.25	-.10	.17	.08	.01	.04	.08	.25	.45*	-.08	.15	.12	.25	-.04	-.06	-.08	-.24
32. TAQ: Parent	.13	.13	.02	.10	.19	-.02	.19	.10	.14	.31	.01	.13	.31	.36	.18	.31	-.17	-.11
33. TSQ	.18	.38*	-.12	.11	.36*	-.12	.25	-.05	.06	.43*	-.21	.08	.30	.40*	.08	.44*	-.26	-.26

Correlation matrix continued

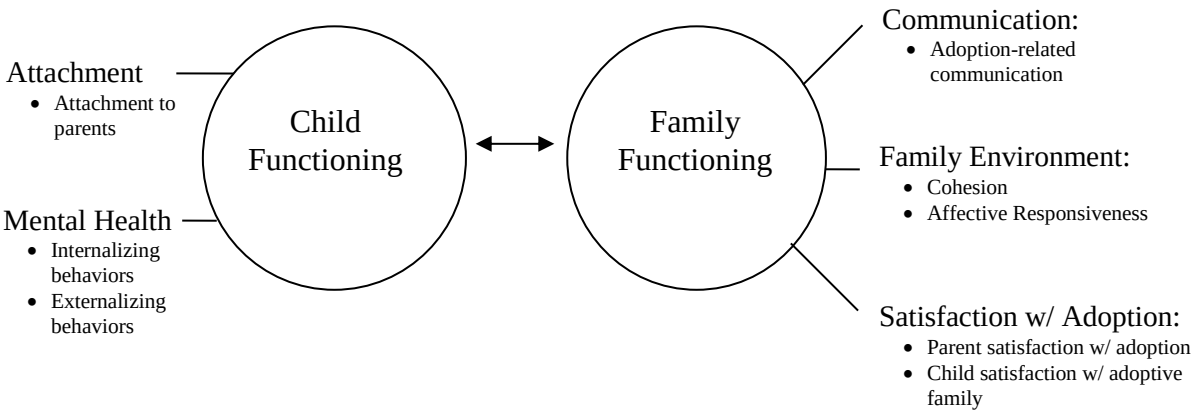
Variable	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
1. IPPA-T1-Mother															
2. IPPA-T2-Mother															
3. IPPA-T1-Father															
4. IPPA-T1-Father															
5. CBCL-T1-Internalizing															
6. CBCL-T2-Internalizing															
7. CBCL-T1-Externalizing															
8. CBCL-T2-Externalizing															
9. ACOS-T1-Mom															
10. ACOS-T2-Mom															
11. ACOS-T1-Dad															
12. ACOS-T2-Dad															
13. FACES-T1: Child															
14. FACES-T2: Child															
15. FACES-T1: Parent															
16. FACES-T2: Parent															
17. FAD-T1: Child															
18. FAD-T2: Child															
19. FAD-T1: Parent	1														
20. FAD-T2: Parent	.48*	1													
21. SWF-T1	-.06	-.31	1												
22.SWF-T2	-.05	-.25	.59*	1											
23. PASS-T1	-.50*	-.42*	.26	.01	1										
24. PASS-T2	-.39*	-.52*	.47*	.30	.79*	1									
25. CRF-S: Expertness (Child completed)	-.02	-.17	.37*	.71*	-.02	.32	1								
26. CRF-S: Expertness (Parent completed)	-.07	-.35	.19	.25	-.08	.25	.27	1							
27. CRF-S: Attractiveness (Child completed)	.03	.05	.28	.47*	.01	.26	.68*	.17	1						
28. CRF-S: Attractiveness (Parent completed)	-.05	-.20	.14	.18	-.05	.20	.21	.74*	.34	1					

Correlation matrix continued

Variable	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
29. CRF-S: Trustworthiness (Child completed)	.00	-.12	.28	.56*	-.07	.18	.73*	.14	.54*	.06	1				
30. CRF-S: Trustworthiness (Parent completed)	.00	-.04	.16	.30	-.09	.10	.34	.62*	.28	.45*	.14	1			
31. TAQ: Child	-.08	.04	.06	.33	-.14	.00	.10	.18	.33	.09	.19	.23	1		
32. TAQ: Parent	-.08	-.2	.29	.28	-.19	.15	.23	.41*	.22	.26	.16	.49*	.40*	1	
33. TSQ	-.13	-.31	.20	.39*	-.09	.24	.35	.48*	.22	.38*	.21	.68*	.25	.64*	1

* p<.01

Figure 1. Proposed model of child and family outcome variables



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