LISTENING TO ADOPTIVE FAMILIES IN RESIDENTIAL TREATMENT:
Moving from Observations to Family-Centered Practice

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AACRC Annual Meeting
April 8, 2011
25% of Walker long-term clients have been adopted or are in the pre-adoption process

Of Walker’s 275 day and long-term residential clients in the past 5 ½ years:

• 43 were legally adopted at the time of admission. (3 of these adoptions dissolved while at Walker)

• 7 were in a pre-adoptive setting at admission.

• 10 were seeking an adoptive match at admission.

• 7 once had been adopted or in a pre-adoptive setting, but the placement had terminated prior to admission.

All students enrolled in Walker’s day and long-term residential programs between 7/1/2005 and 2/28/2011
Definitions

Lack of standardized definitions among states and in the literature

- **Instability**: Ranges from severe dissatisfaction with the placement to termination
- **Termination**: Umbrella term describing both disruption and dissolution
- **Disruption**: Termination of an adoptive placement prior to legalization
- **Dissolution**: Termination post-legalization
Proportion of Legally Adopted Children at Walker is 8x Higher than National Rate

All Children in the US
- Not adopted: 98%
- Adopted: 2%

Children at Walker
- Not adopted: 84%
- Adopted: 16%

National data from US Census 2000. Walker data from all students enrolled in the day and long-term residential programs between 7/1/2005 and 2/28/2011 (n=275)

p<.001
Overview of the Project

• How can we achieve better outcomes for adoptive families in residential treatment?

• **Methods:**
  – Literature review
  – Extensive review of 23 case records of all long-term residential students enrolled 7/1/05 - 2/28/11
  – Interviews with 10 families
PART I: Literature Review
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Different types of adoption</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Overrepresentation of adopted children in mental health settings and special education</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Similar presenting issues as non-adopted kids in mental health settings, yet key differences in info, access and adjustment</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Need for long-term post-adoption services (e.g. respite)</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Risk factors for instability</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>Absence of clinical best practices for adoption dissolution</td>
</tr>
</tbody>
</table>
Different Types of Adoption
All Adopted Children under 18

2007 National Survey of Adoptive Parents, USDHHS
Overrepresentation of Adopted Children in Mental Health/Special Education

- Most adoptions don’t require extensive outside supports
- However, overrepresented in psychiatric or mental health settings, special ed. programs
- Higher prevalence of adjustment problems, externalizing disorders, conduct disorders and antisocial behaviors
- Most disruptive symptoms begin to emerge around ages 5-7

Brodzinsky (1993); Brodzinsky and Steiger (2001); Cited in Barth and Miller (2000); Dickson et al (1990); Testa (2004)
Diagnostic History for Adopted Children vs. All US Children

2007 National Survey of Adoptive Parents, USDHHS

All US children under 18
Adopted children only

Diagnosed at...
* Age 6 or older  
** Age 2 or older  

- ADHD*: 10% vs. 26%  
- Behavior/conduct problems**: 4% vs. 15%  
- Attachment Disorder: <1% vs. 12%  
- Depression**: 4% vs. 9%  

p < .05
Differences Between Adoptive & Non-Adoptive Families Receiving Treatment

• Lack of information on child’s early history, birth family medical history

• Adjustment of family roles/family integration

• Generally higher levels of parental education

• Institutional history (international adoptees)

• Access to post-adoption services

Barth and Miller (2000); Glidden and Pursley (1989); cited in Kramer and Houston (1998); McGuinness and Pallansch (2000); Partridge et al. (1986); Rosenthal and Groze (1990)
Need for Long-Term Post-Adoption Services

- Many pre-adoption services available, but dearth of services available after adoption
- Often accessed to respond to behavioral symptoms
- Services with the best outcomes:
  - Respite care
  - Support groups
  - Parent mentoring
- Under-accessed in comparison to reported need, particularly respite
- Long-term services are more successful

Barth and Miller (2000); USDHHS (2002); cited in Wind et al (2007)
Risk Factors for Adoption Instability

- Adoptions of older children
- History of trauma, abuse, neglect
- Severe behavioral and emotional challenges
- Weak social support network for family
- Lack of prior knowledge about child's pre-adoptive history and behavioral challenges

Barth and Berry (1988); Barth and Miller (2000); Festinger (1986); Goerge et al (1995); Howard and Smith (2001); Howe (2007); McDonald et al (2001); McRoy (1999); Reilly and Platz (2003); Rosenthal (1993); Rosenthal and Groze (1990); Smith and Howard (1994); USDHHS (2004)
Other Risk Factors for Adoption Instability

• First three years after the adoption
• One parent not as committed to the adoption
• Parent's lack of willingness or ability to advocate for services
• Inexperience caring for children with special needs
• Absence of meaningful pre-adoptive relationship with the child
• Inflexible, unrelaxed parenting style
• Parent having unrealistic expectations for child

Barth and Berry (1988); Barth and Miller (2000); Berry and Barth (1990); Coyne and Brown (1985); Festinger 1986; Howard and Smith (2001); McDonald et al (2001); McRoy (1999); Partridge et al (1986); Rosenthal et al (1988); Smith and Howard (1991); Wind et al (2007)
Adoption Dissolution

- No peer-reviewed literature on how to best work with families considering/pursuing adoption dissolution

- The more endangered the adoption, the less guidance available

- Lack of accurate, standardized data on termination across states and research studies

- Estimate: Only 1% of legalized adoptions dissolve
PART II:
Review of Case Records
A Look at the Population of Adopted Clients in Walker’s Long-Term Residential Program

- 16 boys, 7 girls
- Types of adoption:
  - Most (60%) adopted from foster care; the rest were international (Russia, Romania) or domestic adoptions
  - One kinship adoption
  - One-third adopted as part of a birth sibling set
- Age at adoption:
  - Ranged from at birth to 8 years old
  - Mean age: 3 years, 9 months (average lived with family for a little over a year before legalized adoption)
A Look at the Population of Adopted Clients in Walker’s Long-Term Residential Program

• At least 18 of the 23 children had experienced trauma or neglect prior to adoption

• One-third separated from birth parents at birth, while mean age was a little under 2 years

• Some were separated, then reunited with birth parents multiple times before adoption

• One-third went immediately to their adoptive family; the rest had between 1 and 15 foster/institutional placements (Median: 2)
A Look at the Population of Adopted Clients in Walker’s Long-Term Residential Program

• Most adopted by 2 married parents; the rest adopted by single mothers

• Half had other children in family at the time of the adoption

• Adoptive parents tend to be in their late 30s or early 40s

• Over half of the families noted worrisome behaviors within year of adoption (many from Day 1); 80% within first 2 years

Adopted children enrolled in Walker’s long-term residential program on or between 7/1/05 and 2/28/11 (n=23)
Comparison Between Walker’s Adoptive and Non-Adoptive Clients

- No differences in presenting issues at intake (just as apt to present with aggression, self-stimulation, running, sexualized behaviors)

- Markedly longer mean stays in residential treatment

- Adopted parents more apt to reject the initial proposed discharge date

- Greater incidence of neurodevelopmental diagnoses, ADHD and sensory integration deficits

- Less apt to have information about birth history and prenatal care

- Child more apt to have been exposed to drugs or alcohol in utero
On average, adopted children’s length of stay is 6 months longer than non-adopted kids.

All children enrolled in Walker’s long-term residential program on or between 7/1/05 and 2/28/11 and who discharged by 2/28/11 (n=119); first residential treatment stay only.
Parents of Adopted Clients 9x More Apt to Reject Initial Proposed Discharge Date

All children enrolled in Walker’s long-term residential program on or between 7/1/05 and 2/28/11 (n=147)

p < .001
Certain Diagnoses More Prevalent Among Adopted Clients

Enrolled in Walker’s residential program on or between 7/1/05 and 2/28/11

ADHD and Attachment: p<.05; others not statistically significant
Prenatal History for Adopted vs. Not Adopted Clients

Enrolled in Walker’s residential program on or between 7/1/05 and 2/28/11

- No information about birth history
  - Adopted: 40%
  - Not Adopted: 7%

- Actual or suspected exposure to drugs or alcohol in utero
  - Adopted: 65%
  - Not Adopted: 17%

p < .001
PART III: Interviews with Parents
Overview of Interviews

- 10 interviews with parents of clients currently or recently enrolled in our long-term residential program
  - Combination of foster care, international and private domestic adoptions
  - 6 interviews with mothers only, 4 with both parents present
  - 7 had children who had discharged from the program
  - 9 interviews with parents with intact adoptions, 1 interview post-dissolution
  - Many interviews were lengthy and deeply emotional
What They Told Us: Journey to Adoption

• Diverse and different adoption journeys (infertility, from foster care, planning a family as a single parent)

• Lots of resources before adoption

• Fewer resources and no clear roadmap when trouble starts after adoption

• Few knew a lot about child or birth family history before adoptive placement

• Many feel deliberately misled by adoption agency (especially international and foster care system adoptions)
What They Told Us: *Emergence of Symptoms*

- Problems generally surfaced right away, or at least within first 2 years
- Most troublesome problems most frequently cited:
  - Violence and physical aggression
  - Sleep, eating, and sensory difficulties
  - Impulsivity and ADHD
  - Inability to self-soothe
  - Unresponsive to parents’ physical nurturance
  - Self-injury
  - Few friends, few social skills
- Lots of stories about living in fear of personal safety of siblings, pets, themselves; fears increase as parents picture managing the child as an adolescent
What They Told Us: Getting Help and Support

- All families recounted a long journey to get help before coming to Walker:
  - Many “renowned experts” and attachment therapies
  - Many doctors, clinicians and assessments
  - Many labels (especially bipolar and RAD)
  - Many psychotropic medications

- Some but not all parents relate becoming isolated from, family, friends, and community
  - Support groups were helpful to some families, but not all
  - Some parents started their own support networks
  - Some parents felt enduring support from family, close friends, church communities
What They Told Us:

Seeking Residential Treatment

• Many parents report putting off decision to seek residential treatment, even after it was strongly recommended

• Decision usually made after multiple traumatic hospitalizations

• Frequently said: “We waited too long.”

• Many parents report long battles with funding agencies to get needs met at appropriate level of care, both before and after Walker
What They Told Us:
Enduring Stress on the Family

• Some parents said had no choice but to give up or downsize careers

• Two divorces reportedly at least partially due to post-adoption stress

• Many families thought about terminating the adoption but most report never seriously considering it; cited love, duty, and religious faith for making termination an impossible option

• Even so, 6 of the families we interviewed do not see the child living at home full-time for the foreseeable future

• One interview with parent who did terminate the adoption was highly emotional, very regretful; felt helpers left no option
What They Told Us: Mixed Reactions to Walker’s Residential Treatment

- Almost all felt their child was supported and safe at Walker.
- Almost all stressed coming to Walker was not about adoption or attachment, but about very acute family safety issues.
- Several families felt Walker did not listen to the reality of their fears.
- Many felt discharge artificially set by funders, with Walker backing the funders, not the family.
- Some parents felt blamed by Walker staff when families tried to limit time at home.
- Two families cited Walker as paying too little attention to siblings.
- 5 of the 7 families who had left Walker criticized lack of relevant discharge planning and overall lack of support at discharge.
What We Heard and Took Away

• Walker’s practice with high-stress adoptive families probably needs to change.

• Three powerful messages emerged:
  – Trauma x2
  – Permanence with distance
  – Fractured family partnership
“I’m terrified of him being at home, of him hurting me or hurting himself. I can’t control it anymore. When he was small, I could control it better. But if he comes after me now, there’s no way I could protect myself.”
“Permanence for him doesn’t necessarily mean living in a family. Yes, I’d like him to return home someday, but it’s certainly not a viable option for the foreseeable future.”

“He cannot come home. He does not belong there...I’m his mom; I just can’t allow for him to disintegrate again.”
“There’s a lot of lip service about family-driven care but when there’s a final line in the sand about a big decision, it comes down to you bureaucrats, not the family.”
Key Quotes from the Interviews: On Seeking Permanence with Distance

“Nobody likes the idea of a child being institutionalized over long periods, but the belief that the child does best in a family setting is a misguided ideal. You need to reconsider the view that all children thrive on living with a family. It’s too simplistic when a child like mine spent his early years neglected in an orphanage. My son doesn’t know how to be in a family. The thing that you say would benefit him the most is the most stressful possibility for him. Permanence for him doesn’t necessarily mean living in a family. Yes, I’d like him to return home someday, but it’s certainly not a viable option for the foreseeable future.”

“My son and I needed Walker as an extended family. If he could just have been able to stay Walker, I wouldn’t have had to terminate the adoption.”

“For years, I shunned the idea of hospitalizing him or putting him in residential treatment. I thought that removing him from the home would be the worst trauma for my son. But once I made the decision to put him in residential, I knew that was where he belonged. He could not come home. He does not belong there. And now I have to constantly crusade so that won’t happen. I’m his mom; I just can’t allow for him to disintegrate again.”

Some minor details in quotes have been altered slightly to ensure the family’s confidentiality.
Key Quotes from the Interviews: On Discharge and Returning Home

“There’s a lot of lip service about family-driven care but when there’s a final line in the sand about a big decision, it comes down to you bureaucrats, not the family.”

“I’m terrified of him being at home, of him hurting me or hurting himself. I can’t control it anymore. When he was small, I could control it better. But if he comes after me now, there’s no way I could protect myself.”

“I was scared to death. I felt like you just pushed him at me.”
Key Quotes from the Interviews:
On Seeking Help and Working with Helpers

“We’ve probably met over a hundred people in the last four years, just trying to get help.”

“Before we got to Walker, it was just a crapshoot when the doctors would diagnose her. ‘Maybe she has this. Maybe she has that. Let’s try this medication. Okay, well, that didn’t work, so let’s try this instead.’ It was so scary, and we were just so helpless.”

“I wanted a label for her. I wanted to know what was making this happen and what I could do to fix it – that it was not just me being a bad mother. I was relieved to hear, ‘It’s ADHD. Here’s your prescription. See you in a month.’ I just wanted an answer of some kind.”

“So much talking, in so many places with so many people, all about our son. It never ends.”