

Introduction

Adoption-specific therapy was developed from our experience treating children who had been adopted past infancy, either through foster care or internationally. We noticed that often these children had very specific kinds of symptoms and that they frequently did not respond to standard evidence-based mental health interventions in the same way as children who did not have disrupted attachments and trauma histories. Most adopted children and families are resilient and successful, and children who are adopted do much better than children who have never had a permanent family, instead aging out of foster care (Triseliotis, 2002; Vinnerljung & Hjern, 2011) or remaining in institutions (van IJzendoorn, Juffer, & Poelhuis, 2005). However, overall, children who have been adopted have more mental health issues than do children raised in their biological families (Miller, Fan, Christensen, Grotevant, & van Dulmen, 2000). Although families usually came to treatment for help with particular behavioral concerns and problems and not to deal with issues related to adoption, we began recognizing that these serious behavioral and emotional symptoms such as stealing, lying, aggression, running away, hoarding food, depression, and so forth that some children present with, particularly those adopted at older ages, were connected to what had happened to them prior to joining their adoptive families.

<http://dx.doi.org/10.1037/0000096-001>

Adoption-Specific Therapy: A Guide to Helping Adopted Children and Their Families Thrive, by J. Waterman, A. K. Langley, J. Miranda, and D. B. Riley

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We realized that there were strategies and interventions that seemed to be quite effective when used to enhance standard psychotherapy techniques with adopted children; the common element had to do with redesigning interventions to take into account the child's past history of abuse, neglect, and/or trauma and their developmental understanding of adoption.

For example, Josie, 7 years old, was brought to treatment by her adoptive parents because they were concerned that she was very friendly to everyone, and they worried that she was an easy target for kidnapping or a sexual predator. She had come to the family from foster care 2 years prior, having already lived with eight different caregivers, including several previous foster placements and various maternal relatives. Although she generally obeyed her parents' rules and tried to please, the parents didn't feel like they really knew her at a deeper level despite her living with them for several years. The other problem they presented was that Josie lied whenever she might be in trouble and was unable to back down even after it was clearly evident that what she said was untrue. When about to be interviewed, Josie eagerly held the therapist's hand and did not look back at her parents as she left the waiting room. She was friendly and outgoing, and said she wanted to stop lying but she just didn't know how. In treatment, her parents worked diligently to set appropriate limits and develop a reward system for being truthful, and Josie seemed to be on board with joint plans, but whenever she thought she had done something wrong, she felt she could not stop herself from lying about it, and this behavior remained unchanged.

In another case, Willie, 10 years old, and his two dads came in because of his aggressive behaviors at home and in school. He also was stealing from his parents and brother as well as occasionally stealing from peers at school. Willie had been with the family for 14 months and although they had become very attached to him, they were hesitant about finalizing the adoption because of his behavior problems. The parents were concerned that the closer it came to finalizing the adoption, the worse Willie's behaviors were becoming. Once again, standard evidence-based behavioral strategies were not effective in decreasing Willie's aggression and stealing. Although Willie felt he benefitted from learning relaxation and calming strategies such as deep breathing and muscle relaxation in sessions with the therapist, his aggression had not diminished significantly. He had been rejected by several previous potential adoptive placements because of fighting and was able to say that he was sure these parents would reject him too. He also felt that his prospective adoptive parents did not understand the importance of his African American culture, and he was concerned about how others would judge him for having two dads. Finally, he hated the organic food served in the house.

Mai Lei, age 9, had been adopted from China when she was 5 years old and had lived with her Caucasian American single mother for 4 years when they came in for therapy. Mai Lei had a great deal of difficulty speaking English correctly even after 4 years, though she understood everything that was said to her, and she was failing in school. Despite a great deal of tutoring and educational therapy, she had improved very little. Additionally, Mai Lei was quite withdrawn and wanted to be alone in her room. There was another Chinese girl in her condominium complex, and whenever

possible, Mai Lei spent time with that family, leaving her adopted mother feeling left out and rejected. Despite the best intentions of both her mother and her therapist, attempts to encourage more family interaction and closeness were not successful. For example, setting up rewards for spending time with her mom and not in her room did not help.

Through seeing cases such as those described here, clinicians at both University of California Los Angeles Training, Intervention, Education, and Services (UCLA TIES) for Families on the West Coast and Center for Adoption Support and Education (C.A.S.E.) on the East Coast recognized that such families needed a different approach to standard interventions. We noticed common patterns in these children who had known other caregiving situations than their adoptive families, many of which involved situations traumatic for the children. Believing that children are naturally resilient, we began to recognize that the behaviors that were so problematic in their current homes had almost always been adaptive in a previous traumatic or dysfunctional setting. So in looking at the examples described previously, review of records and interviews with parents almost always gave us a clue about the meaning of the children's difficult behaviors and how they may have helped the child cope and even survive in a previous abusive or neglectful situation. This provided the spark for our development of new interventions that took the child's traumatic history into account, both in tweaking evidence-based behavioral interventions and in introducing some attachment-based interventions consistent with the rich clinical literature on adoption dynamics.

For Josie, we realized that having been in at least seven different homes in 5 years, superficial friendliness to everyone was very adaptive. Such behaviors elicited positive reactions from constantly changing caregivers, and it would be dangerous to become too attached to any one person because her experience had been that the caregiver was likely to soon disappear. We also recognized that in her original home, her birth mother had been addicted to methamphetamines, and when high, she often became abusive to Josie when she sought attention or disturbed her, screaming and hitting her. One instance in the records described a situation (which led to her removal from the home the first time) in which her birth mother asked Josie whether she had taken a box that held some drugs. When Josie said she did, she was beaten severely. As a result, it became highly adaptive for Josie to deny any wrongdoing because admitting it led to traumatic consequences. Although lying also led to punishment at times, she sometimes did not get caught. The intensity of her anxiety would lead her to lie whenever confronted with possible undesired behavior.

Understanding these dynamics was necessary for the family and the therapist to be able to intervene in ways that took Josie's previous traumatic context into account in developing a therapeutic behavior plan, recognizing that her problematic behaviors had been adaptive and protective in a previous abusive caregiving environment. The adoptive parents learned not to confront Josie and ask if she had done something she was not supposed to, but instead to deal with it matter-of-factly so she did not have to lie. When the adoptive parents responded calmly and rationally to Josie's behavior and gave reassurances that she is loved and wanted no matter what

her behavior, along with appropriate consequences, Josie gradually learned that this family environment is safe and loving. Over time and with consistent safety and security in the adoptive family, her need to lie diminished greatly, and her sense of safety and security increased. Similarly, her need to be superficially friendly to people diminished as she developed a deeper attachment to her parents. For example, she began to have trepidation around certain strangers and would want to hold the hand of a parent in those situations.

In Willie's case, his behavior problems of aggression and stealing needed to be seen through the lens of his past history. His birth family had been gang involved, and he had witnessed a great deal of violence both at home and in his community by the time he entered foster care at age 5. At one point, his birth mother had taken Willie and gone to live on the streets to escape ongoing domestic violence from his birth father. After that, they were homeless for about 18 months before she returned to the birth father. During that time, she and Willie survived by stealing food from stores, combing through dumpsters, and begging on the street.

When considering his past history, it was clear that responding to strong feelings with aggression was normative in Willie's previous living situation and was modeled by his caregivers. Additionally, his stealing behavior (often stealing food or money to buy food) can be understood as an adaptive response to being homeless and hungry that helped Willie survive on the streets. Assisting the prospective adoptive parents to understand that these behaviors were helpful to Willie in his previous caregiving environment and to look at them from Willie's point of view allowed the dads to experience increased empathy for him. They were then more open to learning new strategies to manage his difficult behaviors. For example, Willie's parents acknowledged to him that they understood he sometimes had not had enough to eat or even warm clothes at times in the past. Noting that he must be afraid of being hungry and not having enough food, they provided a large bowl of acceptable snacks that he liked and made it available 24/7 and also brought some to the school that he could get from his teacher if he felt the need to steal food. They also decided to learn to make some of the foods that he had loved from his original family, such as shrimp and grits, and this turned out to be an important way in which the family incorporated Willie's birth culture into their lifestyle, helping him feel more connected to the adopting family. They also attended a support group made up of other same-sex couples and their children so that Willie could gain support from other children about issues that come up around being in a nontraditional family. Additionally, Willie's parents told him that they would always take care of him and make sure his needs were met. Although there were a couple of hiccups along the way, Willie's stealing decreased dramatically.

With regard to his aggressive behaviors, his parents came to understand both that aggression had been a problem-solving strategy in Willie's birth family and that his aggression had seemed to increase in his previous prospective homes as the adoption had begun to approach finalization, probably as a way of helping him feel he was rejecting the family before they could reject him. Armed with this new understanding, they were able to talk with him about the pattern and assure him that they wanted

him as part of their family regardless of how he might try to push them away. They noted how scary it must be to think that this might be his forever family.

With Mai Lei, it appeared that she and her mother had not really developed an emotional connection, which left Mai Lei unmotivated and depressed and her mother alienated and frustrated. It seemed as if Mai Lei still did not feel comfortable in the United States and held onto her language by avoiding learning English partly as a way of continuing to feel Chinese. After some initial defensiveness, her mother was able to look at their lifestyle and see that no aspect of Mai Lei's heritage was honored in their home. After brainstorming with the therapist, the mother decided that if Mai Lei was having trouble learning English, maybe she should learn Mandarin. After talking it over with Mai Lei, she enrolled in a conversational Chinese class. Mai Lei made fun of her efforts to speak Chinese at home but enjoyed giving her mom pointers on both vocabulary and pronunciation. The more her mother worked on her Chinese, the warmer and more animated Mai Lei became. Mai Lei's mother decided to subscribe to a Chinese language cable station and they were able to watch simple shows together with pleasure. Interestingly, as her mother's Chinese became better, Mai Lei's English proficiency improved as well. This intervention, although certainly not standard, addressed both the lack of attachment in the family and the child's mourning for her original culture.

As these examples show, we believe that to best serve adopted children, especially those most at risk for serious behavioral and emotional distress, the most useful treatment protocol is one that uses an adoption lens that takes into account the child's past history and addresses behavioral, developmental, and attachment-related concerns while building on the child's natural resilience, coping, and competence. We have developed an adoption-specific therapy protocol and named it adoption-specific therapy (ADAPT). This book presents clear, step-by-step instructions for delivering ADAPT, as well as an ongoing case example to illustrate activities and concepts. The book is intended for therapists who treat adopted children and their families.

ADAPT, developed over many iterations, combines what we know about evidence-based behavioral treatments for children and parents (e.g., Chorpita, Daleiden, & Collins, 2014; Eyberg, 1988; Webster-Stratton, 2011) with consideration of the child's past trauma history and adoption dynamics culled from best practices and the adoption literature. Although not yet subjected to rigorous research, the rich past literature on adoption dynamics (e.g., Barth & Miller, 2000; Brodzinsky, 1993; Fahlberg, 1991, 2012; Kerman, Freundlich, & Maluccio, 2009), widely accepted by practitioners specializing in this work, allows us to bring this piece of the puzzle into child behavior treatments. ADAPT was developed to standardize and to test this integration of adoption-specific therapeutic practices with evidence-based behavioral treatments. Interestingly, the large literature on adoption dynamics is targeted almost exclusively to parents (e.g., Berry & Berry, 2016; Caughman & Motley, 2009; Eldridge, 1999; Gray, 2002), and there are few studies to our knowledge that seek to systematically evaluate adoption-focused treatment programs, especially for older children adopted from foster care or orphanages.

Three Kinds of Adoption in the United States

There are three routes to adoption used by American families: domestic infant adoption, international adoption, and foster care adoption. In domestic infant adoption, a birth mother is matched with a family interested in adoption, usually through lawyers or adoption agencies specializing in this field, and they receive the child immediately after release from the hospital. Often the adopters pay the medical bills and living expenses of the birth mother and may be present at the birth. In 2014, approximately 16,312 infants were adopted through private agencies and 5,944 through private individual adoptions (Jones & Placek, 2017).

In international adoption, prospective parents usually work through an international adoption agency in, or with ties to, a particular country. Once a child is identified for them, they travel to the country and after a few days to weeks take the child home with the adoption complete from the providing country's viewpoint. Children are often infants but can be much older. Over the years, fewer countries have participated in international adoption; for example, China, which once was a prolific source, now prefers to keep the children in China, and Russia has also stopped adoptions to the United States. Statistics show that 5,370 children were adopted from other countries in 2016 (U.S. Department of State, 2017); international adoptions have declined steadily from a high of 22,989 children in 2004 (Leinaweaver, 2017). Of those adopted in 2016, the largest group were 5- to 12-year-olds, followed by 3- and 4-year-olds. Despite great decreases in the number of children available for international adoption, China sent the most children: 2,231.

In foster care adoption, children are removed from the birth parents because of abuse or neglect, and if there is not an appropriate birth family member to care for the children, they are placed with a foster family who may or may not wish to adopt. The birth family then receives reunification services, including possible drug treatment, psychotherapy, parenting assistance, and so forth, and is granted progressive visitation with the children. If this is successful, the child returns to the birth family. If the birth parents are not able to provide a safe home, other relatives may step up and provide permanency for the child, either through kinship adoption or legal guardianship. If reunification with a family member is unfortunately not possible, family reunification services are terminated and a permanency plan such as adoption is made. Birth families may still have visitation while the decision about whether to terminate the birth parents' rights is being made. Furthermore, even if the birth parents' parental rights are terminated and the child joins an adoptive family, the birth parents sometimes remain connected to the child by some means, whether sharing photos or special events or having ongoing visitation if that is safe for the child. More and more, this arrangement, called "open adoption," is advocated. In 2015, almost 270,000 children entered foster care, with neglect (61%) and parental drug abuse (32%) accounting for the lion's share of new cases. Of the 427,000 children in foster care in 2015, 111,820 were waiting for adoptive families, and 53,549 children were adopted from public foster care during 2015. The number of adoptions from foster

care has been quite stable over the last decade, with about 21 % of children who exit foster care being adopted. According to The Adoption and Foster Care Analysis and Reporting System, in 2015 the mean age of adoption from foster care was 6.2 years (Child Welfare Information Gateway, 2017; U.S. Department of Health and Human Services, 2016).

This book focuses mostly on children adopted past infancy through foster care or internationally because they are among our most vulnerable children. Not only have they lost their birth family and often a cultural heritage, but many have also suffered multiple placements or orphanage care that may lead to repeated loss of caregivers, abuse and neglect, and trauma in their homes and their communities. As discussed further in Chapter 1, children adopted at older ages experience significantly more behavioral and educational problems (e.g., Gleitman & Savaya, 2011; Nadeem et al., 2017; Sharma et al., 1996b; Waterman et al., 2013).

However, although ADAPT's focus on loss, grief, and trauma will be most relevant to families adopting from foster care or internationally, many of the exercises are useful for any adoptive child or parent, regardless of how old the child was at the time of adoption or how much trauma they have experienced. These exercises will help families understand adoption, form close bonds, and deal with others' attitudes about adoption.

Adoption-Specific Therapy: The ADAPT Curriculum

As illustrated by the case examples presented here, we have come to realize that it is necessary to process certain common aspects of these children's experiences as well as those of the adoptive parents who care for them to optimize successful family formation and to heal past deeply felt wounds. For example, we support open discussion about all aspects of adoption and believe that all information about the child's past, no matter how heinous or painful, should be shared with the child as developmentally appropriate. We also believe that the grief and loss about previous caregivers must be honored and facilitated. Often parents want to reassure children that now that they are in their adoptive home, everything will be fine. We want to help adoptive parents accept and understand the sadness and yearning that most adoptees feel for their birth families even if the birth parents were highly abusive to the child. Although these feelings are most pronounced for older children who have memories of living in and leaving their previous caregiving situation (birth family, foster family, or orphanage), children adopted at birth also feel similar feelings and wonder what was it about them that led their parent to give them up or be unable to care for them. There are also significant identity issues that arise for adopted children as they get older, particularly in transracial adoptions, and these must be addressed as well. If there is significant trauma in their backgrounds, children need to be able to process these with the therapist and view their parents as a supportive resource when they are experiencing posttraumatic stress.

Dealing with such adoption- and trauma-related issues is necessary to successfully treat the significant behavioral and emotional symptoms that bring adoptive families to seek treatment. ADAPT combines evidence-based child coping strategies and positive parenting approaches—largely from cognitive behavioral therapy and modified to take into account the child’s past history—with resiliency-focused, trauma-competent, attachment-based treatment that addresses adoption-related issues of parent–child bonding, loss and grief, developmental understanding of adoption dynamics, identity development, and birth family connections. In each of the seven modules of adoption-specific therapy (20–24 sessions total), parents and children meet separately for several sessions and then come together for a family session. Although the focus of the ADAPT intervention is on children adopted past infancy, we have found that children adopted at birth and their parents can also benefit significantly from adoption-specific therapy.

In Chapter 1, we discuss the theoretical and empirical underpinnings of our approach. Chapter 2 presents an overview of ADAPT, including our basic beliefs about adoption, a summary of module content, and who should use this approach and how. In Chapters 3 through 9, we present the modules with detailed instructions for therapists on how to use the approach with families, along with the ongoing case example of the Springfield family, which illustrates how each session may unfold. In Chapter 10, we discuss the termination session.

Many of the treatment activities described in this book involve handouts. There are 60 handouts in total, all of which can be downloaded for free from the book’s companion website (<http://pubs.apa.org/books/supp/waterman>). Interested readers may also purchase a supplemental ADAPT toolkit from C.A.S.E. for \$95.99 (see <http://www.adoptionsupport.org>).

We are passionate about supporting the resilience of adopted children and their families and hope that you will find adoption-specific therapy very helpful in your own work.