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Childhood Risks Associated with Adoption

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INTRODUCTION

School-age children who are adopted are a diverse group. They include children who were adopted as infants and whose birth parents and adoptive parents have a positive, ongoing relationship. They include children adopted long after infancy due to abuse or neglect in the biological family and whose birth parents are prohibited from contact with them, and they include children who are adopted after lengthy stays in institutional settings about whose birth parents little is known.

Children are considered adopted when individuals other than their biological parents assume legal parental responsibilities for them. Adoptions may be domestic or international and conducted through private or public agencies. Adoptions vary in their degree of openness with respect to contact between the birth parents and adoptive family. Children in open adoptions have information about their birth family and may continue to have contact, whereas children in closed adoptions do not have continuing contact although they may have information. Special needs adoptions involve children in categories that are associated with lower probabilities of finding a permanent home: sibling groups, older child, minority-group status or medical or psychological challenges.

PREVALENCE AND DEMOGRAPHICS

In 2000 the U.S. Census gathered information on the relationship of children to the householder. The distribution of children biologically related to parents was more or less evenly divided by age as a function of the number of children born each year. Among the 1.6 million children who were adopted, however, school-age children and adolescents are overrepresented. The dramatic increase in number of adopted children, as seen in Figure 6.1, represents the multiple paths by which children come into adoption and the diversity of older adopted children.

Data on the type of adoptions that take place each year in the United States are sparse, as only four states (Connecticut, Delaware, Massachusetts, and Minnesota) require that adoption agencies be licensed to place children in

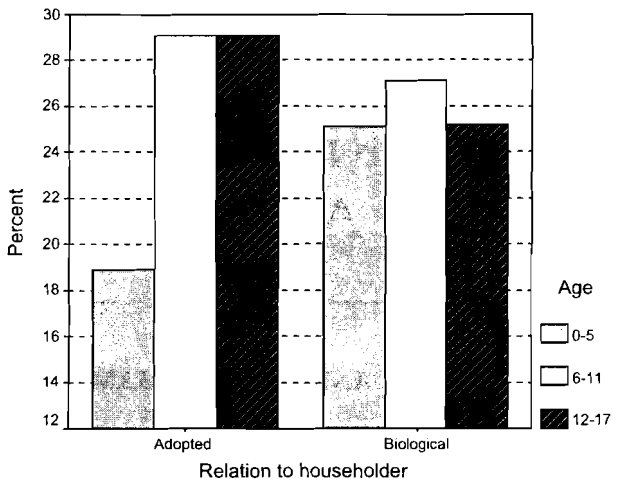

Figure 6.1 Distribution of children by relationship to householder and age of child (Kreider, 2003).

adoptive homes. Policy and practice with respect to who is allowed to adopt varies across the states. One third of the adoptions finalized in Massachusetts in 2004 were of children from foster care; the remaining two thirds were from private agencies (57% international and 9% domestic) (Center for Adoption Research, 2006). Adoption by gay and lesbian couples is prohibited by some states, including Florida and Mississippi (Families Like Ours, 2006). Despite the increase in adoptions by nontraditional families, Massachusetts data indicate that the vast majority of private adoptions continue to be to two-parent families, with 11% to single persons and only 3% to gay or lesbian couples (Center for Adoption Research, 2006).

Of adopted children identified in the 2000 U.S. Census, 13% were born in other countries, 48% from Asia, 33% from Latin America, and 16% from Europe (Kreider, 2003). Some variation in place of origin by age of child reflects changing sociopolitical conditions, most notably the dissolution of the Soviet Union in 1991, which resulted in large numbers of children available for adoption around that time. Although the one-child family policy in China also resulted in a marked increase in international adoptions of Chinese infants over the 1990s, China accounted for only 3% of all foreign-born adopted children in the United States in 2000 compared with Korea at 22%.

Census data reveal the socioeconomic status of households of adopted children in the United States to be higher than the norm. Their annual income was 17% higher than households of biological children on average, and the parents of adopted children were less likely to have dropped out of high school and more likely to have attained advanced college degrees (Kreider, 2003).

Children who are adopted are more likely to be girls than boys. This represents a shift from the well-established sex ratio among the general population in favor of boys. Census data show 106 males for every 100 females among biological children under age 18 but only 90 males for every 100 females among adopted children, with fewer in the preschool years and a narrowing of the gap at later ages (Kreider, 2003). Most infants placed for adoption internationally are girls due to cultural preferences to retain boys in the birth family; 93% of the children adopted from China at the time of the 2000 census were girls.

Women who adopt also prefer to adopt girls, especially when they are single women (Chandra, Abma, Maza & Bachrach, 1999; Groze, 1991). Despite these preferences, the gap does decrease across middle childhood, which probably reflects the fact that abuse and neglect do not occur with such strong gender bias, yielding a more evenly divided group of older children who are in need of adoption.

MAJOR THEORETICAL PERSPECTIVES

Several theoretical perspectives have special relevance to conceptualizing risk and resiliency among children who are adopted. According to attachment theory the child forms a secure base for exploring the world in his or her relationship with a consistent, sensitive and responsive caregiver during infancy and early childhood. This early attachment further forms the basis for other relationships to follow (Bowlby, 1969, 1973). Because adopted children are not likely to have had noninterrupted relationships from the earliest days, attachments—and by this theory, development—may be at risk. However, the system is not without plasticity, and children may develop new attachments with their adoptive family members just as children display different attachment patterns across different relationships outside adoption (Main & Weston, 1981).

The school-age child capable of concrete operational thought—the Piagetian stage of development in which children can consider multiple aspects of a problem simultaneously—is able to process that being adopted by one set of parents also means being "given up" by another. Hence, the very nature of the child's adoptive attachments is complex, as one set of emotional attachments is so intimately tied to another set of emotional losses. The subjective experience of such losses may display in other domains if the child's contemplations or musings interfere with sustained focused attention on the tasks of daily life such as school work and may help to explain the modest gap between school achievement and intelligence quotient (IQ) attainment that emerges across studies of children who are adopted (Main, 1999; van IJzendoorn & Juffer, 2005).

The web of interconnected relationships in adoption may best be conceptualized through a systems or ecological lens. Family systems may be viewed as bounded sets of interrelated parts that exhibit coherent behavior. Although there are several family systems theories, they hold several tenets in common (Walsh, 2003):

1. All parts of the system are interrelated and interdependent.
2. The system has boundaries that may be relatively open and fluid or closed and inflexible.
3. The whole of the family is more than the sum of its parts.
4. There are rules and beliefs that are shared within the system.
5. There may be subsystems or alliances between certain members of the family.
6. Members interact in relatively predictable patterns.

Although services to adoptive families are generally considered desirable supports, Groze (1994) pointed out that the relation of the child welfare system

to children and parents is both a resource and stress to the adoptive family system, as it brings a whole new set of relationships and alliances into the family dynamic.

Bronfenbrenner's (1989) systems theory of development places the child at the center of an active ecology that includes contexts in which the child plays both direct (e.g., family, school) and indirect (e.g., parent's job) roles, as well as the interrelations among members of these contexts and the cultural envelope in which the child and system evolve. Unlike older socialization models, an ecological view sees effects across the ecology as bidirectional. That is, the child is as likely to influence the parent as the parent is to influence the child. Clearly, correlational studies leave the direction of effect open to interpretation, as in Judge's (2003) finding that stress levels among parents of adopted children varied with the extent of behavior problems in their children.

This theory also holds that ecological transitions, or changes in some aspect of the ecology, mark times during which change rather than stability is likely to be seen in the child. Ecological transitions occur with the entry of a child into a family, the exit of a parent or even a change in job or school. Arcus and McCartney (1989) found more variability in young single children's social behavior over a 14-month period among those whose family constellation changed with the addition of a younger sibling compared with those who remained singletons. Similar behavior likely is displayed in the biological children of families who adopt as well as the adoptive children of families who add another child through birth or subsequent adoption. Changes in family structure have been found to vary with behavioral problems among older adopted chidren. O'Connor, Caspi, DeFries and Plomin (2003) reported a correlation of biological risk to psychopathology among adopted 12-year-olds, but only for children whose parents had divorced and not for children in intact families.

WHAT ARE THE RISKS?

In considering the risks associated with adoption in children of school age, it is critical to consider the variety of circumstances tied to adoption. For example, children adopted from child welfare agencies with a history of abuse, neglect and multiple foster placements bring these histories into their adoptive experience. In fact, for these children such experiences are integral parts of their adoption, since without such negative circumstances there would be no need for adoption in the first place.

Children who are adopted appear to be at heightened relative risk for problems across many domains, often beginning with the cognitive advances of middle childhood that permit children to process the salience of their adopted status and the complexity of their losses in the broader social milieu (Brodzinsky, 1993). Among girls adopted from China living in the United States and Canada, for example, scores on the Child Behavior Checklist (CBCL) (Achenbach, 1991) were not elevated for preschoolers. However, depression and anxiety scores were elevated among school-age girls, and more school-age girls than preschoolers (16% v. 5%) scored above normal range for total problems (Tan & Marfo, 2006).

However, as Brodzinsky (1993) was among the first to note, most adopted children appear to do quite well—this despite the fact that he and his

colleagues found that school-age children who had been adopted were rated as having more behavior problems, less social competence and lower school achievement than nonadopted children. Just as Tan and Marfo (2006) found two decades later, most of the adopted children scored in the normal range (Brodzinsky, Schecter, Braff & Singer, 1984).

Risk, on average, is probably not as telling for children who are adopted as the increased risk at the extremes. A nationally representative school survey of 10- to 13-year-old children found moderately increased risk for substance use, skipping school, emotional distress, diminished hope for the future, health and physical problems, fighting and lying to parents among children who had been adopted, especially boys. Moreover, among those children who did evidence problems, significantly more adopted youth were among those with the most severe problems (Miller et al., 2000). Similar patterns were observed in a study following children who had been adopted internationally and a comparison group of nonadopted children in the Netherlands over a three-year period into early adolescence (Verhulst, 2000). Adopted youth reported more of an increase in problems over time, and, although the majority were doing well, more adopted males' ratings fell in the clinical range for delinquency (6.5% v. 1%) and more adopted females' in the clinical range for aggressive behavior (7.3% v. 1.4%).

Not only may risk may be related to adoption per se, but also the heightened sensitivity of adopted parents may be related to potential problems and access to treatments (Miller et al., 2000; Warren, 1992). In fact, in a meta-analysis of 62 adoption studies involving more than 17,000 children, van IJzendoorn and Juffer (2005) found consistent evidence of cognitive catch-up among adopted children compared with children who remained in the original environments such that they concluded that adoption acted as a natural intervention in cognitive development. Of particular interest was a subset of studies indicating that adopted children were referred for special education services at twice the rate of the general population, a finding that may be interpreted as the proverbial glass that is either half empty or half full. Although the need for such services might put children at risk for poor academic outcomes, obtaining appropriate services when needed enhances the probability of academic success.

Biological and Genetic Factors

Adoption has been a paradigm used to examine the relative contribution of genetic and environmental factors to development by comparing the degree to which children resemble their biological and their adoptive parents, but the role of genetics in adoption need not be limited to biology. The emergence of behavioral problems that have a genetic component might represent a challenge to the adoptive family both in terms of fit and experience as well as the standard features of the disorder. For example, parents whose children are diagnosed with dyslexia or other learning disabilities frequently can associate that diagnosis with the profile of someone else in the family when the

just enough psychological distance to permit parents to acknowledge evidence of problems requiring attention, as suggested by the rates of referrals for help among adopted children. The literature has not come close to explaining these potentially very complicated interactions.

There is a growing body of evidence that suggests a continuing role of genetics and biological factors in the development of children who are adopted. The degree to which children adopted from adverse circumstance show recovery in traits clearly genetically influenced (e.g., height, IQ) has been viewed as a hallmark of the power of the environment (Dennis, 1973; Golden, 1994; Scarr & Weinberg, 1976; Winick, Meyer & Harris, 1975). Even from the extreme deprivation of Romanian orphanages, Rutter, O'Connor and the ERA Study Team (2004) found substantial catch-up in weight by age 6 years among children adopted into British families in the United Kingdom. Unlike gains in body weight, however, head circumference failed to demonstrate significant catch-up by age 6 and remained 1.5 standard deviations below norms. Furthermore, the degree of cognitive impairment was correlated with head circumference but not with adoptive parents' level of education, regardless of whether or not the children showed extreme malnourishment at time of entry to the United Kingdom. McGuinness, Ryan, and Robinson (2005) also found overall competence as measured on the CBCL at 11 years predicted by birth weight in children adopted from the former USSR and living in the United States. These data suggest a biologically driven contribution to cognitive levels in the absence of a nurturing early environment and differ from other findings of strong linkages between adopted children's cognitive functioning and adoptive parents' levels of education (Dumye, Dumaret & Tomkiewicz, 1999).

To oversimplify the discussion as one of genetics versus environment, however, is to ignore the pathways by which these two powerful forces likely interact in all children, including those who are adopted. Genetics may mediate environmental effects as with language abilities, achievement and social adjustment (Gilger, Ho, Whipple & Spitz, 2001; O'Connor, Caspi, DeFries & Plomin, 2000). Genetic effects may change with development as do the effects on reading, which amplify during later childhood and into adolescence (Wadsworth, Corley, Hewitt & DeFries, 2001). They may depend on gender as is seen in the risk for conduct disorder, which shows greater genetic effects for boys compared with girls (Braungart-Rieker, Rende, Plomin, DeFries & Fulker, 1995). Genes may have evocative effects that alter aspects of the environment itself. For example, scores of adoptive sibling pairs were found to be significantly less similar when compared with those of biologically related siblings using Home Observation and Measurement of the Environment (HOME) assessments (Braungart, Plomin & Fulker, 1992), and adopted children who were at genetic risk for antisocial behavior were found to experience negative parenting more often than their peers at low genetic risk (O'Connor, Deater-Deckard, Fulker, Rutter & Plomin, 1998).

The complexity of genetic influence is apparent in considering the overrepresentation of attention deficit hyperactivity disorder (ADHD) among adopted children (Deutsch, Swanson & Bruell, 1982). Although this finding has been interpreted as evidence of the genetic transmission of impulsive behavioral profiles that resulted in an unplanned or unwanted pregnancy in the biological parents, a host of environmental and other biological influences may be contributing factors. These include the stresses of an unwanted pregnancy and

the potential for uterine effects, as well as the risks in abusive environments that promote hypervigilance and threaten developing attentional regulation.

Individual Factors Influencing Risk and Resiliency

Juffer, Stams and van IJzendoorn (2004) studied 176 7-year-old children adopted from Sri Lanka, Korea, or Colombia into Dutch families living in the Netherlands using Block's (1971) formulation of ego functioning. According to Block, ego control is the ability to regulate impulse by inhibiting or expressing it, and ego resiliency is the capacity to accommodate the degree of ego control in response to contextual demands. In a replication of findings among adolescents by Robins, John, Caspi, Moffitt and Stouthamer-Loeber (1996), Juffer and colleagues found the fewest problems overall among ego-resilient children, more internalizing problems among overcontrolling children and more externalizing behavior problems among undercontrolling children.

The gender of the child is likely to interact with other cultural factors. A nationwide study in China, for example, revealed that adopted children in one-child families were less likely to be enrolled in school compared with biological children, especially when they were girls (Liu, Wyshak & Larsen, 2004). Gender is also likely to relate to aspects of development in adopted children in much the same way it does in children who are not adopted, although evidence is sparse. Dutch studies of 7-year-olds adopted internationally as infants revealed effects of gender. Compared with boys, girls displayed higher social development and more ego control (but not resiliency) and were rated as popular by their peers more often than typical for the general population (30% v. 13%). Boys, on the other hand, were more likely to display externalizing behavior problems (Stams, Juffer, Rispens & Hoksbergen, 2000; Stams, Juffer & van IJzendoorn, 2002). In adolescence, adoption has been associated with higher risk across domains, with effect sizes larger for males (Miller et al., 2000).

Family Factors Influencing Risk & Resiliency

Children appear at most risk when they enter adoption with a history of early family experience that is either absent or aversive for a prolonged period. Because the child's age at adoption frequently is confounded with time spent in an institutional setting or the duration of abuse or neglect, it is often used as a proxy for the extent of early deprivation.

Hoksbergen, Rijk, Van Dijkum and Laak (2004) found heightened externalizing and total problem scores among 8-year-old children adopted from Romania and living in the Netherlands, with 30% of the adopted group scoring in the clinical range, in a replication of Ames's (1997) findings with children from Romanian orphanages adopted into Canadian families. Of the children in Hocksbergen's group, 72% arrived in the Netherlands with medical problems at an average age of 34 months. Later arrival (after age 2) was associated with parents' assessments of problems encountered in upbringing and the total problem score on the CBCL.

Similar though attenuated effects are found beyond the extreme circumstances of Romanian adoptees. Howard, Smith and Ryan (2004) examined reports of behavior problems among 11- to 13-year-old children who were living with their biological families or who had been adopted domestically (all before 6 months), internationally (average age at adoption 1.5 years) or from

the child welfare system (average age of adoption 3.6 years). Only the last two groups were overrepresented in the top quartile of scores on the Behavior Problem Index.

Although children adopted in infancy are as likely to form secure attachments with their adoptive parents as biologically related children, children adopted at later ages with a history of physical or sexual abuse show compromised attachment patterns across a variety of indicators (Groze, 1996; Singer, Brodzinsky, Ramsay, Steir & Waters, 1985). More 6-year-old children who spent 24 to 42 months in the extreme privation of Romanian orphanages before being adopted into the United Kingdom evidenced disinhibited attachment patterns compared with their peers who had spent less than 18 months in the institutions before adoption (33% v. 6%; Rutter et al., 2004).

Similar patterns emerge in domestic adoptions associated with early aversive family circumstance. Reilly and Platz (2003) studied 249 families of children in special needs adoptions with placements when the child was 3 years on average. More than one third of the children were reported to have severe or profound problems with anger, impulsivity, defiance, tantrums and hyperactivity—all behaviors that can be associated with a history of trauma. The incidence of reported disabilities was also higher than in the general population, exceeding 40% for behavioral, emotional and learning disabilities and developmental delay, and parents reported more problems with sibling groups than with children adopted singly. Curiously, the severity of problems reported correlated with the amount of time the child had lived in the adoptive home. It is critical to recall, however, that age of the child and duration of the parenting effort are confounded with time in the home. Hence, the correlation evident in parental report is more likely a reflection of the developmental emergence of these types of problems over the course of childhood (e.g., learning disabilities become apparent with increased school demands; the sequelae of sexual abuse is triggered by the onset of puberty) or the toll of child behavior problems on parents over time (Hoksbergen et al., 2004) than it is a product of the adoptive family environment.

There is little evidence that adoptive families provide different ongoing environments than nonadoptive families. Deater-Deckard, Fulker and Plomin (1999) found a single difference—higher parent-rated negativity—in annual assessments of the family environments of adoptive and nonadoptive fa nilies when their children were between 10 and 12 years of age. In contrast, cohesion and functioning among families of African American 11- to 14-year-old children adopted transracially was rated higher than the norm. As with families in general, adoptive families are a heterogeneous group. Individual differences in their ongoing dynamic are likely to outweigh commonalities due to adoption.

These differences have been associated with children's social competence and academic performance. Even though Family Environment Scale (FES) cohesion levels declined from age 7.7 to 11 years, higher FES cohesion, along with higher birth weight, was moderately predictive of more total competence on the CBCL in a sample of children adopted from Russia and living in the United States (McGuinness et al., 2005; McGuinness & Pallansch, 2000; Moos & Moos, 1986). In a sample of Dutch children adopted as infants, mother–infant secure attachment and maternal sensitivity predicted positive social and cognitive development at age 7 (Stams et al., 2002).

Attachments in adoption involve more than one set of parents. As children are able to process that their adoption in one family is the loss of another, thoughts about their birth parents are to be expected. Smith and Brodzinsky (2002) studied 8- to 12-year-old children and their coping styles for the loss of birth parent. Not surprisingly, they found that children who were placed at later ages into adoptive homes were less curious about their birth families because they had more firsthand knowledge. In general, however, curiosity and preoccupation were associated with positive coping strategies, but avoidant coping was correlated with anxiety and depression. Negative affect about birth-parent loss was linked to depression and low self-worth. These results are consistent with the work of collaborative studies from Minnesota and Texas. In a large sample of children aged 4 to 12 and their adoptive families, no differences in children's self-esteem or multiple indices of socioemotional functioning were found to vary with the degree of openness in the adoptive family–birth-parent relationship. However, adoptive parents in more open arrangements showed higher degrees of empathy about adoption, talked about adoption more freely and showed less fear that the birth parent would reclaim the child (Grotevant & McRoy, 1997). When a small subset of these children were studied—all of whom were at high risk for poor outcomes due to birth family, prenatal or perinatal factors or preplacement circumstance—children whose families demonstrated more collaboration in relationships across the kinship network were found to have lower levels of socioemotional problems than those whose relationships were less collaborative (Grotevant, Ross, Marchel & McRoy, 1999). It may be that openness enhanced parental self-efficacy, which allowed adoptive parents to support the child's resiliency in the face of risk.

Fathers emerged as significant factors in discriminating Canadian couples who were able to sustain their special needs adoptions and those whose adoptions disrupted within a year of placement (Westhues & Cohen, 1990). Compared with families that disrupted, families that sustained were likely to have husbands who were rated positively by their wives and who themselves rated the family's affective involvement and expression positively. These were also couples who had been married longer, were employed in high-status jobs and were unlikely to have considered adoption due to a history of miscarriage.

Family factors may also correlate with child cognitive abilities. Petrill, Deater-Deckard, Schatschneider and Davis (2005) studied 262 children who had been adopted at about 1 year of age and found that reading abilities correlated with family factors such as parents' level of education, parents' attitudes toward education, the number of books read and parental involvement with homework. Similarly, Dumye et al. (1999) found a strong association between adopted children's levels of cognitive functioning and adoptive parents' levels of educational achievement.

In contrast, cognitive levels were not associated with characteristics of the adoptive family at ages 6 or 11 years among Romanian adoptees whose early years were marked by extreme institutional deprivation (Beckett et al., 2006; Rutter et al., 2004). Hence, the links between family factors and cognition might be limited to children whose experiences are within some normal expectable range and may not extend to children whose early experiences are exceptionally neglectful or abusive, which might result in neurological compromise.

There is no evidence that sexual orientation of the adoptive parents is related to child outcomes (American Academy of Pediatrics, 2002; Paige, 2005). A longitudinal study of the children of lesbian families failed to find that parents influenced the sexual orientation of their children (Golombok & Fisher, 1996). A comprehensive review of the literature provided "no support for the belief that lesbians or gay men are less suitable than heterosexuals to serve as adoptive or foster parents" (Patterson, 1996, p. 270). Of course, families in the gay and lesbian community are not a homogeneous lot. Some data suggest that children—not limited to children by adoption—are better adjusted when lesbian mothers are more egalitarian with respect to child care and when families have a supportive social network (Patterson, 1995, 1996).

The role of siblings in the families of children who are adopted is not well understood. Although child welfare agencies have traditionally attempted to keep siblings together through foster care and adoption, the data are not conclusive. Several studies examined the link between sibling placement and risk for disruption or dissolution. In his review, Rosenthal (1993) found that sibling placements might increase risk for termination, especially when there are children already in the home, and found evidence that sibling placements may be beneficial. Higher levels of anxiety and depression, more social problems and more total problems have been reported among children placed separately from biological siblings compared with those placed with siblings (Erich & Leung, 2002; Groze, 1996). On the other hand, parents who have adopted sibling groups report lower expectations, more child behavior problems and lower family functioning compared with parents who adopt individual children in special needs adoptions (Leung & Erich, 2002; Reilly & Platz, 2003).

As Festinger (1984) noted, these data cannot be evaluated meaningfully without understanding the reasons for sibling or separate adoptions in the first place. Children placed with siblings may show fewer problems than those placed together because their manageable profile permitted social workers to find a single home that could manage multiple children. On the other hand, when children bring an excessive array of problems into foster care and adoption, the placement of several siblings in the same home may simply overwhelm the adoptive family, thus making separate placements the most likely way to ensure permanency.

Social and Community Factors Influencing Risk and Resiliency

Children do not only enter families through adoption; they enter the larger communities in which their families live, communities that present potential challenges as well as resources for the child. Compared with parents of biological children, a higher proportion of parents of children adopted from the child welfare system (mean age 12 years) reported problems with their children's abilities to make friends, to choose appropriate friends and to make good decisions in their community. Along with parents of children adopted as infants, they rated their children as more likely to have problems getting along well with others in the neighborhood and fitting into organized groups (Howard et al., 2004). Problems maintaining friends may cost the child in other domains since close friendships during middle childhood appear to have a buffering effect against the development of externalizing behavior problems in the face of family adversity (Criss, Pettit, Bates, Dodge & Lapp, 2002).

The community can also be a source of support. When 12- to 14-year-olds who had been adopted from the child welfare system were asked to whom they turned to for help when needed, they described an informal network of supportive others including school and friends, family and trustworthy people. Friends and siblings were identified as the most effective sources of support, and adoption professionals were not mentioned. The contention that others did not fully understand the adoption experience was identified as one of the most significant barriers for children seeking advice or other assistance (Ryan & Nalavany, 2003).

Arcus, Milewski, Brown and Merrill's (2002) study of foster care may lend some experimental support concerning the contention that others may not fully appreciate the experience of adoption. When adults were asked to rate the psychological characteristics evidenced in children's drawings that they believed to be created by children in foster care and children living with their biological families, a significant difference emerged in the ratings of participants who had personal experience with someone who had been in care compared with those who never had known anyone in foster care. The experienced group rated the drawings of children purportedly in care as evidencing less happiness and more social and maturational problems than those of children in intact families. However, despite the elevated prevalence of problems with children in foster care, the naïve group simply rated them as less happy.

Although culture can clearly be a central issue in many adoptive families, especially those whose children are internationally and transracially adopted, there is little empirical attention to the link between ethnic identification and outcomes for children. There is evidence that the larger context in which cultural origins of parents and child match or do not match is itself changing. Thirty years ago, Kim (1977) found that only a minority of U.S. parents who had adopted children from Korea emphasized the child's ethnic identity. Twenty years later, 90% of U.S. adoptive parents engaged in a study of international adoptions thought it was important to expose their child to his or her birth culture (Trolley, Wallin & Hansen, 1995). When parents of young children adopted from China were recently asked about the importance of their children's cultural heritage, they consistently agreed that exposure to Chinese culture was beneficial to their children's personal adjustment and identity (Rojewski, 2005).

To explore the link of such exposure to child adjustment, Yoon (2001, 2004) asked children adopted from Korea and living in the United States (mean age 14 years) to rate their parent's warmth, communication and support of ethnic socialization as correlates of the child's self-reports of collective self-esteem, well-being, and distress. Both living in an ethnically diverse neighborhood and parental support for exploring the child's ethnic identity correlated with higher collective self-esteem, which, in combination with parental warmth and communication, was related to more well-being and less distress. Additionally, the presence of a sibling also from Korea—but not siblings in general—was correlated with less self-reported distress.

Deeper questions about culture and adoption challenge the pathways by which some children are considered for adoption in the first place. In a critical ethnographic analysis, Hand (2006) suggested that the overrepresentation of communities of indigenous people in foster care and adoption is, at least in part, the result of a cultural mismatch. She argued that child welfare

institutions and policies fail to attend to the strengths, values and meanings of families such as those in the Ojibwe tribe and therefore foster the movement of children rather than the nurturance of the family of origin through a blend of the best of indigenous and majority cultures.

EVIDENCE-BASED TREATMENTS AND INTERVENTIONS

In this section we examine evidence to support treatment practices to improve the functioning of children and families in need of help.

What Works

No interventions specifically targeting adoptive families that demonstrated success with multiple replications were uncovered in our review of the literature.

What Might Work

Although there are few empirical studies, there is support for interventions to enhance the development of children who are adopted that are based on attachment and family systems theory and that focus on the expanding social world of the child across the school years.

The most common basis for traditional approaches to adoption interventions and supports has been attachment theory (Barth & Miller, 2000; Smith & Howard, 1999). Despite this, there has been only one series of studies examining attachment intervention with adopted children and their parents. Juffer, Rosenboom, Hoksbergen, Riksen-Walraven and Kohnstamm (1997) studied efforts to enhance attachments in adoptive families who either had biological children at the time of adoption (the mixed group, both biological and adoptive children) or who did not (the adoption-only group). The intervention broadly consisted of providing information on sensitive parenting to mothers at 6 and 9 months. Significant intervention effects were observed at 12 months for maternal sensitive responsiveness, infant–mother attachment and infant exploratory competence for the adoption-only group but not for the smaller, mixed sample. The follow-up study at age 7 revealed a different story (Stams, Juffer, van IJzendoorn & Hoksbergen, 2001). There were no effects of intervention evident in the adoption-only group, but there appeared to be delayed effects for children in the mixed group, increased ego resiliency and ego control for girls and decreased internalizing problems for both boys and girls.

Several explanations are possible for these trends, including the confounding differences in the parity and experience of mothers. None of the infants who were adopted into mixed families were the first child in their new family; about half were the second, and the rest were third to fifth. In the adoption-only families the adopted infant was the first child in each case, confounding family type with experience of the parents. New parents, therefore, may have had more room for improvement in their attachment behaviors in infancy. As infants grew into children, experienced parents continued to have models of child development to foreshadow what was to come with the adopted child. Although many of the known effects of parity occur most often in the first postpartum weeks, significant main and moderating effects of parity on mother–infant interaction have been found with 5-month old infants in

nonadoptive families (Corter & Fleming, 2002; Fish & Stifter, 1993). Obviously, parity findings have been generated with biological offspring and may not generalize to adoption of infants or to adoption of older children. Nonetheless, it is possible that attachment-based interventions have limited applications that are appropriate for some of the children some of the time.

Few postadoption services have included evaluations of their success in preventing disruption or dissolution. In reviewing those that have, Barth and Miller (2000) noted general agreement about their effectiveness with particularly high regard for services that connect parents to groups or other adoptive parents that can offer respite and support. The authors argue that the availability of only four projects with small sample sizes and methodological idiosyncrasies require other sources of data to inform postadoption service planning. To that end they summarize findings from studies that reported parents' opinions about the types of services they would find helpful, opinions that fell into three major categories.

Information and educational services began with complete disclosure about the child's medical, social and genetic history. Other services in this category included written materials or presentations relevant to the particular child or to adoption in general. Clinical services included counseling, which was often named as useful but seldom used, and respite, again seldom used but highly praised when it was. Finally, material services included monetary subsidies, medical care and special education. These requests appear to reflect the complicated circumstances of older child adoptions. Barth and Miller (2000) suggested that the traditional attachment model be replaced—or at least supplemented—with multisystemic sources of support that target complex needs, such as those due to abuse or neglect, and do so in a way that adapt as these needs change with development and across social contexts.

These recommendations are in line with findings from Illinois postadoption services for children placed at older ages. Smith and Howard (1999) reported findings with more than 400 families who sought out services. These were not new adoptions. The children had been with their adoptive families almost nine years on average. More than 90% scored in the clinical range on the CBCL, and, especially among children with evidence of posttraumatic stress, problems appeared greatest around age 12. Hence, it is unlikely that attachment work alone would meet the needs of these families. Indeed, Smith and Howard reported that many families had previously sought assistance from a variety of providers without effect.

The central effort of the Illinois program was to teach parents to interpret problem behavior in the context of the child's history and development through individual meetings and participation in support groups. Smith and Howard (1999) reported five cornerstone practices of their adoption preservation services:

1. Workers are flexible and available, able to come to the home and provide 24-hour on-call service.
2. Workers integrate information from a variety of sources during assessments to develop a comprehensive view of the child, family and problem.

3. Workers provide a variety of types of interventions, including support groups, participating in special education team meetings at the child's school and offering counseling services to all members of the family.
4. Adoption issues continue to be raised throughout the service period.
5. Workers encourage parents to care for themselves as well as their children and to depersonalize problem behavior.

Of these, parents were most enthusiastic about support groups. Presumably these groups struck such a responsive chord because other parents struggling with children's problem behavior would "get it," an antidote to the major barrier Ryan and Nalavany (2003) found to children's help-seeking behavior—that others could not really appreciate the experience of adoption.

When participating Illinois parents were asked open-ended questions about the benefits of the program, they praised the nontraditional delivery of services and availability and flexibility of workers. Areas in which they felt most challenged centered around dealing with anger, antisocial and attachment problems, as well as issues involving the family system. For example, "We had been in family therapy before but we were still struggling, in fact, my husband and I were barely keeping our marriage together. The AP was the first agency that informed us of the kinds of challenges that many adoptive children and families face. We just had no idea. I just thought I was doing everything incorrectly" (Zosky, Howard, Smith, Howard & Shelvin, 2005, p. 11). Areas parents identified as being those in which services had the most positive impact were understanding their child's behavior and feelings (most commonly cited), learning advocacy to access necessary resources, improving communication, dealing with the child's anger, understanding and working with attachment issues and understanding the unique grief and identity issues that arise in adoption. In line with Barth and Miller's (2000) suggestion, attachment-based work is a small portion of the types of support work that parents found helpful.

There is considerable convergence with the findings of a survey of 873 adoptive parents eight years after their adoption from public, private or independent agencies in California as part of a larger longitudinal study (Brooks, Allen & Barth, 2002). Although most parents did not use postadoption services, many read books or articles on adoption. Parents who adopted through public agencies used counseling services for child and family more often than other parents. It is important to note that the children adopted through public agencies were adopted later (mean age = 31 months), were slightly older at the time of the survey (mean age = 12 years) and were very likely to have special needs (72% medical or learning; 52% history of abuse or neglect) compared with the two other groups who were adopted during infancy: about 8 years old at the time of the study and much less likely to have special needs. Generally, about two thirds of each group found services to be helpful when used, with public adoption parents somewhat less likely to find services—with the exception of support groups for adopted children—helpful.

Brooks et al. (2002) also asked parents what types of services they would put in place if designing postadoption supports. Information on the child's medical, social and genetic history was identified as important by 85% of respondents. Additional information resources on adoption, including legal and financial aspects, were endorsed by a majority of parents. Single parents

and parents of children who had a history of abuse or neglect or who presented behavioral or emotional problems were likely to endorse clinical services as well, including support groups for parents and children.

Finally, ecocultural theory suggests that interventions not be limited to the family, especially since school is one of the most salient social contexts of middle childhood. In addition to the special education planning and advocacy that Smith and Howard (1999) described, children who are adopted might be particularly sensitive to traditional curricular units. Our review of the literature revealed no empirical studies of the efficacy of curricular or instructional interventions with children who are adopted.

In summary, what might work appears to depend on the parent, the child and the child's history and place in developmental and social contexts. Special needs adoptions require specialized supports and are likely to be enhanced by the social and emotional support of a group of peers with shared experiences and perspectives.

What Does Not Work

When formal sources of support and intervention become necessary, it is unlikely that traditional providers, such as the pediatrician, will be well prepared for some of the complex types of problems that some adoptive families face. Many medical and even psychological training and residency programs fail to provide an adequate curriculum on the topic of adoption as a long-term life process. A nationwide survey of fellows in general pediatrics asked these physicians to rate the quality of their residency training, tapping into areas relevant to adoptive families (American Academy of Pediatrics, 1998). Although many aspects of training were rated as very good, only 31% gave high ratings to their training in developmental and behavioral issues. Moreover, training was rated as poor by significant numbers of physicians in the areas of international health (58%), violence prevention and management (44%), substance abuse (34%) and learning disabilities (37%). Hence, parents are likely to have to search for providers who have specific expertise in the areas in which their child or family is experiencing problems. There are indicators that relevant training opportunities may be improving. As Pavao (1998) observed, the literature on adoption tripled in volume across the 1990s.

Children's needs change with development. Family decisions at the time of adoption should anticipate the needs of the eventual adolescent as well as those of the presenting infant, toddler or child, as there is evidence that the rules of engagement agreed to at adoption placement are not likely to change. Frasch, Brooks and Barth (2000) conducted a longitudinal study of families adopting from foster care and found that mothers tended to be the decision makers with respect to contact between birth and adoptive family. When they had made the decision at the outset not to have any contact with birth families, the decision was likely to stand. Mothers who were open at first—even with hesitation—to contact with birth-family members were likely to continue the relationships across the eight years of the study.

One important lesson from this study is that contact per se can be with any member of the birth family, and, since these were adoptions from foster care in which birth parents were likely to have been abusive or neglectful to their children, most contacts were through related persons other than parents. Relatives such as siblings, aunts or grandparents may be valuable connections

as the child struggles with the complexity of attachment and loss over the course of middle childhood. However, it might be more difficult to initiate contact after it had been terminated than if some relationship had been carved out from the outset.

Adoption is a lifelong relationship. Intervention services that are intensive but brief have generally not been found to be effective in supporting or sustaining that relationship (Smith & Howard, 1999).

Overall Comments on Good Interventions

It is important to recognize the divergence of needs among children who are adopted—from none at all to multiple and severe. Although adoption may be a central issue for some children's problems, it may not be for others. Although attachment-focused interventions may be useful with some children, they will not be for all. There are also differences across development and across contexts. Although children may not display problems at younger ages, they may emerge with development, particularly around the transition to adolescence.

Attachment may be the basis for many intervention programs, but traditional approaches to attachment in mother–infant pairs probably have limited applications to older children. Children adopted as infants and children adopted at later ages likely evoke and tolerate attachment behaviors quite differently from each other. Consider the infant whose immaturity results in total dependence on the caregiver for basic sustenance compared with the 6-year-old capable of independent movement, of getting a jacket when he or she is cold and of making a peanut butter sandwich when he or she is hungry. The infant begins to trust caregivers who respond to his or her needs by holding, feeding, clothing and comforting. Clearly, the new parents of older children will have to search for alternative or additional ways of building mutual attachments, and times during which the child is more vulnerable (e.g., sickness) might become more salient. Moreover, the child who comes into an adoptive home from an aversive history may finally have a safe place to release years of rage and anger, as in one newly placed 6-year-old child's proclamation from his time-out seat, "I hate you! I hate this whole family! And I ain't never talking to you. Did you hear me, Mom? I ain't never talking to you again—not till you're dead!" This example illustrates the importance of helping parents to understand their child's behavior in the context of his or her history, to depersonalize the anger or rage that may find itself expressed and to identify elements of emergent attachment ("Did you hear me, Mom?"). At the same time, it is important for the child to understand his or her anger and to learn appropriate ways to deal with it.

Many families who are not in need of intervention when their child is younger may find that the situation changes dramatically around the transition to adolescence. The psychosocial tasks of adolescence that center on identity development bring adoption issues to the forefront, and especially for children adopted through child welfare, problems tended to peak around 12 years (Smith & Howard, 1999). Although parents who adopted infants outside the child welfare system may not generally use, or endorse the value of, clinical services when their children were younger as Brooks et al. (2002) found, they may do so later. Hence, middle childhood might function as a sort of calm before the storm, a time to ensure that adoption is an open topic in the

relationship and to connect with other parents who have adopted as a source of information and support.

The importance of parent and child support groups in intervention is clear from the results of both Barth and Miller (2000) and Smith and Howard (1999). A group of individuals with shared experience and meaning is a fundamental source of support in daily life and in interventions for a variety of issues from weight loss to dissertation writing to addiction recovery. Technology provides avenues via Web sites and discussion groups for support to individuals living in isolated communities without sufficient diversity to build a personal network.

It is important that individuals with the appropriate expertise and training guide interventions. The degree to which others understand the experience of adoption and the failure of many training programs to include adoption related curricula are barriers to obtaining effective services and supports. The experience of obtaining professional help but finding it not to be helpful, as many of the parents reported to Smith and Howard (1999), may indicate to the parent that the presenting problems are hopeless and may contribute to a declining sense of parental agency and reluctance to seek help when needed. Although parents with more education are likely to seek additional opinions, parents with less may be more likely to view the professional as absolute authority and less likely to have the resources to continue to invest in services that haven't shown benefit. Adoption agencies would do well to clarify the limitations of general practitioners and to provide referrals to appropriate resources.

As Smith and Howard (1999) recommended, interventions for children who have been adopted and their families should possess the characteristics of any good intervention program. They should be guided by an understanding of each family system and the environments in which that system operates. They should be supportive and respectful, should be focused on individual needs and should help families to find whatever resources will help them to function well. Because the challenges of parenting children who have been hurt are not confined to office hours, they should be flexible and creative in designing a system that can be available to families without overburdening caseworkers.

PSYCHOPHARMACOLOGY AND ADOPTED CHILDREN

No studies specifically examining the role of psychopharmacological treatments with children who are adopted were found in our review of the literature.

That said, overreliance on psychopharmacology to the exclusion of cognitive behavioral interventions is one of the risks of the culture of managed medical care. When children move from foster care to adoptive homes, there is likely to be a period of transition to the new family, school and social milieu exacerbating any attentional or behavioral problems the child might have. Hence, it is critical that medications, if prescribed, be reevaluated after the child, family and school have had opportunities to adjust.

Additionally, child posttraumatic stress disorder symptoms frequently present as ADHD, learning or behavioral problems. Although the child with ADHD might benefit from a psychostimulant regime, he or she might also

benefit from pharmacologic or other management of conduct problems, depression or anxiety that may be trauma related.

PREVENTION

This section considers practices that work to minimize the problems associated with adoption and to enhance functioning and well-being for the child and adoptive family. Approaches to child welfare that emphasize family preservation and the employment of support services are attempts to prevent the need for adoption in the first place and are addressed elsewhere (see Chapter 10, this volume).

What Works

No interventions specifically targeting adoptive families that demonstrated success with multiple replications were uncovered in our review of the literature.

What Might Work

Providing complete information to parents at the outset is one potentially powerful method of preventing problems from emerging. Repeatedly, parents have identified this as one of the most commonly requested forms of support in the adoption process (Barth & Miller, 2000; Brooks et al., 2002). Still, significant numbers of adoptive parents report that they had received inadequate information from the agency (58%) or that their child's problems were more extensive than the agency reported (37%) (Reilly & Platz, 2003). As Zosky et al. (2005) noted, this is a grave concern in light of the observation that unrealistic parental expectations are a significant predictor of disruption (Groze, 1994, 1995).

When parents adopt children from cultural backgrounds different from their own, they may be at a loss for how to affirm the child's cultural identity. Vonk and Angaran (2001) sampled adoptive parents who participated in cultural competency training sessions in preparation for, or following, transracial adoptions to assess the effectiveness of such a program in three areas:

1. Increasing racial awareness
2. Increasing awareness of coping skills for dealing with racism or prejudice
3. Increasing awareness of the importance of multicultural planning

Their pilot results with a small group ($n = 20$) indicated positive changes in all areas, and anecdotal reports indicated that a documentary film titled *Struggle for Identity,* which features young adults who have been adopted transracially, discussing their own experiences (New York State Citizen's Coalition for Children, 1998) was a powerful vehicle for discussion and awareness. The support group was a central component of this intervention as parents met regularly with other parents similarly engaged in transracial adoptions. Follow-up studies, more methodologically rigorous, will be informative about long-term effects. Following Yoon (2001, 2004), such programming has the potential to

enhance collective self-esteem and well-being and to lessen distress for the transracially adopted child.

Potential school problems may be prevented with communication and creativity. Pavao (1998) recommended assigning a "family orchard" rather than "family tree" in elementary genetics units. The orchard acknowledges the complexity of genes and environments and the contributions of more than one set of parents to the child's life. Moreover, it is applicable to children in a variety of nontraditional family structures. Not all academic units are so obvious for their potential salience to adoption. When one child was discussing a geography assignment on the city of Seoul (his birthplace) and country of Korea with his mother, he remarked, "I understand how you told me that my birth mother could not take care of me, but what was wrong with all those other billions of people" (Pavao, 1998, p. 48)? This example illustrates the importance of communication not only between parent and child but also between parent and teachers to ensure that the classroom environment is sensitive to, and respectful of, adoption-related issues that might be painful or confusing for some children.

In addition to academic considerations, school brings a host of social relationships into the child's life. The degree to which the child's adoption status interacts with those relationships will vary depending on the social milieu and a host of individual factors. Yoon (2001, 2004) found more positive adjustment indices among children adopted from Korea who lived in ethnically diverse neighborhoods, and Patterson (1995, 1996) reported children of gay and lesbian parents to be better adjusted in neighborhoods presenting a supportive social network including other similar families. Hence, it may be that choice of residence in a diverse environment would contribute to preventing problems in children's social relationships. When that is not possible, efforts to celebrate diversity and to find opportunities for children to connect with others like themselves (e.g., special camps) might be helpful.

Adoption, however, need not rule every relationship the child has, and it is not appropriate for children to feel the need to explain intimate details of their lives to any and all interested parties. Fahlberg (1991) recommended developing a cover story, a response to inquiries that is honest but protective of boundaries. Brief explanations of why a child is not living with birth parents (e.g., "My parents couldn't take care of me so I got a new family who could"; "That's private and I'd rather not talk about it.") offer the child a script for handling interactions that might evoke confusion, conflict or emotional arousal and thereby have the capacity to contribute to the child's sense of agency and social competency.

Authoritative parenting styles—a combination of warmth and limit setting that leaves room for negotiation when appropriate—has been repeatedly linked to positive outcomes for children, from preschool through adolescence and with diverse families, though not necessarily adoptive families. It has been associated with secure attachment as reported by children and adolescents from grades 4 through 11 (Karavasilis, Doyle & Markiewitz, 2003). Authoritative parenting has been associated with adolescents' academic success via development of autonomy and a healthy orientation toward work (Steinberg, Elman & Mounts, 1989). Authoritative parenting has been linked with decreased risk in the presence of drug-using peers during adolescence (Mounts & Steinberg, 1995). It has been found to be effective not only at the level of the individual

parent and child but also for the presence of authoritative parenting among the members of the child's social network. Lower delinquency and substance abuse rates for 14- to 18-year-olds, lower school misconduct and peer conformity for boys and lower distress and higher psychosocial competence for girls were found when authoritative parenting was prevalent among the parents of adolescent's friends (Fletcher, Darling, Steinberg & Dornbusch, 1995). Moreover, these positive associations have been found in a variety of ecological niches across ethnicity, socioeconomic class and parent marital status (Steinberg, Darling & Fletcher, 1995; Steinberg, Mounts, Lamborn & Dornbusch, 1991). Hence, the adoptive family may also benefit from authoritative parenting, especially in preparation for the challenges of adolescence.

What Does Not Work

We found no clear empirical evidence of prevention efforts that failed to work in our review of the literature.

RECOMMENDED BEST PRACTICES

Interventions for the families of adoption should be responsive to the individual needs of those families—needs that may change over time and vary across contexts. The literature suggests that best intervention practices include the following:

- Those that offer information about adoption in general and the child specifically
- Those that provide support groups for parents as well as children
- Those that focus on attachment issues in the context of the child's age and history
- Those that include multisystemic approaches to family support
- Those that are guided by individuals with appropriate training and expertise

Psychopharmacological practices with children who are adopted should ensure that the child's history is fully considered and should be based on careful differential diagnosis and reevaluated as adjustments occur.

Although prevention research is thin, best practices appear to be the following:

- Those that provide complete information from the outset to encourage realistic expectations
- Those that support an appreciation of issues related to ethnic identity, especially when parents and children do not share the same ethnic heritage
- Those that promote communication between parent and child and parent and school
- Those that offer strategies to accommodate to adoption-related issues in school and social contexts
- Those that promote authoritative parenting that is warm, democratic and firm and capable of adapting to the emergent needs and challenges of adolescence

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