A Need to Know

Enhancing Adoption Competence among Mental Health Professionals

THE DONALDSON ADOPTION INSTITUTE

David M. Brodzinsky, Ph.D. • August 2013

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Policy Perspective

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EXECUTIVE SUMMARY

Lori and Robert adopted their sons from foster care when they were 1 and 3 years old; they had been removed from their family of origin after being neglected and physically abused by their parents, who are alcoholics, and had lived in three temporary homes before their adoptive placement. The consequences of the boys' early maltreatment were considerable: defiance, aggression, stealing, attachment problems, learning challenges and more. The succession of mental health professionals from whom Lori and Robert sought help for several years didn't appear to know what to do; they often blamed the parents for their children's lack of improvement and didn't seem to understand the trauma being experienced by all the family members every day.

Adoption issues were seldom raised by any of the therapists – except for one, who suggested the children's problems could be unresolvable, so Lori and Robert might want to consider returning them to foster care. They loved and were committed to their boys, however, so they never considered that option. Instead, with the help of online advice from other adoptive parents, they found a mental health practitioner with expertise in adoption-related issues, and their sons finally started making substantive progress. "We needed help from professionals who weren't only skilled therapists, but who also knew about adoption," they later reported. "It was difficult to find the help. … Thank God we finally did. … It saved our children and our family."

Every sort of family has its particular dynamics, concerns and complexities, whether related to divorce and blended families; single-parent families; families headed by gay/lesbian parents; etc. Adoption is no different; indeed, while it is an overwhelmingly positive institution for children who need the stability and nurture of permanent families, it can often be complicated, encompassing issues from addressing grief and loss for first/birth parents, to shaping positive racial/ethnic identity for children, to dealing with the impact of early adversity, to navigating relationships between adoptive and birth relatives. For many of the millions of people for whom adoption is part of everyday life, these and numerous other issues can be profound and enduring – and, pointedly, can require counseling and other services from a variety of professionals, including child welfare specialists, mental health practitioners, physicians, educational advisors and teachers. Unfortunately, adoptive parents, adopted individuals (as children and adults) and birth relatives often encounter significant barriers in their efforts to obtain the assistance they seek and need.

One of their most frequent complaints is their inability to find mental health care and ancillary service professionals who are adoption-competent – that is, who understand the unique issues associated with their histories and current lives, and how adoption can color or even shape their views of themselves, their identities and their relationships. This point is reflected in a

number of studies over time, including a recent survey on the experiences of adoptive families with mental health professionals (Atkinson, Gonet, Freundlich &, Riley, in press). Over 81 percent of the 485 respondents (84% of adoptive parents and nearly 77% of adopted persons) reported working with one or more mental health professionals. Of those who did, slightly fewer than 25 percent believed the professionals were adoption-competent; another 50 percent indicated some of the professionals were adoption-competent but others were not; and 26 percent said none of the mental health providers they saw knew much about adoption. Some respondents reported experiences with therapists that actually damaged their families. Areas in which therapists were viewed as especially insensitive or lacking in adoption knowledge included attachment, trauma, loss and use of appropriate language.

For a variety of reasons, mental health professionals typically do not receive the training required to fill adoption-related counseling needs and, too often, either do not fully understand why such training is necessary or mistakenly believe the knowledge they already have is sufficient. To address that reality, this report by the Donaldson Adoption Institute seeks to raise the level of awareness among mental health professionals about the nature and importance of adoption clinical competence, heighten their desire to receive such training, and identify various means by which the relevant knowledge and skills can be obtained.

Context and Primary Findings

- Successful adoption is tied to good preparation of all parties prior to placement and to the availability and utilization of effective supports and other help, including counseling, afterward. Adoption-competent therapists are high on – and sometimes at the top of – the list of services that members of adoptive and birth families want and need.
- Genetic risk and early trauma (primarily for children adopted from foster care or institutions) do not inevitably undermine development. Two key factors that facilitate their recovery are comprehensive pre-adoption preparation and education of families, along with the availability and utilization of informed mental health services.
- Graduate education in relevant fields does not usually include adoption issues. A survey of directors of clinical training programs in marriage and family therapy, social work or counseling found only about 5-16 percent offered adoption-specific coursework. Two-thirds of licensed psychologists in a national survey reported no such graduate coursework; fewer than one-third rated themselves as well or very well prepared to treat adoption issues, and 90 percent said psychologists need more adoption education.
- The limitations of medical insurance can pose significant barriers to accessing adoption-competent therapists. Most insurance doesn't provide sufficient mental health coverage to cover the complex, long-term needs of those involved, particularly children who have

suffered early trauma and other adversity; and few if any carriers take into account that adoption-competent therapists may not be on their lists of covered, in-plan providers.

- Which practitioners are adoption-competent is not always clear or easy to determine, in part because adoption counseling has not yet been identified as a professional specialty in the health care fields, with clear guidelines for training, practice and credentialing. Without an appropriate process, many individuals and families will continue to be treated by professionals who are inadequately prepared to understand and help them.

Adoption competence begins with a solid foundation of knowledge and clinical skills gained through an approved graduate program in psychiatry, psychology, social work, marriage and family therapy or counseling. Meeting the needs of individuals and families touched by adoption also requires *specialized* training in assessment, diagnosis and intervention. At each phase of the clinical process, therapists must be attuned to the complex array of historical and contemporary factors impacting the lives of their clients and, specifically, to the ways in which the adoption experience can influence their identity, relationships and development.

Recommendations

- Develop Certification for Adoption Clinical Competence. People want and need to know that the professionals they are working with have the requisite knowledge, skills and experience to meet their needs. This should apply in the adoption realm as much as in any other, so a certification for adoption clinical competence should be developed.
- Expand Adoption Training Programs across the Country. Nearly all existing programs require training in classroom settings, so the number of available professionals is restricted to those who live within commuting distance of current sites. Training needs to expand through more programs and the use of technologies such as webinars, "flip teaching" and "massive open online courses."
- Strengthen the Clinical Components of Existing Training Programs. This can be accomplished by increasing the number of required clinical courses for mental health practitioners; offering additional clinical courses as electives; and/or offering additional clinical courses as stand-alone, post-certificate, continuing education courses. All programs also should offer some type of clinical supervision.
- Develop Outreach Efforts to Inform Mental Health Providers about the Need for Adoption Competency and Opportunities for Enhancing their Knowledge. Broad-based outreach initiatives should be developed to increase awareness on the need for adoption-competence, to identify opportunities for training among mental health professionals, and to explain the benefits of developing this specialized knowledge.
- Educate Insurance Providers about the Unique Nature of Adoption Issues and Advocate for Expanded Coverage. Concerted efforts must be made to educate insurance providers

about the unique clinical needs of individuals and families affected by adoption-related issues. This process will be greatly helped if the mental health field overtly recognizes the value of adoption clinical certification and supports its development.

- Encourage Graduate Training Programs and Post-Graduate Clinical Training Centers to Include More Information about Adoption and Foster Care in their Curricula. The better grounding in these areas that professionals receive while in training, the better prepared they will be to serve the needs of adoption kinship members and to seek to expand their expertise on adoption- and trauma-related issues.
- Encourage Research on Training Effectiveness and Outcomes. To better serve the training needs of professionals and the well-being of adoptive kinship members with whom they work, the Institute recommends that researchers examine the effectiveness of training programs in terms of knowledge gained by participants, changes in clinicians' practices as a result of training, and clients' progress and satisfaction with services.

Conclusion

For a variety of reasons, adopted individuals and their families are more likely to use mental health services than is the general population. Helping adoptive parents manage these life complexities for themselves and their children can be a challenge, often requiring the help of professionals. Adopted individuals, as children and through their life cycles, can encounter a range of concerns (e.g. ones related to identity) with which they want and need professional assistance. Furthermore, birth/first mothers and fathers also frequently need the services of mental health counselors as they struggle to cope with their loss and, for a growing number of these individuals, to find satisfying ways of managing ongoing relationships with their children and their adoptive families. Mental health and allied professionals must be prepared to meet the needs of these individuals and families. They must possess not only the foundations for competent clinical practice, but also a deep understanding of the unique issues involved.

INTRODUCTION

Robert and Lori, a Caucasian couple, adopted two Hispanic brothers, 4 and 6 years of age, who had been placed in foster care three years earlier following neglect and physical abuse by their alcoholic parents. The boys had lived in three foster homes before their adoptive placement. This was the couple's first parenting experience.

Robert and Lori reported that the first few months after placement were relatively problem-free, but difficulties with the boys emerged soon after. Defiance, aggression, stealing, emotional withdrawal, attachment problems, impulsiveness and learning challenges were quickly identified, leading the new parents to seek counseling at a community mental health center. After a year of treatment, with little progress to show for their efforts, they terminated services and sought help from a series of psychologists and clinical social workers over the next two years – all to no avail.

They often felt blamed by the professionals for their children's lack of progress, and they did not believe any of them either understood the trauma experienced by their sons or the level of stress faced by all family members every day. They noted that adoption-related issues were seldom discussed in therapy, except by the last psychologist they consulted. He told them that most adopted children had significant emotional problems and that the early adversities experienced by the boys, coupled with living in multiple foster homes, was sufficiently traumatic that they probably would never recover. When the psychologist suggested they contact their agency to explore the possibility of dissolving the adoption, they knew they were working with the wrong individual.

Loving their children and committed to preserving the adoption and healing family relationships, Robert and Lori made a concerted effort to locate a mental health professional with expertise in adoption. With the help of online advice from other adoptive parents, they eventually succeeded. Two years later, with a great deal of hard work by all family members, the parents reported that they had largely achieved their goal. Although their sons occasionally resisted family rules and still had learning issues, they were no longer aggressive or stole from others, and were becoming more secure in their family relationships.

"We needed help from professionals who weren't only skilled therapists, but who also knew about adoption ... it was difficult to find the help ... thank God we finally did ... it saved our children and our family."

Since its inception as a formal social service in the early 20th Century, adoption has been viewed as a rational, ethical and humane way of ensuring safety, nurturance and family stability for children whose biological parents are unable or unwilling to provide for their physical, emotional, psychological and educational needs. In the vast majority of cases, adoption has proven to be an unqualified success, especially when compared to the outcomes for children who remain in neglectful and abusive homes, who experience multiple foster placements or who grow up in institutional environments (Hoksbergen, 1999; Lee, Seol, Sung & Miller, 2010; Selwyn, & Quinton, 2004; Triseliotis, 2002; van IJzendoorn & Juffer, 2005).

Despite its success, adoption practice has grown more complicated over the years, with more and more children entering their new families at older ages following a history of neglect, abuse, institutionalization or other forms of trauma. These life experiences, coupled with the normative stressors associated with being adopted, have resulted in significant parenting challenges for adoptive families, often leading them to seek the services of mental health professionals (Brodzinsky, 2008; Casey Family Services, 2003; Smith, 2010; Tan & Marn, 2013; Tarren-Sweeney, 2010; Tarren-Sweeney & Vetere, 2013).

Adopted individuals and their parents are not the only members of the adoption kinship network who experience challenging life circumstances. Women and men who place children for adoption, and those who have children removed from their custody by child protective services, also display adjustment difficulties that frequently require assistance from professionals (Neil, Cossar, Lorgelly, & Young, 2010; Smith, 2006).

The experiences of adoptive families and birth/first parents seeking and utilizing mental health services are highly variable. Some are able to identify competent clinicians in their communities who have specialized training in adoption; when this happens, they typically feel quite satisfied with the services received. Others, however, report that professionals in their area do not understand the unique complexities associated with their life experiences or that it is difficult to find specialized clinical adoption services (Casey Family Services, 2003).

It is widely accepted by the professional community that successful adoption for all members of the adoption kinship system is tied to good preparation prior to placement and with the availability and utilization of effective supports and services, including counseling, afterward (Brodzinsky, 2008; Hart & Luckock, 2004; Smith, 2006, 2010; Tarren-Sweeney & Vetere, 2013). Adoption-competent therapists are high on – and sometimes at the top of – the list of post-adoption services that families most-frequently want and need (Casey Family Services, 2003; Smith, 2010). They also are viewed as important sources of post-placement support by birth mothers (Brodzinsky, Smith & On Your Feet Foundation, in press). For a variety of reasons, however, mental health professionals typically do not receive the training required to fill these

counseling needs and, too often, either do not fully understand why such training is necessary or mistakenly believe that the adoption-related knowledge they do have is sufficient.

This paper seeks to raise the level of awareness among mental health professionals about the nature and importance of adoption clinical competence, heighten their desire to receive such training, and identify different means by which the relevant knowledge and skills can be obtained. Existing post-graduate adoption training programs are identified and described[1], and recommendations are offered for improving clinical services to members of the adoptive kinship system and enhancing their awareness of and access to these services.

BACKGROUND AND RATIONALE

Mental Health Issues in Adopted Individuals and Adoptive Families

Research indicates that adoptive families are two to five times more likely to utilize outpatient mental health services than are non-adoptive families (Howard, Smith & Ryan, 2004; Keyes, Sharma, Elkins, Iacono, & McGue, 2008; McRoy, Grotevant, & Zurcher, 1988), and are four to seven times more likely to place their children in residential treatment centers (Elmund, Lindblad, Vinnerljung, & Hjern, 2007; Landers, Forsythe, & Nickman, 1996; McRoy et al., 1988). These figures partially reflect a lower threshold for seeking mental health services by adoptive families (Miller, Fan, Grotevant, Christensen, Coyl, & Van Dumen, 2000; Warren, 1992), but they are also due to higher rates of adjustment difficulties for their children. Higher rates of physical health problems also have been found among children adopted from foster care and from abroad (Chasnoff, Schwartz, Pratt, & Neuberger, 2006; Miller, 2005) and are believed to be a risk factor for post-adoption mental health diagnoses (Hussey, Falletta, & Eng, 2012).

Although research findings vary among studies – probably due to sampling and methodological differences – a relatively consistent pattern has been noted regarding adopted children's

[1] For the sake of transparency, the Institute acknowledges the past and/or current involvement of staff members with one or more adoption training programs. David Brodzinsky helped develop part of the training program at Rutgers University and for several years taught one of its training modules. He also developed and taught part of the training curriculum for the adoption clinical program at the St. Louis Psychoanalytic Institute. Finally, he has served as an external advisor and curriculum consultant for the adoption training program at the Center for Adoption Support and Education (C.A.S.E). Currently, he is a clinical supervisor for this program and serves as a member of a national task force convened by C.A.S.E. to explore possibilities of certification credentialing for adoption clinical competence. Susan Smith has taught part of the adoption training curriculum for the program at Portland State University; she also has served as a consultant and curriculum developer for the C.A.S.E. program and currently serves on the national credentialing task force for adoption clinical competence convened by C.A.S.E., Jeanne Howard has also taught at Portland State's adoption training program.

adjustment (see Brodzinsky, Smith & Brodzinsky, 1998; Harwood, Feng & Yu, 2013; Juffer & IJzendoorn, 2005; and Smith, 2010 for reviews of this literature). Among the key findings are:

- Adopted children and youth show higher levels of psychological and academic difficulties compared to their non-adopted peers, although the majority are well within the normal range of adjustment.
- Differences tend to be greater for learning problems and externalizing symptoms such as attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder than for internalizing symptoms, although a number of studies have found group differences for the latter as well.
- The magnitude of adjustment differences between adopted and non-adopted children and youth, even when statistically significant, is generally small to moderate in effect size, with the exception of mental health referral rates, for which there is a substantially larger group difference.
- Problems manifested by adopted children, especially those placed in infancy, typically do not emerge until the school age years.
- Higher rates of problems are found in later-placed boys and girls, especially those identified as having special needs, than in those adopted early in life.
- Problems among adopted youth often intensify during adolescence.
- By adulthood, most differences between adopted and non-adopted individuals are less prominent, although adoptees still show higher rates of adjustment problems.

Over the past 20 years, psychological research has shifted from comparative analyses of adopted versus non-adopted individuals to questions concerning the reasons for adjustment difficulties among adopted children and youth (Palacios & Sanchez-Sandoval, 2005; Palacios & Brodzinsky, 2010). There are a range of adoption-related issues that can present challenges to those involved in adoption, including identity, loss, a sense of difference, and others. Perhaps the most important conclusion of recent research related to the adjustment of adopted children, however, is that many of the emotional and academic problems they manifest have less to do with being adopted *per se* than with an array of biological and experiential risk factors that pre-date adoptive placement, as well as the failure of adoption professionals to adequately prepare, educate and support parents in managing the challenges they face in the post-adoption years.

Children adopted from the public child welfare system are a more-vulnerable group than are those placed domestically by private agencies or placed from other countries (Harwood et al., 2013; Howard, Smith, & Ryan, 2004; Tan & Marn, 2013). Numerous investigators and adoption scholars – including but not limited to Brodzinsky (2008), Caspers, Paradiso, Yucuis, Troutman, Arndt, et al. (2009), Colvert, Rutter, Kreppner, Beckett, Castle, et al.(2008), Gunnar & Kertes

(2005), Harwood et al. (2013), Johnson & Gunnar (2001), Juffer, Palacios, LeMare, Sonuga-Barke, Tieman, Bakermans-Kranenbug, et al., (2011), Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski (2007), Rutter (2005), Smith (2010), Tan & Marn (2013), Tienari, Wynne, Sorri, Lahti, Laksy, et al. (2004), and van IJzendoorn, et al. (2011) -- have identified the following key pre-placement factors that increase the risk for adopted children's later adjustment difficulties:

- Birth parents who suffer from genetic-based psychiatric and personality problems
- Prenatal malnutrition and low birth weight
- Prenatal exposure to alcohol or drugs
- Prenatal exposure to chronic stress
- Early deprivation through inadequate parenting, neglect or institutional rearing
- Maltreatment and trauma, including physical, sexual and emotional abuse
- Multiple placements and relationship disruptions prior to adoption
- Exposure to caregiver psychopathology and domestic violence
- Inadequate adoptive parent preparation, education and support

The impact of early life adversity on neurobehavioral development has received considerable attention in recent years (Lanius, Vermetten, & Pain, 2010; Nelson, Bos, Gunnar, & Sonuga-Burke, 2011). The picture that is emerging is of particular importance to the adoption community because of the high incidence of early trauma and relationship disruption in the lives of girls and boys who are adopted, especially those placed from the child welfare system and from institutions abroad. Adverse prenatal experiences and those in the early postnatal years have been shown to negatively affect both the structure and functioning of the brain, undermining the development of attachment security, emotion regulation, impulse control, social interaction, executive functions, and learning.

Of particular concern is the neurobehavioral impact of institutionalization, a very common experience in children adopted from other countries. Findings indicate that severe deprivation associated with orphanage life is linked to abnormalities in brain volume, metabolism, neural connectivity, limbic system (e.g., amygdala) regulation and neuroendocrine stress reactivity, all of which increase the chances for long-term negative developmental outcomes (Chugani, Behen, Muzik, Juhasz, Nagy, & Chugani, 2001; Eluvathingal, Chugani, Behen, Juhasz, Muzik, et al., 2006; Gunnar, Morison, Chisholm, & Schuder, 2001; Kertes, Gunnar, Madsen, & Long, 2008; Marshall & Kenney, 2009; Mehta, Golembo, Nosarti, Colvert, Mota, et al., 2009; Nelson et al., 2011; Wismer Fries, Shirtcliff, & Pollak, 2008).

Fortunately, genetic risk and early trauma do not inevitably undermine development. Being raised in a stable and nurturing home, with parents who are well-adjusted and emotionally attuned to their children's needs, often protects children from developing serious psychological

problems and/or facilitates developmental recovery, at least partially, in those who have been affected by earlier life adversities (van IJzendoorn & Juffer, 2006; Palacios & Brodzinsky, 2010). These findings should give hope to families adopting children with special needs and to the mental health professionals who work with them. Two important factors that facilitate recovery for these children are comprehensive pre-adoption preparation and education of families, along with the availability and utilization of mental health services following placement (Brodzinsky, 2008; Smith, 2010). Effective pre-adoption preparation begins with full disclosure about children's backgrounds, the implications of earlier experiences for future development, and the ways in which parents, with support from professionals, can facilitate healing in adopted youth. When pre-adoption preparation is transparent, objective, balanced and supportive, parents are more likely to develop the knowledge, expectations and skills necessary to understand and meet the unique needs of their children. Furthermore, when help-seeking is normalized by adoption professionals and reframed as a family strength (rather than as an admission of weakness or failure), adoptive parents are much more likely to utilize mental health and counseling services. Parents of at-risk children should be encouraged to seek the support of adoption-competent professionals as soon as possible so as to better understand their children's ongoing needs and find effective ways of meeting them.

In summary, elevated risk for psychological and academic problems among adopted children and youth is often linked to multiple pre-placement adversities. In fact, these early life disruptions and traumas may account for the majority of developmental deviations and adjustment difficulties for these individuals. They may also impact the ability of children and their parents to cope with normative challenges associated with adoption and post-placement family life (Brodzinsky, 2011, in press; Brodzinsky & Pinderhughes, 2002; Smith, 2010).

Normative Challenges Related to Adoption

Although being adopted can benefit children by stabilizing their lives, providing them with family permanence, and affording them opportunities for healthier growth and development than they might not have had otherwise, it also presents them and their parents with challenges that can influence self-esteem, identity, family relationships and psychological adjustment (Brodzinsky, 2011, in press; Brodzinsky & Pinderhughes, 2002; Smith, 2010). Understanding how adopted individuals and their parents cope with these issues is critical for mental health professionals to consider in their work with these individuals.

Forming a family through adoption is a different experience than doing so through procreation, creating unique parenting responsibilities over and above those confronting parents by birth. Each stage of the family lifecycle presents parents with new issues to consider. How they understand these responsibilities and the way they carry them out are important factors

impacting the adjustment of all family members. Some of the key parenting issues that can pose challenges for adoptive families include (Brodzinsky & Pinderhughes, 2002):

- Coping with infertility and previous child loss
- Integrating children into the family and forming secure attachments, especially when children have experienced disruptions from previous attachment figures
- Supporting children's efforts to recover from deprivation, abuse and other early traumas
- Talking with children about their adoption, birth family and early life circumstances, and maintaining an open communicative atmosphere about these issues
- Helping children cope with adoption-related loss
- Supporting children's curiosity about and connections with birth family
- Supporting a respectful view of children's birth family and heritage
- Developing and managing relationships with children's birth family
- Maintaining important existing relationships with non-biological caregivers and supports
- Supporting children's adoptive identity
- Supporting children's racial/ethnic/cultural identity

> *"It was important to us that we be like everyone else ... in our families and among our friends ... We just wanted to raise our child and help her grow up like they were doing ... We never seriously considered all the things we had to face ... things that others we knew did not ... Just talking with her about what happened, trying to answer her questions about why her birth mom didn't keep her, why she had to leave her foster home, has been difficult ... at times, painful ... There have been nights when I cried myself to sleep because of the worry I have ... Did we do the right thing? Can we really handle it? Does she really think of us as her parents? Will she be ok? ... There are so many things that get me down ... so much to think about that I hadn't expected."*
>
> - *Mother of a 7-year-old girl adopted from foster care*

Effectively managing adoption-related tasks requires parents to first acknowledge the inherent differences associated with raising adopted children (Kirk, 1964), especially the reality that their sons and daughters are, and will always be, connected to two or more families -- those with whom they live, those who gave them life and, in many cases, those who fostered them. Even in closed adoptions, where there has never been contact with birth families after placement, connections with these individuals exist in children's fantasies, fears and desires (Brodzinsky,

2011, in press; Melina, 1998; Pavao, 1998; Riley& Meeks, 2006). Coping with adoptive parenting tasks and supporting children's adoption adjustment is easier when parents develop and maintain an open, honest and respectful communicative family environment (Brodzinsky, 2005, 2011, in press; Wrobel, Kohler, Grotevant, McRoy, 2003). Doing so reduces their anxiety, fosters more realistic expectations about their children and themselves, and fosters healthier adjustment in their children.

> *"We try to answer his questions honestly and to help him feel good about where he came from ... We are in the process of trying to find them [birth relatives], or at least more about them ... We are planning a trip to Korea next year ... it's what he wants ... and we think it's important for him ... and for all of us as a family"*
>
> - *Mother of a 14-year-old boy, adopted at 15 months of age*

Children also have unique adoption issues to face at each phase of the family lifecycle. As they get older, their ability to understand the meaning and implications of being adopted becomes more sophisticated (Brodzinsky, Singer, & Braff, 1984), leading to increased curiosity about their heritage, the reasons for their placements and the losses they have experienced. Adoption-related loss is quite extensive (Brodzinsky, 1990, 2009, 2011, in press) and often difficult to resolve because of a lack of information about the past, the ambiguous nature of the loss (Boss, 1999), and the lack of recognition and support for the loss. When children's curiosity about their origins goes unsupported and when their pasts are discounted or demeaned, they are likely to experience *disenfranchised grief* (Doka, 1989, 2002), which increases the risk for self-esteem and identity problems, as well as other adjustment difficulties.

Seeking meaning and information about, and/or contact with, one's birth heritage represents a lifelong search for self (Grotevant, 1997; Brodzinsky Schechter, & Henig, 1992) that is both normal and universal for adopted individuals. For some, it is a search that is primarily intrapsychic and private, with little acknowledgment to others about their thoughts, feelings, fears and desires; for others, it is also interpersonal, as they share their questions, concerns and longings with family members, friends and perhaps therapists. Adopted individuals are helped with this process when there is greater information available about their heritage, a family environment that supports their desire to know and search, and the ability to connect and maintain contact with birth family (Brodzinsky, 2005; Grotevant & McRoy, 1998; Grotevant, Perry, & McRoy, 2005; Neil & Howe, 2004; Siegel & Smith, 2012).

> *"My parents don't like it when I ask about my first mom and dad ... so I don't ... But I think a lot about them and just can't understand why they didn't keep me"*
>
> - *8-year-old boy, adopted at birth*
>
> *"It's the master question of my life ... why did she give me away?"*
>
> - *9-year-old boy, adopted at birth*

Different types of adoptions are also associated with their own unique challenges for family members. Boys and girls adopted from foster care or from abroad are often older at the time of placement and have experienced greater pre-placement adversities than children placed as infants domestically (Harwood et al., 2013). These factors make it more difficult for parents to integrate their children into the family, to facilitate stable and secure attachments, and to support children's grief work. Parents adopting children from care and from abroad usually benefit from working with professionals who can help them develop realistic expectations and the skills necessary to facilitate successful transitions to healthy parent-child relationships.

Placement across racial and ethnic lines adds another layer of complexity and stress for adopted individuals. Although research suggests that transracially adopted children, on average, show similar patterns of adjustment compared to those placed within their own race, difficulties with self-esteem and identity often occur (Smith, McRoy, Freundlich, & Kroll, 2008). Children and adolescents placed across racial/ethnic lines sometimes question their fit in the family, experience discomfort regarding their physical appearance and feel marginalized from others, including peers of the same race, and report occurrences of prejudice and discrimination that they do not know how to manage. Coping with racial issues in adoptive families can be a challenge for parents and their children, often requiring specialized preparation, community support and help from adoption-competent clinical professionals.

> *"Looking so different from my parents and brothers is something that's bothered me a lot for a long time ... I don't want to be white like them ... but I wish I just didn't stand out so much ... It makes me feel different, like I don't really belong here."*
>
> - *14-year-old African American boy with Caucasian parents*
>
> *"When I meet other Chinese kids, they often expect me to speak Chinese ... I look like them, but I'm not really ... They grew up with their [birth] parents and I was adopted ... I don't feel that they accept me as being really Chinese ... and I'm not sure what I am myself."*
>
> - *12-year-old Chinese girl with a single Caucasian mother*

More and more adoptions involve some level of contact between the adoptive family and their children's biological relatives; indeed, most domestic infant adoptions in the U.S. today are open placements (Siegel & Smith, 2012). Furthermore, a growing number of child welfare adoptions and international adoptions also involve some type of contact between the adoptive and birth families (Neil & Howe, 2004; Tieman, van der Ende, & Verhulst, 2008). Although research suggests that such contact can be beneficial for everyone involved, it can also pose challenges for the adults and children alike. Successfully managing contact, as it waxes and wanes over time, requires a collaborative arrangement between adoptive and birth family members (Grotevant, 2009; Grotevant, Perry, & McRoy, 2005; Grotevant, Ross, Marchel, & McRoy, 1999). It may also require help from knowledgeable and sensitive professionals who understand the complexities of open adoption arrangements and have the training to support family members in their efforts to reconcile differences in needs or goals.

In summary, adjustment of adopted children and their families is influenced by a host of intrapersonal, interpersonal, situational and contextual factors that emerge over the course of the family lifecycle. Different types of adoptions pose different types of challenges. Although these issues are normal, they can increase stress for family members, potentiating existing vulnerabilities associated with pre-placement risk. Moreover, when poorly managed, these common adoption-related issues can themselves lead to significant adjustment difficulties.

Adjustment of Birth/First Parents

Adoption-related loss is a major life stressor not only for parents whose children are removed by child protective services, but also for those who make voluntary placement plans for their children. Parents whose children are removed from their care typically have experienced a range of difficulties – such as economic hardship, substance abuse, mental illness, domestic violence, criminal behavior and/or incarceration – that have compromised the raising of their children. Although much has been written about the intransigent problems facing women and men whose children are moved to the foster care and adoption systems, there has been little focus on the impact of termination of parental rights *per se* on these individuals or on their ability to grieve their loss (Schofield, Moldestad, Höjer, Ward, Skilbred, et al., 2011). In contrast, more information exists on the adjustment of women who voluntarily place their children for adoption (Smith, 2006). Only a few studies, however, have focused on outcomes for birth fathers (see Clapton, 2001; Cicchini, 1993; Deykin, Patti, & Ryan, 1988; Witney, 2004).

During most of the 20th Century, women who chose adoption for their children were usually unmarried, Caucasian teenagers with no other children. Adoptive placements were completely confidential, with little counseling regarding pregnancy options, or help in coping with whatever decision was made. Very often, placement was less a choice than a response to pressure, inadequate support and feelings of helplessness. Agencies usually determined who

adopted the children, and there was rarely contact between the birth mother and the adoptive parents. In the past few decades, however, adoption practice has become much more open, with birth mothers (and fathers) actively involved in making the adoption plan, choosing the new family and, in many cases, developing plans for ongoing contact after placement (Grotevant & McRoy, 1998; Pertman, 2000; Henney, McRoy, Ayers-Lopez, & Grotevant, 2003; Henney, Onken, McRoy, & Grotevant, 1998; Smith, 2006). In addition, most birth mothers today are in their early to mid-20s and some are parenting other children.

During the period of ironclad secrecy, women were advised to go on with their lives and try to forget about their children (Pertman, 2000; Fessler, 2006). Few, however, were able to do so; research and clinical practice have shown that placing a child for adoption is a major life stressor, one that is complicated by the ambiguous nature of the loss (Boss, 1999). Although physically absent, these women's children continue to be present in their thoughts and emotional lives. For example, Fravel, McRoy and Grotevant (2000) found that most birth/first mothers continue to think about their children with moderately high frequency and emotional intensity, not only on special occasions such as birthdays or Mother's Day, but during their daily lives. Further complicating the resolution of their loss is that fact that it is often ignored, dismissed or diminished by others, leading to disenfranchised grief (Aloi, 2009; Doka, 1989, 2002) and adjustment difficulties.

Research on birth mothers indicates significant post-placement risk for emotional problems, including pathological grieving, depression, guilt, shame, anxiety, anger, diminished self-esteem, somatic issues and PTSD symptoms (Bouchier, Lambert & Triseliotis, 1991; A. Brodzinsky, 1990, 1992; Brodzinsky, et al., in press; Christian, McRoy, Grotevant, & Bryant, 1997; DeSimone, 1996; Deykin, Campbell & Patti, 1984; Fessler, 2006; Roll, Millen & Backlund, 1986; Rynearson, 1982; Wiley & Baden, 2005; Winkler & van Keppel, 1984). Post-placement problems in relationships with parents, peers, romantic partners and subsequent children also have been reported (Carr, 2000; Deykin, et al., 1984; Howe, Sawbridge, & Hinings, 1992).

When women feel forced into making an adoption plan and when the choice of the adoptive family rests with others, they more often experience regret, worry and prolonged grief (Cushman, Kalmuss, & Namerow, 1997). In contrast, having information about the well-being of their children (Wells, 1993) and being able to maintain contact with them following adoptive placement helps birth mothers cope better with their grief and reduces adjustment difficulties (A. Brodzinsky, 1992; Brodzinsky et al., in press; Cushman, et al., 1997; Christian et al., 1997; Ge, Natsuaki, Martin, Leve, Neiderhiser, Shaw, et al., 2008; Henney, et al., 2007; Neil, 2007; Neil, et al., 2010). They also benefit from post-placement support from family and friends, mental health professionals, other birth mothers, and the adoptive family (Brodzinsky, et al., in press).

Given the ongoing grief of many birth mothers (and presumably birth fathers, too) and their risk for post-placement adjustment difficulties, mental health professionals need to be prepared to help them when they seek counseling related to pregnancy and adoption issues. Critical areas that often need addressing include (Ayers-Lopez, Henney, McRoy, Hanna, & Grotevant, 2008; Henney, Ayers-Lopez, McRoy, & Grotevant, 2007; Neil, et al., 2010; Smith, 2006):

- Exploring pregnancy options
- Receiving support during the adoption decision-making process
- Making peace with one's adoption decision
- Resolving grief from adoption loss
- Incorporating the birth parent role into one's identity without lowering self-esteem
- Overcoming adoption's impact on intimate relationships
- Managing ongoing relationships with the adoptive family

Each of these areas represents vulnerabilities for birth mothers and fathers; each requires a deep understanding of the short- and long-term complexities associated with adoption-related child loss and the ever-changing nature of adoptive kinship relationships.

> *"It's been nearly 30 years since I placed my daughter for adoption and not a day goes by that I don't think about her ... I never felt that I had a choice ... no one asked me what I wanted ... my parents simply told me that adoption was the only answer ... that anything else would lead to my ruin ... Over the years, when I tried to explain how I felt about the adoption, how painful it was, and still is, they shut me down ... they won't talk about it ... I wonder how she is, what's become of her, what her life is like ... There is a hole in me that will never be filled"*
>
> - *48-year-old, unmarried birth mother*

BARRIERS TO ACCESSING ADOPTION-COMPETENT SERVICES

The nature of the problems confronting many members of the extended family of adoption are complex and often enduring, requiring counseling and other services from a variety of professionals, including child welfare specialists, mental health

practitioners, physicians, educational advisors and teachers. Unfortunately, adoptive parents, adult adopted individuals and birth/first parents often encounter barriers in their efforts to obtain the assistance they seek (Case Family Services, 2003; Tarren-Sweeney, 2010; Tarren-Sweeney & Vetera, 2013).

One of the most frequent complaints from members of the extended family of adoption (encompassing birth and adoptive relatives) is their inability to find mental health care and ancillary service professionals who are adoption-competent – that is, who understand the unique issues associated with their histories and current lives, and how adoption can color or even shape their views of themselves, their identities and their relationships. This point is highlighted by a recent survey on the experiences of adoptive families with mental health professionals conducted by Policy Works, Ltd., in conjunction with the Center for Adoption Support and Education, or C.A.S.E. (Atkinson, et al., in press; C.A.S.E., 2012). Data were collected from 485 individuals (87% adoptive parents; 9% adopted persons) across the U.S., as well as from eight other countries. Over 81 percent of respondents (84% of adoptive parents and nearly 77% of adopted persons) reported working with one or more mental health professionals. Of those who did, slightly less than 25 percent believed the professionals were adoption-competent; another 50 percent indicated that some of the professionals were adoption-competent but others were not; and 26 percent said none of the mental health providers they saw knew much about adoption. Furthermore, whereas 27 percent of adoptive parents reported working with adoption-competent professionals, only 14 percent of adopted persons did so. A large number of individuals reported seeing multiple therapists over the years who were not adoption-competent; some reported experiences with therapists that actually damaged their families. Areas in which therapists were viewed as especially insensitive or lacking in adoption knowledge included attachment, trauma, loss and appropriate adoption language.

The negative experiences of some adoptive families in seeking help underscore the reality that therapists lacking adoption competence can, at times, do more harm than good. Some of the "unhelpful" advice, guidance, and actions that have been reported by adoptive parents and adoption professionals include (Casey Family Services, 2003; Festinger, 2006; Linville & Lyness, 2007; Massachusetts Department of Mental Health, 1994; NACAC, 2002; Nelson, 1985; Smith & Howard, 1999; Tarren-Sweeney, 2010):

- failing to validate or believe their experiences
- blaming parents for their children's problems
- pathologizing adoption and viewing the family as pathological
- questioning the parents' motives for adoption
- advising parents not to talk about adoption with children because it will "stir things up"

- seeing children with attachment problems without parental presence or input
- telling parents to just give their children back to the state
- failing to gather information about the children's histories or to address the impact of previous maltreatment

Many families seek help again and again without significant improvement (Smith & Howard, 1999); an early Massachusetts study found that some families had sought help from up to 10 different practitioners before locating one who understood their circumstances (Frey, 1986). A recent study of adoptive families seeking mental health treatment for their children found over 80 percent had previously received treatment from another practitioner (Becker-Weidman & Hughes, 2008). The failure to find genuinely helpful assistance can lead some families to receive no help or to grow desperate and grasp at alternative treatments on the fringes of acceptable mental health practice.

Insensitivity and a lack of knowledge about adoption are linked, in part, to the failure of graduate training programs to offer relevant adoption coursework to their students. In a survey of 224 directors of clinical training programs in marriage and family therapy, social work or counseling, Weir, Fife, Whiting and Blazewick (2008) reported that very few programs offered specific coursework in adoption (4.8% to 16.3%) or foster care (2.6% to 22.1%), though these topics were sometimes included as subcomponents of other courses. The impact of limited training in adoption for family therapists is found in other research in which respondents were required to assess a simulated case study of an adoptive family that explicitly involved adoption issues as a presenting problem; it found that only 16 percent of the family therapists focused aspects of their intervention on adoption-related issues (McDaniel & Jennings, 1997). Limited training in adoption is also found in studies of other health care and education professionals. For example, in a national survey of licensed psychologists (Sass & Henderson, 2000), two-thirds of respondents reported having no graduate coursework that dealt with adoption issues; fewer than one-third rated themselves as very well prepared or well prepared to treat adoption issues, and 90 percent said psychologists need more adoption-related education.

Another survey, of clinical psychology professors, reported that the average time spent teaching about adoption at the graduate level was eight minutes per semester, as compared to about three to 10 times that amount on subjects that impact far fewer people, such as autism (Post, 2000; Henderson, 2002). Similarly, Henry, Pollack and Lazare (2006) reported finding no evidence in the literature of adoption-related curricula in the training of medical students, despite the fact that pediatricians (and presumably many other physicians) routinely work with adoptive families as part of their practices. Stroud, Stroud and Staley (1996) and Tayman, Marotta, Lynch, Riley, Oritz, et al. (2008) have made comparable points about the lack of

training for teachers, another group of professionals who routinely interact with and are responsible for the well-being of adopted children and youth and their families.

The expense of mental health services and the limitations of insurance coverage for them also pose barriers to accessing adoption competent therapists (Casey Family Services, 2003). Even though adoptive families, with the exception of those adopting from the child welfare system, generally have greater income and financial resources than non-adoptive families (Krieder, 2003; Howard, Smith & Ryan, 2004; Smith, 2010), many do not possess medical insurance that covers the mental health needs of their children. Insurance companies often limit the number of sessions per year for mental health services, yet children's psychological problems frequently are complex and extraordinarily challenging, requiring long-term treatment; in addition, some children also require residential treatment services, which are seldom covered by insurance (Casey Family Services, 2003). Insurance companies also restrict services and/or payments to mental health providers who are on their managed care lists, without knowing whether these professionals are adoption-competent. Thus, even if a family has excellent insurance coverage, it may not pay for the services of a therapist with the knowledge to be of genuine assistance.

> *"We've had nothing but frustration in trying to get our insurance carrier to accept the therapist who we wanted to work with ... the one our adoption agency recommended. She wasn't on their list of providers and we were told her services wouldn't be covered. We appealed, but were turned down again ... We interviewed a few therapists on their list and tried one of them, but we weren't satisfied ... We ended up going to the person that our adoption agency initially referred us to, but had to pay for the therapy ourselves ... After a while we had to stop because we just couldn't afford it ... We're doing our best on our own now."*
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> - *Mother of two children, 8 and 10 years of age, adopted from the child welfare system*

Accessing experienced and knowledgeable therapists who understand adoption is particularly an issue for families adopting from the child welfare system. These families, on average, have fewer financial resources than those adopting from private agencies or independent practitioners (Howard et al., 2004; Vandivere, Malm, & Radel, 2009); the children they adopt, however, often have the greatest need for mental health services (Casey Family Services, 2003; Harwood et al., 2013; Smith, 2010; Tarren-Sweeney, 2010; Vandivere, et al., 2009). Although families adopting from foster care usually receive a subsidy that includes insurance coverage for

their children (e.g., Medicaid), it is often inadequate to meet their medical and mental health needs (Center for Adoption Support & Education, 2012; Smith, 2010). Moreover, few mental health providers, especially private practitioners, accept this type of insurance because of low fee-for-service rates. Without additional insurance coverage for mental health services, these families are forced to rely upon community mental health clinics, hospital outpatient clinics and other mental health sites that accept subsidy-supported insurance; unfortunately, many of these facilities are staffed by less-experienced clinicians, including ones who are still in training.

Adoptive families living in rural areas, like their neighbors who are raising their biological children, also typically have limited access to mental health services and many barriers to overcome to be able to use them (Robinson, Springer, Bischoff, Geske, Backer, et al., 2012; Ziller, Anderson, & Coburn, 2010). This fact alone reduces the chances of adoption kinship members in these parts of the country finding a local therapist with the specialized knowledge, training and experience to meet their often-challenging needs.

> *"We are one of the few families in our community that is raising adopted children ... Being so far from a large city, we had limited options when it came to choosing a psychologist to help with our son's problems ... Dr. ____ is a good man and seems quite competent, but we've had to educate him about what adoption is all about ... It's been a slow and sometimes frustrating experience ... To his credit, though, he's been willing to consult with another therapist by telephone who we identified as being an expert in the field."*
>
> - *Mother of an 8-year-old boy, adopted at age 3*

Finally, accessing adoption-competent therapists is hindered because referral sources such as adoption agencies, pediatricians, schools and insurance companies often do not know which community professionals have the relevant experience and knowledge. To date, adoption counseling has not been identified as a professional specialty area in the health care fields, with clear guidelines for training, standards of practice and credentialing, although some have called for such development (Atkinson et al., in press; Janus, 1997; Tarren-Sweeney, 2010; Tarren-Sweeney & Vetere, 2013). Current efforts are underway in the U.S. (see Appendix for a list of existing post-graduate adoption training programs) and abroad to foster greater adoption-competence among child welfare specialists, mental health professionals and pediatricians. The efforts of these organizations are a step in the right direction, but without an appropriate credentialing process, referrals to mental health and medical professionals by adoption agencies, physicians and educators will remain a "hit or miss" process, resulting too often in

adoptive parents, adopted persons and birth parents being treated by individuals who are inadequately prepared to understand and help them.

ADOPTION CLINICAL COMPETENCE

Adoption clinical competence can be viewed as a continuum of knowledge, values, skills and experiences related to the assessment and treatment of adoptive kinship members. At one end of the continuum are professionals with little to no knowledge or training in how adoption impacts people and families, as well as little experience in working clinically with them; at the other end are professionals who have broad-based, adoption-related knowledge and a deep understanding of its lifelong influence on individuals and family systems, gained through extensive graduate and post-graduate training, clinical experience and/or clinical supervision.

To date, there is no broad-based professional organizational consensus about what constitutes adoption clinical competence, although existing mental health and child welfare literatures, as well as existing adoption training programs (see Appendix), have identified key areas of didactic training, intervention skills and clinical experience that are vital for meeting the mental health and developmental needs of adoptive kinship members (see also Casey Family Services, 2003). In most cases, adoption training programs have developed curricula through reviews of relevant literature, consultation with other professionals, and their own social casework and clinical experience. The program developed by the Center for Adoption Support and Education has taken this process one step further. Prior to developing its curriculum, *Training for Adoption Competency* (TAC), C.A.S.E. (2009) convened a national task force of adoption and clinical professionals to explore and analyze the mental health needs of the affected population and to identify key areas of knowledge, values and skills that are intrinsic to being an adoption-competent clinical professional.

In reviewing multiple informational sources and drawing on interdisciplinary perspectives, the task force identified 14 elements that constituted adoption-related competence[2]. In addition, in comparing experts' opinions of what adoptive families need from mental health professionals with those of adoptive parents, a high level of agreement was found, ranging from over 90 percent (uses therapies to empower parents to feel entitled to parent their adopted children)

[2] The 14 defining elements of adoption competence included: separation and loss; developmental challenges; development of multiple service systems; family formation and differences; abuse, neglect and trauma; experience with adoptive families and adopted persons; cultural competence; success in supporting strengths; range of therapies for healing; family/strengths/evidence-based approaches to treatment; advocacy; therapies to strengthen parenting; therapies for parent entitlement; professional education and licensure. Specific definitions for each of these areas were included in the survey.

to nearly 98 percent (understands impact of separation and loss on individuals and families; understands developmental challenges experienced by adopted children and families) (Atkinson, et al., in press; C.A.S.E., 2012). These findings add further support to the validity of their definition of adoption clinical competence and the relevance of their training curriculum.

The consensus of the C.A.S.E. task force was that adoption-competent mental health professionals: (a) have the requisite education and licensure in their respective fields; (b) maintain a family- and strength-based approach, as well as developmental and systemic perspectives, in working with adoption kinship members; (c) employ empirically-based and empirically-informed intervention strategies whenever possible; (d) have the training and experience to work with individuals who have experienced abuse and trauma; (e) have an extensive knowledge base related to adoption as a social service practice and as a type of family formation; (f) understand the challenges facing all members of the adoption kinship system, including the bases for those challenges; (g) have the knowledge and skills to support psychological growth and resilience in adopted persons, adoptive parents and birth parents, and to foster healthy relationships within and between adoptive families and families of origin; (g) are culturally competent with respect to the racial and cultural heritage of children and families and are skilled in working with diverse types of families; and (h) are skilled in advocating with other service systems on behalf of adoptive kinship members (Atkinson, et al., in press; C.A.S.E., 2009).

In discussing the meaning of adoption competence in this report, and in making recommendations regarding adoption clinical training, the Donaldson Adoption Institute has drawn from a number of sources, the most important of which include:

- Professional literature in adoption, child welfare and clinical mental health practice
- White Paper published by Casey Family Services (2003) on promising practices in adoption-competent mental health services
- Work of the national advisory board on adoption clinical competence convened by C.A.S.E. (Atkinson et al., in press; C.A.S.E., 2009, 2012)
- Websites of existing adoption training programs (see Appendix A)
- Interviews with directors of adoption training programs
- Research and clinical experience of the Donaldson Adoption Institute staff
- Work by others outside of the U.S. who are actively engaged in developing principles and designing programs for mental health services for foster and adopted children and their families (e.g., Pacheco, Boadas, Freixa, Negre, & Rodriguez, 2013; Tarren-Sweeney, 2010; Tarren-Sweeney & Vetera, 2013).

Foundation in Clinical Competence

Adoption clinical competence begins with a solid foundation of knowledge and clinical skills gained through an approved graduate training program in psychiatry, psychology, social work, marriage and family therapy, or counseling. Such programs typically provide broad-based training in clinical theory, assessment, diagnosis and treatment commensurate with the practice guidelines of their respective professions, as well as training in cultural competence and professional ethics. In short, to be adoption-competent, one first has to be clinically competent, grounded in health and mental health care ethics, and must meet the state requirements for licensing and practice in one's profession.

Specialized Assessment and Intervention Skills

Meeting the needs of adoptive kinship members also requires *specialized* training in assessment, diagnosis and intervention. At each phase of the clinical process, therapists must be attuned to the complex array of historical and contemporary factors impacting the lives of their clients and, specifically, to the ways in which the adoption experience can influence their identity, relationships and development.

Assessment Considerations and Perspectives. During the assessment process, clinicians benefit from maintaining a *bio-ecological perspective* when working with this group of individuals (Bronfenbrenner, 2005; Palacios, 2009). Even more so than in the general population, the lives of adopted children and their parents, as well as birth/first parents, are influenced by a host of interacting contextual factors, including but not limited to: multiple family and extended family systems, the legal system, the child welfare system, the mental health system, the special education system and the medical system. When clinicians appreciate the ecology of adoption and integrate this perspective into their work, they are likely to be more successful in developing intervention strategies that facilitate healthier individual and family functioning.

Adopted children, especially those placed from the child welfare system and from abroad, are an especially vulnerable group, with histories that commonly include prenatal complications, institutional deprivation, neglect, child abuse, and/or relationship disruptions. Special attention must also be paid to assessing the potential for neuro-developmental problems, attachment difficulties and trauma-related symptoms. Expertise in a wide range of areas is needed to effectively assess the factors in the child's history and current situation that underlie current difficulties – a step that is essential to developing effective intervention plans.

Diagnostic Considerations. Traditional diagnostic systems in mental health (e.g., DSM-IV, the newly released DSM-V, and ICD-10) are often inadequate for capturing the complexity of problems manifested by foster and adopted children (Casey Family Services, 2003; DeJong,

2010; Tarren-Sweeney, 2008, 2010). The multiple adversities experienced by these children often lead to contradictions in diagnostic assessment and treatment planning when seen by different professionals and at different times, confusing adoptive parents and undermining their confidence in the mental health system and in their own ability to manage their children's needs. This is often the case for children placed from orphanages or from foster care. Attachment disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder, conduct disorder, major depression and other diagnoses are routinely identified. In many cases, however, these diagnoses, whether applied singularly or as a co-morbid pattern, do not adequately reflect the severity of the children's problems, the challenges facing adoptive parents or the best ways to treat these individuals. Mental health professionals need to recognize the limitations of current diagnostic systems and maintain a more-nuanced perspective in their assessment and treatment planning with this population.

Intervention Strategies. Given that early trauma and relationship disruptions are so common in the lives of many adopted persons, specialized training to treat these problems is important for adoption clinical professionals. Over the past few decades, a number of evidence-based and promising practice interventions have been developed and utilized with traumatized children and adolescents, as well as with those experiencing complex loss and grief[3]. Some of these have been evaluated with samples of foster or adopted children, while others have been evaluated only with general clinical samples. When seeking help for their children, adoptive parents would be well advised to determine whether the clinicians they are working with have expertise with one or more of these intervention models.

Foster and adopted children with known trauma histories, especially those experiencing PTSD symptoms, often benefit from T*rauma-Focused Cognitive Behavioral Therapy* (Dorsey & Deblinger, 2012). TF-CBT is a conjoint child and parent psychotherapy approach that integrates trauma-sensitive interventions with cognitive behavioral and family techniques[4]. Children and parents learn new strategies for processing, managing and integrating their thoughts and feelings related to traumatic life events, leading to increased feelings of safety, improved communication, better parenting skills and healthier family relationships. Another evidence-based intervention for traumatized children, adolescents and adults is *Eye Movement Desensitization and Reprocessing* (Adler-Tapia & Settle, 2009; Shapiro, 1995). In EMDR, clients

[3] Evidence-based treatments (EBT) are generally developed and implemented under highly controlled conditions that are difficult to replicate in everyday practice (Whittaker, 2009). As a result, successful integration of these approaches in community clinical settings represents a challenge for the mental health field. Although the utility of the treatment strategies discussed in this paper have all been supported, in varying degrees, by empirical research, their effectiveness with adoptive kinship members in different types of post-adoption settings requires greater exploration.

[4] Online training in TF-CBT can be found at www.tfcbt.musc.edu

recall traumatic experiences and associations to those experiences, while at the same time attending to their inner thoughts and stimulation from a rhythmic, bilateral sensory (visual, auditory, or tactile) source. Although the mechanism for change is not fully understood, this integrative psychotherapeutic approach has been shown to help individuals process and integrate their traumatic experiences more effectively, reducing their negative impact, including PTSD symptoms, and fostering more adaptive coping strategies.

Several clinical interventions focusing specifically on attachment have also been developed and successfully used with foster and adopted children. One of the most effective is C*hild-Parent Relationship Therapy* (Bratton, Landreth, & Lin, 2010; Carnes-Holt, 2012; Landreth & Bratton, 2006), a structured, time-limited variation of filial therapy that trains caregivers to be therapeutic change agents for children. Typically used with 3- to 10-year-olds, CPRT promotes feelings of safety, acceptance, love and connections through play interactions. A primary assumption of this approach is that relationship (e.g., attachment) problems can most effectively be dealt with in the context of dyadic (i.e., parent-child) interventions rather than in individual therapy. A meta-analysis of 93 outcome-controlled research studies examining the efficacy of play therapy, including separate analysis for the specific efficacy of filial therapy, showed a large treatment effect resulting in reduced parental stress and disruptive behavior by children, as well as increased parental empathy (Bratton, Ray, Rhine, & Jones, 2005).

Other dyadic or family-based interventions focusing on attachment and trauma symptoms have also been developed and used with foster and adopted children and their parents. *ARC: Attachment, Self-Regulation, & Competency* has been recognized as a promising practice for children and youth exposed to complex trauma and relationship difficulties (Blaustein & Kinniburgh, 2010; Kinniburgh, Blaustein, & Spinazzola, 2005). Based on developmental, attachment and trauma theory, ARC uses a variety of psychoeducational, somatic, cognitive-behavioral, relational and psychodynamic interventions to build children's attachments, enhance their self-regulation and increase their competencies in different domains. A preliminary assessment of its effectiveness with young children showed a 50 percent reduction in PTSD symptoms (Kinniburgh & Blaustein, 2006). A third attachment-oriented intervention, D*yadic Developmental Psychotherapy* is also promoted as effective for this population (Becker-Weidman, 2008; Becker-Weidman & Hughes, 2008; Hughes, 2007) and is starting to be used more widely, but there is less empirical support for this treatment approach than for CPRT.

Theraplay (Booth & Jernberg, 2010) and interventions based upon this approach (Weir, 2007, 2011) have also been used with adoptive families. Like the models above, this approach combines play and family therapy, along with psycho-educational parenting strategies, in an effort to build attachment, self-esteem and more-joyful interactions among parents and

children. Although there is less empirical support for the effectiveness of Theraplay with attachment-disordered and traumatized children than of CPRT, it is generally viewed as a promising practice with this population (The California Evidence-Based Clearinghouse for Child Welfare, 2013; www.cebc4cw.org/program/-2/).

Video-Feedback Intervention to Promote Positive Parenting (VIPP) is a fourth strategy aimed at enhancing attachment security in high-risk infants and young children[5]. Developed by researchers at Leiden University in the Netherlands (Juffer, Bakermans-Kranenburg & van IJzendoorn, 2008), VIPP fosters increased parental sensitivity and responsiveness to children's cues through short-term (three to six sessions), home-based, video feedback of parent-child interactions; more recent interventions have also included instruction on sensitive discipline (VIPP-SD). The decision to develop a brief, highly focused treatment model was based on the results of a meta-analysis of 70 attachment-oriented interventions that suggested a "less is more" approach would be effective (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003). A randomized study of 130 Dutch adoptive families with 6-month-olds found the group treated by VIPP showed a significantly lower rate of disorganized attachment compared to a no-treatment group (6% vs. 22%) (Juffer, Bakermans-Kranenberg, & van IJzendoorn, 2005). A subsequent randomized study with parents of 1- to 3-year-olds with high levels of externalizing behaviors, in which video feedback was also paired with instruction on sensitive discipline (VIPP-SD), found the intervention was especially effective in reducing externalizing behavior in children identified as having a specific genetic marker associated with motivational and reward mechanisms and ADHD (Bakermans-Kranenburg, van IJzendoorn, Pijlman, Mesman, & Juffer, 2008).

Various forms of *narrative therapy* also show promise in working with children, teenagers and adults who have experienced previous trauma, complex loss and relationship disruptions (Lacher, Nichols, & May, 2005; Vetere & Dowling, 2005). Narrative therapy is based on the belief that the "stories" people use to describe their lives often restrict them from overcoming personal difficulties. By eliciting clients' stories verbally, in written form, through pictures or by other means, therapists help them "reframe" their life narratives, find alternative ways of

[5]VIPP is one of a number of research-based interventions developed under controlled conditions with high risk infants and young children that have not yet been successfully integrated into community clinical settings. Other examples of successful research-based attachment and trauma related early intervention and prevention programs are found in the work of Philip Fisher, Mary Dozier, Megan Gunnar, and Dante Cicchetti, to name just a few (Bruce, Gunnar, Pears, & Fisher, 2013; Cicchetti & Gunnar, 2008; Dozier, Pelaso, Lindhiem, Gordon, Manni, Sepulveda, et al., 2006; Fisher, Burraston, & Pears, 2005; Fisher & Kim, 2007). What is especially exciting is the efforts of researchers to understand the link between stress neurobiology and the effectiveness of prevention and intervention programs for children with different adverse histories (Bruce et al., 2013), as well as the differential effectiveness of interventions for children with different genetic markers (Bakermans-Kranenberg et al., 2008). Progress in these, and related, areas offers hope for more effective and efficient diagnosis, intervention, and prevention for high risk children in the future.

integrating past difficulties into their lives, identify and support personal strengths and develop healthier relationships with others. *Lifebook* interventions, as well as *journaling*, *written role play*, mask-making, loss boxes and *therapeutic rituals*, commonly used with foster and adopted children, incorporate many of the principles of narrative therapy and are also valuable in preparing children for adoption and helping them with issues of loss, identity and relationships in the post-adoption years (Baynes, 2008; Brodzinsky et al., 1998; Fahlberg, 2012; Imber-Black & Roberts, 1998; Johnson & Howard, 2008; Lieberman & Bufferd, 1999; Riley & Meeks, 2006; Whiting, 1988). Although viewed as promising practices by adoption practitioners, the effectiveness of these latter interventions has not yet been adequately empirically tested.

Finally, given the multiple, interconnected systems impacting the lives of adoptive kinship members, therapists should also consider ecologically oriented interventions such as *multidimensional family therapy* (Liddle, 2010). Developed primarily as a strategy for adolescents with substance abuse and associated mental health and behavioral problems, MDFT assesses and intervenes not only at an individual and family level, but considers extra-familial sources of influence such as peers, school, child welfare and juvenile justice. Although to the best of our knowledge MDFT has not be tested empirically in the adoption field, there is good empirical support for its effectiveness with other adolescent populations who have problems similar to those of adopted children with special needs and their families.

Specialized Adoption-Related Training

To effectively meet the developmental, familial and mental health needs of adoptive kinship clients, it is essential for clinicians not only to have a foundation of clinical knowledge, assessment and intervention skills and experience, but also an in-depth and sensitive understanding of how adoption impacts these individuals. Key areas of training, identified in the definition of adoption competence by C.A.S.E. (Atkinson, et al., in press), and included in most post-graduate adoption training programs described in the Appendix, are:

- Historical and contemporary perspectives on adoption practice
- Adoption law and its impact on family formation and stability
- Nature of the child welfare system and its impact on family life
- Different types of adoptions and the issues and processes associated with each
- Lifespan developmental perspective on adoption, including how being adopted is understood and experienced by adopted persons from infancy through adulthood
- Parenting tasks and adoptive family dynamics at various phases of the life cycle
- Adoptive parent preparation and support needs
- Impact of infertility on adoptive parenting
- Impact of neglect, abuse and trauma on neurological and behavioral development

- Role of attachment and relationship disruption on children's development and family dynamics
- Nature of adoption-related loss and grief
- Issues in transracial and transcultural adoption, including ways of supporting positive racial and cultural identity in children and youth
- Issues in adoption by sexual-minority individuals and couples
- Psychology of search and reunion
- Impact of adoption and child loss on birth parents
- Support needs of birth parents
- Open adoption, including helping participants in their evolving relationships
- Ethical issues in adoption practice and counseling

Supervised Clinical Experience

Becoming a competent mental health practitioner requires more than taking graduate and post-graduate courses. It also depends on putting knowledge and skills into practice under the supervision of a more experienced professional. This is a core assumption in all health and mental health professions, including adoption-related clinical work.

Supervision supports the less-advanced practitioner in forming an identity as a clinical adoption specialist, and it facilitates effective and sensitive application of newly gained knowledge, values, skills and techniques in the service of meeting the mental health needs of adoption kinship clients. The impact of competent clinical supervision is not only better trained practitioners, but also improved quality of care and protection for the public. To date, only one program to our knowledge, requires some type of practice supervision following completion of coursework. Participants receiving the *Training for Adoption Competence* model through C.A.S.E., as well as those trained through its licensed replication sites (see below), are involved in professionally led group supervision, once a month for a six month period, during which they receive feedback and guidance on one of their active clinical or child welfare cases. Group supervision is provided in-person or through audio or video conferencing, thereby allowing the program to utilize experienced supervisors who are located in other parts of the country.

Small group case consultation following coursework is also offered by the program at the University of Denver, once a month for two hours, over a three-month period. The focus of these group meetings is to facilitate the translation of newly acquired knowledge into clinical and social casework practice. Michele Hanna, the director of the program, reported that participants are told specifically that these consultation groups are not offered for purposes of case *supervision,* however; trainees need to consult their agency or clinical supervisor if there are specific concerns or questions regarding the cases in their professional practice. Other

programs, such as one at the St. Louis Psychoanalytic Institute, integrate supervision and case consultation/presentation during portions of the course that are only available to therapists and those in clinical training; still others, such as the one offered by Portland State University, provide a non-required opportunity to join a professionally led peer consultation group following completion of the training program.

Continuing Education

The field of adoption has changed remarkably over the past half century (Pertman, 2011; Pertman & Howard, 2012; Russett, 2012), as has our understanding of the impact of this unique life experience on the lives of the millions of people it encompasses. Undoubtedly, there will continue to be changes in adoption practice in the coming years and, without question, greater insight into those factors affecting the adjustment of adoptive kinship members. Clinical adoption specialists must be committed to staying informed about new research, clinical techniques, policy and practice changes, and professional issues related to adoption and foster care. Continuing education is the means by which most professionals achieve this goal in their respective fields. In short, professionals maintain their competence by remaining current with knowledge and intervention techniques that can inform their practice with their clients.

Treating Adoption Kinship Members: Knowing One's Limits

Being adoption-competent does not mean a therapist is qualified to meet the mental health needs of all clients. Like others in the general population, the affected individuals can, and do, present with a wide range of psychological problems. Some will be related to the adoption experience; others will not. Some will require clinical interventions that are within the scope of the therapist's competence; other problems will be beyond that scope. A fundamental ethical principle of all health and mental health professions is to provide services only within one's area and scope of expertise. This principle, of course, holds true for those who work with adoptive kinship clients. If the tendency of most mental health professionals is to ignore or minimize the role of adoption in their work with clients, the potential problem of adoption clinical professionals may be to overemphasize adoption in the individual and familial dynamics and symptom patterns of the people with whom they work – i.e., *to view their clients primarily through the lens of adoption*. Maintaining an objective and balanced perspective is an essential goal of adoption clinical professionals. So, too, is knowing when a client's problems are beyond one's area of competence and a referral to another professional is needed.

Pathways to Becoming Adoption Clinically Competent

There is no single path to achieving adoption clinical competence, no single degree that will ensure it, and no single graduate or post-graduate training program that can be expected to

fulfill this goal by itself, especially given that knowledge in this area is constantly evolving. Becoming and maintaining competence as an adoption clinician is best understood as reflecting an ongoing, multi-path process.

Graduate training programs in the mental health field and allied disciplines provide opportunities for developing a foundation of clinical knowledge and skills but, as yet, they do not provide much training directly related to adoption and foster care (Henderson, 2002; Post, 2000; Sass & Henderson, 2000; Weir et al., 2008). Hopefully this will change in the future. Graduate-level practicum placements and internships also provide opportunities for developing specialized clinical experience related to adoption and foster care for some professionals, and should be explored further by those in training.

One of the best ways of becoming more clinically competent in these areas is to enroll in a post-graduate adoption training program[6]. Currently, there are at least 16 such programs around the country providing in-depth training in the psychology of adoption and foster care (see Appendix). Some have been in existence for over two decades; others are just getting underway. The Kinship Center's adoption-competence curriculum was the first to be developed, in 1992, and it has been used to train approximately 7,500 professionals in at least six states (Carol Bishop, personal communication, April 2013). The other programs were developed over the past 10 years or so. Some previously well-known adoption-training programs are no longer operating, either because they have been incorporated into others (e.g., the program run by Cascadia Training, Northwest Resource Associates combined with the one currently being offered by Portland State University) or because of funding problems (e.g., the program offered at Hunter College run by Gary Mallon and Joyce Maguire Pavao).

All programs include a mix of child welfare and mental health professionals. Interview feedback from the directors of these programs suggests that such a mixed group offers considerable benefits for the participants in terms of greater appreciation of the interface between child welfare and mental health issues. The program offered by the St. Louis Psychoanalytic Institute, however, represents a variant of this approach. This year-long program includes two semesters (48 class hours per semester); the first semester, which focuses on core issues in the psychology of adoption and foster care, is open to both child welfare and mental health professionals; the second semester, which focuses on clinical assessment and intervention, is only open to mental health professionals (including those still in training). Feedback from the director of the program indicated that this arrangement allows for more in-depth examination

[6] The National Child Welfare Resource Center for Adoption (2007) has published a guide for developing such a program.

and in-class consultation regarding adoption-related clinical issues (Chester Smith, personal communication, June 2013).

Although there is a considerable overlap across programs in many of the core adoption issues covered in their curricula, differences in course content do exist and there is considerable variability in length -- from 45 to 96 training hours. In addition, some programs have a strong clinical focus, whereas others do not. As noted above, only the program offered by C.A.S.E. requires clinical case supervision for a period of time following coursework, and only the St. Louis Psychoanalytic Institute program offers intensive (48 hours) clinically oriented training exclusively for mental health professionals. Although each program offers a certificate attesting to completion of coursework and other requirements, none offers a *certification* in adoption clinical competence. Certification implies confirmation of a specific level of knowledge and skills in a subject matter that is consistent with the requirements of an identified regulatory body. No such organization currently exists, however.

Some of the certificate programs are offered through universities; the majority, however, are offered through private agencies or institutes. Eight of the programs are replication sites for C.A.S.E.'s *Training in Adoption Competence* model [noted below by an asterisk]. Not included in the following list are programs whose primary goal is to prepare and educate adoptive parents. See Appendix for a more detailed description of each program.

- Catawba County Department of Social Services (Hickory, NC), program initiated in 2011
- Center for Adoption Support and Education (C.A.S.E.) (Burtonsville, MD); program initiated in 2009
- University of Connecticut, School of Social Work; program initiated in 2006
- *Foster and Adoptive Care Coalition (St. Louis, MO), program initiated in 2013
- Kinship Center, a Member of Seneca Family of Agencies (Tustin, CA); program initiated in 1992
- *Lilliput Children's Services (Citrus Heights, CA); program initiated in 2011
- *Lutheran Family Services of Nebraska (Omaha, NE); program initiated in 2012
- *Massachusetts Adoption Resource Exchange (Boston, MA); program initiated in 2013
- *Montgomery County Department of Job and Family Services, Children's Services Division (Dayton, OH); program initiated in 2013
- North American Council on Adoptable Children (St. Paul, MN); program initiated in 2008[7]
- Portland State University, Graduate School of Education (Portland, OR); program initiated in 2003

[7] Unlike the other programs, NACAC Adoption Competency Program is geared primarily toward training trainers.

- Rutgers University, School of Social Work, Institute for Families (Piscataway, NJ); program initiated in 2000
- St. Louis Psychoanalytic Institute (St. Louis, MO), program initiated in 2010
- University of Denver, School of Social Work, Butler Institute for Families (Denver, CO); program initiated in 2008
- *University of Minnesota, Center for Advanced Studies in Child Welfare (St. Paul, MN); program initiated in 2011
- *The Villages of Indiana (Indianapolis, IN); program initiated in 2013

Mental health professionals seeking to enhance their adoption knowledge and skills can also do so through continuing education workshops and courses. Some of the programs noted above allow participants to take individual courses without committing to the entire training. Other workshops or courses are offered frequently by adoption professionals and organizations around the country. Some are online (e.g., www.adoptionlearningpartner.org; www.ce-psychology.com) and others are in-person. Some are "stand alone" workshops on selective adoption-relevant topics; others are integrated into a more-comprehensive effort to enhance adoption competency. These workshops and CE programs can be extremely useful for keeping abreast of new research and practice issues in the field. Professionals seeking CE credits for licensure renewal should always check to see whether the individuals and/or organizations offering the training are authorized CE providers for their disciplines.

Clinical adoption competence can also be improved through mentoring and being supervised by a more experienced colleague and/or through peer support groups. (As noted above, the program at Portland State University offers participants the option of joining a professionally-led peer support group following completion of their training.) Consultations with other professionals on specific issues that arise in working with adoption kinship members will ensure that the needs of clients are more likely to be met and that the clinician's knowledge and skills grow over time. Given that adoption clinicians routinely witness the devastating legacy of early trauma in the lives of their clients, mentoring and peer support groups also serve a useful role in helping professionals manage their own stress in working with this population.

In summary, although the most likely way of becoming adoption clinically competent currently may be through enrollment in a comprehensive post-graduate adoption training program, when this type of program is not readily available, professionals who regularly work with adoptive kinship members need to consider alternative ways of deepening their knowledge and improving their skills in this area.

RECOMMENDATIONS

For a variety of reasons, adopted individuals and their families are more likely to use mental health services than is the general population. Prenatal and early-life difficulties predispose some children to adjustment problems long after their adoptions have taken place. In addition, the experience of loss and questions related to identity can complicate normal developmental changes for these youth. Helping adoptive parents manage these life complexities for their children can be a challenge, often requiring the help of professionals, especially for those who have not adequately resolved their own issues related to infertility, who do not adequately understand the impact of trauma on their sons and daughters, and/or who are unduly anxious about their children's curiosity about or connection with their birth heritage. Furthermore, birth/first mothers and fathers also frequently need the services of mental health counselors as they struggle to cope with their loss and, for a growing number of these individuals, to find satisfying ways of managing relationships with their children's adoptive families.

Mental health and allied professionals must be prepared to meet the needs of these individuals and families. They must possess not only the foundations for competent clinical practice, but also a deep understanding of the unique issues confronting adoptive and birth/first family members. Unfortunately, current graduate education programs fail to routinely provide the necessary knowledge and experience required for becoming adoption clinically competent. As a result, too many adoptive kinship members experience dissatisfaction in their efforts to find professionals who can help them understand and resolve specific life difficulties.

To better serve adoptive and birth/first families, the Institute offers the following recommendations:

Develop Certification for Adoption Clinical Competence

When seeking health and mental health care for themselves and their family members, people want to know that the professionals they are working with have the requisite knowledge, skills and experience to meet their needs. Knowing that health care providers not only are licensed in their respective fields, but also are certified in specialized areas of practice, helps inform the public about the choices they make in seeking professional services.

To date, adoption clinical practice is not governed by any regulatory body within the health or mental health care professions. As a result, the public cannot be ensured that professionals who advertise themselves as adoption clinicians have the necessary knowledge and experience to effectively meet their needs. The Institute believes it is time for the adoption field to develop stronger and more-transparent standards for clinical practice for the professionals offering their

services to members of the extended family of adoption. We believe this can best be done through the development of *certification for adoption clinical competence*.

The Center for Adoption Support and Education already has taken steps in this direction, beginning with a feasibility study conducted by an expert on certification. In 2012, with support from the Freddie Mac Foundation and the David Thomas Foundation for Adoption, C.A.S.E. convened a national task force of experts representing the fields of adoption, child welfare, mental health and professional certification to begin looking at the feasibility of developing a certification credentialing process in adoption clinical competence. Among the issues being addressed are: the perceived need for adoption clinical certification by key stakeholders (e.g., adoptive kinship members, adoption professionals, and mental health practitioners); the definition of adoption clinical competence; pathways to achieving competence; means of assessing competence; and the requirements for completing the certification credentialing process. The work of this group is still underway, with a report due in late 2013 or early 2014 (Debbie Riley, personal communication, June 2013).

- **Facilitate Dialogue Among Existing Adoption Training Programs**
  Success in developing a certification credentialing process in adoption clinical competence is likely to rest on gaining the input and cooperation from the various adoption certificate programs that currently exist around the country. Doing so will ensure that the standards set for certification are accepted broadly across the nation.

- **Develop Broad Consensus about the Definition of Adoption Clinical Competence**
  Although there is considerable overlap in the curricula of existing training programs, differences exist in the topics covered and whether some type of clinical supervision is required. Developing certification standards will require consensus about the definition of adoption clinical competence, the clinical supervision required and, importantly, the means by which such competence and experience can be achieved and verified. Input from all key stakeholders, including existing adoption certificate programs and members of mental health professional groups, is critical for ensuring broad-based consensus.

Expand Adoption Training Programs across the Country

At present, at least 16 adoption certificate programs are operating in various parts of the U.S, with several more in development. Nearly all existing programs require that most of the training take place in classroom settings, although Portland State's program already facilitates distance learning and C.A.S.E. is developing plans to do so as well. Consequently, the number of professionals who can be trained is largely restricted to those who live within driving distance of current sites. To meet the mental health needs of adoptive kinship members, a greater

number of such training programs must be developed. This can be achieved in at least two ways. Local groups of professionals comprising mental health, child welfare and adoption specialists can come together to create their own training, guided by the principles and advice offered by the National Child Welfare Resource Center for Adoption (2007) and perhaps with input from existing programs and other adoption professionals; or existing programs can seek to replicate their training models in other locations. C.A.S.E., for instance, has assisted eight other organizations around the country in replicating its *Training for Adoption Competence* model, with other programs in development. To ensure fidelity to its model, rigorous training of new professionals and follow-up assessments of training delivery are being conducted.

Strengthen the Clinical Components of Existing Training Programs

Most existing adoption certificate programs seek to train two types of professionals: child welfare specialists whose primary responsibilities involve assessing, preparing and supporting adoption kinship members during the pre-placement and early placement phase of adoption; and mental health practitioners who offer clinical, counseling and consultation services as part of a post-adoption service program or in a community-based mental health setting. As noted previously, the program at the St. Louis Psychoanalytic Institute has two tracks, with a common core curriculum for all participants during the first semester of training and selected clinically relevant courses only for mental health practitioners during a second semester.

To ensure that current programs better serve the mental health needs of the adoption community and the professionals enrolled in the programs, the Adoption Institute recommends strengthening the clinical components of program curricula. This can be accomplished by several means: increasing the number of required clinical courses for mental health practitioners; offering additional clinical courses as electives; and/or offering additional clinical courses as stand-alone, post-certificate, continuing education courses. We also recommend that all programs offer some type of clinical supervision for mental health practitioners to better ensure that newly developed knowledge and skills are integrated into effective clinical practice. To date, only the C.A.S.E. program and its replication sites require a supervision component; participants receive a "certificate of completion" only after completing both the classroom and the six-month case supervision components.

Integrate Different Approaches for Training Adoption Clinical Competence

All current adoption certificate programs are based primarily on in-person classroom training, with some offering a smaller component of training through online instruction or assigned readings or DVDs. This model restricts the number of professionals who can utilize the program to those who live relatively close to the training sites. To expand the numbers of clinically

competent adoption practitioners, the Institute recommends that programs and other adoption training professionals offer alternative ways for practitioners to receive the necessary training.

Instructional professionals concerned with distance education and those focused on technology-driven learning methods have developed interesting and successful teaching models that address the concerns raised in this report. Webinars offer opportunities for professionals in any location to access professional training on virtually any topic. Adoption certificate programs and other adoption training professionals should consider expanding their training models through live and/or archived web courses. Interviews with the program directors of the existing training centers indicate that some programs have already begun to do so (e.g., Portland State University) or are developing the means to do so. In addition, the St. Louis Psychoanalytic Institute uses video conferencing strategies to provide training to its students by adoption experts who are located in different parts of the country; C.A.S.E. and its replication sites use a similar approach for providing group supervision to their students.

More innovative than traditional webinars and video conference training are "flip teaching" and "massive open online courses" (MOOC). Flip teaching, for example, turns the classroom on its head (http://en.wikipedia.org/wiki/Flip_teaching). Rather than using class time for lectures and assigning exercises for homework, students review archived online lectures before class and engage in more interactive activities during class time, with a focus on putting knowledge into practice. MOOCs are aimed at large-scale interactive participation and open access to material via the web (http://en.wikipedia.org/wiki/Massive_open_online_course). Like other distance education approaches, these rely on videos, readings and problem sets, but also include large-scale interactive user forums that help build a *community of students and educators*, where ideas can be readily exchanged and collaborative projects among participants developed. The broad-based acceptance of this distance education strategy by universities and business organizations around the world led the *New York Times* to dub 2012 "The Year of the MOOC." (http://www.nytimes.com/2012/11/04/education/edlife/massive-open-online-courses-are-multiplying-at-a-rapid-pace.html?pagewanted=all&_r=0).

Integrating distance education strategies with more traditional instructional methods used by current adoption certificate programs, or developing them as independent adoption-training opportunities, offers mental health professionals from around the country ready access to knowledge and skills sets needed to better serve adoptive kinship members.

Develop Distance Supervision and Consultation Models

Translating knowledge and skills into clinical practice takes time and requires supervision by experienced practitioners. Some programs have sufficient staff to meet the clinical supervision needs of their students; others may not. In strengthening the clinical components of their

training, adoption certificate programs should consider incorporating distance supervision into their models. Whether for individuals or groups, a distance supervision model allows training programs to offer students access to highly experienced and skilled clinicians around the country. C.A.S.E. has implemented a six-month distance case consultation/supervision component (through video and/or audio conferencing) in all it training sites, with positive feedback from participants about the process' quality and usefulness (Debbie Riley and Jane Ran Kim, personal communication, June 2013). Portland State University offers an optional, professionally led peer supervision opportunity after completion of its program.

Distance consultation models should also be encouraged for adoption clinicians, especially after they finish their formal training and are working in community settings. Even experienced clinicians, at times, find themselves uncertain about case issues and how best to intervene with their clients. Clinical training emphasizes "knowing one's limits" and seeking help from one's peers when there is uncertainty about how to proceed with a case. These principles also hold true for adoption specialists. Knowing who to turn to for advice and guidance, whether nearby or at a distance, is an important part of a successful clinical practice. The rise of technology has made distance consultation readily available to nearly anyone who chooses to use it.

Encourage Adoption Clinicians to Develop Peer Support Groups

Peer support groups offer professionals opportunities for informal supervision and guidance, as well as emotional support. Adoption clinicians are well advised to seek out others working in the field and to take advantage of the opportunities offered by peer support groups. This is especially important for clinicians routinely working with traumatized children. Witnessing children's suffering and the stress that it brings to adoptive families can be emotionally challenging for therapists, creating significant counter-transference complications and contributing to professional burnout. Peer support groups help clinicians understand and manage their own emotional reactions to case issues and provide opportunities for useful feedback on case management. As noted previously, Portland State's program facilitates a connection between its students and community-based, professionally led peer support groups for adoption professionals.

Develop Regional Professional Organizations for Adoption Clinical Providers

Professional identity and practice is enhanced when one has an opportunity to be part of a community of peers with similar interests and training. Membership in a professional organization is one way in which clinicians and researchers often achieve this goal. To support adoption clinical practice as an emerging specialty area in mental health services, the Institute encourages adoption professionals around the country to develop regional organizations aimed

at promoting best practices in working with adoption kinship members. If successful, regional organizations could lead to a national organization of adoption clinical providers.

Develop Stronger Ties between Local Child Welfare Agencies, Adoption Agencies, and Mental Health Training Programs and Practitioners

The mental health needs of adoptive and birth/first family members are complex and cut across many professional disciplines. Understanding these needs and developing improved services to meet them would be enhanced by better communication and cooperation among child welfare and mental health organizations and providers. To achieve this goal, the Institute recommends that, on a local and regional level, child welfare agencies, adoption agencies, and mental health organizations and providers explore collaborative strategies for developing and implementing more accessible, affordable and effective post-adoption mental health services. Seeking better communication between local child welfare and mental health training programs could also lead to a greater number of training facilities offering educational and practicum experiences focusing on the psychology of adoption and foster care, as well as more informed referrals by adoption agencies to community professionals who are truly adoption-competent.

Encourage Graduate Training Programs and Post-Graduate Clinical Training Centers to include more Information about Adoption and Foster Care

Given the higher prevalence of adopted and fostered individuals and their families in different types of mental health and special education settings, graduate and post-graduate clinical training programs need to include more information about these populations in their curricula and offer students more training opportunities to work with them. Integrating this information into courses and seminars on human development and family life, grief and bereavement, diversity issues, and assessment and treatment of traumatized and attachment disordered individuals are obvious places to start. The better grounding in these areas that professionals receive in their graduate and post-graduate training, the better prepared they will be to serve the needs of adoption kinship members and to seek to expand their expertise on adoption and trauma-related issues.

Develop Outreach Efforts to Inform Mental Health Providers about the Need for Adoption Competency and Opportunities for Enhancing their Knowledge

Mental health providers are often unaware of the existence of post-graduate adoption clinical training opportunities. In fact, they are often unaware of the unique clinical needs of adoption kinship members and the value of specialized training to meet those needs. To achieve the goal of enhancing adoption-competence for a greater number of mental health practitioners, the Institute recommends that adoption training programs and other adoption professional organizations develop coordinated and broad-based outreach initiatives to: (a) increase the

awareness of mental health professionals about the clinical needs of adoption kinship members; (b) identify various opportunities for increasing adoption clinical competence for interested professionals; and (c) explain the benefits of developing specialized knowledge and skills in this area.

Although feedback from program directors suggests that such efforts are promoted at a local level by all training programs, these efforts need to be broadened, both at the regional and national levels, targeting university clinical training centers, post-graduate clinical training centers, child welfare and mental health organizations, continuing education providers, and others. At a time that managed care policies of insurance companies are increasingly impacting families' health care choices, limiting access to a restricted group of practitioners, and limiting the number of sessions and the fees reimbursed for psychotherapy, mental health providers are very interested in new ways of developing and maintaining viable professional practices. Identifying underserved and poorly served populations and developing specialized skills to meet the mental health needs of these niche populations is a strategy that many clinicians have successfully implemented. Creating greater awareness among mental health practitioners of the needs and motivation of the adoption community to utilize mental health services could increase the interest of therapists as they seek to expand their clinical practice.

Educate Insurance Companies and Managed Care Providers about the Unique Clinical Needs of Adoption Kinship Members

Although many clinical problems can be treated with time-limited psychotherapy by a wide range of mental health professionals, others cannot. As noted above, the problems manifested by some adopted children are too complex to be captured by current diagnostic systems and too entrenched to be ameliorated by brief treatment. Furthermore, too few professionals have the training and experience to understand and effectively work with this population, and adoptive parents often find that they cannot locate an adoption competent therapist on their managed care providers' list of approved professionals. To address this problem, concerted advocacy efforts must begin to educate insurance companies and managed care providers about the unique clinical needs of adoption kinship members. This process will be greatly helped if the mental health field recognizes the value of adoption clinical certification and takes appropriate steps to support its development. Professional certification offers adoptive kinship members and their insurance companies a more transparent and valid means to identify practitioners who are truly qualified to work with difficult problems faced by these families.

Encourage Research on Training Effectiveness and Outcomes

Finally, although there are a number of pathways to becoming adoption clinically competent, it is unclear which is most effective. At present, adoption certificate training programs offer the most organized and efficient means of gaining the knowledge and skills necessary to meet the mental health needs of adoptive kinship members. There is no systematic research, however, documenting the effectiveness of these programs or other means of gaining adoption-relevant knowledge and skills. To better serve the training needs of professionals and the well-being of adoptive kinship members with whom they work, the Institute recommends that researchers examine the effectiveness of training programs in terms of: (a) knowledge gained by participants; (b) changes in clinicians' practice as a result of training; and (c) outcome changes for clients in terms of satisfaction with services and reduction in presenting problems.

Several adoption training program directors, in interviews, noted that they routinely conduct pre- and post-training assessments of participants' knowledge of adoption-related information. This is a simple and effective way of determining whether relevant knowledge and skills are being adequately learned. There is no research available, however, on the relative effectiveness of different training strategies for fostering specific adoption knowledge and skills. As programs begin to explore various ways of offering training (i.e., in-person, live distance education, archived coursework, etc.), researchers will need to determine the relative merits and drawbacks of these approaches for facilitating greater adoption competence.

Translating knowledge into practice is another area that needs empirical attention. To date, only C.A.S.E. has reported research on how its training influences participants' professional practices or organizations (Atkinson, et al., in press). Survey data were collected from 185 individuals approximately six to eight months after training. Five aspects of practice change and one aspect of organizational change were identified through grounded theory assessment of respondents' narrative responses: information collected at intake/with referral/in initial phase of assessment; methods used to assess family and/or children; clinical approaches used; use of or referral to other resources/therapies; techniques used in work with children and youth; types of organizational services/supports provided. All respondents reported change on at least two of the six practice/organizational dimensions; over half of respondents reported change in all five practice dimensions and 58 percent reported change at an organizational level. The aspects of practice most often influenced by training were: adoption and trauma-related information collected at intake or during initial assessment (94%); assessment methods used (86%); clinical approaches used (85%); and techniques used to work with children and youth.

Although this research suggests that trainees are successful in integrating newly acquired knowledge and skills into their professional practices, the findings need to be replicated with more objective measures and with designs that follow the application of knowledge over time.

Self-report data about practice change following training are subject to "halo" effects and other reporting biases (Kahneman, 2011). In other words, participants who have invested time and money in a training program may be prone to believe that practice change will occur because that is one of the stated purposes of the training and the reason they enrolled in the program. Future research should consider alternative ways of examining the translation of training into practice and/or organizational change, including but not limited to: direct observation, multiple informant strategies (including input from clients) and/or record review. In addition, research needs to examine whether practice change is sustained over time or is short-lived.

Finally, measuring the impact of adoption-competent training on outcomes for clients is also important, but more complicated. In approaching this issue, one first has to decide what to measure. What type of changes would one expect from being treated by an adoption-competent therapist as opposed to one who has not received such training? Perhaps a place to start is with clients' perceptions of treatment delivery and their views regarding therapists' sensitivity to their needs and concerns. As noted previously, the literature is replete with reports of dissatisfaction of adoptive families and birth/first parents regarding the clinical services they have received from one or more mental health professionals (Atkinson, et al., in press; C.A.S.E. (2012); Casey Family Services, 2003; Festinger, 2006; NACAC, 2002; Smith & Howard, 1999). Given that therapy effectiveness has a great deal to do with the relationship qualities established between therapist and client (Catty, 2004; Levy, 2000), examining the value of specialized adoption training on the therapeutic alliance would be an interesting and relevant line of inquiry. An adoption-competent therapist presumably would be more attuned to the sensitivities and needs of adoptive kinship members and intervene in a way in which they would feel more respected and understood; in turn, clients would likely use clinical services more consistently and effectively, leading to a reduction in presenting problems. Research on the effectiveness of specialized adoption training should prove to be invaluable in helping training programs refine their curricula and training strategies so that professionals are better equipped to meet the mental health and developmental needs of their clients.

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APPENDIX

Adoption Training Programs for Professionals

The following programs offer post-graduate training in adoption clinical competence. For more specific information about course offerings, program requirements, costs, and dates of training, visit their websites or speak to the contact people noted below. Programs marked with an asterisk use the training model developed by the Center for Adoption Support and Education.

***Catawba County Department of Social Services**
Hickory, NC 28602
Contact Person: Dawn Wilson, M.S.W. DawnEWilson@CatawbaCountyNC.gov
Telephone: 828-695-5702
www.catawbacountync.gov/dss/FamilyNET/CaseTraining.asp
Program Initiated: 2011
Program Description and Requirements: Based upon C.A.S.E. model; TAC replication site

Center for Adoption Support and Education (C.A.S.E.)
Burtonsville, MD 20899
Contact Person: Debbie Riley, LCMFT Riley@adoptionsupport.org
Telephone: 301-476-8525
www.adoptionsupport.org
Program Initiated: 2009
Program Description and Requirements: *Training for Adoption Competence (TAC)* is a 13-session (78 hours), manualized competency-based training program for licensed mental health clinicians and child welfare professionals who provide pre- and post-adoption services to prospective adoptive parents, birth parents, adopted persons, and adoptive and kinship families in a variety of settings. Eleven sessions are classroom-based; one session is an at-home module; and a final session provides participants with an opportunity to integrate learning. Each session combines information sharing, written handouts and resources, and experiential learning, including case studies, role plays, and introspective work. Following successful completion of the classroom-based training, students complete a 6-month case consultation/supervision (offered once monthly) in which they present cases and apply classroom learning in their clinical practice. C.A.S.E. uses distance education methods for supervision; it is in the process of developing online training opportunities as well. Empirical support for the impact of training on recipients' knowledge and adoption practice has been shown (Atkinson, et

al., in press). The TAC model has been replicated (or is in the process of being replicated) in eight other sites around the country, with at least one other program (e.g., University of Connecticut) planning on switching to the C.A.S.E. model (see below). [Replication sites identified below by an asterisk *]
Professional Licensure Required: Yes
Clinical or Social Casework Supervision Required: Yes

***Foster and Adoptive Care Coalition**
St. Louis, MO 63144
Contact Person: Melanie Scheetz melanieschEetz@foster-adopt.org
Nickie Steinhoff nickiesteinhoff@foster-adopt.org
Telephone: 314-367-8373 x 2221
Program Initiated: 2013
Program Description and Requirements: Based upon C.A.S.E. model; TAC replication site

Kinship Center
A Member of Seneca Family of Agencies
Salinas, CA 93908
Contact Person: Margaret Ross, MSW
Carol Bishop, LMFT cbishop@kinshipcenter.org
Telephone: 831-455-9965
http://www.kinshipcenter.org/education-institute/classes/professional-classes.html
Program Initiated: 1992
Program Description and Requirements: *Adoption Competence Training (ACT)* is 48 hours (8 classroom sessions, typically over a four month period) of comprehensive education integrating mental health and permanency principles into a multimedia, intensive learning experience addressing adoption and post-permanency practice. The curriculum is designed to inform the permanency practice of child welfare and mental health workers, with a focus on preparing them to help families understand grief and loss, and the impact of the adoption experience on all members of the adoptive kinship networks. Emphasis is given to developing assessment and intervention tools to address adoption-related issues in child welfare and mental health practice. ACT is offered is offered regularly in several locations in CA and upon request in other states. Since its inception it has trained over 7,500 professionals in six different states.
Professional Licensure Required: No
Clinical or Social Casework Supervision Required: No

***Lilliput Children's Services**
Citrus Heights, CA 95610
Contact Person: Edythe Swidler, L.M.F.T. eswidler@lilliput.org
Telephone: 916-830-7739
lilliput.org/Services_Training_and_Consultation.aspx
Program Initiated: 2011
Program Description and Requirements: Based upon C.A.S.E. model; TAC replication site

***Lutheran Family Services of Nebraska**
Omaha, NE 68102
Contact Person: Linda Dubs, L.I.C.S.W. ldubs@nchs.org
Cortney Schlueter, L.M.H.P., L.A.D.C. cschlueter@lfsneb.org
Telephone: 402-483-7879 (L.D.)
402-661-7115 (C.S.)
Program Initiated: 2012
Program Description and Requirements: Based upon C.A.S.E. model; TAC replication site

***Massachusetts Adoption Resource Exchange**
Boston, MA 02110
Contact Person: Lisa Funaro
lisaf@MAREinc.org
Telephone 617-542-3678
Program Initiated: 2013
Program Description: Based upon C.A.S.E. model; TAC replication site

***Montgomery County Department of Job and Family Services**
Children's Services Division
Dayton, OH 45422
Contact Person: Craig Rickett, M.S.W., L.S.W rickec02@odjfs.state.oh.us
Jewell Good jgood@mcadamhs.org
Telephone: 937-276-6515 (C.R.)
937-443-0416 (J.G.)
adoptionsupport.org/index.php/training-institute/training-adoption-competency-t-a-c/
Program Initiated: 2013
Program Description and Requirements: Based upon C.A.S.E model; TAC replication site

NACAC-North American Council on Adoptable Children
St. Paul, MN 55114
Contact Person: Kim Stevens kimstevens@nacac.org
Telephone: 508-254-2200
www.nacac.org/conference/adoptcompetencytraining.html
Program Initiated: 2008
Program Description and Requirements: *Adoption Competency: Train the Trainers* is comprised of 52 hours of classroom training over eight days, typically within a two to three month period. Unlike the other training programs, the one offered by NACAC is not only geared to social casework and clinical service providers, but also to those whose responsibility is to facilitate training of these professionals. Particular attention is given to the complexities facing children placed from the child welfare system who lives have been impacted by prenatal complications, disrupted attachments, abuse, neglect and neurobehavioral problems. Training is offered throughout the country and is adapted to meet the unique needs of the local host, while at the same time preserving the core learning points, goals, and objectives identified by national experts who helped create the curriculum. The training model is highly interactive and includes presentations by participants, either individually or in teams. Trainees are required to participate in ongoing clinical and peer supervision, as well as continuing education, if they are to serve as NACAC approved adoption competence trainers. NACAC does not provide the supervision, although staff trainers are available and encourage ongoing consultation.
Professional Licensure Required: No
Clinical or Case Supervision Required: Yes, if trainees wish to maintain NACAC approval as adoption competence trainers

Portland State University (in collaboration with Oregon Post Adoption Resource Center)
Graduate School of Education, Continuing Education
Portland, OR 997207
Contact Person: Marion Sharp sharpml@pdx.edu
Telephone: 503-725-4876
ww.pdx.edu/ceed/therapy-with-adoptive-and-foster-families-certificate-of-completion
Program Initiated: 2003
Program Description and Requirements: *Therapy with Adoptive and Foster Families Certificate Program* consists of 96 hours of training (56 hours of classroom workshops over eight days which is also available through live video streaming for those at a distance; 40 hours of online courses). The program is designed for both mental health professionals and child welfare professionals. Courses, which are taught by local and

national adoption experts, emphasize understanding the complexities faced by families who adopt children from the public child welfare system and have histories of abuse, neglect, attachment problems, trauma, medical difficulties and behavioral disorders. Participants not interested in completing the full certificate program are welcome to take individual courses. The program was the first to offer its entire curriculum through distance education technology. Following completion of the program, licensed therapists are invited to participate in the Structured Educational Consultation Group sponsored by Cascadia Training (www.cascadia-training.org), a program division of Northwest Resource Association, the parent group of Oregon Post Adoption Resource Center. The consultation group assists therapists in the practical application of emerging theory and research in the treatment of trauma in adopted and foster children and their families.
Professional Licensure Required: Yes
Clinical or Social Supervision Required: No

Rutgers University School of Social Work
Institute for Families
Office of Continuing Education
New Brunswick, NJ 08901
Telephone: 732-932-8758
http://socialwork.rutgers.edu/continuingeducation/ce/certificateprograms/certificateadoption.aspx
Contact Person: Gina Sharpe, LCSW
Program Initiated: 2000
Program Description and Requirements: The *Certificate Program in Adoption* is 45 hours classroom training over nine days. Seven core workshops are required, plus two elective workshops. Of the seven required workshops, four focus on assessment and/or interventions in working with complex adoption challenges (e.g., attachment problems, trauma, behavior management issues, and post-institutionalization problems). The program is geared toward child welfare professionals and mental health professionals. Participants not seeking the full certificate program are welcome to take individual workshops. This program was replicated by Camelot Community Care and offered in Bradenton, FL this year.
Professional License Required: No
Clinical Supervision or Case Consultation Required: No

St. Louis Psychoanalytic Institute
St. Louis, MO 63124
Telephone: 314-361-7075
Contact Person: Chester Smith, M.Ed., L.P.C. cosmith3@charter.net

Program Initiated: 2011
Program Description and Requirements. *The Psychodynamic Studies in Adoption and Foster Care Program* is a one year (96 hours) training program for mental health clinicians and other professionals who are involved in the care or education of fostered and adopted children and their families. Coming from a psychodynamic orientation, this program is divided into two semesters. The first semester is open to all professionals and focuses on the psychological and developmental factors that contribute to mental health issues in fostered and adopted children and their families. These include attachment disruption from birth parents and other significant caregivers in the child's life, along with other forms of trauma that can disrupt normal development. The second semester is only open to clinicians and graduate students in the mental health field and focuses on clinical assessment and treatment of adopted and foster children and their families. Case conferences offer students the opportunity to present their own cases.
Professional License Required: No
Clinical or Social Casework Supervision Required: No

University of Connecticut (in collaboration with Southern Connecticut State University)
School of Social Work
West Hartford, CT 06117
Contact Person: Catherine Gentile-Doyle, L.C.S.W. cgent630@gmail.com
Telephone: 860-570-9129
www.ssw.uconn.edu/wp-content/uploads/2010/04/Brochure-2012-13.pdf
Program Initiated: 2006
Program Description and Requirements: *Clinical Issues in Adoption: A Post-Master's Program* is currently comprised of 45 hours of classroom training over nine days. The program explores the challenges and complexities of clinical work with diverse types of adoptive families, as well as with birthparents. The goal of the program is to train child welfare professionals, community mental health professionals, adoption services providers and private practitioners to establish a cadre of adoption competent professionals who can meet the post-adoption needs of adoption kinship members. Particular attention is given to the needs of families who have adopted through the child welfare system. [Accordingly to Catherine Gentile-Doyle, this program will soon switch to the training model developed by the Center for Adoption Support and Education described above.]
Professional Licensed Required: No
Clinical or Social Casework Supervision Required: No

University of Denver
Butler Institute for Families
Graduate School of Social Work
Denver, CO 80208
Contact Person: Michele Hanna, MSW, Ph.D. Michele.Hanna@du.edu
Telephone: 303-871-2434
www.thebutlerinstitute.org/pd/training/adoption-competent-practice-certification/
Program Initiated: 2008
Program Description and Requirements: The *Adoption Competent Practice Certificate Program* is 45 hours of training (6.5 hours a day for six days of classroom-based coursework, plus six hours of group case application and consultation following completion of coursework; the latter is two hours a month, over three months). The program, which includes both child welfare professionals and mental health professionals, focuses on specialized theories and practices for working with all members of the adoptive kinship system. It also emphasizes the development of a framework for understanding the complexity of being a child or adult in a family by adoption, and the therapeutic skills that enable practitioners to work at the individual, couple, group and family levels of clinical practice. Particular focus is given to social casework and clinical issues associated with child welfare adoptions, including the neurobehavioral and developmental of trauma and other early life adversities. During small group consultations following classroom training, participants are supported in integrating their knowledge into their social casework and clinical practices.
Professional Licensed Required: No
Clinical Supervision Required: No

***The Villages of Indiana**
Indianapolis, IN 46208
Contact Person: Sharon Pierce spierce@villages.org
Telephone: 317-775-6500
www.villages.org/parenting/adoption-training/
Program initiated: 2013
Program Description and Requirements: Based upon C.A.S.E. model; TAC replication site

***University of Minnesota, School of Social Work, Center for Advanced Studies in Child Welfare**
St. Paul, MN 55108
Contact Person: Jae Ran Kim, MSW, LGSW blev0001@umn.edu
Telephone: (612) 626-3831
http://cascw.umn.edu/pacc/
Program Initiated: 2011
Program Description and Requirements: Based upon C.A.S.E. model; TAC replication site