Toward Evidence-informed Pre and Post Adoption Practice

Presented at

New Worlds of Adoption : Linking Research with Practice

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9:15 to 10AM

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Structure of the Talk

- Adoption Outcomes
- Risk and Protective Factors for Adoption Outcomes
- The Path to Adoption Disruption
- Post-Adoption Service Types and Effectiveness
- Service Intervention Ideas
  - Common Elements
  - Common Factors
  - Adoption Competencies
- Future Directions

Prevalence and Relevance

- More than 50,000 children are adopted from foster care each year—
  - At least one-quarter by relatives
- More than 500,000 are now in post-adoption status
  - about $3b spent per year in federal+ state funds for adoption assistance payments and related training and administrative costs
    - Federal government supports twice as many adopted children as foster children but spends only half as much doing so

Adoption Outcomes

a. Continuing without clinical intervention

b. Continuing with clinical intervention

c. Disruption prior to finalization/legalization [never leaves foster care]

About 11% over 3-5 years

d. Dissolution/set aside after finalization/legalization [returns to CWA custody]

About 5% over 3-5 years

e. Displacement [moves to another setting but does not return to custody of CWA]

f. Other adverse outcomes (run away, move to other kind of custody [juvenile services or mental health]

g. Disruption/Dissolution/Displacement/Other (c through f, called "disruption" for short)

About 20% over 10 years (my guess)

h. Adverse Adoption Outcomes (b through f)

Risks Associated with Adverse Adoption ~~Outcomes~~ Experiences

Child and Family Risk Factors for Adoption Disruption

- Older age at time of placement
- Partial disclosure of information regarding child's problems (strengths-based assessments are not enough)
- Threatens people, trouble at school, and cruelty to others are indicators of concern
- More educated and younger mothers may be more likely to experience disruptions
  - Rigid or very high expectations for academic performance and family joining may increase risk

Child and Family Protective Factors for Adoption Stability

- Younger children
- Placement of two siblings into home with no biological children may reduce risk
- Receiving subsidy may increase stability
- Children with physical handicaps have reduced risk

Service Characteristics Associated with Reduced Risk of Disruption

- Comprehensive and realistic information about the child (and adoptive family)
- Parents participate in group "home study" (peer-to-peer) process
- Family receives educational support
- Family pursues timely adoption preservation services that are flexible and long-lasting
- MAPP AND PRIDE have shown no effect
  - Yet the value of this approach has become canon

- THERE HAS GOT TO BE MORE!

Summary: Do Post-Adoption Services Reduce Disruption?

- No affirmative clinical trials showing changes in interim benefits or disruption reduction
- Yet, there is substantial need for PAS because of:
  - Behavior problems of adopted children
  - Inadequacies of Medicaid funded services
  - Dangerous and extreme methods in use (e.g., holding therapy)

Predict Success

- IF YOU NEEDED TO MAKE A PREDICTION ABOUT HOW ANY ADOPTION WOULD TURN OUT, THE BEST PREDICTION WOULD BE

SUCCESSFULLY

Research Regarding the Path to Adoption Disruption

The Path to Adoption Disruption

- Children fail to meet parent expectations
  - Children's behavior does not improve
  - Children do not act in ways that parents view as showing closeness or appreciation
- School related distress
- Injury or harm to birth children or parent
- Sometimes signaled by subsidy adjustments
- Rarely through abuse and neglect and removal

Pathways to Problems II

- Poor information prior to and during adoption
- Inadequate pre-adoption preparation
- Family is unable to obtain needed educational support
- Difficulty with child does not decrease with time (staying the same is not good enough)
- Family pursues help that is too late or focuses only on child treatment (rather than family and environmental qualities)
- Perceived harm to biological children if adoption continues

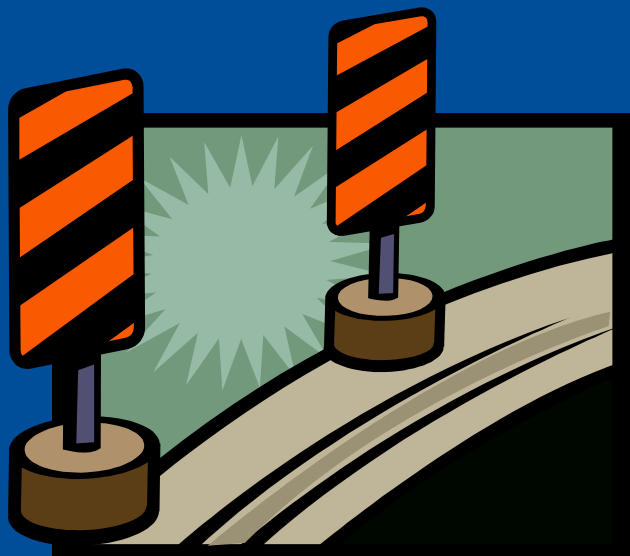
Opportunities for Data Integration on Behalf of Adoption

Home Studies As Source of Information for Service Planning

- Most home studies yield limited information about the family that seeks to adopt and what their service needs may be
- In the decades ahead we should be changing home studies to standardize them to enhance adoption across jurisdictions and to improve pre- and post-adoption service planning

Understanding Subsidy Changes

- Could be an early warning system that could help alert agency to the need for more intensive post-adoptive services
  - Subsidy increases → residential care
  - Family moves may signal family distress
  - Yet, subsidy information is rarely mined



Post-Adoption Services: An End to Attachment Dominance

Post-Adoption Services Have Been Dominated by Attachment Theories and Therapies

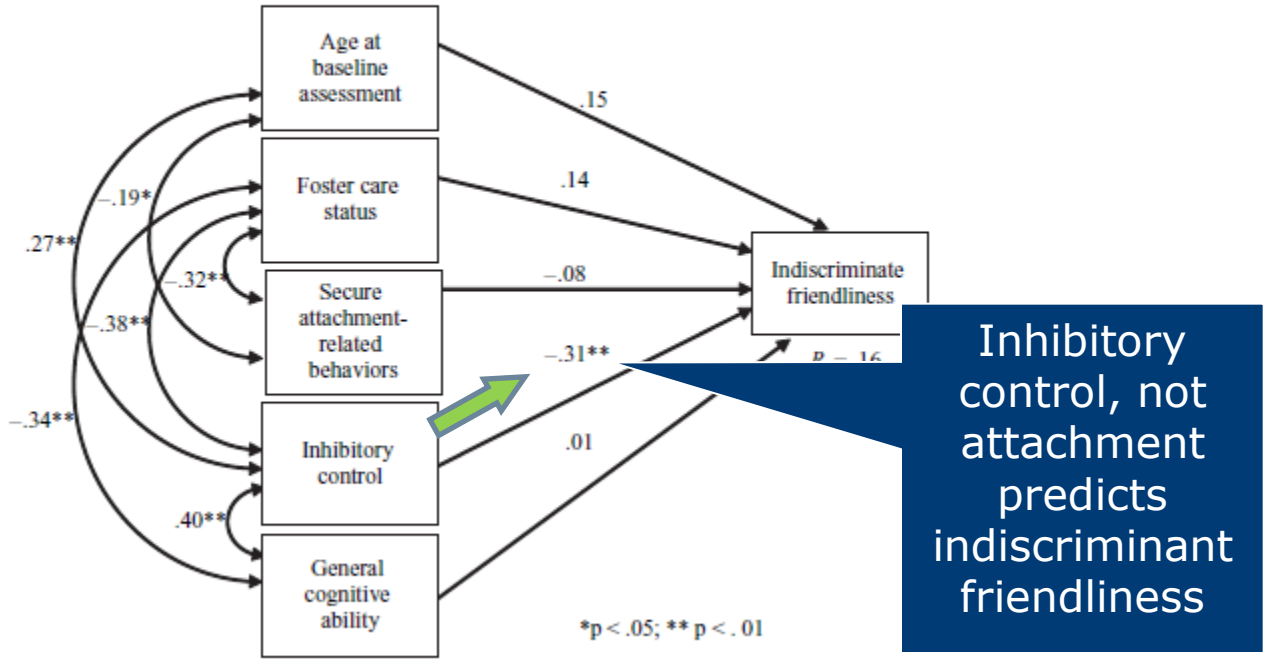
- Assumes that adopted children are more different—than the same--as not-adopted children
  - Not adopted children rarely, if ever, get attachment focused treatment
- Assumes that the stress and disinhibitory responses of adopted children are from attachment rather than other contributors
- Too often assumes that attachment is a practice theory that works across age groups and not, simply, a developmental theory for young children—yet there is no treatment evidence base

Post-Adoption Services Have Been Dominated by Attachment Theories and Therapies

- The principle of PARSIMONY calls for "the simplest and most frugal route of explanation available"
  - Attachment theory adds nothing that other newer neuro-psychosocial interventions can provide

Side-note: Indiscriminate Friendliness, Attachment, and Inhibitory Control

Figure 1
Predicting Indiscriminate Friendliness From the Hypothesized Correlates



Bruce, Tarullo & Gunnar (2009); Pears, Bruce, Fisher, & Kim (2009)

Consistent Nurturing Responsive Parenting Improves Child Connectedness and Self-Regulation

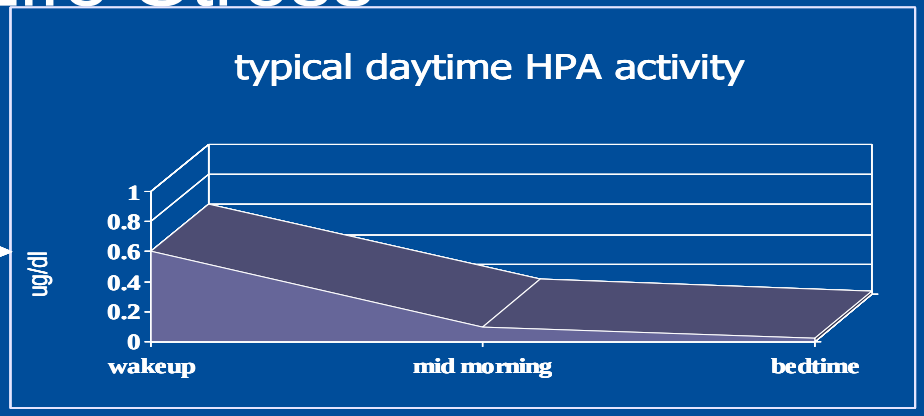
- Has an impact on regularizing stress-hormones
- May improve

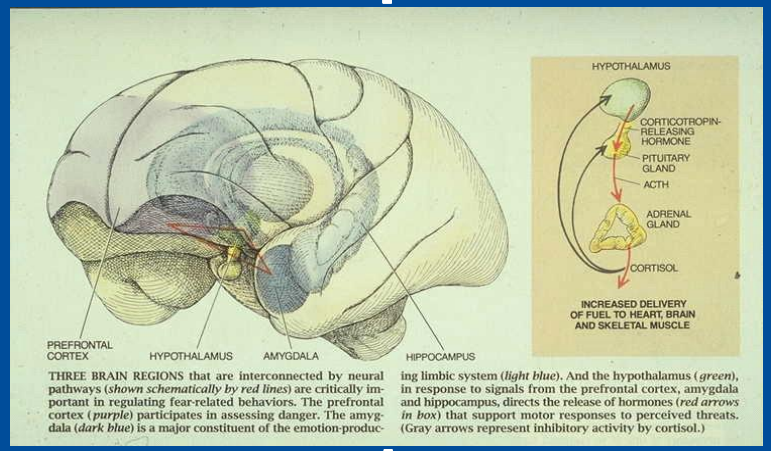
Disinhibitory (Executive) Control & the PreFrontal Cortex

- Self-regulation that contributes to both learning and emotion appears to be heavily influenced by the prefrontal cortex
  - Biology
  - Exposure to “other” regulation
  - Neural reorganization from experience/practice

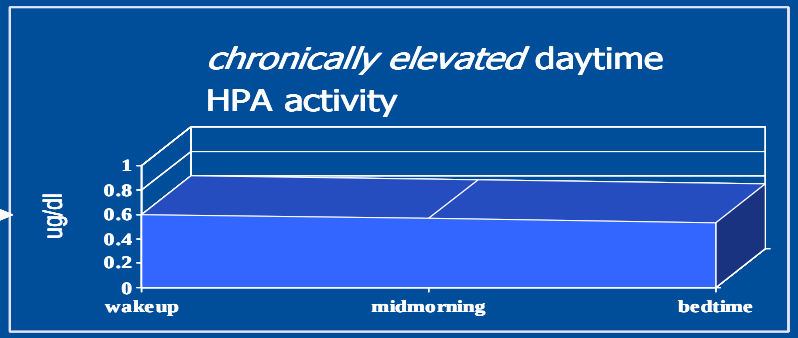
HPA Axis (Hormonal) Dysregulation Associated With Early Life Stress

typical

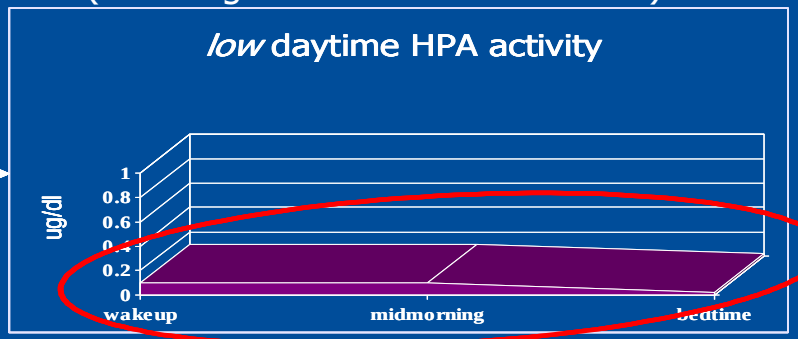




THREE BRAIN REGIONS that are interconnected by neural pathways (*shown schematically by red lines*) are critically important in regulating fear-related behaviors. The prefrontal cortex (*purple*) participates in assessing danger. The amygdala (*dark blue*) is a major constituent of the emotion-producing limbic system (*light blue*). And the hypothalamus (*green*), in response to signals from the prefrontal cortex, amygdala and hippocampus, directs the release of hormones (*red arrows in box*) that support motor responses to perceived threats. (Gray arrows represent inhibitory activity by cortisol.)



(downregulation via chronic stress)



stress-induced 'blunted' patterns

Anxiety and affective disorders

Related Work

- ABC
- MTFC-pre
- KEEP

- Do successful interventions with foster children need to address attachment? No. Adoption?

Fisher, P. A., Kim, H. K., & Pears, K. C. (2009). Effects of Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) on reducing permanent placement failures among children with placement instability. *Children and Youth Services Review, 31(5), 541-546.*

Dozier's ABC Study

- Attachment and Biobehavioral Catch Up (ABC) RCT
  - Normalized Hypothalamus-pituitary-adrenal (HPA) axis functioning among foster children (15 to 24 months) and regularize cortisol production
    - Addresses caregiver's behavior (10 sessions) to help them be "effective responsive interpersonal partners"

ABC: Attachment & Learning Theory

- Across development, foster care is associated with difficulties regulating behaviors, emotions, and physiology. Thus, conditions associated with foster care placement (e.g., disruptions in care, maltreatment) appear to affect very basic and fundamental regulatory processes.
- Interventions have been designed that target developmentally specific manifestations of regulatory difficulties. Although the literature regarding evidence-based interventions for foster parents is quite limited, preliminary findings provide some evidence that nurturing, responsive care can serve to partially remediate early deficits. Even in the case of quite adverse early experience that results in problematic child outcomes. there is some evidence that the development of many systems remains relatively plastic (p. 843).

Dozier, M., Albus, K., Fisher, P. A., & Sepulveda, S. (2002). Interventions for foster parents: Implications for developmental theory. *Development and Psychopathology, 14(4), 843-860.*

MTFC-P Intervention

Foster Parent Consultant

Family Therapist

'Daily Report' Caller

STAFF

Case Manager

Child Therapist
Behavioral Skills Trainer

Child Psychiatrist

Caregiver-Child Relationship

Case Management

Child Needs

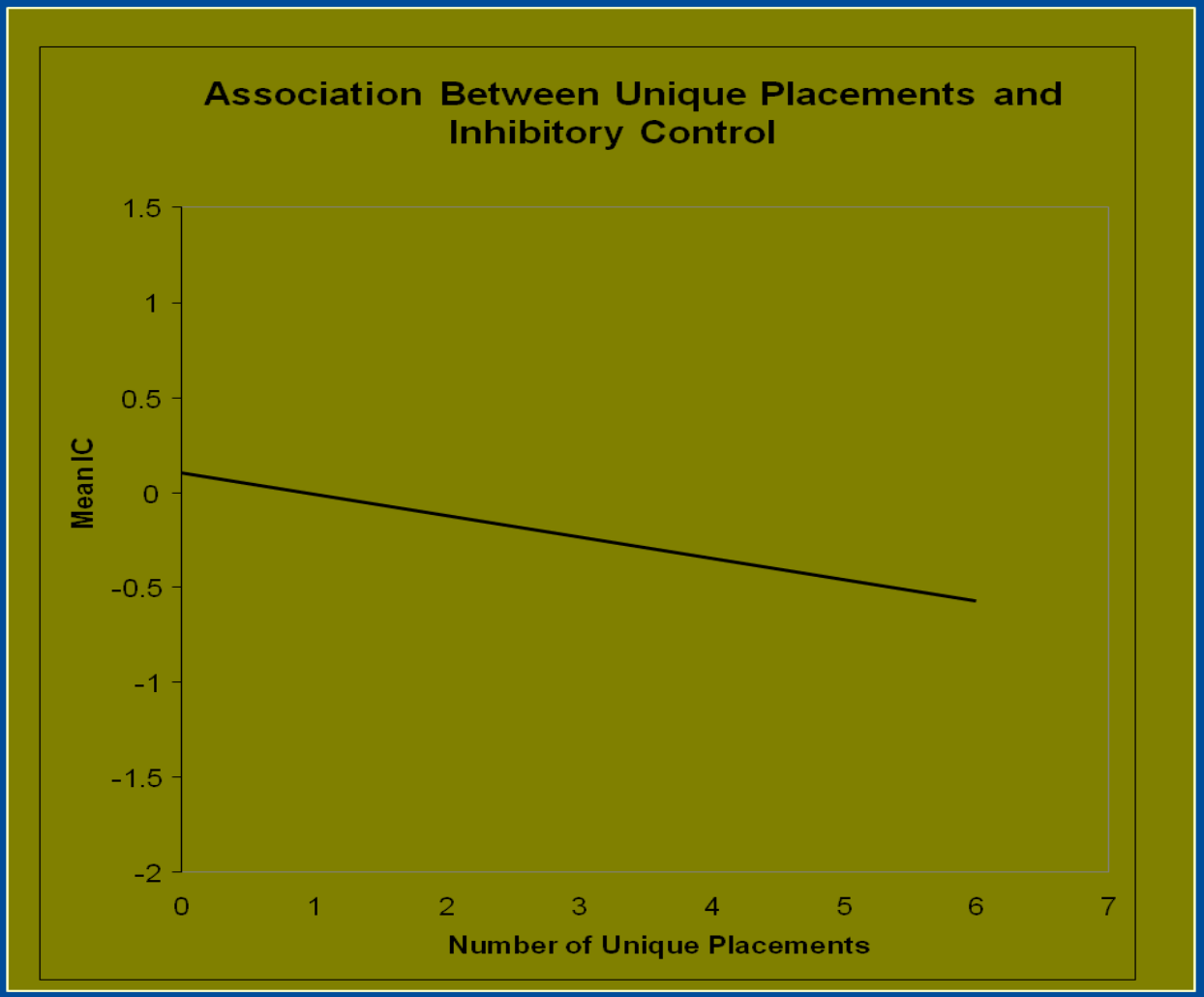
Contexts

Home

Community

Preschool/school

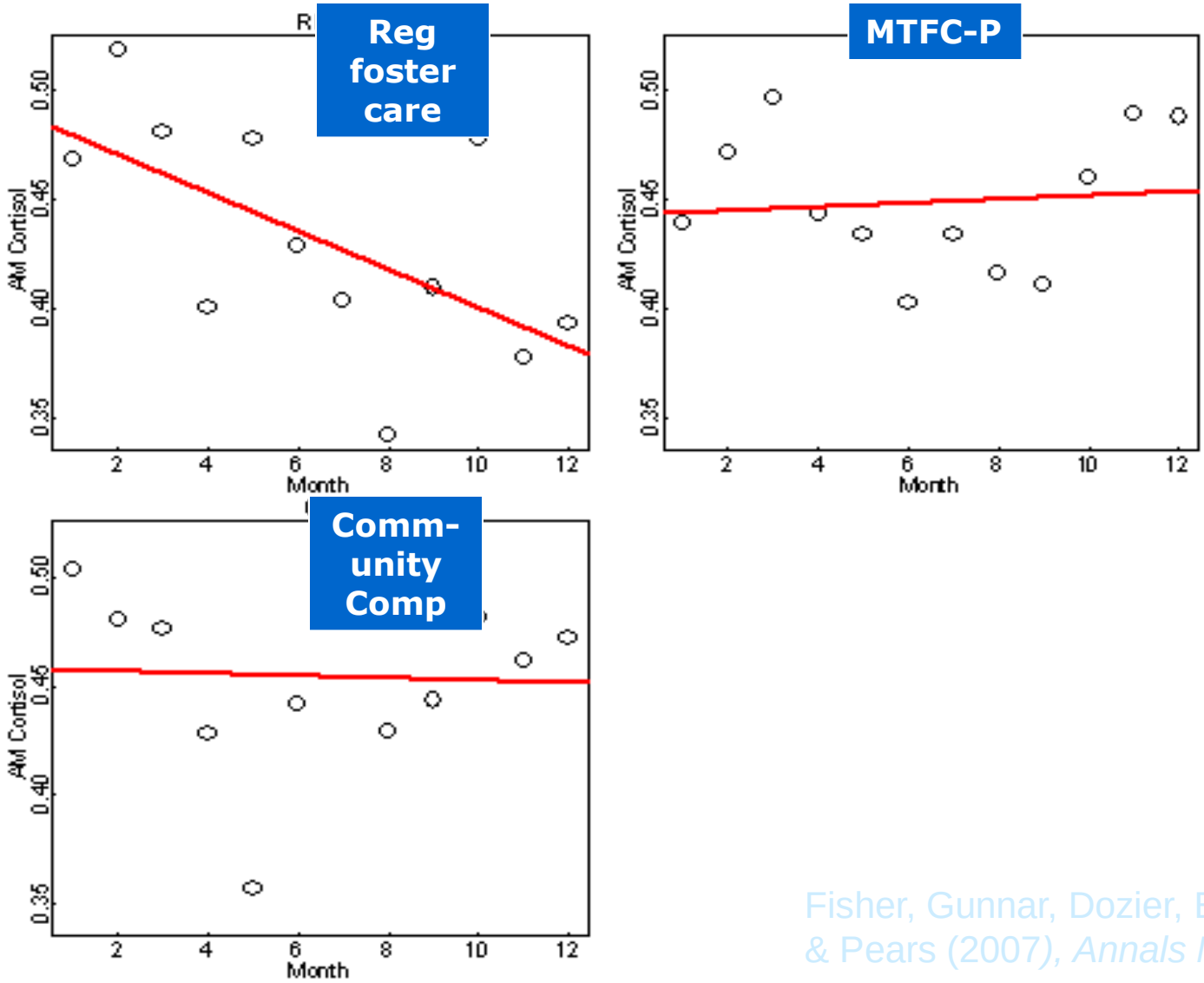
Behavioral Self-control Is Better For Children With Placement Stability



Pears, Bruce, & Fisher (in press)

Also Lewis, Dozier, et al. (2007)

Group Effects On Morning Cortisol Levels Across Time *For Children*

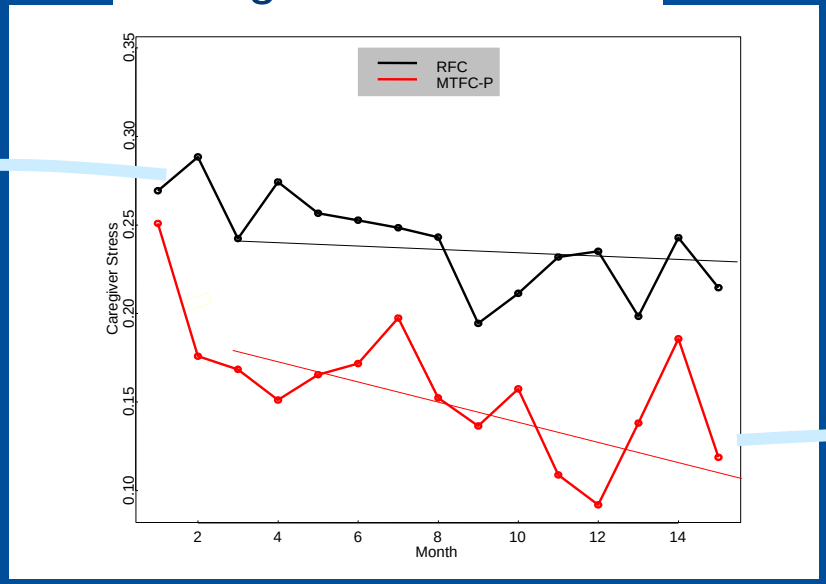


Fisher, Gunnar, Dozier, Bruce, & Pears (2007), *Annals NYAS*

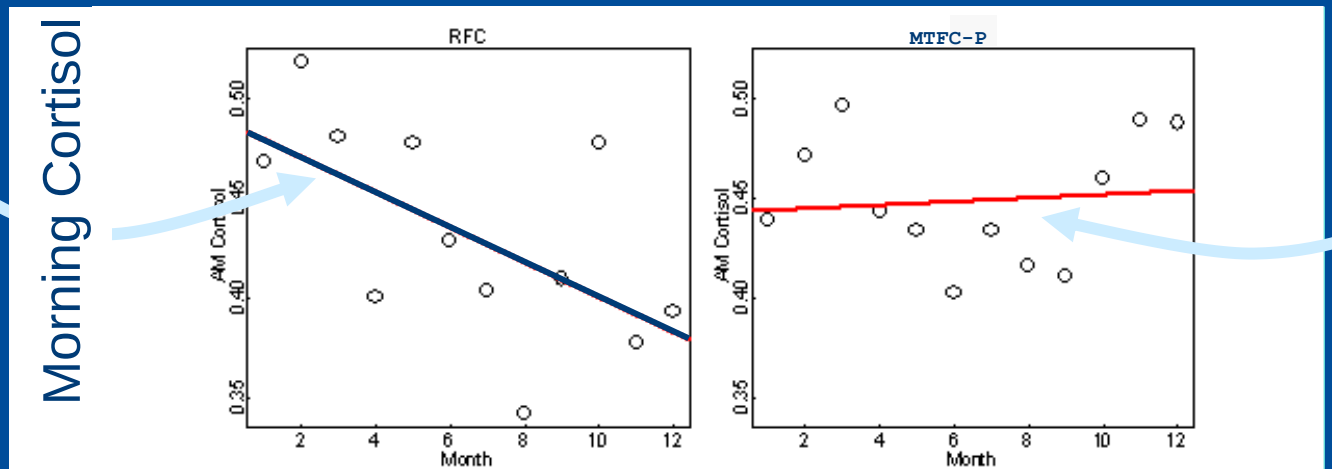
Fisher, Stoolmiller, & Gunnar (2007), *Psychoneuroendocrinology*

Caregiver stress levels are directly related to children's cortisol levels

Caregiver stress



Morning Cortisol

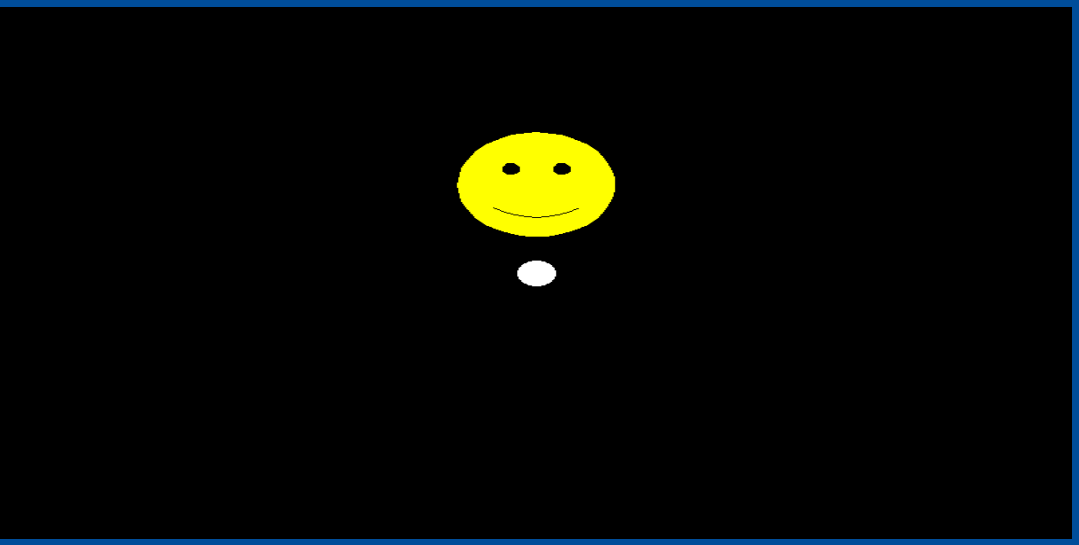


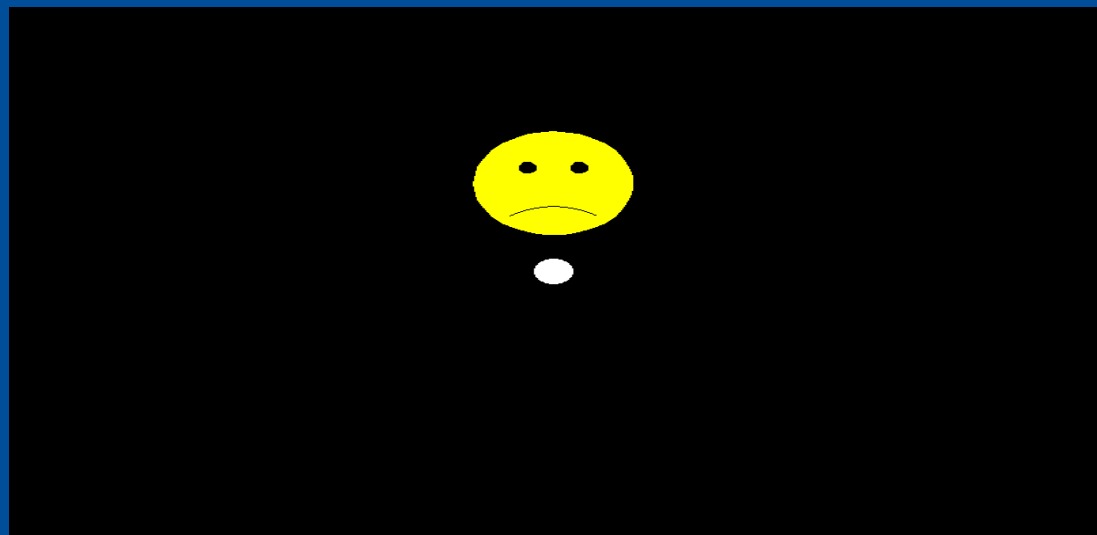
Fisher & Stoolmiller (2008), *Devel & Psychopathology*

Intervention effects on executive functioning:
Negativity study using a color flanker task

ERP *Feedback*

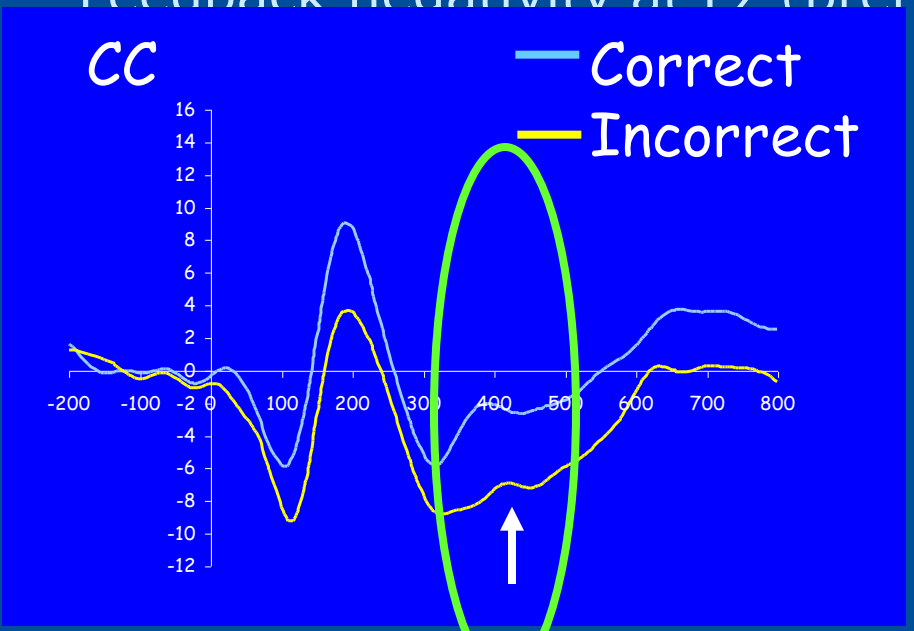
Approval and Disapproval

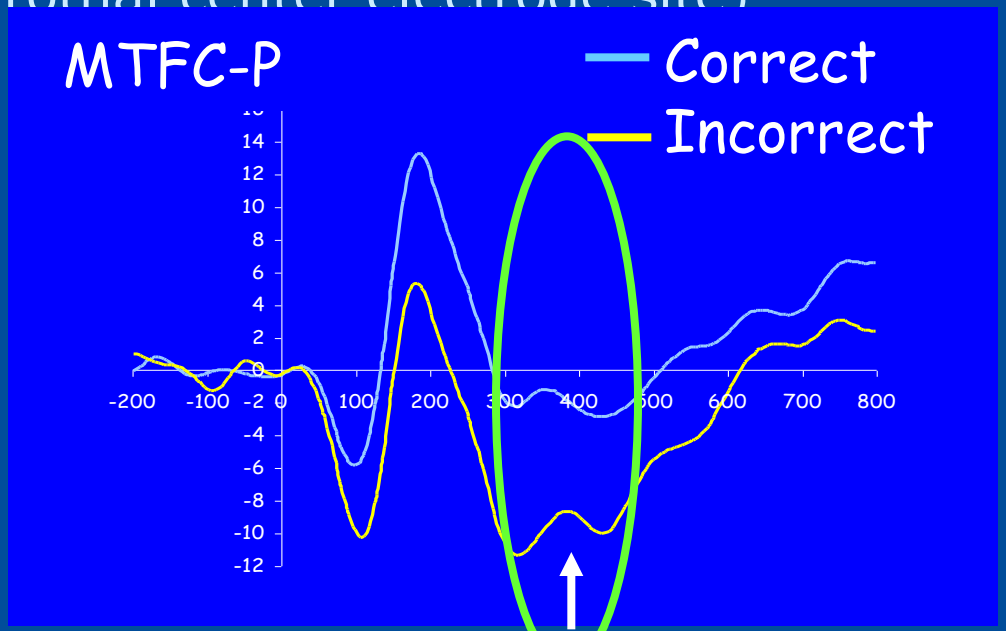




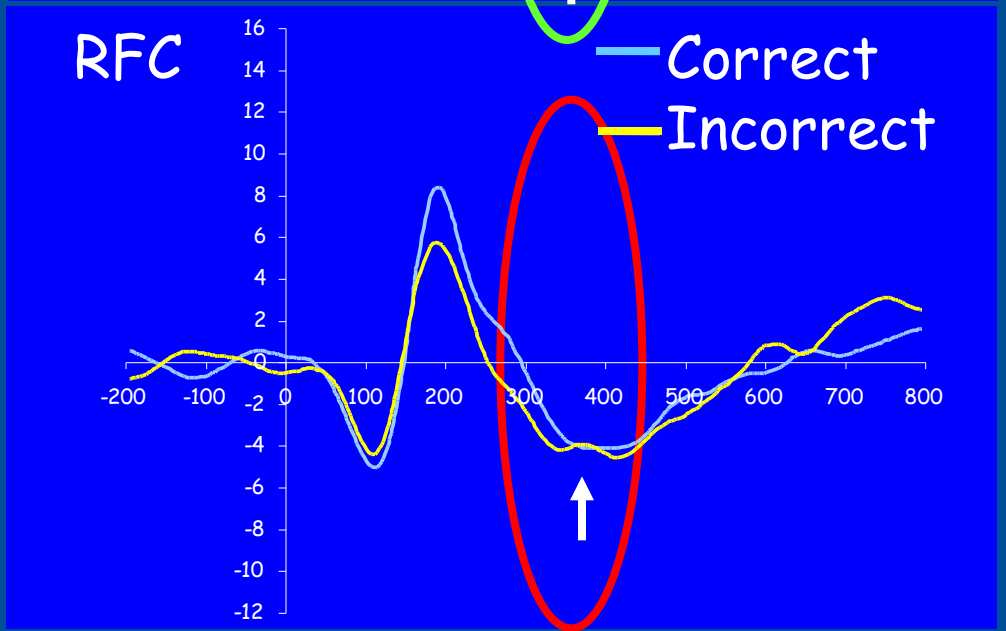
Intervention effects on executive functioning:

Feedback negativity at Fz (prefrontal center electrode site)



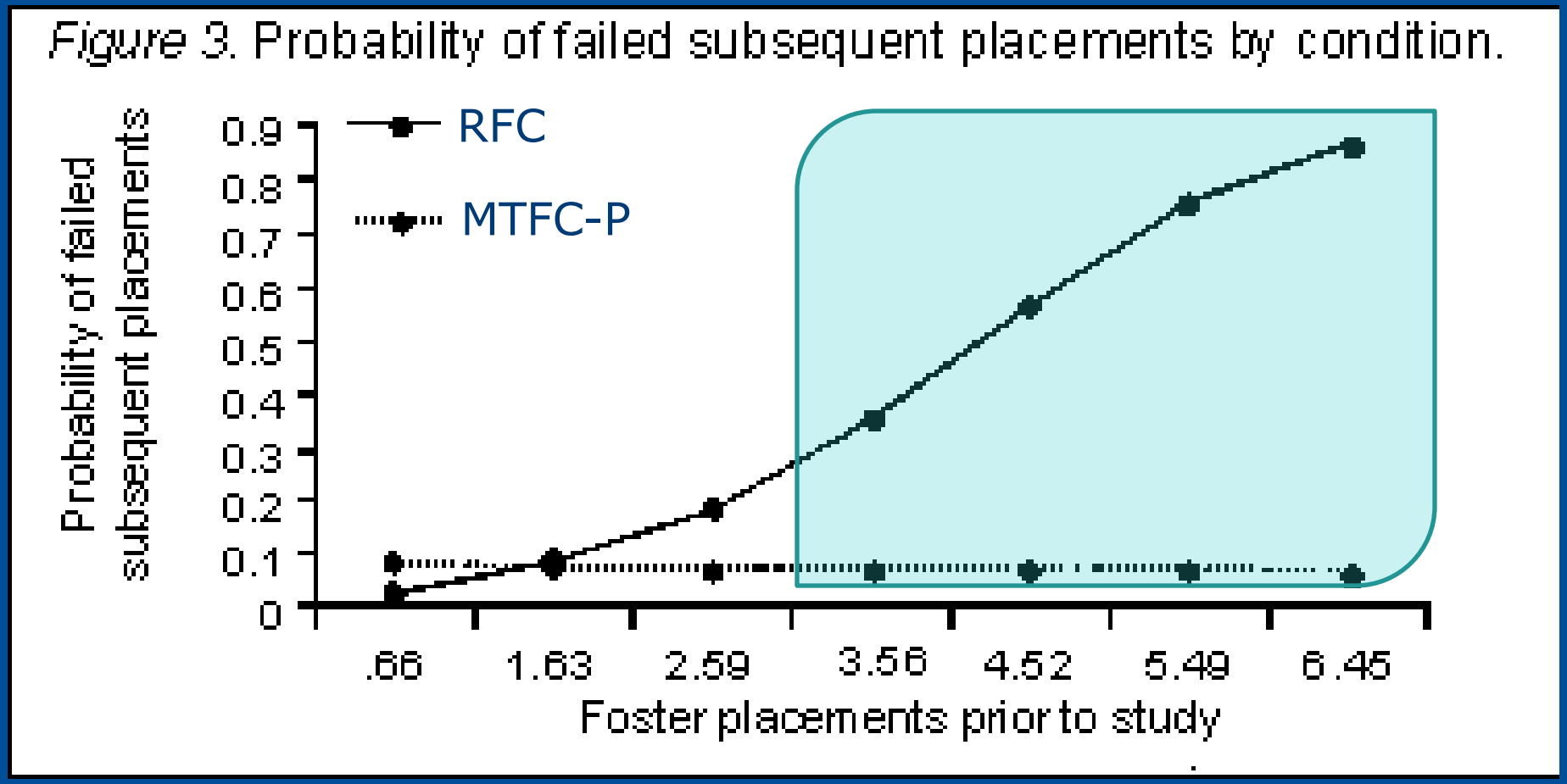


Group:
$F(2, 31) = 1.80$, ns
Interaction:
$F(2, 31) = 5.11$, $p < .05$



Bruce, Martin-McDermott, Fisher, & Fox
(under review)

Effect Of Prior Out-of-home Placements On Placement Moves: MTFC-P Vs. Regular FC



(Fisher, Burraston, & Pears, 2005)

Hypotheses from Research

- Neurobehavioral disinhibition follows a coherent developmental trajectory
  - In many children this trajectory appears relatively unaffected by variations in parenting context
- Additional research may help to test this theory and identify additional preventive interventions

Project KEEP: (MTFC-Lite)

- Foster Parent Groups
  - Good behavioral group work a la Sheldon Rose
    - Appreciate the foster parents efforts
    - Reward their successes
    - Demonstrate and role play skills
    - Pre-teaching (shaping the antecedents)

- Parent Daily Report (PDR)
  - Which of these problems occurred in the last 24 hours?
  - How stressful did you find it?

Project KEEP: Parent Daily Report

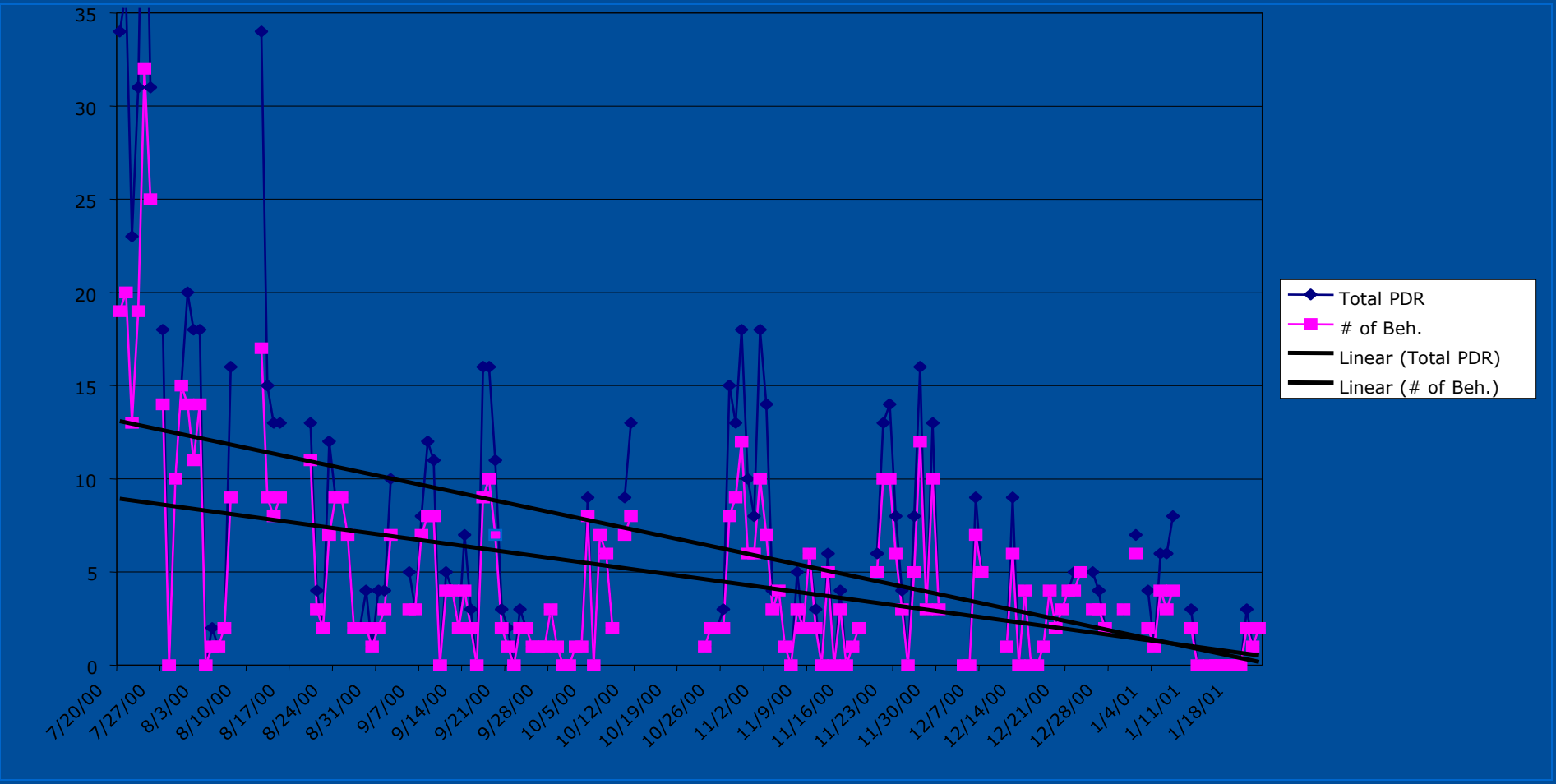
Did your foster child do any of the following behaviors in the last 24 hours?

Did he/she?	1 - Yes 2 - NO		
Child Behaviors		**yes/no**	**Upset ?**
1	Argue		
2	Back-talk		
3	Wet		
4	Competitive		
5	Complain		
6	Defiant		
7	Destructive, vandalize		
8	Soil		
9	Fight		
10	Irritable		
11	Lie		
12	Negative		
13	Boisterous, rowdy		
14	Not mind		
15	Stay out late		
16	Skip meals		

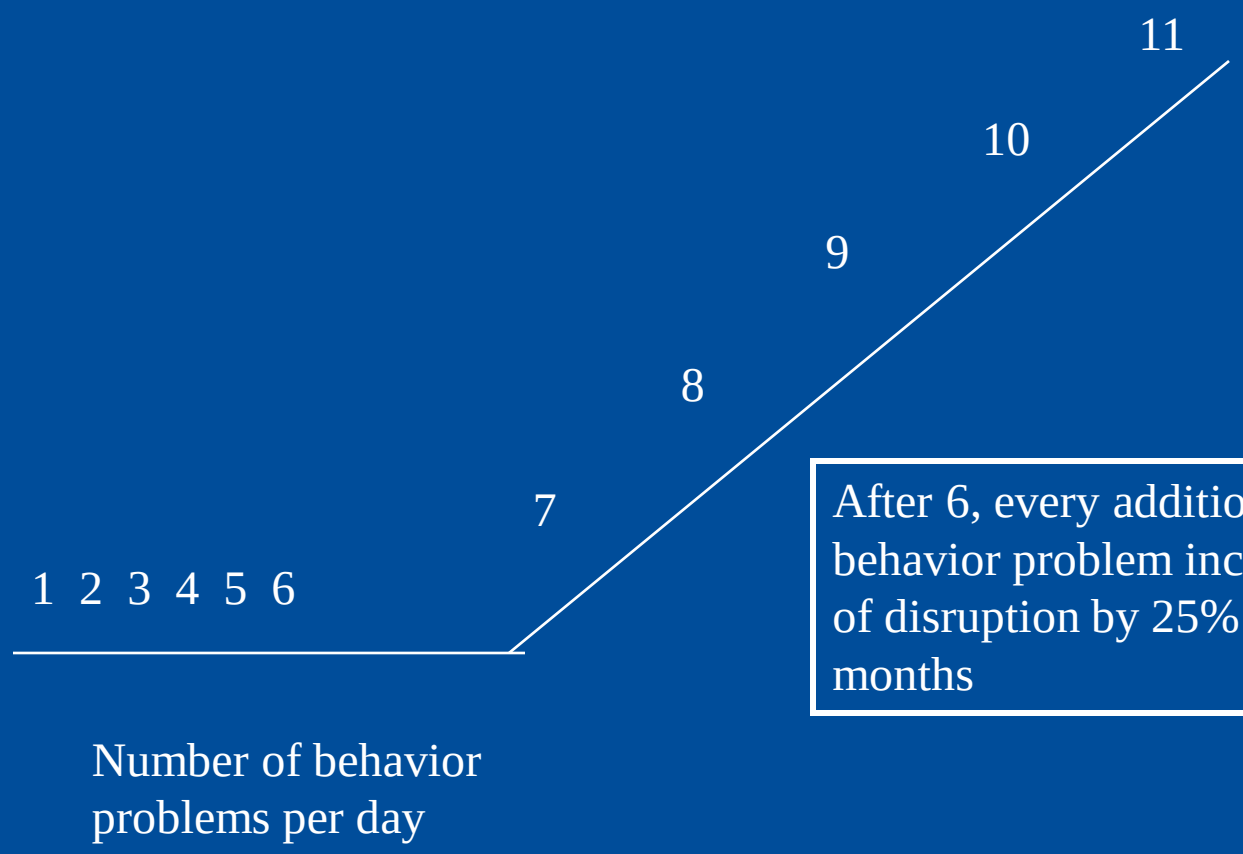
How upset were you?	1 - Not at all 2 - Somewhat/a little 3 - Quite a lot		
Child Behaviors		**yes/no**	**Upset ?**
17	Run away		
18	Swear, use bad language		
19	Tease, provoke		
20	Depressed, sad		
21	Sluggish		
22	Jealous		
23	Truant		
24	Steal		
25	Nervous/jittery		
26	Short attention span		
27	Daydream		
28	Irresponsible		
29	Marijuana/drugs/Alcohol		
30	Any school problem		
31	Inappropriate sexual activity		
32	Rate the day (A-F)		

KEEP: Parent Daily (Weekly) Report

- 5-10 minute telephone call, Behavior checklist format:
  - 0 = behavior did not occur
  - 1= behavior occurred, was not stressful
  - 2 = behavior occurred, was stressful

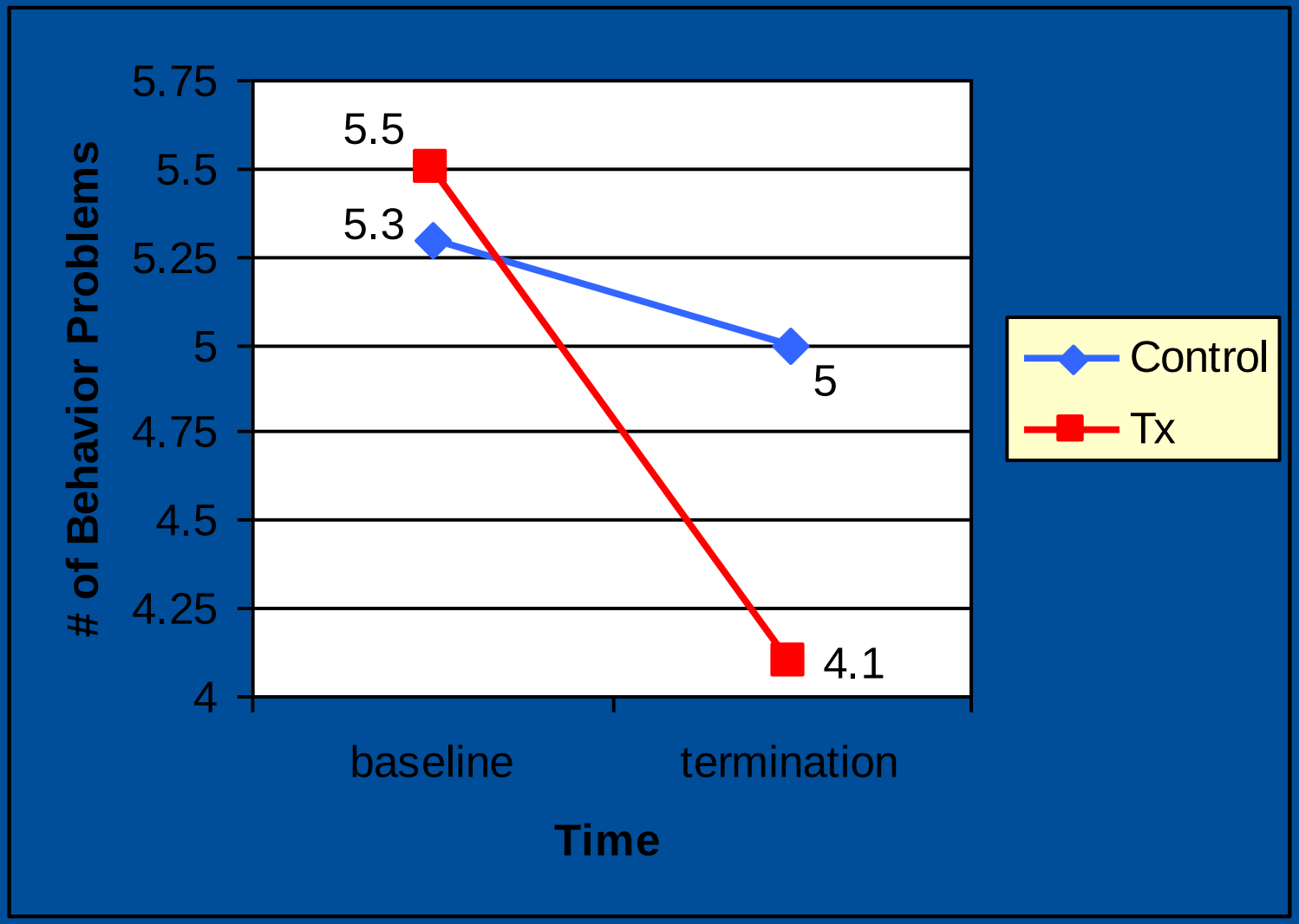


Which Foster Care Placements Disrupt?

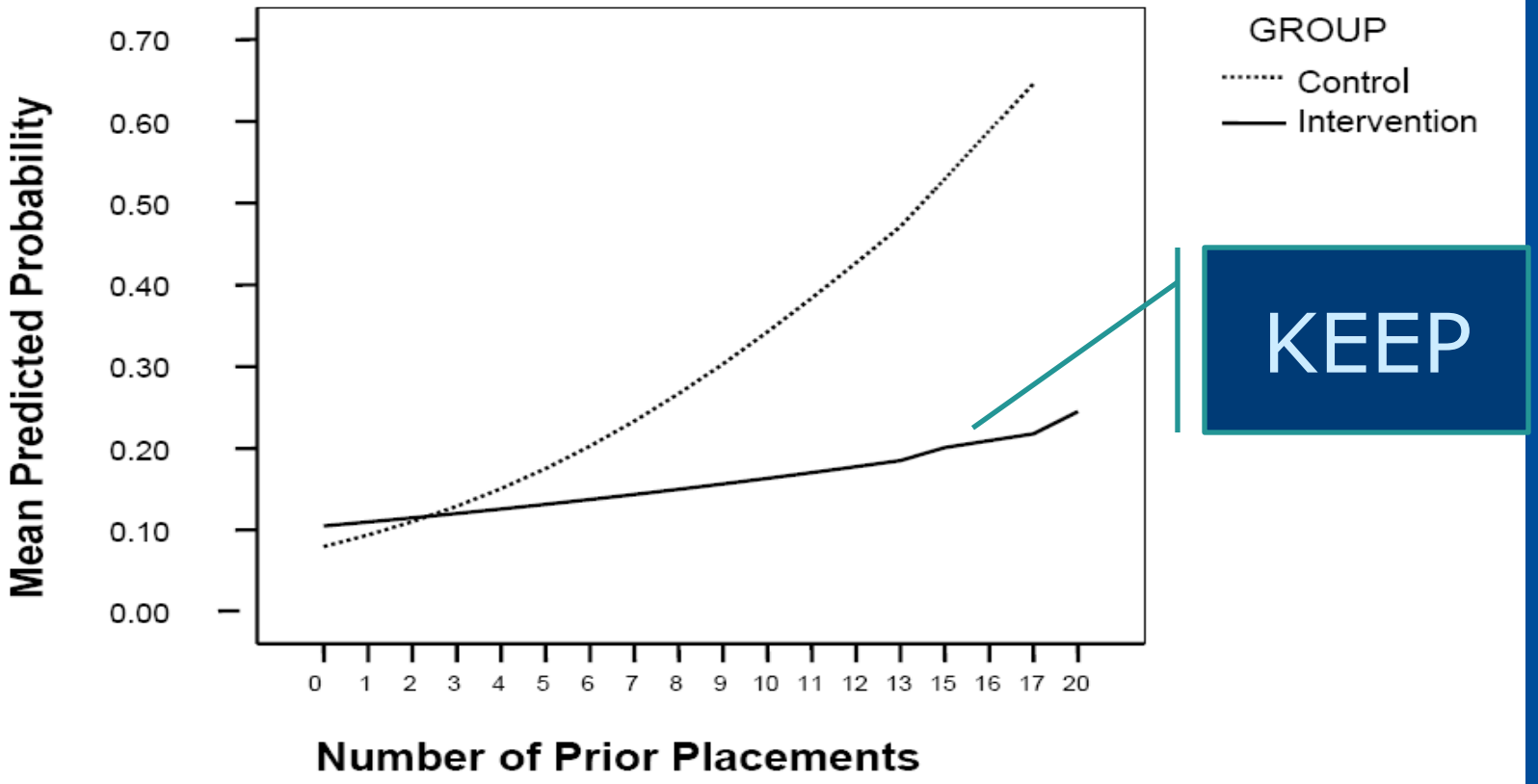


After 6, every additional behavior problem increases probability of disruption by 25% within next 6 months

KEEP Child Behavior Outcome: PDR

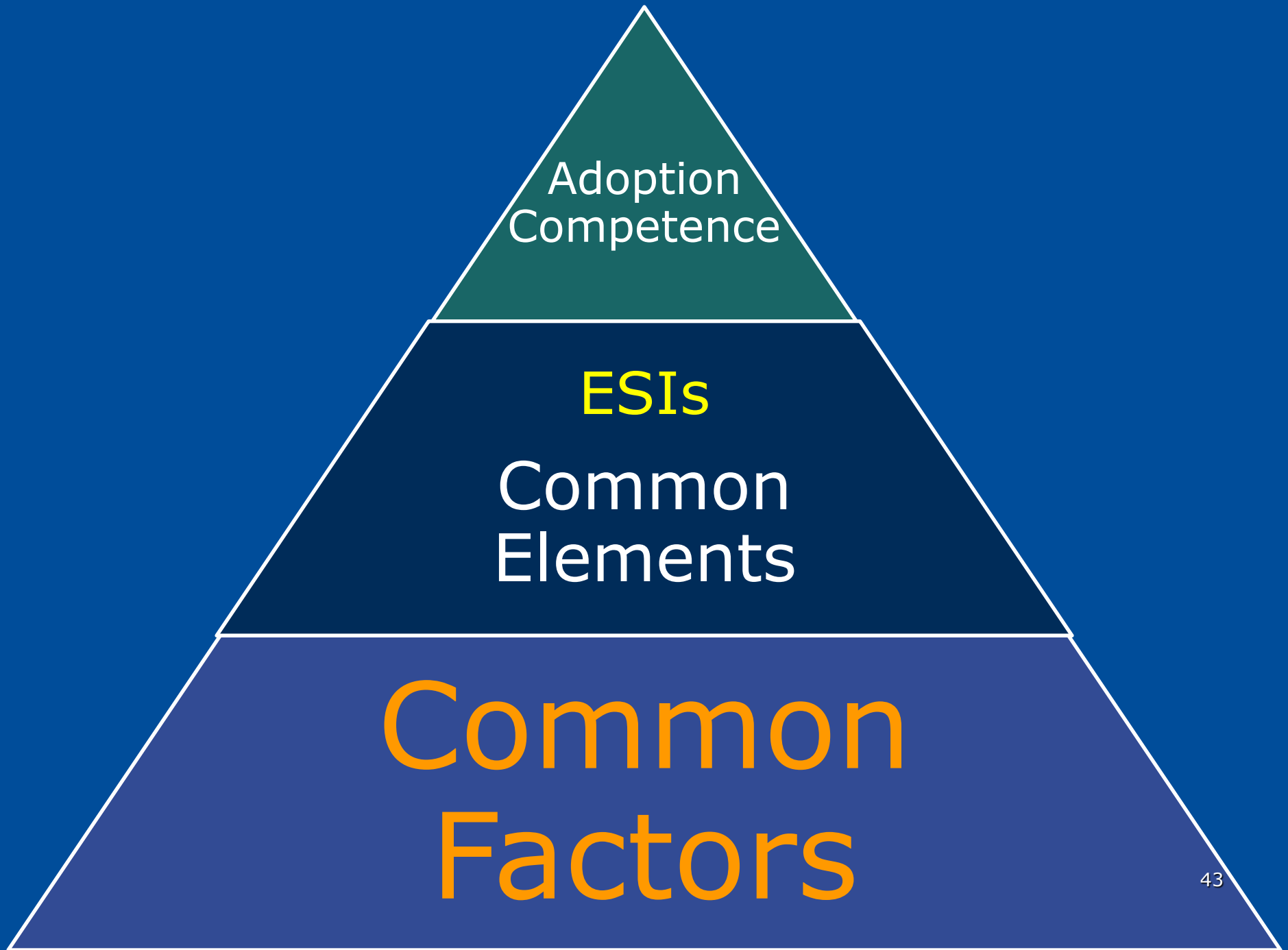


Predicted Probability Of Negative Exit By Prior Placements and Intervention Group



ABC, MTFC-P and KEEP Implications

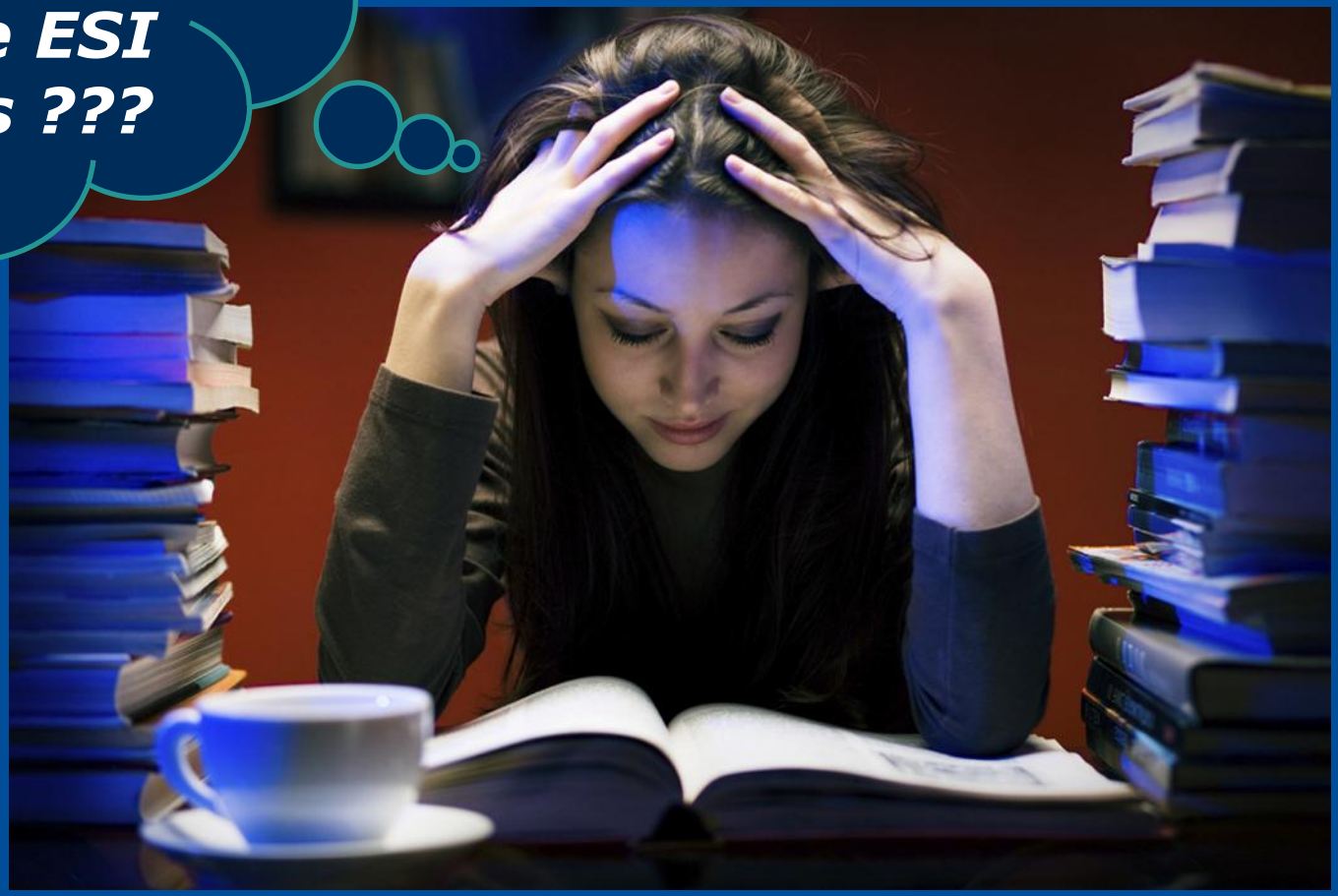
- We can change biological characteristics of children—including stress hormones and executive functioning—with consistent responsive social interventions
- Investing in therapeutic interventions that change physiology and behavior may make it more likely that the improved behavior will be sustained
- KEEP could become a prototype for adoptive parent support—it is much more likely to matter than PRIDE or MAPP which have no parenting support component


Adoption Competence
ESIs
Common Elements
Common Factors

Building on Evidence Supported Interventions for Children and Families

- Manualized ESIs
  - John Weisz's cognitive behavioral treatment manual
  - David Kolko's *Alternatives for Families-CBT*
  - Scott Hengeller's MST
  - Cohen and Mannarino's Trauma Focused-CBT
- Common Elements Approach
  - Chorpita and colleagues
- Common Factors Approach
  - Duncan, Lambert and Sparks CDOI
- Adoption Sensitivity
  - *Adoption Sensitivity* to improve the acceptability of these interventions to adoptive parents

How will I ever master all these ESI manuals ???



The Common Elements Approach

Step 1:

Emphasis on evidenced-based treatments

Step 2:

Development of treatment manuals

Step 3:

Information overload: Too many treatment manuals to learn and manuals change as new knowledge is gained

The Common Elements Approach

- Using elements that are found across several evidence-supported, effective interventions
- "Clinicians 'borrow' strategies and techniques from known treatments, using their judgment and clinical theory to adapt the strategies to fit new contexts and problems" *(Chorpita, Becker & Daleiden, 2007, 648-649)*
  - An alternate to using treatment manuals to guide practice
- Actual treatment elements become unit of analysis rather than the treatment manual
- Treatment elements are selected to match particular client characteristics

Identifying the Practice Elements

- Trained coders reviewed 322 randomized controlled trials for major mental health disorders for children and teens;
  - Over $500 million invested in these research studies
  - Studies conducted over a span of 40 years
  - More than 30,000 youth cumulatively in the study samples

- Approach:
  - What features characterize successful treatments?
  - What strategies are common across effective interventions?

(Chorpita & Daleiden, 2009)

Coding Process for 322 RCTs:

- Frequencies of practice elements from winning treatment groups were then tallied to see what practice elements were most commonly found in effective interventions

- 41 practice elements identified that were found in at least 3 of the 232 winning treatment groups

Tools to Support the Common Elements Approach

- www.practicewise.com
- Subscription-based resources:
  - PracticeWise Practitioner Guides
  - Modular Approach to Therapy for Children (MATCH)
  - PracticeWise Evidence-Based Services Database (PWEBS)
  - PracticeWise Clinical Dashboards

Practitioner Guides

- Summarize the common elements of evidence-based treatments for youth;
- Handouts guide clinician in performing the main steps of the technique
- Currently 29 Treatment elements, including:
  - Response cost
  - Modeling
  - Social Skills
  - Time out
  - Engagement with caregiver

- Guide is searchable by: treatment, audience (child, caregiver, family), purpose, objectives

Example of printable PDF describing practice element:

Practitioner Guide

Activity Selection

Use This When:

To introduce mood-elevating activities into the child's day.

Audience

Objectives:

- to emphasize the link between positive activities and feeling good
- to note that doing more things with someone we like is a good way to enjoy activities
- to explain that we can make ourselves busy so that we don't have time to worry or feel bad
- to discuss helping other people; it makes them and us feel good

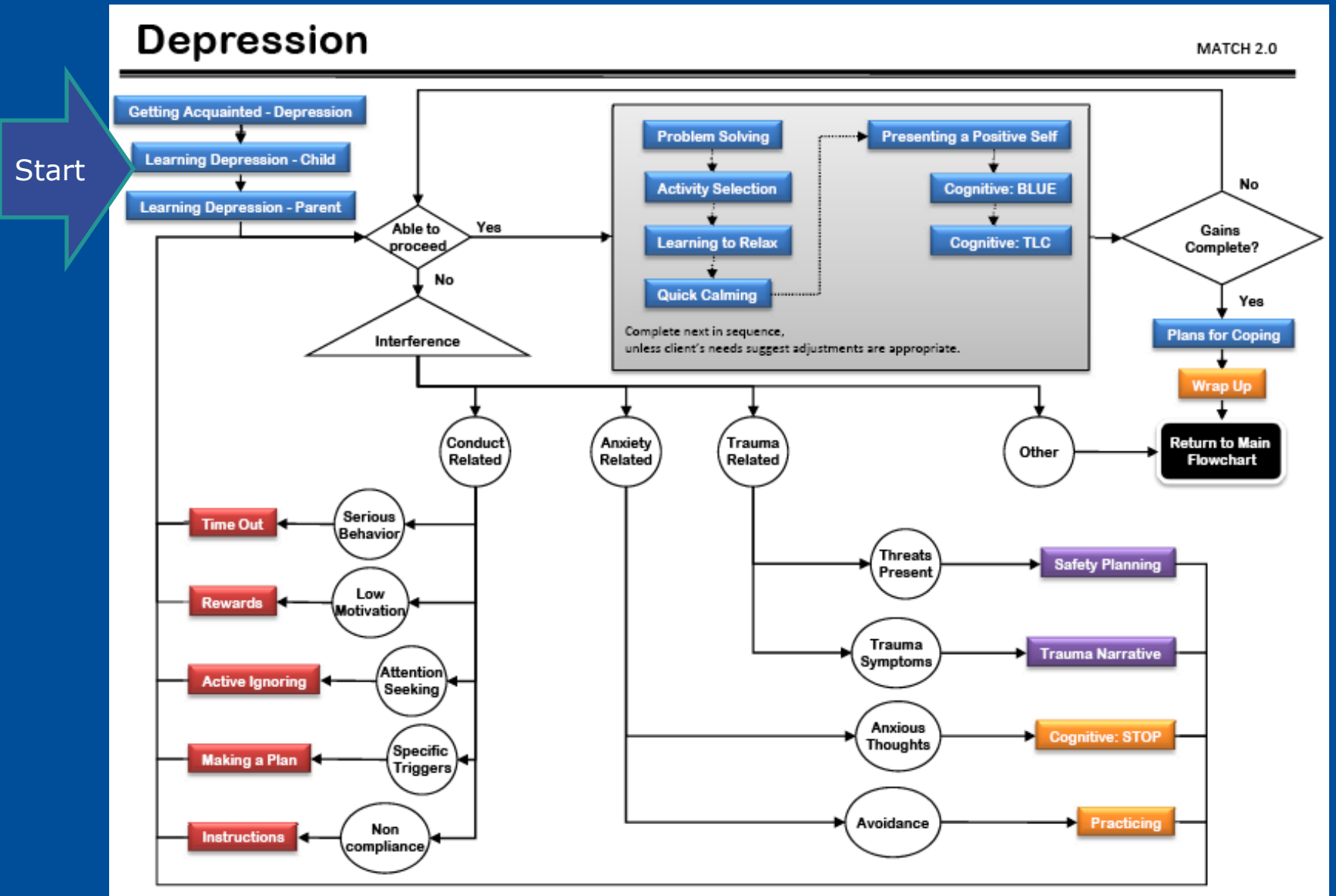
Goals of this practice element

Steps:

☐	Educate in types of mood-lifting activities	Discuss with the child that today you will focus on activities that can all help get our minds off of bad feelings and make us feel better. These are activities that: 1) we enjoy, 2) are done with someone we like, 3) keep us busy, or 4) help someone else.
☐	Illustrate connection between activities and feelings	Help the child to grasp that: • doing activities we enjoy can make us feel good • doing activities we do not enjoy (or doing nothing) can make us feel bad You may start by telling the child about a time when doing things you (or a boy or girl you know) did not like made you feel bad, and then doing something you liked made you feel better.
☐	Illustrate how activities can be mood-enhancing for the child	Demonstrate that activities, feelings and actions are connected for the child personally. To help make this point: • Ask the child to identify 2-3 examples of times when he/she felt bad, then did something enjoyable, then felt better. • Discuss these experiences with the child.
☐	Generate simple pleasant activities	1) Ask the child to list 10 (or less, depending on time) easy-to-do activities that he/she can do to elevate his/her mood. 2) Encourage the child to come up with as many as he/she can 3) Make suggestions if the child has trouble thinking of activities. 4) The activities must be: • simple, • free, • do-able almost any time, and • virtually guaranteed to make the child feel good. The list might include such activities as calling a friend, throwing a ball outside, spending time with a pet, remembering a fun experience, or stretching.

Steps for using this practice element

MATCH Example: Putting Together Practice Elements



Clinical Dashboards

- Microsoft Excel based monitoring tool
  - Tracks achievement of treatment goals or other progress measures on a weekly/session basis
  - Documents which practice elements were used when
- Dashboard can be customized:
  - Display up to 5 progress measures
  - Write-in additional practice eleme
- Potential uses:
  - Documenting session activities
  - Tracking client progress
  - Clinical supervision

Progress and Practice Monitoring Tool

Clear All Data

Redact File

Progress Measures

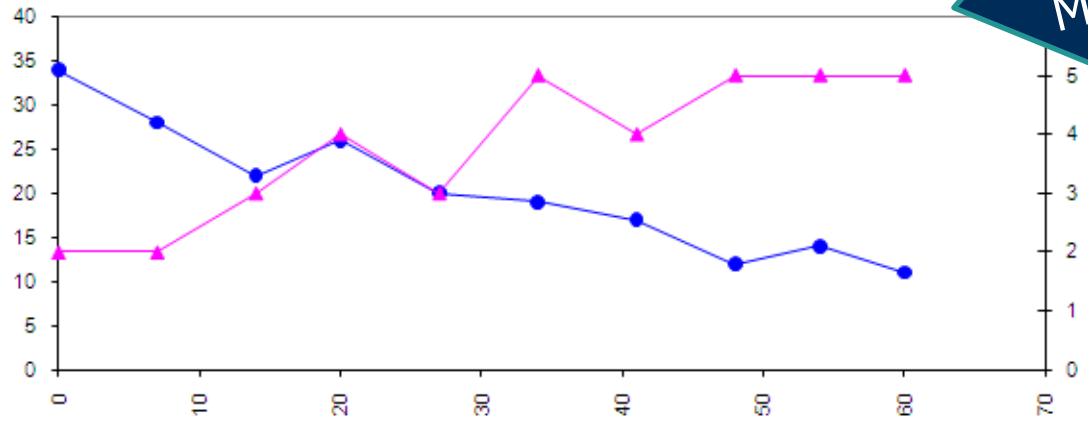
Progress Measures:

Left Scale

Youth CDI Score

Right Scale

Days Attended School

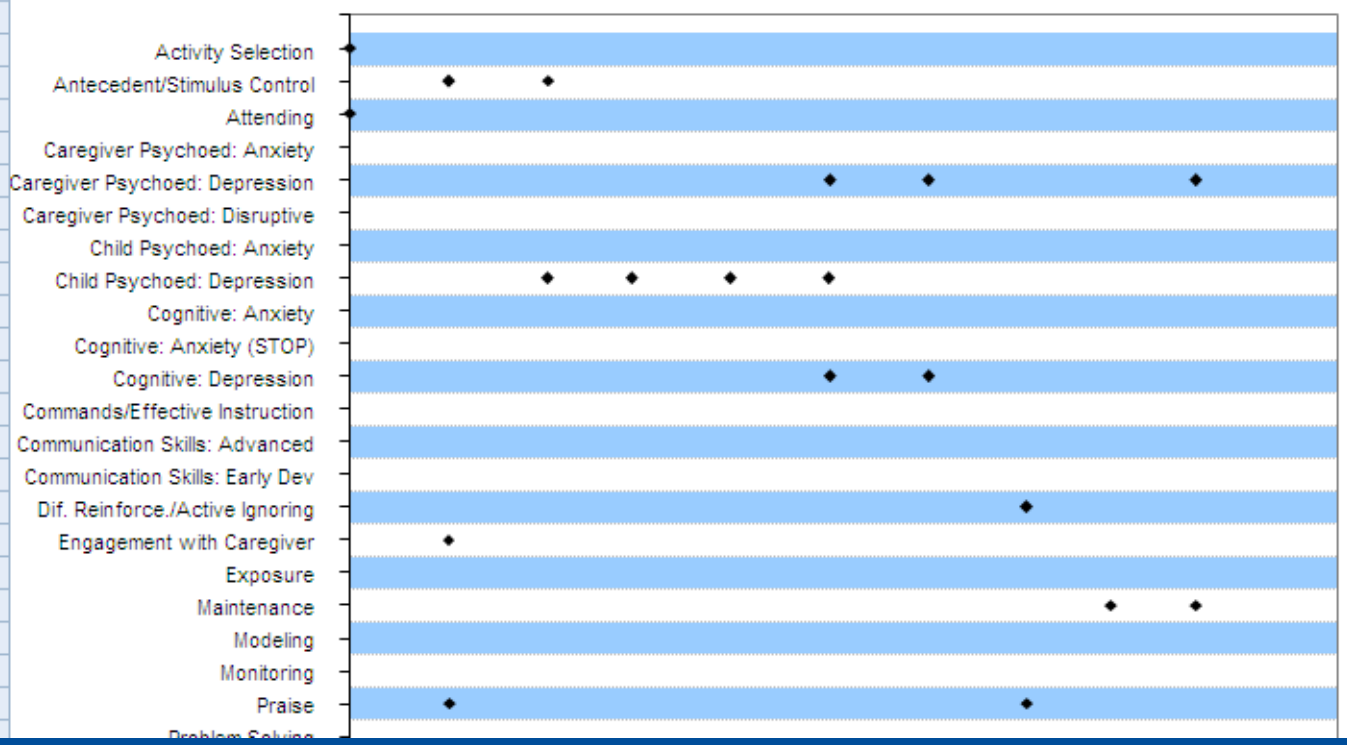


Display Measure:

Yes	Youth CDI Score
Yes	Days Attended School
No	Tx Goal #1
No	Treatment Goal #2
No	Treatment Goal #3

Display Time:

To Last Event



Common Factors (CDOI)

- Effective therapy arises from allegiance to a treatment model, monitoring of change, and creating a strong therapeutic alliance
  - Feedback from clients on their level of functioning
  - Feedback to therapists on the therapeutic alliance
  - A coherent treatment approach that encourages action to change

Duncan et al., (2010) Heart and Soul of Change: Delivering What Works in Therapy (2nd Edition). Washington, DC: APA

Positive Implications for Therapy

"A continuous feedback or practice-based evidence approach individualizes psychotherapy based on treatment response and client preference;

systematic feedback addresses the dropout problem, as well as treatment and therapist variability, and could increase consumer confidence in the outcome of therapeutic services" (p. 702).

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*(4), 693-704.

Client-Directed, Outcome-Informed (CDOI) Treatment & Wrap Around

- Adapt to specific individual and family needs based on client feedback
- Move from punitive and restrictive to optimistic and responsive interventions
- **Utilize brief and systemic client-report measures throughout therapy**
- Strengths-based and culturally responsive

"At its core, wraparound is flexible, comprehensive, and team-based." (p. 65)

Sparks, J. A., & Muro, M. L. (2009). Client-directed wraparound: The client as connector in community collaboration. *Journal of Systemic Therapies, 28,* (3), 63-76.

Tools for Feedback: ORS and SRS

- Reliable and valid four-item, self-report instruments *used at each meeting*
- Scored and interpreted in a **collaborative** effort between client and therapist
- Rather than the therapist assigning meaning to a client's feedback, the *client explains the meaning* behind the mark on the scale
- Help identify ***alliance*** strengths and weaknesses in therapy

Sparks, J. A., & Muro, M. L. (2009). Client-directed wraparound: The client as connector in community collaboration. *Journal of Systemic Therapies, 28,* (3), 63-76.

Formatted for Children… the CORS and CSRS

- Similar scales designed for use with children ages 6-12
- Written at a *third grade reading level*
- Used to ***track effectiveness and therapeutic alliance*** as reported by children and their parents or caretakers.
- CORS shows strong **reliability** (alpha=.84) and **validity** as compared to a longer youth outcome questionnaire (Pearson's coefficient=.61)
- Gives youth a voice in their own therapy

Duncan, B. L., Sparks, J. A., Miller, S. D., Bohanske, R. T. & Claud, D. A. (2006) Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome Measure for children, adolescents, and caretakers. *Journal of Brief Therapy, 5,* (2), 71-88.

Outcome Rating Scale (ORS): Adults

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill out according to how you think he or she is doing.

Individually

(Personal well-being)

I ---------- I

Interpersonally

(Family, close relationships)

I ---------- I

Socially

(Work, school, friendships)

I ---------- I

Overall

(General sense of well-being)

I ---------- I

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Child Outcome Rating Scale (CORS)

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. If you are a caretaker filling out this form, please fill out according to how you think the child is doing.

Me

(How am I doing?)

I ---------- I

Family

(How are things in my family?)

I ---------- I

School

(How am I doing at school?)

I ---------- I

Everything

(How is everything going?)

I ---------- I

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Session Rating Scale (SRS V.3.0): Adults

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and I ---------- I **I felt heard, understood, and respected.**

Goals and Topics

We did *not work on* or talk about what I wanted to work on and talk about. I ---------- I **We worked on and talked about what I wanted to work on or talk about**

Approach or Method

The therapist's approach is not a good fit for me. I ---------- I **The therapist's approach is a good fit for me**

Overall

Overall, today's session was right for me. I ---------- I **There was something missing in the session today.**

Child Session Rating Scale (SRS V.3.0)

How was our time together today? Please put a mark on the lines below to let us know if how you feel.

Listening

Did not always listen to me I ---------- I **Listened to me.**

How Important

What we did and talked about was not really that important to me. I ---------- **What we did and talked about were important to me.**

What We Did

I did not like What we did today. ---------- I **I liked what we did today.**

Overall

I wish we could do something different. I ---------- **I hope we do the same kind of things next time.**

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Implementing CDOI Services

- ✓ Using a formal feedback form such as the ORS/CORS and SRS/CSRS can unite the *treatment* discourse with the client-directed *wraparound* ideology

Sparks, J. A., & Muro, M. L. (2009). Client-directed wraparound: The client as connector in community collaboration. *Journal of Systemic Therapies, 28,* (3), 63-76.

First CDOI RCT

- Couples using the feedback measure, **ORS**, (N=103) at pre- and posttreatment and follow-up, compared to couples receiving treatment as usual (TAU) (N=102):
  - **Achieved almost 4 times the rate of clinically significant change**
  - **Maintained a significant advantage on the ORS at 6-month follow-up**
  - **Showed greater marital satisfaction and lower rates of separation or divorce**
- The feedback condition showed a moderate to large effect size (0.50)

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*(4), 693-704.

Client Feedback as a Common Factor (or Element)?

- This study provides **reliable support** for alliance building and monitoring treatment progress for clients and therapists in couple therapy.
- **Feedback tools (e.g., ORS and SRS) that are not linked with a certain therapy or method can be used in *community settings* more easily than specific treatment packages.**
- *Further research* may show the extent to which the increased therapeutic engagement or allegiance effects can influence the positive effect of the feedback tools.

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*(4), 693-704.

Evidence Supported Interventions, Common Elements, Common Factors

IS THIS ENOUGH?

- Possibly, but additional adoption competence is likely to be important to implementation of therapeutic and case management interventions

Adoption Competences (sample)

- Examples of Clinical Adoption Competencies
  - Issues in the adoption triad
  - Legal issues in adoption
  - Differences between adoptive and not-adoptive families
  - Loss, grief, separation, trauma, attachment
  - Genetics, neuroscience, prenatal exposure to stress and drugs
  - Openness in adoption
  - Advocacy

Multifiniality

- There are many ways to help, or not help, adoptive families
  - There is no single truth for families about whether their problems require an adoption focus, or not
  - There is no reason to think that a primary focus on addressing attachment issues is the right—or even a useful—path for treatment

5 Take Home (or at least consideration) Points

1. We do not know what services reduce adverse adoption outcomes and should take our lead from families and more generally, from treatment science
2. Expectations of families matter at all points in the adoption process
3. Adoptive families are more like other families than they are different, so common therapeutic treatments are the starting point for most of them
4. Adoption competence may increase parent and child engagement and may improve efficacy (if it does not interfere with other active treatment elements)
5. Every treatment approach fails to make rapid changes in a sizable proportion of distressed families

Thank you very much

Partial References

Ahn, H. N., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology, 48, 251-257.*

Barth, R. P., & Brooks, D. (1997). A longitudinal study of family structure, family size, and adoption outcomes. Adoption Quarterly, 1, 29-56.

Barth, R. P., & Miller, J. (2001). Building effective post-adoption services: What are the empirical foundations? *Family Relations, 49*, 447-455.

Barth, R., Wildfire, J., Lee, C.,K,Gibbs, D. (2002, December). Assessing the field of post-adoption services: Family needs, program models, and evaluation issues. (Contract No. 100-99-0006). Washington, D.C.: .S. Department of Health and Human Services.

Barth, R.P., Wildfire, J., Lee, C.K., & Gibbs, D. (2003). Adoption subsidy dynamics. *Adoption Quarterly*, 7(2), 3-27.

Berry, M., Propp, J., & Martens, P. (2007). The use of intensive family preservation services with adoptive families. *Child & Family Social Work, 12*(1), 43-53.

Brooks, D. & Barth, R.P. (1999). Adjustment outcomes of adult transracial and inracial adoptees: Effects of race, gender, adoptive family structure, and placement history. American Journal of Orthopsychiatry, 69, 87-102.

Chorpita, B. F., & Viesselman, J. O. (2005). Staying in the clinical ballpark while running the evidence bases. *Journal of the American Academy of Child and Adolescent Psychiatry, 44(11), 1193-1197.*

Chorpita, B. F., Becker, K. D., & Daleiden, E. L. (2007). Understanding the common elements of evidence-based practice: Misconceptions and clinical examples. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(5), 647-652.

Partial References

Coakley, J. F., & Berrick, J. D. (2008). Research Review: In a rush to permanency: preventing adoption disruption. *Child & Family Social Work, 13*(1), 101-112.

Cohen, J. A., Mannarino, A. P., Zhitova, A. C., & Capone, M. E. (2003). Treating child abuse-related posttraumatic stress and comorbid substance abuse in adolescents. *Child Abuse & Neglect, 27*(12), 1345-1365.

Fisher, P. A., Gunnar, M. R., Dozier, M., Bruce, J., & Pears, K. C. (2006). Effects of therapeutic interventions for foster children on behavioral problems, caregiver attachment, and stress regulatory neural systems. In *Resilience in Children (Vol. 1094, pp. 215-225).*

Foulkes Coakley, J. (2005). Finalized adoption disruption: A family perspective. Unpublished manuscript, University of California at Berkeley.

Gibbs, D., Barth, R. P., & Houts, R. (2005). Family characteristics and dynamics among families receiving post-adoption services. *Families in Society, 86*, 520-532.

Goerge, R.M., Howard, E.C., Yu, D., Radmosky, S. (1995). Adoption, disruption, and displccement in the child welfare system (1976-1995). Chicago: Chapin Hall Center for Children at the University of Chicago.

Lahti, M., Detgen, A. (2005). Main Adoption Guides Project: Final Evaluation Report. University of Southern Maine.

Smith, S. L., Howard, J. A., Garnier, P. C., & Ryan, S. D. (2006). Where Are We Now?: A Post-ASFA Examination of Adoption Disruption. *Adoption Quarterly, 9*, 19-44.

Testa, M.F. (2008). *Subsidized Guardianship: Testing the effectiveness of an idea whose time has come.* Unpublished manuscript, Children and Family Research Center, University of Illinois at Urbana-Champaign

Wind, L. H., Brooks, D., & Barth, R. P. (2007). Influences of Risk History and Adoption Preparation on Post-Adoption Services Use in U.S. Adoptions*

doi:10.1111/j.1741-3729.2007.00467.x. *Family Relations, 56*(4), 378-389.