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Challenges of Child Trauma on Adoptive Families' Social and Emotional System

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This is to certify that the doctoral dissertation by

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Abstract

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Abstract

Adoption-focused psychoeducation is deemed essential in maintaining the permanency of traumatized children within a new family unit. However, adoptive parents of traumatized children struggle to find training to address their unique concerns. Guided by the lens of psychodynamic theory, the purpose of this study was to investigate the challenges faced by adoptive families of traumatized children. Special focus was placed on the social and emotional relationships of the adoptive parents of traumatized children, to identify the realistic expectations towards attachment from the families' perspectives. Fifteen families were randomly selected to participate in this study from a group of 30 parents who adopted traumatized children in Arizona. A phenomenological approach was utilized to gather information from face-to-face and telephone interviews. The data analysis utilized the horizontalization approach which highlighted significant statements that were classified into codes. Thematic categories were drawn and summarized. Textual descriptions evolved from the thematic groups acknowledging their experiences and how these lived experiences guided their decision to adopt a traumatized child. Verification techniques, data mining, journaling, clustering, brainstorming, and peer reviews were used to ensure the quality of data. Emergent themes emphasized the need for adoption-focused training specific to traumatized children. Further research on this phenomenon should determine the significance of specialized psychoeducational training versus general foster care training, before and after adoption. Positive social change may result in tailoring existing training programs to meet the needs of families who adopt traumatized children.

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Dedication

In loving memory of Amie C. Ford, my mom, who inspired me to pursue the dream of obtaining my PhD, and to James K. Ford, Sr., my dad, who reminded me to keep the faith while running this race. Dad, thank you for staying around to see me obtain this degree. You will never understand how important it was for me to have you here for this. Loving you, with all of my heart, Jacqueline.

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It is indeed a great honor and privilege to thank many people for their inspiration, support, patience, and contribution in helping me to reach this level in my academic career. Yet, I must first stop and give honor and glory to God, my Heavenly Father, who has called me for such a time as this. I do not feel worthy of such a call, but I am grateful that He has allowed me to be His hands and feet in being a catalyst for social change towards this population of people. I am sincerely grateful.

Next, to all of the foster parents, kinship placements, and adoptive parents who decided to take on the rewarding challenge of providing a traumatized child a chance at a new life, in a new environment where the risk of trauma recurring is reduced. And to all of the adopted children who have experienced childhood trauma and have learned to trust again, your strength and experiences are there to help another child in overcoming their past and achieve new life within their new families.

To my four adopted children, Ariana, Mireya, Gabriel, and Joelle, thank you for teaching me life's lessons of what it means to raise and stand beside an individual who has experienced childhood trauma. Before you entered my life, things were "normal". After going through the roller coaster ride of life with all of you, I have gained the necessary knowledge to help teach other adoptive parents how to help their adopted children to maintain permanency while being members of a supportive network.

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No, it has not always been easy, but thank you. You both have been there for me, encouraging me and praying for this day to come. I love you two so much.

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Chapter 1: Introduction to the Study

Introduction

Adoption in the United States has become one of the most instrumental tools to alleviate the increasing number of children raised within the public welfare system. Adoption has an impact on everyone involved, and there are many benefits to adoption (Child Welfare Information Gateway, 2012). The benefits resulting from adoption tend to vary. The child perceives a sense of hope, love, and a sense of belonging and a place to call home (Child Welfare Information Gateway, 2012). The adopting parents view adoption as a solution (i.e., solution for their inability to bear a child or the desire to help a child). The community's perception of the adoptive family differs (Wegar, 2000). Adoption causes a reduction in homelessness, teenage pregnancy, addiction, criminal behavior, and suicide (World Association for Children & Parents, 2012). Therefore, adoption affects everyone involved.

The effects of adoption tend to change after its finalization (Child Welfare Information Gateway, 2013). Support, services, and resources that once existed are no longer available to the newly adoptive parent. Adoptive families struggle to find the necessary resources needed in raising their newly adopted child. Meyers (2011) suggested that sometimes adoptive parents are unable to meet their child's needs because they are too damaged. Post (2013) suggested that prior adoptive trauma has a negative effect on the adoptive family while they are attempting to create an ideal and harmonious family unit. Although prior adoptive trauma can affect the parents' ability to establish

permanency for the traumatized child, researchers have addressed ways to train and equip adoptive parents in meeting this challenge.

The purpose of this study was to understand the challenges faced by the adoptive families in order to empower them in finding solutions to help the child in bonding within the new family unit. With the increasing number of children exposed to traumatic experiences, finding more effective strategies to support the adoptive family is imperative (Child Welfare, 2012; James, 1994).

Background

Adoptive families agree that emergency foster placement is necessary; however, they perceive the necessity of finding a permanent home outweighs temporary placement. According to the U.S. Department of Human Health Services (2013), 94,626 of the 400,540 children were adopted from the public welfare system. The permanency placement of some children was not always successful (Child Welfare, 2010; Festinger & Maza, 2001; McDonald, Propp, & Murphy, 2001; Ruggiero, 2010). The urgency for placement cannot outweigh permanency. More emphasis must be placed on adoption (Mapes, 2012; McDonald et al., 2001; Smith, 2010). Preservation of the adoptive family can occur when placement supports exist (Forbes, 2008; Mapes, 2012; Smith, 2010). Barriers exist among professionals who provide direct and indirect services (e.g., therapy, support, and subsidy) to adoptive families (Casey Family Services, 2003b; Mapes, 2012; Smith, 2010). These barriers continue to challenge the successful adoption of traumatized children. When any serious disturbance and trauma exist within the nucleus

of the family, the child may suffer from attachment issues to the adoptive parent (James, 1994; Pickert & Shuster, 2012).

The risk of adoption failure has increased among adoptive families of traumatized children (Brodzinsky, 1992; Casey Family Services, 2003b). Agency adoption failure can occur before or after it is legally finalized. Meyers (2011) revealed that disrupted adoption occurs before the adoption is legally finalized. The rate of "disruption is 10% to 20%" (Meyers, 2011, p.83). Dissolution occurs after the child has been legally adopted. The approximate "dissolution rate is 1% to 10% "(Meyers, 2011, p.83). In both cases, failure occurs, and the child is returned to the public welfare system (Brodzinsky, Smith, & Brodzinsky, 1998; Grotevant & McDermott, 2014; M. A. Baker, personal communication, August 15, 2013; Mapes, 2012; Meyers, 2011; Smith, 2010; Wilke-Deaton, 2005). Such results could be due to the lack of services and resources readily available in meeting the adoptive family's needs (McDonald, 2001). A lack of supportive services may impede successful adoption outcomes (Child Welfare, 2013; Mapes, 2012; McDonald, 2001; Pickert, 2010). Adoption permanency of traumatized children is the least studied by researchers (Brodzinsky, 1992; McCormick, 1991; McDonald, 2001; Pickert, 2010). In order to address the factors associated with thriving post adoptive experience, more research is required in cultivating healthy relationship among adoptive families. James (1994) suggested that many adoptive parents do not understand what it takes to care for the traumatized child. It takes more than the will to survive and thrive in challenging adoptions. James noted that, as the fetus must be in the womb to survive, so must a child have human attachment relations in which to develop,

feel protected, nurtured, and become a productive human. Healthy human attachment develops as the child's circle of security grows through the trust with their new primary care giver. As the relationship develops, the child can master this developmental stage.

Many researchers have sought to understand the challenges that disrupt the developmental balance in the child's ability to form healthy attachments. Scholars question whether the problem lies in the child's behavior or the adoptive family's parenting style (Brodzinsky et al., 1998; Grotevant & McDermott, 2014; M. A. Baker, personal communication, August 15, 2013; Ruggerio, 2012; Wilke-Deaton, 2005). Children removed from their original caregivers tend to present with challenges in adjusting to or establishing a new attachment (Brodzinsky et al., 1998; Grotevant & McDermott, 2014; M. A. Baker, personal communication, August 15, 2013; McDonald, 2001; Pickert & Shuster, 2010; Wilke-Deaton, 2005). Some children perceive the loss of their primary caregiver as devastating and confusing. They tend to be in denial. They perceive their loss as a "loss of love, safety, protection, even life itself, and prolonged unavailability of the primary attachment" (James, 1994, p. 7). Some children tend to question their importance in the eyes of their parents. Some question what they did and if they are able to change what went wrong. Unfortunately, the mind of the child is still developing. Therefore, their internal perceptions of why the loss occurred maybe convoluted or fragmented. Their first primary attachment no longer is available to them and thus the child denies their emotional responsiveness which causes the relational hub to become damaged. The relationship between the child and its primary caregiver is crucial. Bowlby (1969) claimed intimate attachment between human beings acts as the

"hub" from which a person's life revolves. Bowlby suggested that these same dynamics are true of other attachment relationships in life. Humans require intimacy. Bergin (2009) indicated that attachment is the foundation of the child's socioemotional well-being. Intimate socialization promotes healthy and secure relationships in life.

Secured, attached relationships allow the child the opportunity to balance their need, exploration, and growth within their environment (The Early Years Foundation, 2007). Bowlby (1969) suggested that healthy child and parent (caregiver) relationships are essential. Relationships are the foundational threshold that allows the child to formulate healthy attachments through which the child is able to gain a secure base in order for exploration both physically and emotionally (Schore, 2003a, 2003b). Bowlby focused on helping children through the attachment process while helping the parents (Bretherton, 1992). Bowlby (1958) explored the difference between insecurity and attachment and the beginning of attachment theory and questioned the first developmental stage as being oral and the first relationship as being analytic. The attachment theory, in essence, describes the long-term interpersonal relationship that exists between humans. Bowlby (1958) attempted to understand separation anxiety and distress in children when they were separated from the mother (primary caregiver). Children develop cognitive impressions through early experiences and attachment to their primary caregiver. When the child is removed from their caregiver, they present threatened and lost. Separation anxiety is a result of unconscious internal conflicts. Bowlby (1958) viewed the reaction of a child being separated from their primary

caregiver evolves in three stages: protestation (adult anxiety); desperation (depression); and detachment.

The exploration of early relationships between the mother and child was viewed from various perspectives. Child development in attachment theory includes the interaction between the environments, as well as genetic predispositions (Hart, 2011). In the past, the effects of child trauma and adoption were well-researched topics. Researchers sought to understand that phenomena using a systematic and psychodynamic theoretical approach. The psychodynamic approach that is used with traumatized children generally is cognitive behavior therapy (CBT). Cognitive Behavioral Therapy is used to promote safety and stabilization. The psychodynamic approach helps the child in processing their traumatic memories.

Published research on adoption and trauma has declined causing limitations within this study. Many organizations have attempted to resolve the issues in child trauma and adoption by providing resources and rendering support through psycho-education to adoptive parents (Adoption Learning Partners, 2010; APAC-Alabama Post-Adoption Connection, 2010; Casey Foundation, 2010). Scholarly articles have been replaced with blogs on the challenges of child trauma on the adoptive family's social and emotional system that leads to disruption/dissolution. Berger (2012) discovered that no national data exist on disruption/dissolution in adoptions. There is a need to equip adoptive families in overcoming the challenges of failed adoption (i.e., disruption/dissolution) continues to exist.

Statement of the Problem

Adoptive families, along with the adopted children, face many challenges. Actual challenges formulate when the child has experienced traumatic events during his or her life prior to adoption (Brodzinsky et al., 1998; Grotevant & McDermott, 2014; Mapes, 2012; Wilke-Deaton, 2005). Most adoptive families do not fully understand the requirements of raising a traumatized child (James, 1994; Mapes, 2012; Pickert & Shuster, 2010; Post, 2006; Ruggerio, 2010). Once the adoption is completed and challenges begin to arise, many adoptive families realize that they are not fully equipped to handle the reality of the presenting issues (James, 1994; Pickert, 2010; Post, 2013; Ruggerio, 2010). The newly adopted child, now living apart from his or her biological parents, tend to struggle with forming new attachments as the child wrestles with questions of disloyalty and estrangement (Forbes, 2008; Park, 2010; Ruggerio, 2010).

Adoptive parents revealed they sought out professional services to address the child's pre adoptive traumatic challenges, as these factors have an impact on the entire family (Park, 2010). Cohen, Coyne, and Duvall (1993) suggested that adoptive parents tend to refer their adopted children for clinical services, which are unrelated to general marital or family dysfunction. Miller, Finn, and Grotevant (2000) noted that many adoptive parents refer their adoptive children for clinical services at a higher rate than non adoptive parents. Adoptive families face many challenges when attempting to work through their child's issues with the assistance of clinical services. Some parents found the only solution was to remove the child from the home (Cohen et al., 1993; Grotevant & McDermott, 2014; Mapes, 2012; Pickert, 2010).

Foster, pre adoptive, and adoptive parents undergo a rigorous amount of training to become a foster parent. Training includes first aid, CPR, disciplining, love and logical, mini map, and other state-required classes. Adoptive parents do not receive many of the needed specialized classes. Classes on attachment, crisis response, parenting the traumatized child, grief and loss, and working with neglected/abused children are rarely given. Adoptive parents struggle to find courses to address these concerns (Child Welfare Information Gateway, 2013). These specialized trainings are essential to help maintain permanency when working with adoptive families and traumatized children (Casey, 2003). Adoptive families require both professional and natural supports in order to be prepared for this challenge. Professional services such as therapy, respite care, crisis intervention, psycho-education courses, and direct family support helps the family work throughout difficult adjustment periods (Child Welfare Information Gateway, 2013). The traumatized child tends to lack sensitive responsiveness, especially when he or she has been a part of the child welfare system. Secure attachments develops internal working models which direct the child's thoughts, feelings, and emotions and helps in their future relationships (Grotevant, 2014; Hartman, 1984; M. A. Baker, personal communication, August 15, 2013; McDonald et al., 2011; Post, 2006, 2013).

Purpose of the Study

This study is significant from the perspective of the adopted family, the reasons why they may be challenged in receiving professional alliance within the home, school, and community, all of which are essential in order to survive and thrive in the midst of a difficult adoption (Grotevant & McDermott, 2014; James, 1994; Post, 2013; Ruggerio,

2010). Previous researchers looked at the challenges faced by the child as opposed to the challenges faced by the family. The purpose of this study was to investigate the challenges faced by the adoptive families of traumatized children when striving to survive and thrive through challenging adoptions.

The results of the study may add to an existing knowledge of adoption issues. It may provide adopted families additional insight into an active intervention that takes into account the impact that trauma has on a family's social and emotional system. Adoption in and of itself can be a powerful tool for social change because the adoption process allows the individuals involved the opportunity to grow into a new family unit. The number of children exposed to domestic violence, physical abuse, sexual abuse, and neglect has increased. It is imperative to find more effective strategies to support the adoptive family in assisting the child (Child Welfare League of America, 2010, 2013; Post, 2013; Smith, 2012, 2013).

Research Questions

RQ1: What challenges do parents face in raising their adopted traumatized child?

RQ2: Which methods have parents used to encourage their adopted traumatized child in developing a secure attachment?

RQ3: How do the parents perceive/describe the family dynamics after adopting their traumatized child?

Theoretical Foundations

Failed adoption (disruption/dissolution) affects the adopting family and child, as well as the community. Homes, schools, and community settings have been affected by

the increase in the number of children being removed from their biological homes and being placed into the public foster care system. Failed adoption builds a pressure within the family unit to conform to the expectations and requirements of Child Protective Services (CPS) while facing scrutiny and stereotyping from society.

Failed adoption can be explained through the psychodynamic theory. In the area of psychotherapy, the psychodynamic theory was considered to be the most dominant school of thought among clinical psychology and psychiatry practice in the early 20th century. This approach includes a focus on the unconscious thoughts of the individual in order to formulate an understanding of his or her relationships, experiences, and how he or she sees the world. Failed adoption (disruption/dissolution) and the psychodynamic theory are connected through the examination of the adoptive family's unresolved conflicts and symptoms that arise from dysfunctional relationships, which may lead to a dissolved adoption. Adoptive families may find themselves being challenged more than ever before. Failed adoptions occur by the child's inability to attach to their new family.

The attachment theory is widely used to explain relationship development between a child and its primary caregiver. Bowlby's (1969) theory of attachment derives from the psychodynamic theory. According to the theory of attachment, the infant/toddler must develop a secure base with a primary caregiver before age 2-years-old. Thus, adoptive parents who are ill-equipped or non versed (e.g., lacking information necessary) to understand and approach the child's needs unconsciously find themselves harboring painful and vulnerable feelings. These thoughts may stay in the unconscious because they are too difficult to deal with (James, 1994; Hushion, Sherman, & Siskind,

2006). This maladaptive process of repression, denial, and rationalization develop as a means to defend oneself and tend to cause the adoptive parent more harm than good. Adoptive parents need to examine their perspective or understanding of grief and possible narcissistic injury, while consistently remaining in tuned to their child's lived experience as an adoptee (Marsh & Ruth, 2008).

According to the psychodynamic theory, human behaviors and feelings are impacted by unconscious motives rooted in childhood experiences. The psychodynamic approach used in the area of adoption is Bowlby's (1969) theory of attachment. Attachment theorists illustrate the dynamics of maintained long-term human relationships. In this theory, Bowlby examined the relationship development between the infant/toddler and at least one primary caregiver by age 2-years-old. Bowlby and Ainsworth (1969, 1973) addressed the dynamics of long-term human relationships and explained the importance of the parent/primary caregiver's role, especially during the social and emotional stages of the infant/child. Bowlby (1969) suggested that child relationships are essential. Attachment theorists suggest that, in healthy child development, it is imperative that interaction take place in various environments (Hart, 2011). Understanding the attachment element experienced from the adoptive parent's perspective could enhance the therapeutic alliance. The therapeutic alliance is what Sonkin (2005) revealed about the therapist attachment development while building an alliance in the therapeutic relationship. In providing the child an opportunity to learn to trust again within a healthy relationship, he or she is afforded a chance to attach to his or her new caregiver. Bowlby believed that this form of attachment figure could happen

without the child's awareness. The attachment theory includes four characteristics: proximity maintenance, separation distress, haven, and secure base (Hazan & Zeifman, 1999). Bowlby suggested that these same dynamics are true of other close attachment relationships in life.

Attachment theory is used to clarify how the parental relationship influences the child's development. The traumatized child lacks in sensitive responsiveness, especially when he or she has been a part of the child welfare system (Child Welfare, 2010; Grotevant & McDermott, 2014; M. A. Baker, personal communication, August 15, 2013; National Child Traumatic Stress Network [NCTSN], 2005, 2012). These children are not afforded the opportunity to consistently attach to a secure base because they are moved from house to house, causing an unsecure base for exploration. Secure attachments help the child to develop internal working models which direct the child's thoughts, feelings, emotions, and hope in their future relationships (Grotevant & McDermott, 2014; M. A. Baker, personal communication, August 15, 2013). Attachment is one area that challenges the adoptive parent.

Traumatized children and their adoptive families are more at risk for failure due to a lack of services and resources readily available in meeting the needs of the child and family (Casey Family, 2003). More independent studies need to be conducted to understand the issues that the adoptive families experience (Keck & Kupecky, 2009; Post, 2013; Smith, 2010). Forbes (2008) revealed that the adoptive parent must live at a higher level of consciousness when parenting the traumatized child in order to stay attuned to their emotional state. Forbes suggested that the only way bonding and

attachment can occur was by maintaining positive emotional experiences, which can allow the healing process to take place. Professionals question what can be done to help adoptive parents in gaining more understanding and confidence in raising their newly adopted child. Brodzinsky's (1998) stress and coping theory is used to screen adoptive families to ensure the existence of compatibility (good fit) and to make certain that the adoptive family is emotionally regulated. Bowlby's (1969) attachment theory places emphasis on the primary caregiver's responsiveness to the child's needs. Bowlby's attachment theory explores proximity maintenance, safe haven, and secure base (ensuring closeness or a type of intimacy where the child can explore from and return to) as well as separation anxiety, which is considered to be normal and adaptive in infants and is a part of their survival tools (Collins & Feeney, 2000). In this study, I examined how the insecure base of the adopted and traumatized child challenges the adoptive family's social and emotional system.

Importance of the Study

The number of children being adopted from the public foster care system has increased. In the Adoption and Foster Care Analysis and Reporting System (AFCARS), the U.S. Department of Human Health Services (2013) revealed that 94,626 of the 400,540 children in the foster care system were adopted through the public welfare system. This number does not include the 14,213 children designated to pre adoptive licensed homes possessing a signed agreement with the state to foster and adopt (U.S. Department of Health and Human Services, 2013). However, the number of children adopted from the public welfare agency during 2011 was 50,516 (U.S. Department of

Health and Human Services, 2013). In the past, the criteria for adopting a child differed then the criteria that is in place today, and the characteristics of the adoptive parent were primarily of middle socioeconomic status, upper-socioeconomic status, married, infertile, and nondisabled European American couples between the ages of 30s to 40s (Brodzinsky, Patterson, & Vaziri, 2001; Derdeyn, 1990).

The characteristics of adoptive parents have expanded to include individuals from low-income families, older individuals, single parents, and same-sex couples (Brodzinsky et al., 2001; Derdeyn, 1990; Smith, 2011). These changes surfaced due to the Adoption Assistance and Child Welfare Act (1980) and The Adoption and Safe Families Act (1997). The Child Welfare Act afforded an opportunity for special needs children (i.e., older age at placement, minority, racial, status, multiple sibling group, exposed to neglect and/or abuse, chronic medical problems, and mental and psychological disturbance) along with non traumatized children to be adopted (Administration for Children and Families, 1980). The Adoption and Safe Families Act was passed with the purpose of reaffirming a commitment to permanency planning for foster children through reunification with the birth family or a concurrent plan for severance and adoption.

This study is significant from the standpoint of the adopted family, the reasons why they may struggle in receiving professional alliance within the home, school, and community, all of which are essential in order to survive and thrive in the midst of a difficult adoption. The results of the study added to an existing knowledge base, while providing from the adopted family's perspective additional insight into an effective intervention that takes into account the challenges that trauma etches on the adoptive

family's social and emotional system (Adoption and Safe Families Act, 1997). With the increasing number of children exposed to domestic violence, physical abuse, sexual abuse, and neglect, finding more effective strategies to support their adoptive family in assisting their child, not only to survive but also to thrive, is imperative (Brodzinsky, 1992; James, 1994; Mapes, 2012; McDonald, 2001; Pickert, 2010; Ruggerio, 2010; Smith, 2010).

Scope of the Study

The nature of this study was a qualitative phenomenological focus to better understand the thoughts, feelings, experiences, and challenges that adoptive families face in their attempt to establish permanency for their adopted child (Creswell, 2007). Qualitative data were used to better answer the research question of a study and to gain a new perspective in the area where limited research has been conduct or in areas that would benefit a more in-depth (Hoepfl, 1997). The qualitative approach allowed me to obtain firsthand knowledge of the challenges and the lived experiences from the adoptive families' perspective. An understanding of their perspectives could provide more effective therapeutic treatment and supports to a population of individuals in need of psycho-education, supportive services, insurances and financial subsidies, and positive outcomes towards permanency in their adoptive homes after placement (Child Welfare, 2010, 2012; McDonald, 2001; Rushton & Monck, 2009). The desired goal of this research was to provide a greater understanding amongst professionals regarding the factors or aspects that places barriers between the adoptive child and their families by providing more specific therapeutic treatment for the whole family unit (Child Welfare,

2010, 2012; McDonald, 2001; Rushton & Monck, 2009). The qualitative approach was used to gain a better understanding of how child trauma interplays with the adoptive family's social and emotional system. It also gave insight into the parent's perception of any challenges faced, not only in the home, but also in the school and community. In the past, qualitative studies approached the issues found in this phenomenon from the child's perspective (Forbes & Dziegielewski, 2009). A phenomenological approach of the problem would explore, inductively, the perspective of the adoptive parents themselves.

Definition of Terms

*Disruption/Dissolution***:** Refers to interruption within the family unit. A disruption occurs before the adoption has been legally finalized resulting in the child returning to the foster care system (Child Welfare, 2012; Meyers, 2011). Dissolution occurs when the legal relationship between the adoptive parents and the adopted child is severed, either voluntarily or involuntarily after the adoption is legally finalized (Child Welfare, 2012).

*Pre adoptive placement***:** "The placement of a foster child, for whom the permanency plan is adoption, with people who have been approved as an adoptive resource, pending the child becomes legally free for adoption" (Adoption Legal Risk-Child and Family Policy Manual, 2007, p. 1).

Unprivileged information: Complete medical, mental health, developmental, psychological, educational, and social information about the child and his or her biological family (Child Welfare Information Gateway, 2013).

Well-informed/unprivileged information: Information given or received by potential adoptive parents before making a legally finalized decision to adopt (Child Welfare Information Gateway, 2013).

*Wrongful adoption***:** Accusations of undisclosed information withheld from adoptive parents by adoption agencies leading to an adoption. Undisclosed information can include a variety of things, such as serious physical emotional or psychological defects or deficiency (Meyers, 2011; National Adoption Information Clearinghouse, 2012).

Delimitations and Limitations

Limitations in qualitative studies relate to its validity and reliability (Creswell, 2007). Therefore, measures were taken to reduce the limitations in the study. The validity of this study was supported by current literature searches, with validation of the findings by trained peer reviewers (Creswell, 2007). The major limitation in this qualitative study related to scholarly literature published before 2010. Current evidence-based research on failed adoption is lacking. Next, past experiences were bracketed. Peer reviewers authenticated data and verbatim transcripts verifying themes revealed from the data collection (Creswell, 2007). Finally, interviews, data analysis, and coding and verified member checks by the participants were completed. Validity was the ultimate outcome goal of this research, based on trustworthiness (Creswell, 1998).

Summary

The purpose of this study was to understand, from the perspective of the adopted family, the reasons why they may be challenged in receiving professional alliance within the home, school, and community, all of which are essential in order to survive and thrive in the midst of challenging adoptions (Child League of America, 1996; James, 1994). Earlier researchers have placed more of an emphasis on the struggles endured by the child instead of addressing the challenges of the family unit, as a whole, in their quest for permanency (Brodzinsky, 1992; James, 1994; McCormick, 1991; McDonald, 2001; Pickert, 2010). In this study, questions were addressed, while bringing forth social awareness and positive social change in order to influence the areas of adoption, especially when dealing with traumatized children. In Chapter 2, I will present the literature review.

Chapter 2: Literature Review

Introduction

Trauma is unique. Every individual who experienced such an event experiences it differently (Lee & James, 2011). Trauma is defined as any event that imposed a life altering or life threatening experience in such a way that the individual is deemed unable to function (Smith, 2012). The United States experienced an increase in children being placed in the public welfare system due to various traumatic situations of violence, neglect, and abuse. Foster children in the United States escalated over the last 2 decades making up the vast number of children adopted (Child Welfare Information Gateway, 2013; Smith, 2010). Adoption is used to reduce the number of children growing up in the public welfare system.

Adoption continues to be a valuable solution for the growing number of children living within the public foster care system. The U.S. Department of Human Health Services (2012) reported that over 400,540 children were adopted from the public welfare system. This number does not include the 14,213 children who were designated to pre adoptive homes (U.S. Department of Health and Human Services, 2012). In September 2012, the number of children in the foster care system reached 399,546 (Children's Bureau, 2013). In 2012, over 83,905 children were adopted in the United States alone (Children's Bureau, 2013). The number of children being adopted from the foster care system reveals adoption is one valuable solution. The desire is to have children raised in a loving and caring environment and not the foster care system.

In the adoption literature, failed adoptions are referred to as disruptions. While these acts were found to be complex and emotionally charged, they have occurred more often than reported (Mapes, 2012; Smith, 2010). Although statistical data may vary, the University of Minnesota and Hennepin County (2010) conducted a study of the U.S. adoption practices and found that between 6 to 11 % of all adoptions faced disruption before the adoption was finalized. The University of Minnesota and Hennepin County revealed that age was one critical variable in the rate of disruption. Children older than age 3 had a likelihood of disruption between the ranges of 10 to 16 % (The University of Minnesota and Hennepin County, 2010). The rate of disruption is worse for teens, ranging as high as 24 %, or 1 in 4 adoptions (Barth, Berry, Carson, & Goodfield, 1986; Festinger, 1990; Schmidt, Rosenthal, & Bombeck, 1988; Westhues & Cohen, 1990).

Researchers have attempted to determine the cause of disrupted adoptions. Barth and Berry (1988) suggested that older children were washed over from the initial success of permanency planning. Grotevant and McDermott (2014) revealed that, when disruptions or dissolution occurred in the adoptive home, the child is then at a higher risk for problems with adaptation, especially in the area of internalizing, externalizing, and attention. Another layer of trauma occurs in the area of trust, bonding, and attachment. Foster children develop negative behavior associated with bonding and attachment due to loss, deprivation, abuse, and physical development problems (Keck & Kupecky, 2009; Rushton & Monck, 2009; Spangler, Johann, Ronai, & Zimmermann, 2009; Wilke-Deaton, 2005). Trauma is defined as any stressful event, which was prolonged, overwhelming, or unpredictable (Lee & James, 2011; Post, 2012; Smith, 2012; Wilke-

Deaton, 2005). Trauma can also be defined as a life-threatening and life-altering set of events or experiences in which the individual has no control over and is an actual or perceived threat of danger where the individual feels overwhelmed and/or in an incapacitated state in which he or she is unable to cope as usual (Brodzinsky et al., 1998; James, 1994; Karp & Butler, 1996).

Non infant foster children are categorized as special needs due to age and racial characteristics in various entities (Brodzinsky et al., 1998; Children's Bureau, 2013; Forbes & Dziegielewski, 2003; James, 1994; Karp & Butler, 1996; NCTSN; 2012; Smith, 2010; Wilke-Deaton, 2005). Lived experiences are causational factors that escalated the child's confrontational reasoning ability with their newly adoptive parents (Brodzinsky, 2008; Brodzinsky et al., 1998; Grotevant & McDermott, 2014; Smith, 2012). Adoptive parents of these children may be at a disadvantage from the onset. They adopted more than the child itself; they took on the child's pre adoptive experiences as well (Forbes & Dziegielewski, 2003). As the traumatized child attempts to bond, he or she tends to struggle with mistrust and uncertainty, which is embossed on the forefront of their mind from past experiences (Wilke-Deaton, 2005). When mistrust and uncertainty transfers into placement the effect impacts the adoptive family's relationship as well (Brodzinsky, 2008; Brodzinsky et al., 1998; Grotevant & McDermott, 2014; Smith, 2012). While the adoptive family attempts to engage the child in their family, the child continues to struggle with past inner conflicts, which make parenting the child more difficult (Smith & Howard, 1998).

Challenges in Attachment

The development of human attachment begins within the first years of life. Bowlby (1969) suggested that the relationships between the child and the primary caregivers are essential. Relationships are seen as the foundational threshold that allows the child to formulate healthy attachments (Brodzinsky et al., 1998; Grotevant & McDermott, 2014; Schore, 2003a, 2003b; Wilke-Deaton, 2005). As the secure base is instilled for exploration, the child's increased need and ability to navigate in both the psychological and physical world develops (Schore, 2003a, 2003b).

Bowlby suggested helping children to find their way while helping the parents to feel secure was vital (Bretherton, 1992). From this point on, a difference between insecurity and attachment between the mother and child was explored (Bowlby, 1958). According to the attachment theory, the development of childhood includes the interaction between environments as well as genetic predisposition (Hart, 2011). Understanding the attachment element experienced from the adoptive parent's perspective was vital to enhance the therapeutic alliance. In fact, Bowlby (1969) felt that the intimate attachment between human beings acted as the hub from which a person's life revolved.

It is those initial relationships that Bowlby believed the individual attached to a personal therapist. Bowlby (1969) noted that attachment happened without the child's awareness, and the attachment theory developed four characteristics: proximity maintenance, separation distress, haven, and secure base. Bowlby suggested that these same dynamics were true of other close attachment relationships in life. Wilke-Deaton

(2005) suggested that when the professional is looking to understand attachment theories or even attachment, in general, it is important to realize that children tend to have more than one primary caregiver. Past researchers focused on the relationship with the mother and child. Yet this has been noted as only one of the primary caregivers (Brodzinsky, 2008; Grotevant & McDermott, 2014; Smith, 2012; Wilke-Deaton, 2005).

Attachment theory is used to clarify the impact on how the parental relationship influences the child's development. Traumatized children tend to lack in sensitive responsiveness when raised in the foster care system (M. A. Baker, personal communication, August 15, 2013; Wilke-Deaton, 2005). These children lack a secure base because they moved from house-to-house, causing an unsecure base from which they can explore (Brodzinsky, 1992; McCormick, 1991; McDonald, 2001; Pickert, 2010; Rushton & Monck, 2009). Secured attachments help the child to develop internal working models that direct the child's thoughts, feelings, emotions, and hope in his or her future relationships (Brodzinsky et al., 1998; Grotevant & McDermott, 2014; M. A. Baker, personal communication, August 15, 2013; Wilke-Deaton, 2005). The internal working model of each traumatic event influences the outcome of the organization and functional capacity of the adoptive family's outcome depending on the complexity or longevity of each experience (Grotevant & McDermott, 2014).

Within attachment theory, James (1994) defined attachment as a reciprocal process by which the child and his or her caregiver endure emotions and physical affiliation. In addition the reciprocal processes engage each party (caregiver and child) into the bonding and attachment approach (Wilke-Deaton, 2005). One facet of the

reciprocal approach resembles the action of the primary caregiver establishing or instilling trust, morals, beliefs, and love in the form of bonding, which allows the child to begin to formulate an attachment relationship with the caregiver (Wilke-Deaton, 2005). When applied to traumatize children, it is easier to understand why children who are removed from their original caregivers tend to present as challenged in adjustment or establishment of new attachments.

When the attachment is severely disrupted, the child's physical, social, and mental developmental balances are interrupted as well (Grotevant & McDermott, 2014). These disruptions are displayed in academia and other school areas, adjustment within various environmental settings, externalizing and impulsive displayed symptoms, hyperactive behavior, conduct problems, and substance abuse issues (Anda et al., 2006). These misunderstood challenges stigmatize the adoptive family unit and render many of them ill-equipped because these families tend to lack information about their child's past traumatic experiences which is required to advocate for the needs of their new family. The lack of background information and parental stressors are the strongest service-related predictors of disruption (Groze, 1996; Rosenthal, 1993). Family preservation is crucial in order to maintain the relationship of the pre-existing family unit and provide the child with stabilization and permanency in a safe and secured environment (Brodzinsky, 1992, 2008; Grotevant & McDermott, 2014; James, 1994; McDonald, 2001; Smith, 2012; Wilke-Deaton, 2005). Therefore, it is necessary that placement supports be established allowing the child to generate a new bond of trust with his or her new caregiver. When the circle of security (trust) is generated, and a healthy relationship

(nurturance and protection) with the caregiver is created, the child's psychological human development is constructed (James, 1994).

Review of the Literature

Research is needed to explore evidence-based strategies for working with adoptive parents of traumatized children. Adoptive parents may not receive well-informed documentation about the child before the adoption was finalized. Agencies may withhold vital information as seen in *(Burr v. Board of County Commissioners of Stark County, 1986).* Funding needs to be allocated for preadoption training to ensure the adoptive parents are equipped with understanding and knowledge of the challenges that present in adopting traumatized children. Postadoption services (therapies, respite care, subsidies, and support groups) must exist to empower the stability of the parent and the family unit as a whole. Of particular importance is the need for the awareness of the knowledge and understanding of the challenges of child trauma on the adoptive family's social and emotional system. As the child's social, emotional, and behavioral problems manifest, the parents' unrealistic expectations of the child may cause disruptions within the new family unit (Barth & Berry; 1988). These gaps laid the foundation for this study by pointing out the challenges that adoptive parents faced in the area of attachment. Adoptive families are apt to be challenged with new stressors just to face the child's rejecting behavior (Barth & Berry, 1988; Wilke-Deaton, 2005).

Challenges of Well-informed Decisions

All states suggest that adoptive families receive information about the potential adopted child and the circumstances that placed him or her in the welfare system.

However, receipt of such information happens less often (B. Troupe, personal communication, April 16, 2014; National Adoption Information Clearinghouse, 2013). To make well-informed decisions on whether to adopt or not, this information has been found to be essential (B. Troupe, personal communication, April 16, 2014 (National Adoption Information Clearinghouse, 2013). According to the Child's Bureau (2012), accurate information about a child's background, to the extent allowed by law, should be shared. Initially, this is done with an introduction of a limited scope of information. If the family still shows interest, then the limited scope is continued through full disclosure of obtainable information (Child's Welfare Information Gateway, 2012; Mapes, 2012; Smith, 2012).

Well-informed decision making is a realistic exploration of adoption. The Child Welfare Information Gateway (2010) revealed that this process is a relevant resource for ensuring a legal permanent, nurturing family for every child. When such information is received, the adoptive families are equipped with information on how to advocate for the needs of their potential child. Also, some foster care and adoption agencies have used such information to cross-match potential adoptive families to certain adoptive children. Adopting parents have the opportunity to preview potential genetic defects, generation, and environmental experienced events. Such genetic defects could have an impact on the child's medical, behavioral, social, and emotional mental health. Therefore, such information needs to be shared before the adoptive parent commits to a life-long relationship with the child. Some agencies find this to be a detrimental step in finding a good home for some children. However, it is not enough just to place the child in a home

where disruption or dissolution can take place. The goal of this decision-making process is to alleviate further potential trauma. Adoptive families cannot meet the needs of the adopted child being ill-equipped (Child Welfare Gateway, 2010, 2012; Forbes & Dziegielewski, 2003; Grotevant & McDermott, 2014; Smith, 2012; Wilke-Deaton, 2005). When the informed decision-making process is carried out, it allows the potential adoptive family the chance to obtain the necessary training to raise a traumatized child (Child Welfare Gateway, 2010, 2012).

Such training can be in various areas. Training in adopting traumatized children is required for there to be stability and permanency (Brodzinsky, 2008; Forbes & Dziegielewski, 2003; Grotevant & McDermott, 2014; Smith, 2012). The National Academy of Sciences reported the consequences of abuse (trauma) has been found to reshape the brain of the traumatized child. The results of this reshaping leave a long-lasting effect, especially when the child is untreated (Schulte, 2013). The effects influence the child's physical behaviors as well as their mental health behaviors (Schulte, 2013). In fact, many states require adoption agencies and attorneys to collect medical and genetic information on the child that can be shared with the adoptive parent (Dinwoode, 2014).

In adoptions, the adopting parent is required to sign consent where they agree to take and raise the child with the same privileges as their birth child (Child Welfare Gateway, 2010, 2012). Every state regulates their consent to adopt. Consent to adopt is not governed by federal laws. However, consents to adopt are required by all states (Children's Bureau, 2013).

Although adoption consent is designed to ensure the protection of all parties involved (child, birth parent, and adopting parent), it was not designed to protect adoptive parents from wrongful adoption. Wrongful Adoption is a legal term that refers to the failure of an adoption agency or worker to disclose known information about a child to the prospective adoptive parents (Child Welfare Information Gateway, 2013). Valuable information which includes known medical or psychiatric. Wrongful adoption occurs when adoption workers stand unclear on adoption law and what is to be disclosed. Many adoption agencies are attempting to obtain placement of the child in a permanent home. Although unprivileged information regarding the child is required at the time of placement, sometimes the pertinent information has been knowingly omitted. Some families receive less than accurate preplacement (well-informed/unprivileged) information (Arizona Revised Statues, 2013). Well-informed decisions are only capable of being made when adoptive parents receive all relevant information about the child. Well-informed decisions derive from information gathered on the child and his or her biological family. The Child Welfare League of America (CWLA, 2013) proposed that a standard of excellence be in place for all adoption services. The adoptive family should receive complete unprivileged information on the child, their birth family and other birth relatives two generations back (CWLA, 2013). Therefore, included in the well-informed decision-making process is unprivileged information. The Arizona's Revised Statues 8-514 (2013) viewed unprivileged information to include but was not limited to

- Demographic information
- Type of custody and previous placement

- Pertinent family information including the names of family members who, by court order, may not visit the child
- Known or available medical history including but not limited to (a) allergies, (b) immunizations, (c) childhood diseases, (d) physical handicaps, (e) other idiosyncrasies (e.g., psychological, mental health, etc.), and (f) the child's last doctor
- A summary of the child's history of adjudication on acts of delinquency, as may be public record and available in the file of the clerk of the superior court (pp. 1-3).

Sometimes adoption agencies have limited knowledge of the child's past traumatic experiences. Therefore, they too are challenged with understanding the complexity of the child's trauma (Wilke-Deaton, 2005). Many adoption agencies have learned that all prospective parents are required to have disclosed non-identifying information where with an informed decision to adopt can be made. Adoptive parents are commissioned not to assume they received all medical, psychiatric, and social information about their potential adopted child (Child Welfare Information Gateway, 2013; Riggs & Kroll, 2004). One historical case of a wrongful adoption was Burr vs. Board of County Commissioners of Stark County (1986) in Ohio. In this case, the adoptive parents struggled with challenges of their child. It was discovered that known; unprivileged information was purposefully withheld about the birthmother's mental illness. The agency's worker knowingly withheld information and misrepresented the child as a child who was healthy (Combs, 1986). The adoptive parents were led to

believe that the 17-month old baby was being placed up for adoption by his 18-year-old mother. Allegedly, the grandparents were said to have abused the child and the mother's desire to make a better life for herself in another state (Combs, 1986). The adoptive parents immediately proceeded with the adoption based off of the information received. Their lives and that of their sons throughout his childhood indicted a myriad of physical and mental health problems. This case pointed out how necessary it was for adoptive parents to inquire about their child's past in order to have obtained child abuse, medical, psychiatric, and placement history.

Adoptive parents need to advocate to receive complete historical information, both known and unprivileged, to formulate a well-informed decision about adoption. Such information includes medical and mental health issues, social and emotional, behavioral, educational, legal, and any genetic predisposition information that could have an adverse effect on the development of the child and the stability of the new family. All of this information should be granted prior to the finalization of the adoption to alleviate any further disruptions in the child's life or dissolution of the new family unit. When knowledge of the child's past is received, the adoptive parents are equipped in making well-informed decisions in adopting. This knowledge prepares the adoptive parents and allows for them to advocate for the needs of their child, thus reducing the challenges associated with adopting a traumatized child.

Due to the increase in the number of children in the public welfare system and in out of home placement, child protection agents may strive for placement over permanency when they seek out residency for a child. The gaps in the research laid the foundation for this study by pointing out the challenges that adoptive parents face in the area of well-informed documentation. When the release of medical and mental health disclosures is not discovered until after the adoption finalized, the adoptive family is challenged. Disclosure failure could result from a lack of undocumented information unrevealed even to the child protection service workers.

Challenge of Placement versus Permanency

Permanency is stemmed from active participation between a youth and an adult who have searched in finding a permanent connection. The adult is committed to providing the youth with a safe, secure, and stable relationship demonstrated with unconditional love and lifelong support (Brodzinsky et al., 1988; Forbes & Dziegielewski, 2003; M. A. Baker, personal communication, August 15, 2013; Smith, 2012).

Over the last 2 decades, the number of adoptions from the public welfare system in the United States has increased (Child Welfare Information Gateway, 2013). The Children's Bureau (2013) reported that on September 30, 2012, there were an estimated 399,546 children in the public foster care system. Close to half of those children (47 %) resided in nonrelative placement, and of this 47 %, 24 % of these children had a goal of adoption (Children's Bureau, 2013). There must be a paradigm shift from placement towards the direction of achieved permanency and assured supports, which are needed to

transition these children from disrupted relationships to a healthy adulthood outcome (Donaldson, 2010). This shift is needed because many children are placed in homes that are not equipped to deal with the challenges these children present, such as abuse, neglect, multiple placements, and other preadoption experiences that inflict physical, psychological, emotional, and developmental harm on them (Donaldson, 2010).

There are few families that willing to adopt traumatized children. With the number of children who are still waiting to find their forever home, these homes are fewer. These special needs children require specialized parenting once they are adopted into their permanent home (Forbes & Dziegielewski, 2003; Keck & Kupecky, 2009; Smith, 2012). Forbes and Dziegielewski (2003) claimed that there are many reasons provided required for specialized parenting; however, the common thread is found in the mental and behavioral health arena. Mental and behavioral health issues, such as oppositional defiant disorder (ODD), conduct disorder (CD), reactive attachment disorder (RAD), posttraumatic stress disorder (PTSD), and/or depression are common in special needs children (Forbes & Dziegielewski, 2003).

The child welfare system is mandated with the responsibility of placement of children who are wards of the state (National Association of Social Workers, 2009). The Adoption Assistance and Child Welfare Act (1980) renders the goals of family preservation and permanency as priority goals (National Association of Social Workers, 2009). Every adoptive home is required to be screened before placement and supervised monthly while the child is placed in the home. Although, in the beginning, the targeted objective is placement, researchers have shown that this not sufficient enough (Barth &

Berry, 1988; Forbes & Dziegielewski, 2003; James, 1994). Best practices for adoption entail not only establishing the formulation of the family, but also cultivating their success (Donaldson, 2010). However, in order for this goal to be carried out, policy makers and professionals must revisit state and national priorities to strengthen and sustain the adoptive family (Keck & Kupecky, 2009; Petra & Kohl, 2010; Randall, 2009; Smith, 2012).

Professionals and policy makers must define, alter, and advocate for the resources necessary to strengthen and sustain the adoptive family unit. Through obtained knowledge and supportive resources, the adoptive parents will be equipped with the essential tools needed to assist their child in enjoining the family unit, causing stabilization to take place on the child and family. This knowledge prepares the adoptive parents and allows for them to advocate for the needs of their child, reducing the challenges associated with adopting a traumatized child (B. Troupe, personal communication, May 2, 2014; Barth & Berry1988; Brodzinsky et al., 1988; Forbes & Dziegielewski, 2003; James, 1994; Keck & Kupecky, 2009; M. A. Baker, personal communication, August 15, 2013; Petra & Kohl, 2010; Randall, 2009; Smith, 2012; Wilke-Deaton, 2005).

Many adoptive parents lack understanding of the various forms of the trauma their adopted child may have experienced. Prolonged exposure to neglect, domestic violence, multiple placement, and trauma within the home and system become a challenge for these parents (James, 1994; Wilke-Deaton, 2005). The adoptive parents face challenges in the area of placement versus permanency. Placement is not enough (Brodzinsky et al.,

1988). Policy makers, along with other federal officials, must begin to look at the long-term effects that trauma has on the child, as well as the family unit as a whole. Forbes and Dziegielewski (2003) revealed that researchers have not examined the outcomes or effects on the adoptive family. Yet, understanding the challenges and perspectives of adopting children of trauma needs to be studied in order for the adoptive parent to obtain the specialized training in parenting traumatized children (Forbes & Dziegielewski, 2003).

Challenges in Understanding Endured Trauma

Researchers found that the direct impact of experienced trauma from 40% of CPS cases was unknown (U.S. Department of Health & Human Services, ACF, 2010). Acts towards children produce complex traumatic experiences with extended consequences. These acts affect the child, their families, and the community (English, 2005; Higgins & McCabe, 2003; Sabol, Coulton, & Polousky, 2004; Wulczyn, 2009; Zielinski, 2009). These children often experience multiple forms and incidents of abuse or neglect. The National Child Abuse and Neglect Data System (NCANDS) revealed that 40 % of the substantiated victims received preventative services within their homes (U.S. Department of Health & Human Services, ACF, 2010). Researchers have revealed the events in which children are traumatically affected. Although these events cause psychological-threatening or physical threats that fuel the child to launch their flight, fight or freeze responses, the child may not qualify for the diagnosis of PTSD (American Psychiatric Association, 2000; James, 1994; M. A. Baker, personal communication, August 15, 2013; Wilke-Deaton, 2005). PTSD in these children occurs because the child's

neurophysiological responses continue to linger in a chronically aroused state, even though the intimidation, risk, or danger has ended (Terr, 1992). Traumatic events, such as domestic violence, car accidents, neglect, physical and sexual abuse, national disasters, or even medical procedural trauma cause lingering effects which incapacitate the child's ability to function or self-regulate physically and emotionally (Brodzinsky, 1992; Grotevant, & McDermott, 2014; James, 1994; M. A. Baker, personal communication, December 15, 2013; McDonald, 2001; Pickert, 2010; Ruggiero, 2010). In their presentation, physical and emotional dysregulation are masked by a range of behaviors, which include the following: dissociation, enuresis, eating issues, hyper arousal, heightened startle response, elimination issues, focusing/concentration challenges, sleeping problems, sensory issues, and isolation and attachment issues (Grotevant & McDermott, 2014).

In the past, the criteria for adopting a child differed then the criteria that is in place today (Adoption Assistance and Child Welfare Act (1980). In the past, the adoptive parents were primarily middle socioeconomic status, upper socioeconomic status, married, infertile, and European American couples ages 30s to 40s without any form of disability (Brodzinsky et al., 2001; Derdeyn 1990). In the past, when a couple went to adopt a child, their reasons may have stemmed due to their inability to conceive a child. Today, individuals from low-income families, older individuals, single parents, and same-sex couples adopt children from the public welfare system (Brodzinsky et al., 2001; Derdeyn 1990). These changes surfaced with the Adoption Assistance and Child Welfare Act (1980). This act afforded an opportunity for special needs children (i.e.,

older age at placement, minority, racial, status, multiple sibling group, exposed to neglect and/or abuse, chronic medical problems, mental and psychological disturbance) along with non-traumatized children to be adopted (Administration for Children and Families, 1980). The Adoption and Safe Families Act (1987) passed with the purpose of reaffirming a commitment to permanency planning for foster children through reunification with the birth family or a concurrent plan for severance and adoption.

Summary

Many parents fail to understand or gain the knowledge about the challenges endured when adopting a traumatized child. The basic training that families receive only begins to scratch the surface of what is to come. Lavner, Waterman, and Peplau (2014) suggested that the services rendered to adoptive parents should be required throughout the transition to parenthood. These services need to promote the well-being of the family unit as well as the child. James (1994) revealed that it is not enough to merely survive and thrive in difficult adoptions; adoptive families needed to understand how equipped they must be to establish a healthy relationship when parenting the traumatized child.

Many adoptive families experience more challenges in the lack of postadoption services. According to Casey Family Services (2003b), continuous barriers exist among professionals who provide direct and indirect (e.g., therapy, support, and subsidy) services to traumatized children and their adoptive families. Ruggiero (2010) believed that families face three challenges in attempting to parent traumatized children. Two of these challenges deal primarily with the foundation that equips the parent for his or her new task. Ruggiero suggested that adoptive parents are unprepared in the preadoption

phase for raising children who struggle emotionally from traumatizing experiences; currently, there is a lack of postadoption services, especially in the area of behavior supports. These children and their adoptive families are at risk for failure. Failure in an adoptive home is perceived as the child being admitted in long-term therapeutic placement or even being returned to the welfare system (Casey, 2003b). Such results may be due to the lack of services and resources readily available in meeting the needs of the children and their families. Forbes (2008) acknowledged that parenting traumatized children are different from parenting non-traumatized children. Forbes contended that adoptive parents often face various issues that have a connection to the child's past traumatic experience or event. These challenges often are the cause of a significant alteration of the family's life, which causes an imbalance. Forbes revealed that stress and demands of special needs adoption range around 1/5 to 1/4 of the unsatisfactory reported adoptions. This contributes to 10% of disruptive adoptions which leads to the child returning to the foster care system. These hurdles highlighted some of the critical issues in adoption failure. Constant challenges in adoption permanency (e.g., remaining, maintaining, and integrating as an active member of the new family) of the traumatized child are the least studied. Therefore, researchers must address the needs and factors associated with strong, vigorous, and thriving post adoptive experiences (Forbes, 2008; James, 1994).

Researchers have looked to understand the issues or challenges that disrupt the developmental balance in the child's ability to form healthy attachments instead of viewing the challenges through the lens of the adoptive family. McGlone, Santos,

Kazama, Fong, and Mueller (2003) conducted a study to understand the nature and the extent of parental stress endured by adoptive parents of special needs children. Adoptive parents revealed that they sought out clinical services to address their child's pre-adoptive factors (e.g., biological and earlier experiences or abuse and neglect), which had an influential impact on the entire family. Adoptive families face challenges where the only solution to the problem was to remove the child from the home (Cohen, Coyne, & Duvall, 1993). Multiple placements increase additional layers of trauma.

Researchers have examined the challenges that adoptive parents have faced when adopting a child who has experienced trauma. However, scholars must also understand from the adoptive family's perspective and not just the child's perspective of the causes of failed adoption. Scholars have provided insight to the challenges of child trauma on the adoptive family social and emotional system. Researchers have revealed the importance of the foundation for human preservation within the family unit. Research is needed to explore evidence-based strategies for working with adoptive parents of traumatized children. The ultimate goal of prevention services appears to center around the child and family's environment. Here the catalyst is focused on positive changes among the primary family. The traumatic effects that an adoptive child experience affect the entire family unit; therefore, professional services are required for the whole family (Higgins & McCabe, 2003).

The significance of this study aimed to understand, from the perspective of the adopted family and their children, the reasons why they may be challenged with receiving professional alliance within the home, school, and community. The results of the study

would add additional insight to actual knowledge for intervention while taking into account the impact of trauma etched on the adoptive family's social and emotional system. Adoption can be a powerful tool for social change. With the increasing number of children exposed to domestic violence, physical abuse, sexual abuse, and neglect, finding more efficient strategies to support their adoptive family in assisting their child, not only to survive but also to thrive, is imperative.

Chapter 3: Research Method

Introduction

The process of qualitative research renders data on a problem by collecting detailed information from interviews and observation with informants in their natural environment (Creswell, 1998). Within the qualitative study design are five major traditions of inquiry, including the phenomenological method (Creswell, 2007). In this chapter, I discuss the phenomenological methods approach used in this qualitative study. I used a multiple embedded phenomenological design as discussed below. A discussion of personal and professional backgrounds are reviewed for managing possible bias. Finally, sample selection, recruitment, data collection, and data analysis procedures are described.

Phenomenological research is to understand the collective experiences of a group. Patton (1990) detailed the aim of phenomenological research. Patton based this method of research on the assumption that there is an essence or essences to shared experience. These essences are the core meanings mutually understood through a phenomenon commonly experienced. The experiences of different people are bracketed, analyzed, and compared to the identity of the essences of the phenomenon, like the essences of loneliness, the essence of being a mother, or the essence of being a participant in a particular program. The assumption of essence, like the ethnographer's assumption that culture exists and is important, becomes the defining characteristic of a purely phenomenological study (Patton, 1990,).

The phenomenological research approach is well suited for studying affective, emotional, and often intense human experiences (Merriam, 2009, p. 26). This type of research reduces individual experience to a phenomenon and takes it towards a more universal thinking, while exploring beneath the surface of policy implementation to reveal an in-depth understanding contributing to how individuals understand complex situations (van Manen, 1990). Phenomenological studies complement health sciences, especially sociology and psychology research, and have a potential to build knowledge of social work and social sciences (Borgatta & Borgatta, 1992; Creswell, 2007; Swingewood, 1991).

In this study, the phenomenological method was employed to understand the challenges of child trauma on the adoptive family's social and emotional system. The main purpose of this study was to understand the perspective of the adoptive family and the reasons why they may be challenged in receiving professional services within the home, school, and community. The ability to participate in professional services across these domains is essential in order to survive and thrive in the midst of difficult adoption experiences.

Research Questions

Three research questions will guide this study:

1. What challenges do parents face in raising their adopted traumatized child?
2. Which methods have parents utilized to encourage their traumatized adopted child to develop a secure attachment?

3. How do parents perceive/describe the family dynamics after adopting a traumatized child?

Overviews and Principles of Phenomenological Method

Phenomenological studies include a process commonly used in psychology and other social science disciplines to study a problem through observation and interviews (Creswell, 2007; Moustakas, 1994; van Manen, 1990). Phenomenologists investigate experienced events through the process of induction, human concern, and passion without statistical variables (Fellows & Liu; 2008). This approach aims at determining what an experience means for those who have had the experience and are able to provide a comprehensive description of it. Drawing primarily from Creswell (2007) and Moustakas (1994), this study, deliberate use of the phenomenological research approach was made. The primary target of the phenomenological study is to gain concrete meaningful knowledge from individual experiences about a common problem (Moustakas, 1994). Phenomenological studies are used to highlight groups of people that rarely have been the topic of previous studies (Creswell, 2007). Particular traditions within the qualitative research were considered. Biography researchers explore the life of an individual. Although this is possible, challenges arose because of the potential basis for conducting this form of study. Ethnography researchers can describe and interpret thoughts, feelings, and other variables of a specific culture or social group. This tradition was ruled out due to time constraints. A case study allows the development of an in-depth analysis regarding a single case or in regards to multiple cases. With this type of qualitative research, additional insight into previously researched information may be

gained based on the analysis. However, the desire was to obtain the perceptions of a group of individuals rather than an individual. Grounded theory is when the researcher desires to develop a theory.

In previous studies of child trauma and adoption, scholars primarily looked at the challenges faced by either the child or the mother (Casey Family Services, 2003b; Forbes, 2008; Park, 2010). In the phenomenological study, researchers view a problem of interest. Then central themes are established from real-life events that constitute the nature of the lived experience (Creswell, 2007; Moustakas, 1994; van Manen, 1990). Finally, phenomenological studies allow future research to understand complex social phenomenon, such as the challenges of child trauma in the adoptive family's social and emotional system (Creswell, 2007; Moustakas, 1994; van Manen, 1990). These factors can influence the outcomes of adoption. The adoptive family survives and thrives in challenging adoptions or the adoption fails. If adoption fails, the child is returned to the foster care system, adding another layer of trauma (James, 1994). Within a phenomenological study, an approach is the bounded systems. Bounded systems are divided in terms of time, place, and physical boundaries (Creswell, 2002). These created limits served as perimeters for inclusion and exclusion guidelines (Creswell, 2007; Fisher & Zivani, 2004; Gerring, 2004; Hancock & Algozzine, 2006; Miles & Huberman, 1994; Padgett, 2008). Cases can be bounded physically like group homes, licensing agencies, or community settings by time, place, or experience (Stake, 2006). Participants in this study were considered bounded by their shared experiences (i.e., involvement in the

adoption of traumatized foster children) and treatment (all families received mental health treatment for their children while they were part of the foster care system).

Application to Adoptive Families

There were several reasons why a phenomenological approach was selected. In this study, I desired to understand families who struggle with the challenges of raising a child that experience trauma. Although a quantitative study could be used to categorize statistics of adoptive families, while rendering insight into the challenges faced when raising the traumatized child; a quantitative study could not attain the in-depth understanding needed to achieve the desired outcome. In order to obtain that in-depth understanding of the challenges child trauma has on the adoptive family's social and emotional system, a qualitative research design was considered the best option. Phenomenological studies are conducted when the researcher wants to investigate or determine problems or situations important to understand the shared experience of the phenomenon or issue (Creswell, 2007; Duke, 1984; Giorgi, 1985, 1994; Moustakas, 1994; Pokinghorne, 1989; Tesch, 1990). Qualitative research was an appropriate approach to answer the following research question: What challenges do parents face in raising their adopted traumatized child? This experience is not something that can be gained through a direct question/answer type of format.

Phenomenological research allowed for an understanding of the common experience and how it can influence the development of policies practices, while gaining a deeper understanding about the features of the phenomenon (Creswell. 2007). Investigating the problem from this perspective allowed a streamlined form of data

collection like including single or multiple interviews with the participants to occur (Creswell, 2007) and to obtain their perspectives on the factors that contribute to the challenges faced.

Data were collected from adoptive parents who were familiar with the challenge of childhood trauma with their own adopted children. Creswell (2007) revealed that collecting data using the phenomenological approach requires in-depth interviews and multiple interviews with the participant. Fifteen families who had experienced the challenges from childhood trauma of their adopted children were interviewed. Loving Arms Foster Care Agency, Grace to the Nations Church, Arizona Counseling & Treatment Services, and Providence Yuma, Arizona agencies were contacted in the hopes of gaining their participation in locating adoptive families for this study. Interviews were conducted in a location of the participant's choosing. The participants for this study were adoptive parents of traumatized children. One criteria of this study required all parent to be between the ages of 24 to 75. The initial interview took place over the phone or at the referring agency's location. Thereafter, the interviews took place in a location that was covenant to the participant. The overall goal was to interview five to 15 participants. The qualitative research sample size should be large enough that most perceptions are explored, but not large enough that information becomes repetitive (Mason, 2010).

The adoptive parents were asked broad in-depth questions which focused on gathering data that will lead to the textual description and structure of their experiences:

1. What challenges do parents face in raising their adopted traumatized child?

2. Which methods have parents used to encourage their adopted traumatized child in developing a secure attachment?
3. How do parents perceive/describe the family dynamics after adopting a traumatized child?

These were a few of the questions used to determine outcomes that helped to provide an understanding to the common experience that each adoptive parent faced.

Horizonalization phenomenological data analysis was used to build the database from the questions. Horizonalization requires the laying out of all the data and analyzing it equally so that no one thing is more important than another (Creswell, 2007). The Interview transcripts which highlighted significant quotes or statements were analyzed which rendered an understanding of how these adoptive parents lived the experience of the phenomenon. Significant statements were categorized and given meanings before they were placed into clusters (Creswell, 2007). The transcriptions were reviewed by each participant to validate the information transcribed. Peer reviewers ensured the reliability and validity of the meaning gathered from the data, ensuring trustworthiness. This task was accomplished by having the peer reviewers analyzed the verbatim transcripts and developed an independent list of themes.

A description of the significant themes and statements that the adoptive parents experienced was written. Moustakas (1994) defined this as textual and structural description. The structural description is the content or the setting that influenced these adoptive parents' experience of the phenomenon. From the structural and textual description, a composite description was written that presented the essence of the

phenomenon (Creswell, 2007). Creswell (2007) suggested that this passage should focus on the common experience of the participants.

Multiple Embedded and Rhetorical Structures

A primary goal was to understand the challenges of childhood trauma on the adoptive family social-emotional system along with its philosophical assumptions. Embedded research design was used for descriptive studies, which are focused on understanding the general situation surrounding a phenomenon and uncovering possible correlations between the phenomena (Creswell, 2007; Moustakas, 1994). Embedded design involves more than one unit of analysis, focusing on different aspects of the case (Scholz & Tietje, 2002). Embedded in this study were 15 adoptive parents participating in therapy with their adopted children (either before or after the adoption) and parents adopting children from a traumatizing circumstance from the foster care system.

All researchers bring assumptions and biases to the research regardless of the method that they use. Bracketing takes the necessary steps in eliminating potential biases in the study design, analysis, and findings (Creswell, 2007

Role of the Researcher

The role of the researcher was a participant in the research project. The researcher must clearly identify and describe the relationship and perspective they have in regards to the population to adequately address bias in the study (McCaslin & Scott, 2003). A researcher must understand that there will be a degree of bias based on his or her understanding. It is important for the researcher to look at individual bias not necessarily as a weakness but as a normal part of the process. Individuals view diverse

elements from a unique perspective based on their own history. Seeking peer review to assist in evaluating the researcher's potential bias is imperative (Creswell, 2007). Dr. Marion A. Baker, Psy.D. and Brittany A. Canfield, MS conducted the peer review. The procedures that were used to guide the implementation of the study included ethical procedures, selection of participants, data collection techniques, data analysis techniques, verification of trustworthiness/authenticity, data interpretation, and dissemination of findings.

Ethical Procedures

Procedure placement was established to ensure the ethical protection of participants. Protected individuals include economically challenged participants. Due to these reasons, no compensation was gifted to the individuals in any way for their participation. Locations convenient to the participants were selected to reduce the expense for participants without offering financial reimbursement for travel. Meeting participants in a convenient place of their choice was a good option under these circumstances. Confidentiality was explained as well as notification of how to contact individuals with any questions or concerns. Within this process, potential conflicts were addressed and the participants were given a copy of the informed consent form. Potential conflicts such as confidentiality; the length of time records of the study are kept; mandated reporting; and safety concerns.

Study participants were protected through confidentiality measures, which included coding or encrypting documentation and storing data in a locked file, separate from the coding documentation, which was also stored in a separate locked location.

Meeting individuals where they feel safe and secure is important in assuring the protection of the participants. These records will be kept for five years after the completion of this study in accordance to human research protection (45 CFR 46.115(b)). The records will be maintained electronically on a flash drive and store in a locked safe.

One ethical dilemma to consider is determining whether consents only from the individual are needed or if consents should be gained from the group as a whole (Greely, 2001). The Institutional Review Board (IRB) rendered information about the type of consents needed from a nonprotected group. The signed consent forms of the participants outlined background information regarding the study and its procedures, and the risks and benefits of the study. No payment was offered. The participant's privacy/confidentiality, as well as whom the participants can contact with any questions or concerns. The procedures that were employed for obtaining consent explained the details of the consent in-depth and asked the participants if they would still like to participate in the study. The consent relayed the following information: a.) the role of the researcher as a doctoral student; b.) method of participant selection and c.) understandable explanation regarding the reason for the research. The expected length of the participant's involvement in the study was explained, a statement concerning the voluntary nature was outlined, as well as a statement that there was no penalty for discontinuing or refusing to participate in the study.

Participants were contacted via e-mail after they have expressed interest to the adoption agency, church, or therapist in participating in the study. At that time, I explained the process of the research, which included the informed consent. The safety

and protection of adoptive families' (including children) rights was a top priority in the research process. If the participants still wanted to participate in the study, the informed consent was reread to the participants in person prior to the interview process. Signed informed consents were secured prior to conducting the interview.

The interview was carried out in a location of the participant's choosing so that they were comfortable. All the questions came under the overall research question of understanding the perception of the adoptive parent, but they also come from an attachment-based lens on also understanding the attachment history of the adopted child.

Data Collection Techniques

A qualitative research technique that was used to collect data was the interview. An analysis of any personal records that the adoptive parents wished to share was also considered to provide additional context to the challenges of child trauma on adoptive families' social and emotional system. Understanding the challenges of these adoptive families was the primary goal of the research project.

The guided interview approach consisted of general questions that were the same general questions for each participant with the opportunity for participants to add additional information (Valenzuela & Shrivastava, 2012). Having specific guidelines on data collection and sources is essential.

Reliability and validity must be considered when considering data analysis processing (Welsh, 2002). According to Creswell (2008), without the assurance of reliable and valid research, the research obtained is not useful. It is imperative that the quality of data be insured within the qualitative research process.

The procedures used by the researcher to ensure quality and verification of findings would include peer debriefing where a colleague could supply alternate interpretations and provide a new perspective. Another aspect the researcher could use would be reflective journaling. This way of documenting looks at the researcher's own thought process throughout the research study. Data that were obtained from adoptive parents were analyzed and coded into categories based on attachment theory. Various theoretical perspectives were considered when evaluating data collected from adoptive parents.

Finding reputable software that has technical support is essential. The integration of data analysis software in the qualitative study process is increasing due to the capabilities of software (Bourdon, 2002). Information was coded based on recurring themes seen within the research. Coding allowed patterns to be identified within the data. Being able to integrate data and analyze from multiple sources, as well as through multiple methods, is another aspect to consider. Basit (2003) emphasized that coding is one of the most significant elements in organizing and analyzing data. Coding the data in order to incorporate a wide range of details would add depth to the entire process.

Verification of Trustworthiness/Authenticity

Verification techniques were used to ensure the trustworthiness or authenticity of findings. These techniques included the use of an audit trail, researcher's journal, transcripts, audiotapes, notes, early data analysis and interpretation, as well as effective communication with peer reviewer and research participants (Byrne, 2001). These techniques helped to verify authenticity of findings as well as keep the researcher on

track in assuring the data are trustworthy. Even inexperienced researchers can make mistakes, but employing appropriate techniques will limit the likelihood of inadvertently producing substandard data.

The researcher must be credible and able to document experience, qualifications, perspectives, as well as assumptions based on his or her history (Byrne, 2001). Another element of credibility includes establishing credible research methods (Byrne, 2001). The research method of interviewing is a credible form of research for gaining an in-depth understanding of the experience and challenges within this specific population. The term reliability is traditionally a concept used within the context of quantitative studies, but the term and use are also relevant in the process of evaluating qualitative research (Golafshani, 2003). Validity is an element to consider regarding qualitative research and is described in various ways throughout qualitative research (Golafshani, 2003). The traditional concepts of validity and reliability are relevant to qualitative research.

Strategies used to document transferability included using sufficient description in order to allow others the ability to draw conclusions regarding the transfer of the data to other populations. Data quality must be ensured within the qualitative research process. Integrating data from more than one source must be evaluated. I aimed to gain a perspective on the challenges of childhood trauma on the adoptive family's social and emotional system. Integrating the research was done by obtaining appropriate data to store and sort the elements of the various interviews.

Bracketing

As an adoptive parent, there have been many challenges faced with each child. I have adopted children have been sexually and physically abused, neglected, and emotionally abused by their biological family. The system was hard to navigate in the beginning. As I looked at the needs of the children, I forced myself to become educated on what they needed to advocate for them to reach success in their life. I am a court-appointed surrogate. I have been a therapeutic foster parent, and a regular foster parent. As a single parent, the walk has not been easy. The adoption process can involve therapy, dentist appointments, doctor's appointments, allergists to see, visitations, child protection case manager visits, licensing worker visits, and all kinds of challenges with various types of appointments which all center around the court or the family member's needs.

As a therapist, I have worked with child protection services and the adoptive families. In my professional experiences, I have met a number of families that have gone into the foster care industry in an attempt to give a child a better life; yet, they did not fully understand how to survive and thrive within challenging adoption. In the eight years that I have to work in the field, I have worked with over 50 families that struggled in this area. Families struggling with the effects of substance abuse on their children. Many families fail to understand why their new child behaves in certain ways, why a child has a hard time listening or following the rules, why the child lies, and why the child is sexually inappropriate.

The main goal of this study was to find direction on what will create social change, not only for the adoptive family as they look to survive, but also for the community, schools, and churches involved. Another goal was to present the outcomes of the study to policy makers. Hopefully, government level social agencies would be willing to hear these results and take action towards making the necessary changes to serve better the people looking to adopt traumatized children. Trauma does not affect just one person or one individual. Trauma interplays in all facets of a family. It leaves a long lasting effect on an individual; trauma is a significant cascading ripple in the water with each breath, each flashback, and each remembrance of the life-threatening life-altering event (Shapiro, 2012). It is here that the adoptive family has the ability to impact the life of their new child by embossing or etching a new pattern for the child while allowing attachment and bonding to occur (Ainsworth, Blehar, Walters, & Wall, 1978; Bowlby, 1988; Brodzinsky et al., 1998). This is where social change begins within the adoptive family.

Types of Potential Tools

There are various types of tools that can be used to gather information for validity which are evidence-based. The tool used for screening was the Trauma Symptom Checklist. The tool used for data analysis was MAXQDA, which is a qualitative data analysis program.

Conclusion

The purpose of this research project is to evaluate theoretical, empirical, as well as the methodological rationale for qualitative research within the population of adoptive

families seeking therapeutic treatment when dealing with challenges of child trauma. This research was conducted through the phenomenological approach, and interviews were obtained from participants. In Chapter 4, I will present the results of the study.

Chapter 4: Results

Introduction

Adoption has an impact on everyone involved (James, 1994; Post, 2013). The benefits of adoption have reached further than any other resource to alleviate the increasing number of children who are raised in the public welfare system (Child Welfare Information Gateway, 2010). Adoption, in itself, can be a rewarding experience (Child Welfare Information Gateway, 2010; James, 1994; Post, 2013). However, Post (2013) suggested that prior adoptive trauma can render a negative effect on the adoptive family while they are attempting to create an ideal and harmonious family unit. The negative effects varies from family to family. Some of families experience financial hardships, relationship problems, and physical and mental fatigue.

In this chapter, results of the qualitative analysis conducted to answer research questions while exploring the lives of 15 adoptive families and the challenges that they faced after adopting a child who had experienced trauma before their initial adoption are presented. This chapter contains a discussion of the data collection and analysis techniques used in exploring this phenomenon. In addressing the triangulation of collected data, thematic analysis conducted by two peer reviewers is presented. This chapter includes an overview of both textual and structural descriptions of the meanings emerging from the participants' interviews.

Problem Statement

Many adoptive families are faced with the challenges of their adoptive child's unresolved pre adoptive trauma. It is these day-in and day-out issues (i.e., not knowing

where to turn or where to find support) that challenges the adoptive family's social and emotional system (Child Welfare Information Gateway, 2010; James, 1994; Post, 2013).

Purpose of the Study

The purpose of this qualitative, phenomenology study was to explore and identify the reasons adoptive family may be challenged in the receiving professional resources within the home, the school, and the community, all which are essential in order to survive and thrive in the midst of a challenging adoption. In this study, I examined how demographic attributes, such as marital status, race, relative status, number of children adopted, age, and area challenges the adoptive parent's social and emotional system. The overarching research question examined was the following: What role does child trauma play in challenging their adoptive families' social and emotional status? This question was guided by four preliminary themes and a priori of specific questions: (a) based on the personal experience, what aspects or characteristic of marital status, race, relative status, or number of children adopted contributed to the adoptive parent's ability to attach with their adopted child? (b) What attributes of these adoptive parents influenced their decision making process? (c) What demographic attributes of these adoptive parents affected their understanding of endured trauma?

Introduction to Recruitment Process

The adoptive parents were recruited from the Southern Arizona region. Adoptive families were recruited from Grace to the Nation's Church; Loving Hearts Foster Care and Adoption Agency; All the Kings Horses Children's Ranch; Visions Unlimited Academy; and through therapists Jean Ware, Traci Grabb, and Samar Adi. These sites

and therapists were chosen for recruitment because of the number of adoptive families that are served by these agencies and professionals. Participants of the study were located in Benson, Marana, Phoenix, Safford, Thatcher, Tucson, and Yuma, which allowed a broader random sampling.

Recruiting and Identifying Agency Involvement

Colleagues were used to locate agencies and therapists that specialized in providing services to adoptive families and children of trauma.

Collaboration with agencies. Calls were placed to potential agencies and therapist to set up appointments to speak with them about the possibility of recruiting volunteers for this study. The study was individually introduced to the various agencies and therapists. The purpose of the study was explained and answered questions. I informed the agencies and therapist, who referred the volunteers, that their role as the referrer is considered as potential collaborators. I had the agency leaders and therapist to sign a letter of cooperation and an authorization letter before distributing the recruitment flyers.

Soliciting peer reviewers. I spoke with two potential peer reviewers to solicit their assistance in addressing the need of triangulation for the collected data from this study. These peer reviewers received brief information about the purpose of the study and why I deemed the study as to being important. Both peer reviewers specialized in the area of child trauma and qualitative inquiry. One reviewer currently reviews dissertations for Liverpool, and the other has been a psychologist for over 25 years in addition to

teaching at the university level. The peer reviewers received information about the study including (a) population, (b) the problem faced, and the transcripts.

Solicitation for participants. Flyers soliciting participation for the study were created. Flyers were distributed to the collaborating agencies and therapists. Administrators, therapists, and teachers identified parents who had adopted children from the public welfare system.

Initial phone calls to solicit participation. Thirty one adoptive parents were called. An introduction was made and the research project was explained. Thirty adoptive parents who were approached agreed to participate in the study. One parent declined participation. Each parent scheduled an appointment to review consent forms and be administered the Trauma Symptoms Checklist for Young Children (TSCYC). The TSCYC was used as a screening inclusion criterion to identify potential qualifying participants.

Introduction of study and consent signing by participants. The study was introduced and explained individually to each adoptive parent. The purpose of the study was explained and answered questions. Each adoptive parent signed a letter of participation. The participation letters were referred as consent forms. The research process was explained at the time of the consent signing to each adoptive parent. It was explained that all consents and qualifying TSCYC forms would be placed inside of an unmarked sealed envelope. A blind/random sample of 15 envelopes would be selected. Selected individuals would be scheduled for an interview. Qualified nonselected participants were placed on reserve. This sample size was obtained according to

Creswell's (1998) guideline for phenomenological qualitative research. Creswell suggested that when using this method, the sample size should be between five to 25 participants. Fifteen participants were selected through a blind/random selection. Nonbiased status was ensured through blind/random sampling. Once the saturation level was reached, the rest of the interviews ceased. Once the study was completed, the remaining qualifying noninterviewed participants were referred back to their respective agencies for therapeutic support.

Qualifying for the Study

This study required that its participants meet the certain criterion in order to participate in the study. The qualifications required that adoptive parents were (a) 24- to 75-years-old; (b) have adopted children from the foster care system; (c) willing to recall memories from lived experiences in raising their adopted child and to answer questions about them; and (d) completed the TSCYC with a qualifying score above 40, which suggests high probability of PTSD. In addition, individuals under 24, and individuals currently undergoing therapy for traumatic experiences, mental or emotional health services, and women who were pregnant did not qualify to be in this current study.

Trauma Symptom Checklist for Young Children

TSCYC score was used as inclusion criteria to identify families with children obtaining high scores (above 65) on the scale. The following is a basic overview of the TSCYC's criteria for potentially diagnosing a child with PTSD. However, first it is imperative to understand that one assessment cannot conclusively produce this diagnosis. Therefore, this assessment was used as inclusion criteria. The TSCYC was completed by

the adoptive parent. This instrument measures the extent to which the parent/caregiver endorses eight different types of potentially trauma-related symptoms in their child. Each of the eight clinical scales stands independently at the items level. However, the PTS total summary scale is derived from the "posttraumatic stress scales PTS (i.e., PTS-I, PTS-AV, PTS-AR)" (Briere, 2001, p. 6).

The TSCYC score is clinically elevated in the area of anger (*T*-score of 65 or higher), when an indication that anger and/or aggressive behavior has been observed in the child's displayed behavior. Children with a *T*-score of 65 or higher on the anger scale were described as often seen by others as irritable, hostile, or aggressive (Briere, 2001). In general, children with high anger scale scores often got into trouble at home or school for fighting, temper tantrums, or "talking back." They were seen more likely to have problems in social contexts arising from their angry outburst and/or aggression towards peers.

The anxiety scale (*T*-score of 65 or higher) measures the level of the child's generalized anxiety and worry, especially when it placed the child in its fight, flight or freeze mode. The child presents with an intense feeling of imminent danger (Briere, 2001). The posttraumatic stress intrusion (*T*-score of 65 or higher) evaluates the magnitude or depth to which intrusive traumatic memories are relived by the child (Briere, 2001). In other words, the intrusion of thoughts resurfaced to the level that the child relives frightening memories. An elevated PTS-IT score suggests that the child's current thoughts and behaviors are significantly affected by the intrusion of traumatic-related memories.

The posttraumatic stress avoidance (*T*-score of 65) evaluates the extent of posttraumatic avoidance observed in the child. Clinically elevated scores on the PTS-AV scales suggest that the child is using his or her cognitive, behavioral, and/or emotional avoidance strategies in an attempt to avoid posttraumatic distress (Briere, 2001). These children have taught themselves skills to block out past traumatic experiences. Normally this is through disassociation. Thus, at times the child may be unwilling to talk about the trauma. The child may attempt to avoid places or people and even situations that remind him or her of the trauma. The posttraumatic stress arousal (*T*-score of 65 or higher) indicates the autonomic hyperarousal is often viewed in children who have experienced trauma (Briere, 2001). These children are often confused with children who have attention deficit hyperactive disorder (ADHD). These children tend to display behaviors such as jumpiness, impulsivity, hyper-vigilant, inability to concentrate, and sleeping problems (Briere, 2001).

The total posttraumatic stress PTS-TOT raw score of 40 or greater, in a child with a history of prolonged trauma exposure, would imply a diagnosis of PTSD for the child (Briere, 2001). This total scale takes into to account the overall level of the posttraumatic symptomatology that the child has experienced.

MAXQDA

MAXQDA is a software program designed for qualitative and mixed method data research. It is used in the academic, scientific, and business settings. It is a remake of the winMAX program, which was developed in 1989. This program was chosen because of

its ability to code and assist in developing themes from a large number of interviews in a timely manner.

Data Collection and Analysis

The data collection process used face-to-face and telephone interviews. The data was collected from 15 adoptive parents: with a child from the foster system; (b) between the ages of 24 and 75; (c) willing to recall memories experienced raising a child that suffered trauma, and (d) qualified according to the TSCYC. The focus of the semi-structured, face-to-face and telephone interviews were to gain an understanding of the challenges that the child trauma has on the adoptive family's social and emotional system. Moreover, how these challenges influenced the adoptive parents' decisions in the adoption process.

Ethical conduct procedures of research were followed throughout the study. The IRB approved consent form was read aloud to each adoptive parent, and questions were answered. The participants then signed the consent forms (See Appendix A). Each participant received a copy of the consent form to keep for their records. Upon the completion of the interviewing process, participants were debriefed and allowed to add and correct the information gathered. Five individuals did not qualify according to the TSCYC protocol (See Appendix B). The TSCYC protocol's guideline renders five criteria that must be met for a probable PTSD diagnosis. Twenty-four of the participants qualified according to the trauma symptoms checklist protocol (i.e., the PTS-TOT raw score of 40 or greater). All 24 of the qualifying participants' trauma symptom checklists assessments and consent forms were placed into individualized envelopes. Next, 15

envelopes were randomly selected for the interview. Random selection of 15 unidentifiable envelopes eliminated any potential preferences or biases. The other nine remained available in case one of the participants was to drop out of the study. Using the blind random selection would provide a more valid result.

Location

Interviews were rendered in various locations, which were most convenient to the participants. Two interviews were held at Grace to the Nations Church in one of the pastoral offices. One of the interviews took place at the Loving Heart Foster Care and Adoption Agency's corporate office. One interview was scheduled in the counseling office from a referring therapist. Nine of the interviews were conducted at the family's home or office. Three interviews were completed over the telephone as requested by the participants. All interviews lasted 80 minutes and were audio-recorded for transcription purposes. The TSCYC was administered to the adoptive parents to complete (See Appendix B). The TSCYC was the screening tool used to identify families that would proceed to the interviewing process. Those that were not selected, but had high scores, were given therapeutic support through referral resources (i.e., their agencies, churches, and therapists). One family received a referral to the Fetal Alcohol Resource Center. All families received information from the TSCYC assessment to share with their therapist. Also, information about the benefits of requesting a psychological evaluation was given to the parents.

The analysis of the data was approached by using Moustakas' (2004) steps for data analysis. The horizontalization approach reviewed significant statements that

rendered insight in understanding the lived experiences, challenges, and motivations of these families in adopting a child who had encountered trauma. Defined statements classified and determined the required codes for using the MAXQDA qualitative software program. The definition of initial codes, associated terms, and phrases received meaning before they were uploaded into the MAXQDA. The MAXQDA software tallied the codes as they presented significantly within the participants' transcripts revealing the most crucial or fundamentally lived experiences of these adoptive parents. Thematic categories were then drawn and summarized from the codes invariant constituents to answer research questions. Textual descriptions evolved from the thematic groups acknowledging the experiences and how these lived experiences guided their decision to adopt a child from the public foster care system.

Demographic Profile of the Study Participant

A total of 15 ethnically diverse participants participated in the study. Four of these participants were single parents while 11 were married couples. Five of the participants adopted relatives. Three participants were grandparents raising grandchildren. Fourteen of the participants resided in Arizona. Table 1 shows the profile of the participants.

Table 1

Demographic Profile of the Study Participants

Participant	Status	Race	Relative/Non Adoption	# of Adopted Children	Age	City/State
02	S	Caucasian	Nonrelative	1	9	Tucson/AZ
05	M	Bi-racial	Nonrelative	4	6	Vail/AZ
06	S	Hispanic	Nonrelative	2	8	Yuma/AZ
07	M	Caucasian	Nonrelative	1	5	Tucson/AZ
08	M	African American	Nonrelative	2	4	Tucson/AZ
09	S	Caucasian	Relative/Grand-children	4	3	Benson/AZ via Branson/MO
010	S	African American	Nonrelative	1	5	Tucson/AZ
012	M	Caucasian	Relative & Nonrelative	6	5	Vail/AZ
013	M	African American	Nonrelative	1	2	Tucson/AZ
015	S	Caucasian	Nonrelative	2	5	Oro Valley/AZ
016	M	Bi-racial	Nonrelative	2	2	Phoenix/AZ
017	M	African American	Nonrelative	1	8	Marana/AZ

018	M	Caucasian	Relative/Grand children	2	8	Thatcher/AZ
024	M	Caucasian	Relative & Nonrelative	4	0	Cascabell/AZ
025	M	Caucasian	Relative	2	0	Benson/AZ

The population consisted of adoptive families (adults) of children who experienced trauma and were adopted from the public welfare system. The study criteria specified that no pregnant women or individuals currently receiving therapy for individual PTSD could participate. These stipulations were a part of the exclusion precedent clause (See Appendix C). Five of the participating families had adopted children related to them which is referred as kinship care/ adoption. The racial demographic breakdown of participants in this study was eight European American parents/couples, six African American parents/couples, and one Hispanic American mother (See Appendix E). Seven of these families adopted children of a different race than their own. Ten of the participants interviewed had adopted more than one child. Of the 30 consents received, five of them were referred to the study by one of the professional therapists. Six of them were recommended to the study by the Loving Hearts Foster Care and Adoption Agency. Grace to the Nations Church referred 15 of its members to the study, and volunteers already participating in the study introduced the last four to the study.

Presentation of Findings

Moustakas' (2004) steps in data analysis were used to examine each transcript for pertinent codes. A priori interview guide was developed based on the research question,

literature reviews, and the attachment theory. The interview questions guided the participants in a general direction while allowing them to answer the questions as they desired. The advantage of this style of interviewing was that it ensured the data collection was systematic and comprehensive (Hoepful, 1997; Patton, 2000). The data were audio-recorded using the Ever-Note recording system. They were then transcribed and placed into a Word document and uploaded into the MAXQDA qualitative analysis program. Using MAXQDA software, along with Moustakas' steps, participants were interviewed, collected textual datum, and then analyzed the developing themes from the data. The developed themes enabled detection of the similarities and differences between the responses received by these adoptive parents. A summary and reflections of each interview were written after the completion of the interview. The content of the reflections contained demographic information, central themes derived from their discussions, new questions, and any difficulties encountered during the interview. Two relevant questions arose at the end of each summary: (a) what stood out most in the encounter and (b) what overall impression lingered after the interview? The analysis compared the invariant constituents found within the central themes.

Listing and Preliminary Grouping

The MAXQDA software has the capability to list the keywords and phrases emerging from the transcripts of the participants. This coding process allowed the elaboration of the meaning each code through the use of a memo system. For example, one of the codes dealt with the challenges of permanency. A definition of struggles and

hardship in keeping the child was given. A sub-code for family struggles arose due to the overlapping areas that were not covered but still seen as a challenge.

The next phase of analysis involved coding of the data. Similar content from each participant's interview was grouped under one label or one code. Coding allowed information to move from the raw text and to develop the themes that allowed each research questions to be answered. Transcribed interviews were imported into the MAXQDA software to code and categorize narrative text while generating topics for a clear understanding of the study itself.

Open coding of the interview transcripts allowed a line-by-line view of the responses. This process revealed information relayed from the participants' viewpoint. One of the codes was training. Under this code was the description of it, which included the types of training, whether they were basic training, advanced training or self-taught training (e.g., internet training and reading books). All training received by these families were labeled with this code. This category contained anything that pertained to the type of training that the adoptive parent received before, during, and after their adoption. In the memo section of the coding, the definition was rendered for each particular code. For example, with the code-named behavioral health, the definition included behaviors presented by each child, such as tantrums, crying, anger, stealing and fighting. Once all interviews were coded, a consideration of approaches resonated on how to present these findings. Some of the findings included permanency in relationship to the commitment of the adoptive parents and the traumatized child. Others concentrated on the various levels of training received and specialized training. These

grouped codes provided the foundation for determining the themes. MAXQDA analysis matched the codes with the participants' verbatim responses.

The preliminary groupings in the study were coded on the following four dimensions: (a) attachment, (b) permanency .vs. placement, (c) decision-making process, and (d) endured trauma. Each dimension addressed relevant questions. What challenges have arisen in the area of attachment; placement; and decision-making; and endured trauma in becoming an adoptive parent? What rewards or benefits have were gained or learned from these experiences? From these questions, essential texts and phrases were coded, sorted, and identified were relevant to this study.

Reductions and Elimination

Extra steps were taken ensuring that the coded data bore accurate and valid representation of the phenomenon. Each transcript was re-evaluated searching for more descriptive statements to discuss in the data presentation. Reviewing the data was essential to determine whether the conveyed lived experiences accurately and sufficiently depicted the phenomenon**.**

Clustering and Thematizing

Thematic labels were developed from the clustered experiences of the participants. Explicit themes materialized based upon invariant constituents. The preliminary and listing coding reports formulated the thematic labels critical to the research questions: (a) attachment experiences of adoptive parents, (b) placement .vs. permanency experiences in adoption, (c) motivations in the decision-making process to adopt, and (d) the dilemma of understanding endured trauma. Fifteen adoptive parents

offered their lived experiences, lending to the meaning, essence, and horizon of this phenomenon.

Thematic Label 1. This theme was determined from four questions and answers the following sub research question: Based on their experiences, what challenges of child trauma and attachment contributed to your adoption decision? The invariant constituents central to the theme were as follows: (a) child's struggle with abandonment issues, (b) role of the adoptive parent, (c) trust versus mistrust, and (d) lack of training on bonding and attachment.

The first invariant constituents, child's struggle with abandonment issues, emerged from 13 of the participants in this study. Adoptive families who are challenged by the adoption decision-making process have a child who struggled with abandonment issues. All of these participants had adopted children from the public foster care system. Children were taken from their biological parents and tend to lack closure on what happened. Participant #005 adopted a teen who had multiple placements. She stated: "My son had a hard time dealing with various issues surrounding his placement into the system. He was even raised by members of his biological family who failed to treat him as a family." Participant #007 described how her son struggled with the issue of abandonment: "My son informed us that he could not call us mom and dad. It was not because we were not good people but that he felt that he was abandoning his biological mother."

The second invariant constituent, the role of the adoptive parent, suggests that the child may present with challenges that caused barriers for the adoptive parent to fulfill their job as the parent. Participant #006 stated,

> My oldest son still refuses to acknowledge me as his mother. He resents the fact that he is not with his biological mother and he feels that I am the blame for that. He accepts my husband as the father. But this causes a major battle.

Participant #025 stated, "My daughter had to play the role of the mother so long that she refused to allow me to take on my role until recently."

The third invariant constituent, trust versus mistrust, suggests that adoptive parents and their new child struggled with challenges that may cause barriers in their relationship due to trust issues. Participant #012 stated

> My daughter made our relationship extremely challenging. She informed us that she could never trust us because she did not understand why someone would want to be her parents. She had a good relationship with our son but not with us as adults. I remember her telling us that blood is thicker than water and that we were not her blood. We adopted her sister later to help balance things for her. However, this did not work. Her sister attached to us, but she did not. She was even upset with her sister for doing so.

Participant #013 stated,

> My oldest adopted child had issues with telling us the truth. This is an area that we struggled with because of our morals. Our daughter had problems being

where she stated that she would be. She also struggle in following through with promises.

The fourth invariant constituent, lack of training on bonding and attachment, suggests that adoptive parents found that more of their challenges stemmed from being under prepared, ill-equipped, and untrained. Participant #017 stated

> What training?" We didn't get any training! Oh, unless you count the basic information that they supposedly give you about the child. And we found that that information is not true. The lack of training has been a major barrier. If it were not for friends and other church members who have adopted, we would have returned him to the system. We had to educate ourselves, and we are still learning.

Participant #018 stated,

> We live out in such a rural area that we were pretty much on our own. We did not receive training, and this has caused major issues. In fact, our older children were against us adopting these children. However, how could we turn our backs on them? They were our flesh and blood!

Table 2

Attachment Experiences of Adoptive Parents with Adopted Child

Invariant Constituents	# of participants to offer this experience	% of participants to offer this experience
Child's struggle with abandonment issues	13	82%
Role of the adoptive parent	15	100%

Thematic Label 2. The second thematic label, placement versus permanency, was determined from three invariant constituents. This theme was identified from three issues and answers the following sub research question: Based on their experiences, what challenges of child trauma and placement versus permanency contributed to the idea of decision adoption? The invariant constituents central to the theme were as follows: (a) family's struggle with attachment, (b) inter-conflict with returning the child back to foster care system, and (c) a lack of homes available to care for these children.

The first invariant constituents, the family's struggle with attachment, emerged from 15 of the participants in this study. This invariant constituent suggests that adoptive families who are challenged by the adoption decision-making process had a child and struggled with returning a child back to the foster care system once they have attached to them. Participant #015 stated,

My son and I attached early in the relationship. He had not seen his biological mother since he was two or three. She was sick and unable to care for him. She had given him to a friend to care for him until she got well. Her friend took him across state lines and then got arrested which placed him in state custody. I wanted to be a mom without going through the pregnancy thing. Moreover, he needed a mother. So we have been together ever since. I could not imagine life without him.

Participant #025 stated,

My husband and I have raised our son since he was 18 months. We cannot even begin to think about returning him; he is a part of us. We have had to place him in a residential treatment home for two years, but we visited him weekly. We did not give up on him, and that is what he needed to turn things around.

Table 3

Placement versus Permanency

Invariant Constituents	# of participants to offer this experience	% of participants to offer this experience
Family's struggle with attachment	15	100%
Inner-conflict with returning child back to foster-care system	15	100%
Lack of available homes	15	100%

Thematic Label 3. The third thematic label, motivation in the decision-making process to adopt, was determined from three invariant constituents. This theme was identified from three themes and answers the following sub-research question: Based on their experiences, what challenges of child trauma and motivation in the decision-making process contributed to adoption? The invariant constituents central to the theme were: (a) adoption subsidies and resources, (b) desire to maintain family connection, and (c) a lack of homes available to care for these children. Participant #018 stated,

> Our desire in adopting our great-grandchildren was to maintain our connection with them. They are a part of our family. No one else was able or willing to

come forth because they did not want to have their mother involved. We had no other choice!

Participant #010 stated,

I love my son. However, this would have been difficult without the support that I received through the actual adoption subsidy. I had to make him my full-time job. There was no way that I could work with all of the appointments he had. I could not see placing him back into the foster care system. Unfortunately with the lack of qualified homes, he would have been forced to live his life as a foster child forever.

Table 4

Motivation in the Decision-Making Process

Invariant Constituents	# of participants to offer this experience	% of participants to offer this experience
Adoption subsidies and resources	15	100%
Desire to maintain family connection	9	60%
Lack of available homes	15	100%

Thematic Label 4. The fourth thematic label was determined from three invariant constituents. This theme was identified from three themes and answers the following sub-research question: Based on their experiences, what challenges of child

trauma and understanding endured trauma affects the decision-making process contributed to adoption? The invariant constituents central to the theme as follows: (a) lack of specialized training, (b) a lack of education in understanding what the child has gone through, (c) a lack of lack in support groups, and (d) a lack of professional alliance between adoptive parents, adoption agencies, and mental health providers. Participant #017 stated "What training? We never received any training. We had to learn firsthand what our child was experiencing. Who would have ever thought a child could endure so much trauma." Participant #005 stated,

> I have had to fight to get services for my children. It appears that there is a lack of the continuity of services and support amongst the professionals, mental health worker, and the school. Then when we bring up concerns about our child's behavior, they think we are exaggerating. They just don't get it. As adoptive parents living with the child and the trauma that haunts them, we are going through a lot.

Table 5

Dilemma in Understanding Endured Trauma

Invariant Constituents	# of participants to offer this experience	% of participants to offer this experience
Lack of specialized training	13	82%
Lack of education in child trauma	13	82%
Lack of support groups	15	100%
Lack of professional alliance between adoptive parents, adoption agencies, and mental health providers	15	100%

As there are many forms of qualitative data collection and analysis methods used in this type of research. In this case, structured interview using a set of questions focused on child trauma and the challenges it has on adoptive families' social and emotional system. The interview questions guided the participants in a general direction while allowing them to answer the questions as they desired. The advantage of this style of interviewing was that it ensured the data collection was systematic and comprehensive (Hoepful, 1997; Patton, 2000). Data were analyzed by filtering through the responses provided in the interviews and selecting key pieces of information to contribute the

various aspects of child trauma and the challenges it had on the adoptive family's social and emotional system. Components of the qualitative data were identified such as keyword, category, and theme(s) as they pertained to the participants' responses to their experiences with their adopted child's past trauma.

Further, in the formation of the mini theory of this particular data set, three fundamental elements throughout the analysis process was used:

1. Sensitizing- issues, concerns, meaning
2. Theoretical
3. Practical- development, logic

The table below is a visual display of the components of the qualitative data derived from the analysis. Sixteen interview questions were categorized and placed them into a priori interview guide based on the research question, literature reviews, and the attachment theory.

Fifteen respondents were separated by transcript where the corresponding keyword, category, and theme(s) are provided.

Eighty percent of the participants felt that, although their adoptions were successful, the training received was not a part of their successful outcome. Shortly after their adoptions, these participants expressed feeling under prepared, unprepared, uninformed, and unskilled for the challenge they had taken on. The differences between participants consisted of the various categories in which they felt under prepared, unprepared, and uninformed. Such as unprepared to attach due to a lack of training felt by Participant #005; under prepared in knowing how to care for a child who had experienced

trauma suffered by Participant #017; or uninformed and experienced a sense of victimization in the decision- making process felt by Participant #016, and unskilled in understanding the behaviors that their adopted child presented with experienced by Participant #018. In addition, keywords found were (a) none, basic, good, adequate, under the category of training; (b) basic, very little, self-informed, kind-ship/well-informed, and informed, under the category background information received; (c) routine, bonded, secure, family, and insecure under the category of attachment; and (d) unaware, confused, aware, and understanding under the category of decision-making process. Participant #002 described feeling "unaware and under prepared" as a result of their adopting a child who experienced trauma in utero. Participant #007 felt a sense of commitment while experiencing the development of a family "bond" as the child began to trust and grow closer to them as a result of the adoption. For Participants #009, #025, and #018, there existed a sense of ensuring that their "grandbabies stayed within the family" and that family values, tradition, and security were the key elements of adoption, which shaped the way in which these participants viewed the experience. For Participants #008 and #012, there was a sense of feeling under prepared with the basic information received about their children's background information. Participant #015 expressed that she was well-prepared and expressed that her adoption left her feeling bonded with her son. Participants #006, #010, and #013 all believed that they received excellent training that equipped them in handling their child's behaviors. Lastly, participant #024 felt that they were adequately trained and well-prepared to meet the needs of their child, which was an important factor in their adoption.

Each participant's interview encompassed either one to four themes to reflect their overall experience in adopting a child who had experienced trauma. There was a recurring theme of feeling unprepared, under-prepared, and unskilled. Three participants expressed feeling prepared when reflecting on their social and emotional stability about the greater picture they discovered in adopting a child that experienced trauma. Other themes were identified that varied from the other interviews. One participant's idea consisted of the comparison between feeling prepared and then being faced with the knowledge that they were underprepared. The last interview consisted of a theme of sharing stories capturing the journey this family walked through in one of their adoptions; the participant could share these memories as a learning tool in an adoption support group.

Table 6

Transcripts of Adoptive Parents on Professional Training Received on Attachment, Permanency .vs. Placement, Well-Informed Decision Making, and Understanding Endured Trauma

Transcript	Key Word	Category	Theme
#002	None Minimal Secured Confused	Training on raising children who experienced trauma. Background information on child	Unprepared" Uninformed"
#005	None Self-obtained Routine	Self-educated researched background information	Underprepared" Uninformed"
#006	Good Basic	Trained in Attachment as a nurse.	Prepared Knowledgeable
#007	None Minimal	Trained through family and friends who had adopted and very minimal background information received	Underprepared Unprepared Uninformed
#008.	None Basic	Trained through family and friends who had adopted. Basic background information	Underprepared, first time mother Uninformed
#009.	None Informed	Training on parenting children who experienced trauma. Background information due to Kind-ship	Underprepared Knowledgeable
#010	Good Informed	Trained by Licensing Agency. Background information	Prepared" Knowledgeable

		received	
#012	None Basic	Professional Training Minimal Information Received	Unprepared; Uninformed; Child Protection Services was so desperate they called us to see if we had finished our packet because they needed to place a child immediately."
#013	Adequate Informed	Trained by Licensing Agency Background Information Received	Prepared, Equipped, Knowledgeable
#015	Basic Minimal	Trained by School District; Background Information Unknown	Underprepared, no training by the licensing agency Uninformed
#016.	None Minimal	Training about the "dos and don'ts" No Background Information	Underprepared Uninformed
#017.	None Basic/Minimal	Trained through family and friends who had adopted Incomplete Background Information Received	Unprepared Uninformed
#018	Basic Minimal/Self-Obtained	Professional Training; Kind-ship Care; Self-Obtained Information	Unprepared; Trouble with hierarchy in receiving professional support Uninformed
#024.	Adequate Informed	Trained on the Job. Former Head-Start Director Informed	Prepared Knowledgeable
#025	Good Self-Obtained Kind-Ship Care		Prepared, They are my grandchildren

Mini-Theory

In qualitative research, it is not so much about results answering specific questions but in allowing the results to guide the researcher in better understanding the area or population being studied. The qualitative research focus was as follows: the challenges that child trauma has on adoptive family's social and emotional system. Having this in mind, what can be understood about child trauma, about adoption, as a result of these interviews depended on the adoptive parents' level of openness to child trauma. A collective experience occurred as stories, memories, and lessons lived by these adoptive parents were heard. The lived experiences varied impinging on the types of trauma and the extent to which the child trauma played a role in their lives.

The sensitizing information that was gathered throughout the interviews raised a few issues in identifying a collective meaning of the challenges of child trauma on adoptive family's social and emotional system. Notably in the lives of these participants, there existed disconnect between a well-informed decision-making process and receiving background information, on the child and its family, when deciding to adopt. Three of the interviews were with participants who adopted grandchildren. These families had initially felt that they were aware of the child's background information; however, they expressed a sense of being unaware of the complexity of the trauma that their grandchildren endured. A sense of realization lingered after the adoption. A sense of surprise that a child of theirs endured such trauma: like displaying sexual acting out; aggressiveness; and even the difference of living style (i.e., a disheveled appearance across life domains). There was a sense of collective meaning in an unprepared or

underprepared, which seemed to transcend many of the interviews even when negative connotations were made.

In the theoretical quality of the interviews, 80 % of the participants expressed that establishing trust with their adopted child was foundationally essential in helping their child adjust to their new environment. This echoes the findings of Bowlby (1969), who found that children attach to more than one primary caregiver. Bowlby suggested that the primary caregiver provides a form of security through established trust, which is necessary for nurturance. The caregiver is seen as the hub in which the child walks throughout the circle of security while exploring their new environment (Bowlby, 1969).

Final Identification of Invariant Constituents

Each participant's transcript was reviewed to verify that each invariant constituent was valid through the listing and primary grouping code report in MAXQDA.

Individual Textural-Structural Descriptions

In this section of the chapter, the textual and structural descriptions of the participants were viewed. Farquharson (2009) suggested that using the textual and structural descriptions together can provide insight into how each participant viewed their lived experiences based on the perceptions and feelings expressed or communicated within their transcripts. I employed verbatim response and literal interpretation of the participants' words, thus refraining from losing the meaning of the phenomenological thoughts or experiences.

Individual textural-structural description for Participant #002. Participant #002 a former foster-child who was adopted and desired to give back. Participant #002 a single mother adopted a child born addicted to meth and exposed to alcohol in utero. Participant #002 stated "I envisioned that this was going to be entirely different mainly because I grew up in the system until I was adopted. I received no training which left me feeling unprepared and uninformed. We are attached to each other."

Participant #002 described her lived experience with adopting a child who had experience trauma. Thus, she stated:

> I adopted my child when she was very young, newly out of the hospital. The CPS worker gave me some information about the child's family. Both parents were drug addicts and were unable to care properly for the child. Because the child was born addicted to meth and cocaine, she was not able to go home with the mother. I had the child for a long period before the adoption finally took place. I felt unprepared in raising the child after she turned three-years-old. I received no education, or training, or what felt like no support in understanding the effects of trauma upon her life. I was not prepared for the constant visits to different doctors or the treatment that she would need because I was unaware of what I was going to face. I experienced a lack of professional alliance. I did not receive the support that I thought needed to be in place. It appears as the support was there before I adopted my child, but once I adopted her everyone left. There have been positive moments in raising my daughter. She is a loving. She is kind, and her smile lights up the room. I just love her; there was no way I could give her back

to the state! Although, I feel like people were not truthful in everything that this child had experience in utero. I do see the cognitive delays. I do see the fetal alcohol syndrome effects. I do see her struggles with education. I think out of the whole adoption process, I feel like I was not given the power or authority or education and training to make a well-informed decision. If I had received more information that could assist me with my decision to adopt or not, it would have been helpful. However, once this child came into my life and my home there was no way I was going to turn my back on her. The information would have been useful as far as treatment is a concern.

Individual textural-structural description for Participant #005. Participant #005 represents a married couple who had adopted a total of four children. The wife's interview shared their lived experiences as a family and the various challenges them in raising children who have experienced child trauma. This mother shared more about her recent experiences with her five-years-old daughter.

"I received the minimal amount of training. However, we had already adopted her siblings. Nothing prepared me for this. I was left feeling underprepared and overwhelmed." She shared this

Our experiences with the adoption process and the challenges that we have faced varied with each child. I was one that thought I knew quite a bit about the children we adopted. How wrong I was with this one. We had already adopted the siblings of this child, so when their biological mother approached us asking

> for us to take the baby, we felt that we could not deprive the siblings of being raised together. I thought the attachment issues that I experienced earlier with the older siblings would not be an issue because we were taking the baby straight from the hospital. As the child grew, her attachment to me was very challenging in that I could not go anywhere without her. I never had a break from her. This challenge caused issues in other relationships. Her siblings detached themselves from her. They found her annoying. My husband and I had very little time for each other. Her relationship with him was different. She did not display the demands on him as she did with me.

Participant #005 talked about how placement versus permanency influenced their decision to adopt this child. She stated:

I believe that the decision was ours to make. We felt that it was important to keep the siblings together. We have had foster children come into our home where we have seen families broken apart. We did not want to see these siblings torn apart. Well, when looking at permanency is that they are ours, and that is our problem. Right now, I feel like everybody else stepped out the minute we adopted. Now we have no help with resources (i.e., training, therapy, and supports).

Participant #005 talked about the family's decision-making process. She stated,

> Again, in the decision-making process I did not get any information to assist me in making this decision. The decision was pretty much already made because I knew she was going up for adoption before I got her. I did not realize the challenges that I was going to have with her, not behaviorally. I understood the

> medical concerns to a degree. I had no knowledge of any information that they would've given me. I got it all myself. I knew it all myself. I just feel like when they belong to the state, the state takes care of them. However, once they become yours, you are on your own. Nobody wants to give you a diagnosis or nobody wants to label them. There are no resources! Even the case manager that supposed to be helping you in the adoption process is not helping. The worker is just pushing paper. I don't feel like we have any support behind us. There's a lack of support!

Participant #005 talked about the challenges of understanding the endured trauma her child experienced. She stated,

> My child is something else Jacqueline. She reminds me a lot of one of my old foster children. She breaks things in her rage and screams like somebody is killing her. She also scratches and pulls out her hair. The medications are not working. Well, I am going to have case manager sit upstairs without the child knowing because she will not act out in front of others. Ron ordered a camera system, and we are going to film her for a solid week and I am going to march her butt into the clinic. I am at the end of my rope trying to help her and getting no correct diagnosis, but she has something serious going on. It is so sad that I sit in my room and cry. A 5-year-old emotionally bullies me. We had EEG done last week, and I will get neuro-psychological result Tuesday. Something has to be done. I just can't explain it I have had her since an hour old saved her life at least four times. She lives in a stable home. The neuro-psychological be our fifth

> evaluation on this kid, and nobody has anything! We had no training for trauma for children prior to the adoption. Moreover, I feel like every adoptive parent deserves to receive training, specialized training to address what we might face. When I stop to recognize the trauma that my child endured (anxiety, scared, startled, anger, verbally and physically aggressive, the crying and the tantrums) I can see the importance of specialized training. Her behaviors have had an immense effect on our relationship because I've been distancing myself from her. I do not know quite how to deal with her abuse towards me. So I distant myself when she is nasty to me. How can I love somebody when they are that way to me? I do not know how to deal with this, so I just walk away. How do you deal was something that? Yes, I considered to be challenging because I'm out of resources and I'm grasping at straws to figure out what works and what does not work.

Individual textural-structural description for Participant: #006. Participant #006 represented a single parent who had adopted two children. Participant #006 shared her lived experiences as a family who has faced various challenges in raising children who have experience child trauma. This mother shared her recent experiences with her boys. She shared this,

> I had good training before I adopted my last child. I got better training once we started the EMDR therapy. The specialized training helped me to learn how to assist my boys in learning how to cope with different things happening in their lives. I call different agencies to see what kind of training that they have

upcoming, I read books, I search the internet, and I seek help from their team. I have talked with my therapist about ways to start up supportive groups amongst adoptive parents. I did not experience any challenges in my adoption process in regards to the children. The challenges that I encountered had to do with the professionals not following through on their word. I think that this had a negative effect on one of my children because he already had trust issues with the system. I did not receive any information to help me with my decision-making. I feel that my profession helped to equip me in my adoption process.

Individual textural-structural description for Participant: #007. Participant #007 represented a married couple who had adopted one child. Participants' #007 shared their lived experiences as a family that had faced various challenges in raising a child who has experienced child trauma. This couple shared their recent experiences with their son. They shared this:

Man, unique challenges, first you have to deal with the child. A child that is being adopted into your home and you do not have that bond right away. Next, dealing with the child that already has set ideas and ties and set values that may be different than what you were ready to deal with. In the end, the child is the most pliable. They are about those, in short, about boundaries and the firmness with their connection with who their parent is. The older, they are the more difficult the child. Be sure, they can rationalize when they get older but they have deeper and gained expectations on parents. Expectations and some of those belief limitations may make the transition a lot more difficult. I say if you can get the child when

they are young, go for it because when they get older is not easy. Another thing with our son, because he was on the older side, he missed his parent, and he cried at night. His bedtime was a bad time. He would be losing his mom, and that was a unique challenge and so was bonding with him. The lack of day to day contact with his mom was a big trial with him. It was a slow the process. He had to come to grips with the idea of bonding with these lovely people (parents) while not betraying his mother. If the child understands that being granted a stable home and bonding with its parents, it can aid the transition. Maybe it is not with the biological mother but is letting the kids know that it is okay is important. We also dealt with unique behavioral problems, but you know you are entering counseling with that understanding that will be behavior problems that you have to work out. When it came to placement versus permanency, we already had made up our mind. We loved him and were committed to him before he was to us. His stability in our home at first it was difficult, but then he rocked. Yeah, it was a difficult transition it helped that we knew him before that we even thought about adopting him. He knew us. We were not new to him, but it was rocky. We set boundaries and had expectations for him. Once the boundaries were established, things smoothed out. Moreover, then he became a teenager, and things got rocky again. Love the resources that we had at that time with the licensing agency. Ha, ha, ha! What the licensing agency helped with was the adoption. All of our resources came through our friends. Whether they were adoptive parents or not we would ask them for advice. Advice like: how did you

> deal with this; or what did you do with your child when they did this? We were blessed that we had many individuals that work in the industry or experts in the behavioral health field especially people at our church. We had a large support team that was available to us because so many of our friends, at the church, where adoptive parents too. However, if we did not have those resources we probably would not have known where to start because we did not know where to go. Okay, this is my problem, what agencies do you have to go to when the licensing agency does not have an answer? There's no there's no listing in the phone book for adoption help. Ha, ha, yeah that is it. It just doesn't, but it makes you just hope that you have a good agency that can point you to someone when they do not know the answer themselves. Good luck, we did not get the professional help from our licensing agency.

Individual textural-structural description for Participant: #008. Participant # 008 was young new mother who decided to take on adopting two special needs children. This mother went through the training with an individual from her church, while that individual was the foster mother to the children she would adopt. This individual took Participant 008 into her home and taught her how to be a mother. Participant 008 had this to say,

> I never felt attachment issues, especially between my daughter and I. Her brother, seems to be still attached to the former foster parent and family that he lived with; so we had to distance ourselves from that family for a while until he could attach to me. These seem to be issues and one of the struggles that we faced. However,

it was not long that we were able to reunite with that family once he attached to me. These challenges, which that we faced in the area of attachment, dealt with his defiance, his opposition, and his strong will. I took those challenges and turned them around so that the positive could come forth from his strong will to accomplish different things in his life. I did not receive any training from professionals, therapists, agencies. I went from being a single person to being a parent without going to the foster care system. Yes, the kids were adopted from the foster care system. However, I did not go that route to adopt them. All of my training came from that woman at the church who took me under her wing. Yes, I do believe that parents need to receive the specialized training. However it seems like this is something we lack to help children who have no homes and who are a part of the system, and it seems to be growing. When I look at permanency versus placement with these children, I had already grown to love them when they were living with their former foster mother. The foster mother had been searching for a potential family to take these children because she was told that the state was not going to allow a single-parent to adopt these children. Hearing that information was a struggle for me at first. I loved these children, and they were not going to allow the adoption to take place. In fact, they were looking in other states, and it was almost like they were farming out the children. They took their pictures, and they put them on children on the websites telling people that they need a family. Once we got the green light that I would be able to adopt the children. I moved into the home with that woman and her family and began to

learn the lessons that I found to be valuable. These children are my children. I remember up until even the court date when the foster mom had to go to the court and speak to the judge for me to get the children. The state had changed her mind and decided that the children would be best off living with that foster mom as her adopted children. That lady told the state their decision was unfair. It was unfair because she had taught the children that the next person they called mom, would be the mom. It was unfair because she had brought them up for two years to know her as their aunt. It was unfair because she had to make herself look bad, in front of the courts, for me to be able to adopt these children. So to ever return the children to the state, that's not happening. Their home is in my home and that the former foster mother is their adopted aunt. When I think about the decision-making process, I didn't receive any information from the state to make it will inform a decision. My profession causes me to do a lot of research, and I know the legal system very well. I researched I found the information I need it but then again the commitment was already there for me to be the mom of these children. When it comes to the endured trauma yes, I recognize the trauma that these children went through. The trauma that they went through before they were at their last foster home. They were in respite care and during that respite care the worker noticed that they were playing a game where one would stand against the wall and act like she was being beaten. The other child would come and comfort the crying child. But then they would laugh about it. It was that information that she saw that force her to call the licensing worker and explained what she just

> experienced with these children and the trauma that they were still in while living in the foster care system. That is when the state decided to keep the children with the adopted aunt and remove them from the placement the former foster home. This is how I came into their life. My children are my babies. Their biological parents lived on the streets. Their biological father was a gang member. They have attachment issues, but they have attached to me and their adopted aunt and her family. They have trust issues. They have ADHD, PTSD. There are number of other traumatic symptoms and diagnosis that they have as a part of their treatment. I think the biggest thing that I can say is that I felt unprepared professionally. I was prepared with the help of that adoptive mother from our church. How many adoptive families are going to have someone like I had to help with the needs of my children?

Individual textural-structural description for Participant: #009. Participant # 009 was young grandmother who decided to take on adopting four of her grandchildren. This participant had dedicated her life to helping her family when she learned that CPS took custody of her grandchild because of their parents' drug addiction. It took months of hard work. She had to deal with interstate child protection agencies before finally having her children placed with her. She expressed her lived experiences like this:

> My grandchildren knew who I was. However, we had not seen each other in years. It was not easy changing my role from the cool grandmother to the mom. Their little minds were confused. The challenges in the attachment were different in that it had become necessary for us to bond in a different way. They had to

learn how to trust me to provide for their needs. And we had to get to know each other during this process. My grandson was not willing to accept the fact that his father was not going to be a part of his life for the time being. Sometimes I was not seen in a good light. They wanted their father. When I stop to think about placement versus permanency, I have to say that permanency is more important. Permanency helped to stabilize my children. They needed structure and not to be uprooted because of their parents' lifestyles. We had a therapist, at the beginning of our journey that helped us to work through this phase of attachment issues. I believe that it is important, as a parent, to receive as much training as possible in working with children who have experienced trauma. It helps to equip us for the job that we have taken on. In the decision-making process, I had no other decision. These were my grandbabies, and I was not willing to have anyone else raise them. I did not receive any information. I had to fight for what I did receive. I guess you can say the decision was mine, although I had no choice. In the beginning, it was just the two. But now I have four out of the five children. I am learning, more through research and a good friend, about the endured trauma that my kids have experienced. I know that their posttraumatic experiences will require therapy and support. The training that I received in the past for posttraumatic stress disorder came through therapy.

Individual textural-structural description for Participant: #010. Participant # 010 was single mother who decided to take on adopting a young boy who had experienced years of trauma. This mother had already reared her children and was living

alone. At first this mother was just fostering the child. It was through her fostering that she met this young child who was in need of someone to love him. She stated,

> I have had a wonderful experience. Attaching was a major challenge, especially in the beginning. My licensing worker worked very close with me because my son was what they called high needs. He was diagnosed with posttraumatic stress disorder, oppositional defiant and had been so abused as a little child. He still had an incredible bond with his biological mother. Although I did not receive training, my agency did a good job of presenting case studies, therapeutic technique, and simulated scenarios. No one can prepare you for the screams in the night, the regressive behaviors, the defiance, and the pain of watching and experiencing the pain my adoptive son experienced. I learned more from his therapist as to how to handle his trauma. Yes, training is needed for adoptive parents to understand this child. Traumatized kids react very differently to discipline, positive and negative consequences and rewards earned. I was surprised by my son's reactions. For instance, once when I told him that he was going to receive a consequence from me instead of a spanking, he threw a chair at the door and said, "Just kill me! I know you want to kill me!" There is no way that an adoptive parent would understand how to work through this without specialized training. My child has PTSD and trauma-induced ADHD. The first few years this was a source of great family anxiety. My child's tantrums caused delays in appointments leading to extra time walking through coping skills. I cannot imagine giving him back to the state after finally getting him to a stable

level in his life. So when looking at permanency versus placement I will always say that permanency is more important for my son. My job is the best and hardest job I have ever done. The blessing comes from seeing a child flourish and grow with healthy guidance. In the adoption process, I was fully informed of the adoption procedures and the challenges we would face before, during and after adoption. As far as understanding the endured trauma that my child has experienced I find the post treatment services necessary and essential due to the nature of my child's abuse. He will need therapeutic intervention for many years. One thing I have done for him was to create a sense of security for him so that he knows that will not be abused again and that he is valuable. The other is being constantly vigilant that my son is not exposing himself to venerable situations sexually, as he is passive and open emotionally to this type behavior.

Individual textural-structural description for Participant: #012. Participant # 012 represented a married couple who were unable to have children. Their desire to have children was the reason for their decision to adopt. This couple ended up adopting a total of six children. Two children were the husband's biological nephews. Another two were African American girls. These two were sisters whose biological mother was a substance abuser. Their oldest was an Italian girl whose biological mother was "unfit" due to mental health issues. Their last was a biracial infant diagnosed as failure to thrive and had fetal alcohol effects. These parents talked about their journey and this is what they stated:

Well, we first feel that it is important to share about our first experience as foster parents. We remember how we received a phone call from the state asking us if we had already submitted our application to become adoptive/foster parents. When we stated no that we had just received it, they insisted on us calling them as soon as we finished because they had a child that they wanted to place in our home. We thought that this was strange because they had not even taken the time to get to know us. So, the child we decided to talk about is our oldest. We were there for her in every way yet she was very unreceptive. She was placed in our home at first as a foster placement. She never attached to me as her mother or my husband as her father. She struggles to be herself maybe because she failed to recognize who she was. She had made up in her mind that she was not going to attach to us. Her detachment became a struggle in her teen years even more so. The challenges that we faced in the area of attachment was that our daughter placed a wedge between us and refused to allow us to get close. She faced a lot of issues in the area of trust versus mistrust. She was told that her parents didn't want her. Her biological mother told her that her father was dying well before he even got sick and died. The strain in their relationship appeared to pore over into our relationship. We received a little training in this area before adopting her. We felt like we were not trained to care for a child with this amount of emotional and physical trauma. We still worked very hard to attach to her yet today she still is not attached to us, her daughter is but she's not. We believe there is training that adoptive parents and foster parents can take to help formulate relationships while

teaching parents how to attach when the child doesn't want to. Specialized training would be very helpful. When we look at placement versus permanency, we made the decision to love this child whether she wanted to be loved or not. Our goal was to provide for her and to give her the stability she was lacking. It was difficult to trust her because she would lie over the smallest things. The decision-making process that was one that was more difficult. We didn't receive the information that we needed before adopting. But it was a decision that we knew in our hearts. Our morals that we needed to stand up to the plate for this young lady. I'm not going to lie, at times I regret the decision that we made, but we made it as a family. We didn't get any information that we needed. I just have to keep thinking about that; we didn't get any of the information we needed or any of her true diagnosis. There was no psychological evaluation done on this child. A psychological evaluation is something that should've been done, but it wasn't. We had to do a lot of praying and trusting in God. Many people in our church who have adopted children. But, I think we were one of the original couples in the church that have adopted children from the foster care system. Therefore, we had no training. No training in her drama or how to endure that trauma. No training in how to recognize or cope with her trauma; or the next steps of caring for somebody enduring trauma. We had to rely upon our faith. Our faith in God and that he would help us because we felt like this was a call on our lives. We like to say that we think it is a necessity that adoptive parents received training in working with traumatized children.

Individual textural-structural description for Participant: #013. Participant # 013 represented a married couple who adopted a child who attended the same church. This couple had an established relationship with the biological mother and was in the process of working with her in order to maintain her permanency with her child. This is what they had to say about their lived experiences:

> Our daughter was our godchild at first. So there was already an attachment to her. She would come and stay with us on the weekends, and she was a part of our family. However, once we adopted her things had changed. Some of the challenges we face was the first year she had very little communication and very little interaction with teachers with friends. The lack of communication was a challenge because she had a hard time adjusting to trusting people again. Now as she has grown older, she has come to the realization the acts that were done to her. We too have gained more understanding of what happened. She has been in and out of therapy out all of her life. Adjustment initially was hard. But like I said before, now that she's in her new home she feels safe, and she feels secure. She has her room. The big thing for her was cleanliness because where she was before was not clean. There was a lot of urine and nasty stuff all over. So her adjustment has been great because she's been introduced to how a normal household should function. She is attached to us here at the house, but her birth mom still lives in Tucson. She still has no desire to see her. Sometimes, once a year and she may think about, it like on her birthday but she end up crying, and it appears worse for her than the trauma. She still believes the reason things

happened to her were her mom fault. She feels like her mother's behaviors are unforgiving. What we learned about permanency and the effect that it has on this house, is that when you decided to adopt you have to know that this is forever. Once the child takes your last name, they are as if they are your biological child. They have every right to everything as if they were biological. So permanency for us has been great because although she's not biologically mine, she's our daughter, and we address as our daughter and she is our daughter. The main thing that CPS told us was that our daughter will receive services because she was in CPS or state care. They informed us that she would have services until she's 18. We were informed due to the trauma our daughter experienced that the trauma may resurface in her teen and early adult years. They informed us that they would be there to give her the assistance that she needs. Our adopted child has the actual diagnosis, but she's sleeping. She's on medication, and there are things that bother her like she doesn't like men. She doesn't like black clothing or black fingernails. She still shies away from men. There is some self-pleasure with her because of her past. This is an area where I feel that we were unprepared or ill-equipped. Sometimes we do find that she is masturbating. She experiences and turns online anger. Her facial expression sells it, but she won't speak it and some of her actions show it as well. She cannot bring herself to talk about it, so that's why I call it internalized anger. I don't know what causes it other than her past trauma or just being immature or inattentive.

Individual textural-structural description for Participant: #015. Participant # 015 was a single woman who had never been married or had any children before adopting. This mother had taught in one of the school districts in Arizona. She stated that she had always desired to have a child but without going through the pregnancy process. When her son was placed in her home it was her opportunity to fulfill her motherhood goal in life. This is a glimpse of what she had to say about her lived experiences as an adoptive mother.

> Our daughter was our godchild at first. So there was already an attachment to her. She would come and stay with us on the weekends, and she was a part of our family. However, once we adopted her things had changed. Some of the challenges we face was the first year she had very little communication and very little interaction with teachers with friends. The lack of communication was a challenge because she had a hard time adjusting to trusting people again. Now as she has grown older, she has come to the realization the acts that were done to her. We too have gained more understanding of what happened. She has been in and out of therapy out all of her life. Adjustment initially was hard. But like I said before, now that she's in her new home she feels safe, and she feels secure. She has her room. The big thing for her was cleanliness because where she was before was not clean. There was a lot of urine and nasty stuff all over. So her adjustment has been great because she's been introduced to how a normal household should function. She is attached to us here at the house, but her birth mom still lives in Tucson. She still has no desire to see her. First I want to share

about my training. The only training that I receive, well I'm an educated, so I feel like I am trained in its certain areas especially ages and stages, was the basic training as a foster parent. The basic training received gave me a good overview of the possibilities, but it is quite different when one is living them. An example of what they taught was: the child may do this, or they might do that and you may want to try this. But when you're living through the situation, sometimes you can't recall the good advice received. I think that in the overview of the framework, they never sugarcoated the issues of how these children might present. An overview framework was my training experience. Then I'm going to CPES where most of the training rendered on prevention intervention, rights, and responsibilities. My son has completely adjusted and attached to the home. I mean we really feel in sync, aside from sort of getting through this transition and schooling. He is friendly, and he articulates that he loves his older. Right now, they're having head butting issues but that's older sibling stuff. He is very loving and has he taken his older brother under his wings ever since he met him. His sister his is adopted by another adoptive family, but we all consider each other family. When I think about permanency, it's never occurred to me that he would never be with me. Permanency comes in when you know your mind that we're in this together no matter what it takes. Our lives together have never been horrible. Yes, his teen thing is been a little dicey but is never been horrible. One of the foster training stated that "at some point you as the adoptive parent will have to claim him." They shared that the child was going to push every button to try to

push you away. They stated that it if I see that occurring then I need to claim him and say with him that we are in this together and that no matter what you, we're going to do this together. I always remember that, and I made that commitment to him. The decision-making process for me was different. The only bit of information that I desired to receive was the biological information. All that they were able to give me was very basic. He and his mother were homeless in another state. The mom was incarcerated for 30 days and asked a friend to watch him. The friend proved to be unreliable and unstable mentally. She drove to Tucson with the child and they that's how he got into the system. He was put in foster care and he never got to see is a mom again. I had been a foster parent of other kids for two years. I knew that I love to do this and that I wanted to be a mom. So when I met him, I was totally prepared to take him on forever. I didn't receive anything other than his general health. He is not followed by a behavioral health system. I've always covered this myself. I guess I should've known more because I just learned that behavior health counseling is covered. Well, I guess I have to fight, I should've known more than what I know now. My son has endured trauma. I even experienced one level of it when we moved into our new house. We moved when he was in fourth grade and ever since that time he comes into my room at night. He knows that I am a sound sleeper and that I don't know when he comes in. I have a king size bed, and so he slips in and sleeps on my bed without waking me. Sometimes he wakes up in the middle of the night, or he'll wait until I sleep and then he comes in. The disruption of his sleep has been the

> biggest indicator that something is bothering him. The way the house is organized is different now whereas before the rooms were right next to mine. Now they're further apart, so I think he worries a lot. He does not like change, and he did not want to move and he keeps begging can't we go back.

Individual textural-structural description for Participant: #016. Participant # 016 represented married couple who felt like adoption was their ministry. The couple originally started their adoption process living in California. They moved to Arizona before adopting their second child. This is a glimpse of what they had to share about their lived experiences with this phenomenon.

> Before adopting our daughter, we got general information about our child, and we were given scenarios on behaviors that could happen with her. We were given CPR training that's all I can remember. Our daughter was a cutter, self-loathing, lacked trust, a runaway, and exhibited fear or an inability to understand the difference between reality and fiction. An example of that, if she was watching a movie, on television, she thought it was real. The self-loathing behavior evolved because she was not used to having parents. It took our daughter a long time to trust us. We even experienced trust issues after the adoption finalized. I think that this was one of the major challenges, lack of trust, because she was not used to having a family. She didn't trust that we wouldn't be fair to her. Yes, we found this challenging. It did not matter if we told her how much we loved her. She just could not grasp a hold of this fact. She would turn around weekly and talked about how we were different towards her and that we treated her differently than

our biological children. This experience has taught our family to have compassion for others. The experiences were difficult but full of passion. Our daughter was so negative that this adoption traumatized our entire family. We adopted her sister to help establish some form of attachment. Adopting her biological sister did not suffice. She traumatized her biological sister. I think the children should be in counseling. I do believe adoptive families should be in a group counseling, and the child should be in individual counseling, and family counseling as a part of bringing somebody into the home. We had to go find counseling and services for her, but there should be an extra list that is provided for the family's support or family groups of adopted children. Things should be established through the adoption agency that are readily available, other than just the social worker coming out to make sure that your house is in order. Permanency, I'm trying to think, when we made the decision to bring her in our home, our decision was permanent. Our decision was a dedication agreement, and there was no going back. We decided that it was permanent whether the child wanted it or not. We, as her parents, partnered together because the child challenged us constantly. She did not want us to be a part of her family. We incorporated the opinion of the entire family into the decision-making process in bringing her into the family. We always talked about the relationship and that this was their sister. We didn't make any difference between biological or adopted. We had to train our daughter how build a healthy relationship and to practice healthy behavior.

Individual textural-structural description for Participant: #017. Participant # 017 represented a married couple who felt like adoption was their ministry. The couple originally started with a desire to open a boy's group home and to help young men trapped within the system. This is a glimpse of what they had to share about their lived experiences with their adoption:

> What training? You mean that crap that they gave us. The basic stuff gave for the regular foster parent whose children had no trauma at all. It was just basic and general training. Yeah, we might have been told about the laws and the possibility of getting a child that has had trauma. I didn't get any training. We faced a lot of unique challenges when we adopted our son. These challenges placed a lot of chaos in the home that did not exist before. We experienced various challenges, and a lot of them were by trial and error. The challenges we faced were not necessarily in a good way. We believe that things could have been avoided if we were given truthful information from the beginning. For us, we have been blessed that our church home has an adoption rate of 80%. So we have a huge support group, and we did not have to do this without the supports in place. But as far as education or training, the social system sucks! I mean the information received held back vital information they said things that were not true, but we were already on to something else by then. Well, I mean over the course of the years, we believe that he has adjusted well. But again it is been over the course of years. I think that it came slower than what it would have if we had the proper tools from day one. In looking at training to help with permanency

versus placement, we did not receive any. Again we were left unprepared. Being military, we understand the importance of stabilization, and teamwork. Our goal was to provide that for this little boy. Our son's post trauma diagnoses are Posttraumatic Stress Disorder and Reactive Attachment Disorder. There were times where he exhibit sexual night terrors, and those were sleepless night terrors because he'd thrash about at night. Although change has been slow, it has been by the grace of God that our son did not experience issues with males. He lived experiences (sexual) were with women. I want to say as far as the Adoption system and permanency are concerned, it is important that the adoptive parent knows as much as possible about the child they are attempting to adopt; because there's no going back. And if your children that have the special traumatized issues there need to be some monitoring program out there for a year or two before the adoptive parent takes those last steps. They only information that we were ever given to assist in making this decision was in the initial classes that they do for foster parents. Truly, that was the only information that we were given. Outside of that, anything else we had to learn on our own. The help that we obtained was through the people that knew.

Individual textural-structural description for Participant: #018. Participant # 018 represented a married couple who adopted their great grandchildren in order to keep them out of the foster care system or adopted outside of the family unit. This is a glimpse of what they had to share about their lived experiences with their adoption:

We received little to no training at all. What we did receive was primarily the nuts and bolts in raising a foster child but nothing else. The insights looked at where we needed to go and what we needed to do in case a problem aroused with the children. What worked with our child didn't always work with our adoptive children. Although they are flesh and blood family, they are different than our biological children but we are striving to be a family. It has been hard to deal with especially when she is screaming and throwing fits. It's always, me, me, and me. We have looked for help. We live in a small rural area, and there is not a lot out here. Sometimes we think about moving to a big city where we can get the children the help that they need. We have faced many unique challenges with adopting our great grandchildren. Things have improved, but we have found ourselves taking two steps backward because of some of the things our daughter has done. We rely on our religion. However, the church in small rural cities have not helped because we are seen as older people raising our grandchildren. We have recognized our child's trauma issues. We have dealt with several incidents of stealing recently. She also has demonstrated bouts of anger, frustration, and harm towards her younger brother. I learned about an online program that we have to ignore her tantrums and other stuff. You have to pick and choose your battles. We make her go to her room, so we don't have to listen to it and then she stomps her feet, but she normally displayed remorse when she'd returned. And if your children that have the special traumatized issues there need to be some monitoring program out there for a year or two before the adoptive parent takes

those last steps. They only information that we were ever given to assist in making this decision was in the initial classes that they do for foster parents. Truly, that was the only information that we were given. Outside of that, anything else we had to learn on our own. The help that we obtained was through the Attachment in our home is different than what is expected by others. We were in no way prepared for raising traumatized children. Attaching was hard, and nothing about their trauma could ever prepare us for permanency. Things just do not go the way that we planned. Permanency is forever! Coming out of retirement to adopt our great grandchildren was hard! We stop and have talked things out, at times we really do not know how much more of this we can take. We did not receive the support or help from the mental health agencies or the foster care agency. We believe that this is why you hear so many parents have returned their adopted children back to the system. It has been because the adoptive parent and families were not getting needed information about their adopted children. Our family, at first was against us adopting the children. And they were not happy at all with our decision. They didn't think that we were making much sense because we had just gone into retirement. Our daughter who is the biological grandmother and because of her ex-husband she could not take and raise her grandchildren. We don't know what to call everyone in the family because of our children and our great-grandchildren. Our great-grandchildren call us mom and dad, but they call our children uncle or aunt. She knows that we're not the biological parents, and she is told her brother that we are not their

biological parents. We wanted them to know that we're not their biological parents, but this fact would not keep us from loving her. I think the hardest time we have experienced was when we were in public, and we would hear crap like: oh you poor parents, we feel so sorry for you. We don't feel sorry for ourselves these are our kids! Therefore, as a family we were doing what we have to do. We never received support from CPS or the child's attorney when it came to the decision-making process. In fact, the only thing that the case manager stated we needed was to consider adoption or guardianship. That is what the CPS worker told us! Then she said the best thing for us to do was to adopt because at least that we will be able to get an adoption subsidy. If we had not adopted the children, well there was a theory of fear, a fear that we would lose them. I don't think that there wasn't a time that we had gone to the courthouse and the Judge asked us do you want to adopt them. Do you want to adopt them? Every time we went to court. We already had our mind made up. We knew what type of life our children would have had without us.

Individual textural-structural description for Participant: #024. Participant # 024 represented an older married couple who felt like adoption was their ministry. The couple originally adopted children years ago. The wife is a retired head start educator and had worked in the field for many years. They were introduced to their son when he was one and a half years old. This is a glimpse of what they had to share about their lived experiences with this phenomenon.

Our son has experienced various difficulties in his life. We have found that if we stand beside him that he can achieve the goals that we have planned for him. Attachment in the beginning was difficult. However, we used the lessons taught during our mini map training. We also worked with an attachment therapist to help him to overcome adjustment difficulties. Our son knew his biological mother. He had problems attaching because his desire was to stay with her. He struggled with the fact that she kept one of his other brothers. This challenge opened the door for him to experience abandonment issues. He attached with his adopted brother. He looked up to his brother. I remember the day when his brother left for the military, our son had to re-enter therapy again for abandonment problems and aggressive behaviors. When we think about permanency, we both believe that we have committed ourselves to this young child. It has been our desire to prove him with stability and some form of attachment. Reactive attachment therapy empowered us to gain new skills to help him work through different things he experiences around being adopted and having a forever home. Although we did not receive information that could help us in our decision to adopt our son, we were very knowledgeable because we knew the family prior. So we believe that we knew more about our son and his family. When it comes to understanding his endured trauma, we believe that this is where we could have gotten more information than the state. In recent months, we learned that our son was Fetal Alcohol Effect. Fetal Alcohol Effect began to uncover and shed light on his behaviors and learning difficulties. Our son has

been removed from our home on several occasions and for up to a year. He has endured: attachment issues, abandonment issues, and substance and alcohol abuse, physical and sexual abuse. We attempt to keep up with training. We meet with his therapist to way to modify our life, for our son's life. Our son struggles within the school system. The school was where we experience the most aggressive behaviors. His former therapist stated there was a correlation between his learning delays, and aggression especially when a contributing variable was peer perception. She explained to us how he appeared to become jealous when his classmates grabbed ahold of what was being taught and he did not. We see this behavior happening more, the older that he gets. We are committed to our son. We are hoping that now that we have moved into the city that we can get better help for him.

Individual textural-structural description for Participant: #025. Participant # 025 represented an older married couple who felt like adopting the grandchildren was the only option for them. This is a glimpse of what they had to share about their lived experiences with this phenomenon.

The training that we received was minimal until we came to our case manager (mental health). Now she is helping us out. We are learning how to cope with the trauma that our grandchildren endured. The training that we are now receiving aids in benefiting our children to adjust to their new home significantly. We see a fetal alcohol specialist that helps us to work on behavioral modification plans that aids in guiding our child through the use of specific routines. Also working with

the children on their trauma problems, I still have my issues to work out such as anger and OCD and me dyslexic. Now I am dealing with a wonderful little girl who has this amazing fantasy and a creative ability that she has created her fantasy world, and it is hard to pull her out of it at times.. I had no choice but to seek help. It was hard at first to obtain support, but then I started making progress. I spoke with the school administrator, the special needs educator, and then I received a referral to a couple of different agencies by my primary care physician. We have adjusted well. Right now, I think that they're feeling stable. I believe that they're feeling comfortable and stable with me being a mom and my husband being their dad. My oldest one is 7. There was a hiccup in the system, but now she feels secure that nobody is going to take her away from us. She is permanent with us. The little one, we pretty much checked him out of the hospital, he was ours from the beginning. I believe that we are attached to each other. My oldest is afraid that she is going to be taken away again and that she is confused because she still sees her biological mother. I believe that there is harbored anger in her heart because of the things her mother did to her and her brother. These issues are challenging because I do not have training in this area. My daughter reports that I scare her when I am disciplining her. I am unsure if she was scared or if she was attempting to control the situation. We attempt to stay tried and true with our disciplining. There is no give or take on it. For example, our oldest got caught stealing a peer's lunch, and she got in trouble for that behavior. She had been penalized verbally for it because I corrected her right

when it happened. I wanted her to know that stealing is not right. She needed to know how the other child felt. So the next day I packed the little girl a special lunch and made her apologize and to give it to the little girl. My child melted. I do not know if this frightened, offended or embarrassed her because there are times that she just shuts down and does not express her emotions fully. Adopting our grandchildren has had an effect on our lives. We do not have date nights anymore. We just about have given up on everything. We switched our date nights to family nights. I know that we need our alone time, but this is the decision that we made together. We were not willing to have anyone else raise our children. It is frustrating when one has to give up their bed space. I do not think that I have gone to the bathroom by myself. Showers are the only private time that I get and at times it's not private, especially when you have little fingers opening up the curtains and saying mommy what are you doing. Permanency is great. My husband and I talked about stepping up to the plate before the oldest child was born. My husband asked if we could adopt the child before she was born especially with the type of lifestyle that his daughter was living. I told him no that he needed to give his daughter a chance. Unfortunately, the daughter placed the child into situations that traumatizing to her. I don't know if we were either given any information because it was my husband's daughter. We saw the path that she was taking and where she was going. We chose together this is what we're going to do. We told her if you don't like it it's too bad. We were going to do, and we're going to do it even though you're 25 years old. You can't take care

of your children because of the lifestyle you have chosen to live. We have decided that you're not going to take these kids down the path that you're going down. So we were not given any information. We gave the information and made our decision that this is how things were going to be. We could have done it the easy way or the hard way. Maybe we thought too quickly and didn't think it out as far as our health and wellness were a concern. But then again, we felt that our health and wellness needed to go on the back burner because these children needed a chance. We already had our chances. We got to live and experience life. Now we want our grandchildren to be able to say that they also got to experience life. Adoptive parents have experienced enough love to give a child that has experienced trauma so that they can someday return the love to another needy child.

Composite Descriptions

Statements that describe the lived experiences of an individual that contributes to understanding a phenomenon is what Moustakas (1994) referred to as composite descriptions. When participants of a study contribute their lived experiences, the researcher incorporates the reflected lived experiences to develop the composite description of the themes identified in the study (Moustakas, 1994). The following descriptions reveal the described themes derived from the participants relating to their adoption experiences. All composite descriptions were culled from the individualized textural-structural descriptions presented earlier in this chapter.

These themes summarized the effects associated with adoption where adoptive families experienced challenges due to attachment, trust, bonding, and abandonment issues. These adoptive families perceived that their challenges stemmed from the lack of specialized training geared towards how to care for children that experienced trauma. These participants perceived their faced challenges caused them to seek information that empowered them to develop skills, insights, and strategies to ignite and maintain healthy relationships with their adopted child to preserve the family unit.

Placement versus Permanency Influence the Decision-Making Process

Arizona is challenged by a lack of homes to place their foster children into increase permanency for their children. This theme summarized the effects associated with adoption. Adoptive families experienced challenges based on their struggle with attachment, inner-conflict with returning the child to the foster care system, and the lack of homes available to care for abused children. These adoptive parents shared how the challenges of child trauma and placement versus permanency contributed to their adoption decision. These parents expressed how proper training, along with receiving complete information on their child, would have assisted in their decision-making process instead of leaving them feeling as though they were all alone or on their own after they have signed the adoption papers.

Motivation in the Decision-Making Process

The decision-making process in adoption is a decision that is permanent. This decision is one that should not be taken lightly. Therefore, it is essential that adoptive parents strive to be well-informed with the needs of their adopted children. This theme

summarized the effects associated with adoption where adoptive families experienced challenges based on their struggle to receive full disclosure of the issues that their adoptive children have experienced. Based on their experiences, these adoptive parents shared their lived experiences and the challenges they faced when vital information was withheld. These adoptive families displayed their commitment towards their pledge to be their child's parent for life even under the unforetold circumstances.

Dilemma in Understanding Endure Trauma

Ninety-five percent of the participants reflected on their struggle for understanding the trauma that their child had experienced. This theme summarized the effects associated in adoption when adoptive families experienced the dilemma with understanding endure trauma. Theses adoptive parents based their experiences on their challenges in understanding how endured trauma affects the decision-making process in adoption; how understanding their child's endured trauma was influenced by the lack of professional alliance (between adoptive parents, mental health providers, and adoption agencies) supports groups, specialized training; and the lack of education in understanding what the child has gone through.

Peer Reviewed Analysis

The last phase of the data analysis was having two peer reviewers review and analyze the transcripts of the participants and ensure that the desired information was being obtained. Peer reviewers took the transcripts and developed their set of themes independently before meeting to discuss the final findings. Both peer reviewers were trained in this area. One reviewer reviews dissertations for Liverpool and the other has

been a psychologist for over 25 years also to teaching at the university level. Both reviewers had been trained in qualitative inquiry. The peer reviewers were given brief information about the study and what I was looking for. The information included (a) population, (b) the problem faced, and (c) the transcripts. A consolidation of the peer reviewers' findings is presented below.

Peer Reviewers' Collective Insights

Fifteen interviews were conducted using the approved open-ended questions to each of the participants. These questions addressed the significant challenges that adoptive parents may experience with raising a child who has experienced trauma. As they read the various transcripts, the reviewers agreed that each participant described their lived experiences differently. However, the content was generally the same. These families presented with various challenges resulting from a lack of training, a lack in receiving documentation in order to be well-informed about the child that they were adopting, and the fact that what they needed to learn was self-taught. The reviewers highlighted and discussed with me some of the common responses by the participants. A couple of the responses stemmed from the questions regarding the unique challenges that these parents faced and the recognized forms or types of trauma that challenges these parents when raising a child who has experienced trauma. The reviewers recognized that these participants were versed with the trauma symptoms and the symptoms presented as unmanaged behaviors. The reviewers viewed the overall themes in this study as these families, through self-avocation, defining what was occurring in their homes and internally in their unique ways. This was a direct result of having little to no information

or training on how to understand the ways in which their homes, families, and internal lives have changed. The results of their findings agreed with what I had assessed during the interviewing and transcribing process. I had a final dialogue with the peer reviewers collectively to discuss what developed from the study. Next, a discussion of comments, memos, and themes were processed and incorporated into the final review.

Reliability and Validity

A member check is a technique used for trustworthiness and evidence of validity. It can be seen as a controversial technique where the researcher can formally or informally meet with the participants of a study to cross-check the data received. In this study, I provided the participants with the opportunity to correct errors and challenge any misperceived interpretations by reviewing their transcripts. Also, member checking afforded each participant the opportunity to give more information if they desired. Member checking allowed me to summarize preliminary findings while confirming particular aspects of the data received. I also shared the various themes that evolved found the transcripts. Consistency was found between the themes and with the lived experiences of the participant by the peer reviewers.

Summary

From the gathered information from the interviews, the challenges child trauma has on the adoptive family's social and emotional system are prevalent. When breaking these pieces of information up into a visual representation of the responses, meaning can be conjured from the detail each participant provided in their individual interviews.

Future researchers should conduct a longitudinal study to determine which form of training would be supportive for equipping adoptive parents raising children who have experienced trauma. In addition, future studies should be conducted to determine how beneficial it would be for adoptive parents to receive at least two generation of medical, mental health, and behavioral health information on the child as a form of the decision-making process.

The purpose of this study was to look at the challenges that child trauma have on the adoptive family social and emotional system. I looked to gained insight from adoptive parents in the state of Arizona. I found that was imperative to take the time and listen to the stories of the parents of adopted children who previously experienced trauma. One of our nation's mottos or slogans is "No Child Left Behind." However, this is what is happening when adoptive parents are not given all of the information on how to help mold their children into whom they are meant to be. The results from this study will direct the discussion on four main challenges of child trauma on the adoptive family's social and emotional system. In Chapter 5, I will present the results, conclusions, and recommendations for future study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Adoptive parents face various challenges that present and evolve from the previous traumatic experiences lived by their adopted children. According Casey Family Services (2003b), families that adopt children who experienced trauma tend to be challenged with barriers from professionals who are there to provide direct and indirect services. Such barriers continue to avert favorable outcomes for these families who live with the aftermath of child trauma (James, 1994; Post, 2013). The purpose of this study was to examine the challenges that child trauma has on the adoptive family social and emotional system. I looked to gain insight from adoptive parents all over the state of Arizona. I deemed that it was imperative to take the time and listen to the stories of parents who had adopted children who previously experienced trauma. In this chapter, I discuss the results of four major challenges that 15 adoptive families faced when working with their adopted child who experienced trauma.

The population was diverse with the highest percentage being European American, followed by a smaller percentage of African American and biracial, and the smallest percentage of Hispanic American. Eleven out of 15 of the participating adoptive families were from a financially stable two-parent home. Families were more likely to have some professional services in place due to their child's past traumatic exposure. Thirteen out of 15 adoptive parents identified four major challenging areas through adopting children who have experienced trauma.

Challenges of Attachment

In this research, 80% (12) of the adoptive parents had reported challenges dealing with attachment issues to their adoptive child. Bowlby (1969) suggested that relationships between a child and his or her primary caregiver were essential. Relationships are seen as the foundational threshold that allows the child to formulate healthy attachments (Brodzinsky et al., 1998; Grotevant & McDermott, 2014; Schore, 2003a, 2003b; Wilke-Deaton, 2005). The adoptive parent must be able to recognize when serious disturbance and/or trauma exists within the nucleus of the family. Serious attachment issues are at risk in the parent-child relationship (James, 1994; Pickert & Shuster, 2012). In fact, when there is a loss of a child's primary attachment figure, the child views this as a loss of everything (Bowlby, 1969; James, 1994, Pickert & Shuster, 2010). Bowlby stated that the parent and child relationship is imperative in order to see growth within the child. Trust is a major issue for attachment. When early childhood trauma is experienced, adoptive parents are challenged with the aftermath or effects of their new child's trauma. When a child or an individual has gone through an abusive situation with someone who they are emotionally attached to (i.e., the caregiver), they tend to forget about the severity of the abuse itself. This form of betrayal causes a difficulty for the child to learn how to trust or to even recognize someone who should be trustworthy.

One adoptive parent in the study spoke about the challenge that she and her husband faced in the area of attaching with their son. They adopted their child between the ages of 6- and 8-years- old. A healthy or a somewhat healthy bond had already taken

place between the biological mother and this child. The child told his adoptive parents, that although they were a nice couple he could not bond with them or call them mom and dad due to the fear of betraying his biological mother. Other participants shared similar stories. The perceived challenges on attachment, through the experiences lived by these 15 families, addressed understanding how to work with their child on deregulated emotions and behaviors stemmed from their unresolved childhood traumatic experiences.

Another parent talked about her child's irritability, anger, sleeping problems, and inconsolable ability to regulate the child's emotions as one of her primary challenges toward attachment. Cloitre et al. (2009) suggested the more a child experiences trauma, the more the complexity of their symptomology is increased. The hub that revolves around the individual's life is the foundation from which intimate attachment is developed (Bowlby, 1969).

The adoptive parents in this study reported that their adopted children had already formed a bond to their biological primary caregiver before the adoption had taken place. It was not the goal of these parents to replace that role, but to become one of the child's primary caregivers. As one parent put it: "We wanted them to know that we were not their biological mother and father but we still loved them as though we were." The lived stories of these 15 adoptive parents revealed that they are fully committed to forming a bonded relationship with their adopted child. Their goal seems to be one of trying to help his or her child reach their fullest potential. Bowlby (1969) indicated that, while treating the child and helping him or her to find his or her own way, the parent needs help in

feeling secure and attached. This is a vital piece of creating the necessary links in attachment for future healthy relationships.

The 15 adoptive parents in this study expressed that if they were given the specialized training they needed, more progress could have been made in the area of attachment with their children in a shorter period of time. Twelve out of 15 of the adoptive parents from this study stated that they received no information on how to work with their child. They felt that if they had received a full disclosure about their children, they could have helped the child move forward, even faster, in establishing a healthier relationship.

Based on the shared views of the participants of this study, one of the four frequent challenges faced by adoptive families was the perception of attachment. The theme of attachment added valuable meaning to the challenges child trauma has on the adoptive family's social and emotional system. Attachment deals with the intimacy or connection between the parent and their child.

An overall view of the findings revealed issues arose among these participants in the area of attachment. There are unforeseen strains on the parent-child and family relationship. The conveyed message shared by the parents presented the unforeseen strain as their adopted child's struggle with betraying their biological parent. It also conveyed strains in other areas to include reciprocal investment of the parent-child relationship, partner intimacy, and time for other family members.

Another meaning derived from attachment issues was that bonding did not formulate naturally leaving a disconnection between the parent and child. The message

conveyed here sparked a reflection to James' (1994) theory that many adoptive parents are not prepared or are ill-equipped when it comes to raising children with traumatic experiences. The misconception that a newly adopted child will naturally formulate a bond with their new parents is inconceivable. Bonding takes time. Trust must be earned. The child who usually attaches to new adoptive parents is one that is said to have possible issues with attachment themselves.

Insecurities existed among most invested parties that lead to many of the adoptive parents struggles with the challenge of a lack of specialized training. The lack of training among these adoptive parents appeared to be the biggest factor in the challenge of attachment. The message conveyed expressed that many of these parents second guessed their original reasons for adopting. These parents sought out ways to formulate connections to establish skills that would help their child in overcoming barriers of their experienced trauma. It was discovered that learning new techniques in the middle of a challenge was itself another challenge. These participants perceived their faced challenges forced them to seek information that empowered them to develop skills, insights, and strategies to ignite and maintain healthy relationships with their adopted child to preserve the family unit.

Challenge of Well-Informed Decision-Making

It is not understood why certain information is withheld from a parent who is required to treat the child as their own. Well-informed decision making is a term that the National Children's Information Gateway (2012) has deemed as an essential part of parenting, especially for adoptive parents who have adopted children out of the public

welfare system. According to the Child's Bureau (2010), ethical requirements exist which allows detailed background information on a potential adoptive child be shared. Initially, this is done with an introduction of limited scope of information. If the family still shows interest, then the limited scope is continued through full disclosure of obtainable information (Child's Welfare Information Gateway, 2012; Mapes, 2012; Smith, 2012). The Child Welfare Information Gateway (2010) revealed that well-informed decision making is a process that is a relevant and intricate resource for ensuring a legal permanent, nurturing family for every child. This process equips the adopting family with information so that they are able to advocate for the needs of their adopted children (Child's Welfare Information Gateway, 2012; Mapes, 2012; Smith, 2012).

A well-informed decision renders information about dealing with the child's medical background. Background information, at least two generations, is deemed essential because it affords the adoptive parent pertinent insight on both the parent and grandparent mental health and medical status. When a child has to go to the doctor for something that the adoptive parent has never experienced, it can become rather confusing, especially when life-threatening events occur. A situation such as this occurred with one of the participants in the study. The participant had been raising her child for 10 years, and on his 11th birthday, he had a grand mal seizure. These adoptive parents expressed being ill-equipped for this medical emergency. Nowhere in the adoption was paperwork provided regarding the child having a history of seizure disorders. That is because no information was given on the medical history of this child's

biological family. The adoptive mother spoke about the struggles that she faced without the necessary information. Several months went by with multiple seizures. However, no information or insight was given. All of this could have been avoided if the parents had received the well-informed information.

Thirteen of the 15 adoptive parents in this study expressed that they believed that they should have received all of the information on the child and their family in order to make a well-informed decision. These parents expressed that the information would equip them to answer medical question, assist them in helping the child complete family tree projects in school, and to help the child with self-identify. The other two families were kinship care adoptions. Therefore, they had the basic knowledge of the family, at least on one side of the family. The parents expressed that the emphasis should not be placed on just finding a home for these children. The same level of care and consideration should be placed on equipping adoptive parents with knowledge so that attachment takes hold.

Based on the shared views from the participants in this study, the second frequent challenge faced by adoptive parents was in the area of a well-informed decision-making process. The theme in the well-informed decision-making process guided a new meaning in the challenges faced by adoptive families.

Issues arose among these participants in the area of the well-informed decision-making process. All fifteen of these families recognized that it was their decision to adopt. They understood that once the decision was made, that it was for life. These families were committed to their children.

Their message conveyed that they knew little about the child that they were adopting, even those families who were relative placement adoptive families. Although the commitment was apparent, the message revealed was that many adoption agencies lacked giving adoptive parents truthful information or fully disclosing information needed to assist them in making their well-informed decision. These parents perceived that more information would have better equipped them in advocating for their children's needs. It is clear that being well-informed could have helped them in understanding their child's endured trauma.

Challenges in Placement versus Permanency

Ensuring placement is deemed crucial for the preservation of these children within the adoptive family unit (Forbes, 2008; Mapes, 2012; Smith, 2010). If placement fails, the traumatic effects of the disruption are experienced by entire family unit (Bowlby, 1969; Child Welfare Information Gateway, 2013; James, 1994; Pickert & Shuster, 2010; Post, 2013). Permanency is an active process of linking an adult and child together in search of a permanent connection while providing a safe, secure, and stable relationship (Brodzinsky et al., 1988; Forbes & Dziegielewski, 2003; M. A. Baker, personal communication, August 15, 2013; Smith, 2012). With the growing number of children being raised in nonrelative placement, there must be a paradigm shift from placement towards the direction of achieved permanency. Assured supports are needed to transition these children from disrupted relationships to a healthy adulthood outcome (Donaldson, 2010). Placement is not enough (Brodzinsky et al., 1988). Many children reside in ill-equipped homes. Some adoptive families lack the necessary training to deal

with the challenges suffered by these children. Many adoptive families lack the training to deal with the challenges suffered by these children. Traumatic experiences such as abuse, neglect, multiple placements, and other preadoption experiences can inflict physical, psychological, emotional, and developmental harm on them (Donaldson, 2010). Many families are unwilling to adopt traumatized children (Donaldson, 2010; Forbes & Dziegielewski, 2003; Keck & Kupecky, 2009; Smith, 2012).

All 15 parents expressed that their goal was to provide a forever home for the children that they adopted. Their comments raised concerns for future research on understanding what they signed up for and exactly what supports should be required. These parents struggled because they were not receiving the necessary supports to keep the placement from disrupting. These parents were fully committed to their children even through the challenges that arose. One parent stated that she had several kids placed in their home. She said, "The minute they heard that I had an empty bed they were calling. Some agencies do what they call a matching process, but that does not always happen." The matching process is important because it sets the atmosphere for the bonding process to begin.

Based on the shared views from the participants in this study, the third frequent challenge faced by adoptive parents was in the area of placement vs. permanency. The theme placement vs. permanency revealed new meaning in the challenges faced by adoptive families.

An overall view of the findings suggested issues arose among these participants in the area of placement vs. permanency. The findings indicated that these families

recognized that a "good fit" between the child and the adopting family. Five of these families adopted relatives. The message that they conveyed during their interviews was a strong indicator of family preservation. These participants proclaimed a message on family morals, traditions, and heredity that binds their family together.

Many of these families revealed that once attachment developed with the child it was easier to commit to becoming a permanent placement.

The participants in this study conveyed a strong message that permanency is more important than placement. They perceive that moving children from one home to another contributes to additional layers of trauma observed by insecurities, abandonment and attachment challenges. The overall message suggested that permanency was a foundational factor in the decisions made for adoption by these participants. It also reveals that matching the child with the potential adoptive placement could ensure stability in placement.

Challenges in Understanding Endured Trauma

The U. S. Department of Health and Human Services (2010) revealed that 40 % of the children taken into care experienced multiple levels of trauma. Acts towards children produce complex traumatic experiences with extended consequences that affected the youth, their families, and the community (English, 2005; Higgins & McCabe, 2003; Sabol et al., 2004; Wulczyn, 2009; Zielinski, 2009). These children tend to experience posttraumatic stress because their neurophysiological responses continue to linger in a chronically aroused state, even though the intimidation, risk, or danger has ended (Terr, 1992). Complex traumatic events (domestic violence, car accidents, neglect,

physical and sexual abuse, national disasters, or even medical procedural trauma) cause lingering effects. Thus incapacitating the child's ability to physically and/or emotionally self-regulate (Brodzinsky, 1992; Grotevant, & McDermott, 2014; James, 1994; M. A. Baker, personal communication, December 15, 2013; McDonald, 2001; Pickert, 2010; Ruggiero, 2010).

A couple of parents shared details about their children's inability to self-regulate. The first parent spoke about the child's inability to understand why he was taken from his biological mother and not his other siblings. The result of not understanding the reasoning behind the state's decision caused the child to struggle with bonding. He presented as angry and destructive to the point that he had to be placed in a therapeutic foster placement for over a year. The parents reported that although their child was provided for, being separated from his new family added to the complexity of his trauma. This family questioned why in-home services or training were not provided to the parents for the parents to understand the child's diagnosis and the trauma he endured in his first three years of life.

The second parent reported that she received the child right out of the hospital. She stated that she was aware of all of the medical issues that her daughter endured. She even reported that she was informed that the medical issue would continue to present itself as a challenge because of its extent. However, the mother was not aware of the child's behavioral challenges. This mother felt that because she received her directly from the hospital, she would have a different outcome than this child's two biological brothers that the adopting mother had already adopted. This mother did not understand

the layers of trauma that this child had experienced. Trauma even occurs in utero. All 15 participants expressed that understanding the forms of trauma, and some of the signs to look for, would have been beneficial in helping to preserve their families. One participant stated "We need more than the basics, but we do not need a degree."

Adoptive parents are not given the information, support, education and tools to help mold their children to whom they are meant to be. These 15 adoptive parents contradicted some of what other researchers have suggested. One contradiction was that many families are unwilling to adopt traumatized children (Donaldson, 2010; Forbes & Dziegielewski, 2003; Keck & Kupecky, 2009; Smith, 2012). In this study, many families were willing to adopt a child that has experienced trauma.

Many times adults who adopt are on a quest to find ways to help children who are hurting. Some adoptive parents view the adoption process through a rose-colored lens. Although their intentions are great, James (1994) suggested that adoptive parents lack the proper tools to assist them in what they are doing. Adoptive parents need to be well-equipped in order to take these children from brokenness into wholeness so that they are surviving and thriving. The parents in this study agreed with this suggestion. They stated their desire to be trained and to have supportive resources in place. One parent talked about how the education level needed to be up to an individual standard across the board. Training needs to reflect the types of trauma these children may present with and how the trauma may be observed.

The last major challenge faced by the adoptive parents, within this study, was understanding the endured trauma of their children. Based on the shared views of the participants in this study, this theme added meaning in the area of endured trauma.

The overall view of the findings conveyed the meaningful message that these parents desire to be trained or equipped on how to help ease their children's pain. They want the necessary tools to help their children learn to cope with their endured trauma. These parents found it hard just to sit back and watch their children hurting, confused, and unable to self-regulate due to unconscious stimuli. These findings revealed compelling information about the pledge of adoptive parents. The message affirmed their commitment to their children.

Overall, the revelation of this study affirms parents are committed to adopting children with traumatic experiences. In return, they request that they receive specialized training to equip them for doing their job. These parents desire to empower their children in overcoming their past traumatic challenges for them to pursue healthier lives. Adoptive parents believe that they should be given full disclosure of their child's past. They are required to commit to raising the child as their own. Therefore, they need the necessary tools to advocate for their child.

Limitations/Delimitations

Data in the study had limitations. One of the limitations was the fact that five participants did not meet the inclusion criteria from the TSCYC. Some of the participants may have under-reported details about their children’s past trauma on this administered assessment. The challenge was that various therapist and church pastors

had already reported that these participants adopted children had experienced trauma. At the therapeutic level, these participants should have qualified for the study on that merit alone. However, the use of the TSCYC as a qualifying instrument, by under-reporting information, the parent disqualified themselves from the study. Future researchers might want to look at other tools that will look at prolonged exposure to violence or another instrument that can better identify various forms of trauma experienced by adopted children. Future researchers may also want to conduct a longitudinal study on this population to gain insights on how the adoptive parent perceives the effects of pre-exposed trauma in adopted children over time. Moreover, future research may want to examine how the effects of trauma impacted the lived experiences of the family over time.

A second limitation was that two participants exited the study before the interviews began. I was not able to obtain interviews with all potential participants or to collect all possible data linked to those participants. Fifteen out of the 24 remaining volunteers were questioned. Future researchers might consider obtaining more volunteers to eliminate changes to their sample size.

A third limitation occurred as three of the randomly selected participants requested to be interviewed by telephone. Individuals who were referred to the study had adopted in Arizona. However, these three participants had moved out of state. No direct observable contact was made with these families. Therefore, it was difficult to assess if the families were over or under reporting their lived experiences.

A fourth limitation occurred as one participant's young children were disruptive the interview, so the discussion took the total allotment period. Accommodations were made for this unplanned event. Although the family continued their meeting after situating their children, it was uncertain if the family was able to express their lived experiences fully. A reconnection was made with the family during the member checking process. It was learned that the member was confident and happy with the report that they had shared.

The fifth limitation found was with kin-ship adoption. Five families adopted relatives to keep them from becoming a ward of the state or placed for adoption with nonrelatives. Kinship adoption could be a topic for future research. The reason behind their adoption gave a different meaning to the challenges faced. Future researchers might engage in understanding if there is a difference between the challenges faced in adopting a child who has experienced trauma when the adopting individual is a relative versus a nonrelative.

Another limitation came with the lack of prior research studies on this topic. Previous researchers focused on the struggles that were faced between the mother and the child. In those studies, the researchers were looking at the issues of attachment between the mother and child. However, the challenges faced by the family had not been addressed, especially when looking at the family unit as a whole. This phenomenon is the one that requires future researchers to assess and observe through possibly a longitudinal study. Time constraints was another limitation of this study. The desired

goal was first to complete this Ph.D. program and then to perhaps go back into the study itself to conduct a more in-depth longitudinal study

Another limitation dealt with the potential bias that have been could project as an adoptive four children who experienced trauma. For this reason, extra precautionary measures were taken to alleviate bias or prejudice within the results of this study including steps such as bracketing, member checking, and peer reviewers were used.

Finally, the chosen sample for this study was generalizable to adoptive parents of children adopted from the public welfare system. This group presented with limitations due to its size. The study was based on a small, purposive sample of adoptive parents who resided in Arizona and who were affiliated with the referring therapists, churches, school, and foster care agencies, were contacted. These families were randomly selected from a larger referred group of participants because they met the criteria of the TSCYC and for the abundant information that they could render on their lived experiences among this phenomenon. It would have been difficult to compare these findings with adoptive parents in general (i.e., private adoptions, closed adoptions, or nonpublic welfare adoptions) because other variables may alter their experiences.

Recommendations

These adoptive parents believed that the best tool they could have received was to be trained and adequately prepared for rendering services to children who experienced trauma. Therefore, future researchers on adoption should consider the types of training that will begin equipping this population in carrying out their job. Next, future

researchers should consider what the National Children's Information Gateway states about well-informed decision-making. Here, future researchers might want to look at particular parents who receive two generations worth of information on the biological family and another set who does not. Scholars could conduct a longitudinal study following the lives of at least 15 adoptive families to see if receiving well-informed documentation makes a difference. Adoption agencies would benefit from having research on different supportive services and the outcomes within the home. Last, future researchers can study the effects that respite services has on maintaining the family unit when attempting to understand the challenges of child trauma on the adoptive family's social and emotional system.

Implications for Social Change

Adoption in and of itself can be a powerful tool for social change (Meyers, 2011). The number of children exposed to domestic violence, physical abuse, sexual abuse, and neglect has increased (Child Welfare League of America. 2010, 2013; Post, 2013; Smith, 2012, 2013). There is a need for more individuals to take on the challenge of adoption. There are many individuals who are willing to take on this challenge. However, it is important for adoption workers to understand that family unity does not always occur once the adoption paperwork is completed. In fact, this is often the time when many of the social and emotional challenges begin (Donaldson, 2013). Desire is not enough. It is imperative for individuals to be equipped with knowledge, coping skills, and support. Thus moving families beyond thriving to surviving in difficult adoptions (Child League of America, 1996; James 1994). Understanding the adoptive family's perspective could

contribute to providing more effective treatment and supports. This population of individuals is in need of psychoeducation, supportive services, insurances and financial subsidies. Such positive outcomes can promote permanency in their adoptive homes after placement (Child Welfare, 2010, 2012; McDonald, 2001; Rushton & Monck, 2009).

Conclusion

Many adoptive parents are willing to take on the challenge of raising a child who has experience trauma. However, they desire to be trained and to have supportive resources in place to take on the task. Adoptive parents are committed to raising the children that they have adopted. Adoptive parents desire to be informed of the trauma the children have faced. Supportive resources prepare the adoptive parent for potential challenges that they will face. Social change begins with one action. The ripples of change could extend to professional agencies and down into these homes by equipping adoptive parents with essential tools. These adoptive families can begin to reach out and form bonds that originate trust and attachment between the adult and child within the family unit. As attachments adhere, the family unit thrives and survives within difficult adoptions.

References

Adoption and Safe Families Act of 1997. Pub. L. No.105-89, 42 U.S.C. §§ 620-679 (1997).

Adoption Assistance and Child Welfare Act of 1980 P. L. 96-272

Adoption Learning Partners. (2010). Retrieved from http://www.adoptionlearningpartners.org

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, N.J.: Erlbaum.

American Academy of Pediatrics. (2010) Section on adoption and foster care. Adoption directory membership list .Retrieved on July 8, 2014, from http://www.aap.org/en-us/professional-resources/publications-and-journals/Pages/Publications-and-Journals.aspx

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D.,…Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*, 174-186. http://dx.doi.org/10.1007/s00406-005-0624-4

Annie E. Casey Foundation. (2010) *Funding permanency services: A guide to leveraging federal, state, and local dollars*. Baltimore: Annie E Casey Foundation.

APAC-Alabama Post-Adoption Connections. (2010). Retrieved July 8, 2014, from http://www.casapac.org/index.shtml

Arizona Revised Statures. (2013). Retrieved from www.Azleg.gov

Aronson, J. (2010). Impact of adoption on adoptive parents. Retrieved from www.childwelfare.gov

Barth, R., & Berry, M. (1988). *Adoption and disruption: Rates, risks, and responses*. New York, NY: Aldine de Gruyter.

Barth, R., & Berry, M. (1994). Adoption of drug-exposed children. In R. P. Barth, J. D. Berrick, & N. Gilbert (Eds.). *Child welfare research review* (vol.1; pp. 273-294). New York, NY: Columbia University Press.

Barth, R. P., & Miller, J. M. (2000), Building effective post-adoption services: What is the empirical foundation? *Family Relations, 49,* 447–455. doi: 10.1111/j.1741-3729.2000.00447.x

Basit, T. N. (2003). Manual or electronic? The role of coding in qualitative data analysis. *Educational Research, 45*(2), 143-154. http://dx.doi.org/10.1080/0013188032000133548

Bernzies, K., & Mychasiuk, R. (2009). Fostering family resiliency: A review of the key protective factors. *Child & Family Social Work, 14*(1), 103-114.

Bertaux, D. (1981). From the life-history approach to the transformation of sociological practice. In D. Bertaux (Ed.), *Biography and society: The life history approach in the social sciences* (pp. 29-45). London, England: Sage.

Blaustein, M., & Kinniburgh, K. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. New York, NY: Guilford Press.

Booth. P. B., & Jernberg, A. M. (2010). *Theraplay: Helping parents and children build better relationships through attachment-based play* (3rd ed.). San Francisco, CA: John Wiley.

Borgatta, E. F., & Borgatta, R. V. (1992). Encyclopedia of sociology (Vol. 4). Retrieved from http://www.sesp.northwestern.edu/docs/publications/16511665225230b3b2ad63d.pdf

Bourdon, S. (2002). The integration of qualitative data analysis software in research strategies: Resistance and possibilities [30 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 3*(2), Art. 11, http://nbn-resolving.de/urn:nbn:de:0114-fqs0202118.

Bowlby, J. (1969). Attachment and loss. Retrieved from http://www.scribd.com/doc/46786672/Bowlby-1969-Attachment-and-Loss-Volume-1-Attachment

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment* (2nd. ed.). London, England: Hogarth Press.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation*. New York, NY: Basic.

Bowlby, J. (1988). *Secure base: Clinical applications of attachment theory*. London, England: Routledge.

Bretherton, I. (1992). The origins of attachment theory-psychology. *Developmental Psychology* (1992), 28, 759-775. Retrieve from http://www.psychology.sunysb.edu/attachment/online/inge_origins.pdf

Briere, J. (2005). *Trauma Symptom Checklist for Young Children (TSCYC*). Odessa, FL: Psychological Assessment Resources.

Briere, J. (1996). Trauma Symptom Checklist Children (TSCC). Odessa, FL: Psychological Assessment Resources.

Brodzinsky, D. M. (1990). A stress and coping model of adoption adjustment. *The Psychology of Adoption*, Vol. 3, No. 1, pp. 3-24.

Brodzinsky, D. M. (1992). The impact of family structure on the adjustment of adopted children. *Child Welfare, 71*(1), 69-76.

Brodzinsky, D. M., & Huffman, L. (1988). Transition to adoptive parenthood. *Marriage and Family Review, 12*, 267-286. http://dx.doi.org/10.1300/J002v12n03_13

Brodzinsky, D. M. (1993). Long-term outcomes in adoption. *The Future of Children*, *3*(1), 153-166. Retrieved from http://futureofchildren.org/futureofchildren/publications/docs/03_01_12.PDF

Brodzinsky, D. M., Smith, D. W., & Brodzinsky, A. B. (1998). *Children's adjustment to adoption: Developmental and clinical issues*. Thousand Oaks, CA: Sage.

Brodzinsky, D. M., & Phinderhughes, E. (2002). Parenting and child development in adoptive families. In M. Bornstein (Ed.), *Handbook of parenting.* Retrieved from http://www.adoptioninstitute.org/publications/2008_02_Parent_Preparation.pdf

Brodzinsky, D. M. (2005). Reconceptualizing openness in adoption: Implications for theory, research, and practice. *Psychological issues in adoption: Research and Practice*, 145-166.

Brodzinsky, D. M. (2008). Adoptive parent preparation: Meeting the mental health and developmental needs of adopted children. Retrieved July 4, 2014, from: www.adoptioninstitute.org/policy/2008_02parent_prep.php

Byrne, M. M. (2001). Evaluating the findings of qualitative research. *AORN Journal, 3,* 1-3. http://dx.doi.org/10.1016/S0001-2092 (06)61966-2

Casey Family Services. (2003). *Strengthening families and communities: Promising practices for adoption-competent mental health services.* A white paper. Retrieved from www.caseyfamilyservices.org/pdfs/casey_mhpaper_sum.pdf

Chambers, R., & Potter, C. (2009). A typology of family needs in child neglect cases. *Families in Society, 89*(5), 18-27.

Cherry, K. A. (2006). What is attachment theory? Retrieved from http://psychology.about.com/od/loveandattraction/a/attachment01.htm

Child Welfare Information Gateway. (2010). Impact of adoption on adoptive parents. Retrieved from www.childwelfare.gov

Child Welfare Information Gateway. (2011). Parenting after adoption. Retrieved from www.childwelfare.gov

Child Welfare Information Gateway. (2012). Finding and using postadoption services. Retrieved from www.childwelfare.gov

Child Welfare Information Gateway. (2012). *Foster parents considering adoption*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway. (2013). Disruption and dissolution in adoption. Retrieved from www.childwelfare.gov

Child Welfare Information Gateway. (2013). *Consent to adoption*. Washington, DC: US Department of Health and Human Services, Children's Bureau.

Children's Bureau. (2013). Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research

Chorpita, B. F., & Daleiden, E. L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trails. Jo*urnal of Counseling and Clinical Psychology, 77*(3), 566-579.

Combs, C. G. (1986). *Case note: Wrongful adoption: Adoption agency held liable for fraudulent representations: Burr v. Stark County Board of Commissioners, Ohio St. 3d 69 491 N. E. 2d 1101*. University of Cincinnati Law Review: University of Cincinnati

Cook, A., Spinnazzola, J., Ford, J. A. Lanktree, C., Blaustein, M., Cloitre, M. Van der kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric S Annals, 35*, 390-398.

Cradle. (2010). Post-adoption services. Retrieve July 2, 2014, from http://www.cradle.ord/postadopt_home.html

Creswell, J. W. (2002). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research*. Upper Saddle River, NJ: Merrill Prentice Hall.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed). Thousand Oaks, CA: Sage

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Los Angeles, CA: Sage.

Early Years Foundation. (2007). Child development overview. Retrieved from http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/eyfs_cards_0001207.pdf

Eth, S., & Pynoos, R. S. (1985). *Posttraumatic stress disorder in children (Progress inPsychiatry Series)*. Washington, DC: American Psychiatric Association

Evan B. Donaldson Adoption Institute. (2010). Keeping the promise: The critical need for post-adoption services to enable children and families to succeed. Retrieved from http://www.adoptioninstitute.org/research/2010 10 Family Education: http://life.familyeducation.com/adoption/adoptive-parents/45782html#ixzz2srEgs9bLhtml#ixzz2srEgs9bL

Family Preservation and Support Services Act of 1993, P. L. 103-66.

Fay, J., Fay, C., & Cline, F. (2010). *Becoming a love and logic parent curriculum.* Golden, CO: Love and Logic Institute.

Fellows, R. & Liu, A. (2008). *Research methods for construction*. New York, NY: John Wiley & Sons.

Festinger, T., & Maza, P. (2009). Displacement or post-adoption? A research note. *Journal of Public Child Welfare, 3*(3), 275-286. http://dx.doi.org/10.1080/15548730903129889

Finkelhor, D. (2009). Crimes against children. Retrieved from david.finkelhor@unh.edu

Finkelhor, D., Turner, H. A., Ormrod, R., & Hamby, S. L. (2009). Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics, 124,* 1411-1423. http://dx.doi.org/10.1542/peds.2009-0467

Finkelhor, D., Turner, H., Ormrod, R., & Hamby, S. L. (2010). Trends in childhood violence and abuse exposure: Evidence from 2 national surveys. *Pediatrics & Adolescent Medicine,* 238-242. http://dx.doi.org/10.1001/archpediatric.2009.283

Forbes, H., & Dziegielewski, S. F. (2003) Issues facing adoptive mothers of children with special needs. *Journal of Social Work, 3*(3), 301-320. Retrieved from http://www.beyondconsequences.com/issues.pdf

Fuller, T., Brulin, C., Cohen, L., Lis, M., Rollock, N., & Sheridan, K. (2006). Supporting adoptions and guardianships in Illinois: An analysis of subsidies, services and spending. Urbana-Champaign: University of Illinois. Retrieved July 11, 2014, from http://cfrc.illinois.edu/pubs/rp_20070901_ConditionsOfChildrenBH2006.pdf

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597-607.

Greely, H.T. (2001). Informed consent and other ethical issues in human population genetics. *Annual Review of Genetics, 35,* 785-800.

Grotevant, H. D. (2009). Emotional disturbance regulation over the life course in adoptive kinship networks. In G. M. Wrobel & E. Neil (Eds.), *International advances in adoption research for practice* (pp. 295-316). London, England: Wiley-Blackwell.

Grotevant, H., & McDermott, J. (2014). Adoption: biological and social process linked to adaptation. *Annual Review of Psychology, 65*(1), 235-65. doi: 10.1146/annurev-psych-010213-115020.

Groze, V. (1996a). A 1 and 2 year follow-up study of adoptive families and special needs children. *Children and Youth Services Review, 18*, 57-82. http://dx.doi.org/10.1016/0190-7409 (95)00054-2

Groze, V. (1996b). Successful adoptive families. Westport, CT: Praeger.

Groze, V., & Rosenthal, J. A. (1993). Attachment theory and the adoption of children with special needs. *Social Welfare Research and Abstracts, 29*(2), 5-12. http://dx.doi.org/10.1093/swra/29.2.5

Hartmann, A. (1984). *Working with adoptive families beyond placement*. New York, NY: Child Welfare League of America.

Hazan, C., & Zeifman, D. (1999). Pair bonds as attachments: Evaluating the evidence. In J. Cassidy and P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 336-354). New York, NY: Guilford Press.

Higgins, D. J., & McCabe, M. P. (2000). Multiple forms of child abuse and neglect: Adult retrospective reports. *Aggression and Violent Behavior 6*, 547–578. http://dx.doi.org/10.1016/S1359-1789(00)00030-6

Higgins, D. J., & McCabe, M. (2003). Maltreatment and family dysfunction in childhood and the subsequent adjustment of children and adults. *Journal of Family Violence, 18*(2), 107-120.

Hoepfl, M.C. (1997). Choosing qualitative research: A primer for technology education researchers. *Journal of Technology Education, 9*(1), 47-63.

Hushion, K., Sherman, S. B., & Siskind, D. (Eds.). (2006). *Understanding adoption: clinical work with adults, children, and parents*. Rowman & Littlefield.

Jacob, E., Miller, L. C., & Tirella, L. G. (2010). Developmental and behavioral performance of internationally adopted preschoolers: A pilot study. *Child Psychiatry & Human Development, 41*(1), 15-29.

James, B. (1994). *Handbook for treatment of attachment-trauma problems in children.* New York, NY: The Free Press.

Jones, J. (2009). Who adopts? *Characteristics of women and men who have adopted children*, NCHS Data Brief, No. 12. Center for Disease Control and Prevention. National Center for Health Statistics.

Jones, L. M., & Finkelhor, D. (2007). Updated trends in child maltreatment. Retrieved from http://www.unh.edu/ccrc/pdf/Updated%20Trends%20in%20Child%20Maltreatment%202007.pdf

Karen, R. (1998). *Becoming attached: First relationships and how they shape our capacity to love*. New York, NY: Oxford University Press.

Karp, C. L., & Butler, T. L. (1996). *Treatment strategies for abused children*: *From victim to survivor.* Thousand Oaks, CA: Sage Publications.

Karen, R. (1998). *Becoming attached: First relationships and how they shape our capacity to love*. New York, NY: Oxford University Press.

Keck, G. C., & Kupecky, R. M. (2009). *Parenting the hurt child: Helping adoptive families heal and grow.* Colorado Springs, CO; NavPress.

Lavner, J. A., Waterman, J., & Peplau (2014). Parent adjustment over time in gay, lesbian, and heterosexual parent families adopting from foster care. *American Journal of Orthopsychiatry, 84*(1), 46-53. doi.10.1037/h0098853

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Mapes, D. (2012). It takes more than love: What happens when adoption fails? *Today Moms*. Retrieved from http://www.today.com/moms/it-takes-more-love-what-happens-when-adoption-fails-918076

Marshall, M.N. (1996). Sampling for qualitative research. *Family Practice*, *13*(3), 522-525. http://dx.doi.org/10.1093/fampra/13.6.522

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131-149. http://dx.doi.org/10.1007/BF00975140

McCaslin, M., & Scott, K.W. (2003). The five-question method for framing a qualitative research study. *The Qualitative Report*, *8*(3), 447-461.

McCormick, J., & Wingert, P. (1991). Whose child am I anyway? *Newsweek*. P58.

McDonald, T. P., Propp, J. R., & Murphy, K. (2001). The postadoption experience: Child, parent, and family predictors of family adjustment to adoption. *Child Welfare. Child Welfare League of America.* Retrieved from http://www.highbeam.com/doc/1P3-67282959.htm

Meyers, J. E. B, (2011) The APSAC Handbook on child maltreatment (3rd ed., pp. 3-97). Thousand Oaks, CA: Sage.

Metz, E. C., & McCall, R. B. (2010). Behavior problems in children adopted from psychosocially depriving institutions. *Journal of Abnormal Child Psychology, 38*(4), 459-470.

McGlone, K., Santos, L., Kazama, L., Fong, R., & Mueller, C. (2003). *Developmental disabilities: Theory, research, and intervention*. New York, NY: Praeger.

Merriam, S.B. (1998). Qualitative *research and case study applications in education*. San Francisco, CA: Jossey -Bass Publishers.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation.* San Francisco, CA: Jossey-Bass.

Morse, J. M. (1994). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 220-35). Thousand Oaks, CA: Sage.

National Child Traumatic Stress Network. (2012). The 12 core concepts: Concerns for understanding traumatic stress responses in children and families. Retrieved from www.nctsnet.org

National Child Traumatic Stress Network. (2005). Understanding child traumatic stress. Retrieved from www.nctsnet.org

New Jersey Adoption Resource Clearing House. (2010). Retrieved from http://www.njarch.org

North American Council on Adoptable Children. (2009). Developing a parent-to-parent support network. Retrieved July 10, 2014, from: http://www.nacac.org/adoptalk/parent2parentnetwork.pdf

Palacios, J., Wrobel, G. M., & Neil, E. (2009). The ecology of adoption. *International advances in adoption research for practice*, 71-94.

Patton, M. Q. (1990). *Qualitative evaluation methods* (2nd ed.). Thousand Oaks, CA: Sage.

Paulsen, C., & Merighi, J. (2009). Adoption preparedness, cultural engagement, and parental satisfaction in inter-country adoption. *Adoption Quarterly, 12*(1), 1-18.

Petra, M., & Kohl, P. (2010). Triple P and the child welfare system: A promising fit. *Children and Youth Services Review, 32*, 611-618. http://dx.doi.org/10.1016/j.childyouth.2009.12.008

Pickert, K., & Shuster, S. (2010). When the adopted can't adapt. *Time International (South Pacific Edition, 17*6(2), 22-27.

Post, B. (2006). The adopted child: Trauma and its impact. Retrieved from http://www.streetdirectory.com/travel_guide/201812/child_adoptions/the_adopted_child_trauma_and_its_impact.htm

Post, B. (2013). The adopted child: Trauma and its impact. Retrieved from http://postinstitute.com/blog/2013/11/06/the-adopted-child-trauma-and-its-impact-bryan-post/

Prinz, R. (2009). Dissemination of a multilevel evidence based system of parenting interventions with broad application to child welfare populations. *Child Welfare, 88*(1), 127-132.

Randall, J. (2009). Towards a better understanding of the needs of children currently adopted from care: An analysis of placements 2003-2006. *Adoption & Fostering, 33*(1), 44-55.

Robison, M., Lindeman, S. L., Clemmons, M. P., Doyle-Buckwalter, K., & Ryan, M. (2009). I deserve a family ll: The evolution of an adolescent's behavior and beliefs about himself and others when treated with therapy in residential care. *Child and Adolescent Social Work Journal, 26*(4), 291-306.

Rosenberg, M. B. (1989). *Growing up adopted*. New York: Bradbury Press.

Ruggiero, J. A. (2010). When adoption isn't easy. *Newsweek, 15*5(17), 14.

Rushton, A., & Monck, E. (2009). Adopters' experiences of preparation to parent children with serious difficulties. *Adoption & Fostering, 33* (2), 4-12.

Sabol, W., Coulton, C., & Polousky, E. (2004). Measuring child maltreatment risk in communities: A life table approach. *Child Abuse & Neglect, 28*(9), 967-983. http://dx.doi.org/10.1016/j.chiabu.2004.03.014

Schore, A. N. (2003a). *Affect dysregulation and disorders of the self.* New York, NY: Norton.

Schore, A. N. (2003b). *Affect regulation and the repair of the self*. New York, NY: Norton.

Schulte, B. (2013). Child abuse's long-lasting effects. *Arizona Daily Star*: Washington Post

Shaver, P. R., & Mikulincer, M. (2002.) Adult attachment strategies and regulation of emotion. Retrieved from http://1st-socrates.berkeley.edu:bobley/images/affective%20science%20readings/Shaver/20100309110651377pdf

Smith, S. (2010). Keeping the promise: The critical need for post-adoption services to enable children and families to succeed. Evan B. Donaldson Adoption Institute. Retrieved from http://adoptioninstitute.org/pubs_cat/adoption-support-and-preservation

Smith, S. (2012). New: Untangling the web; the Internet's transformative impact on adoption. Evan B. Donaldson Adoption Institute. Retrieved from http://adoptioninstitute.org/pubs_

Smith, S. (2012). The vital role of adoption subsidies: Increasing permanency and improving children's lives. Evan B. Donaldson Adoption Institute. Retrieved from http://adoptioninstitute.org/pubs_keeping the promise

Smith, S. (2011). Expanding resources for children III: Research based best practices in adoption by gays and lesbians. Evan B. Donaldson Adoption Institute. Retrieved from http://adoptioninstitute.org/pubs_cat/adoption-support-and-preservation

Sonkin, D. J., & Durphy, M. (1997). *Learning to live without violence: A handbook for men* (Rev. Ed.). Volcano, CA: Volcano Press.

Sonkin, D. J. (1999). *Domestic violence and attachment theory: Clinical application to treatment with perpetrators*. Volcano, CA: Volcano Press.

Spangler, G., Johann, M., Ronai, Z., & Zimmermann, P. (2009). Genetic and environmental influence on attachment disorganization. *Journal of Child Psychology and Psychiatry, 50* (8), 952-961. http://dx.doi.org/10.1111/j.1469-7610.2008.02054.x

Strengthening Families and Communities: Promising Practices for Adoption-Competent Mental Health services. (2003). A white paper. Retrieved from www.caseyfamilyservices.org/pdfs/casey_mhpaper_sum.pdf

Terr, L. (1992). *Too scared to cry: Psychic trauma in childhood.* New York, NY: Basic Books.

U.S. Department of Health and Human Services: Adoption Assistance and Child Welfare Act of 1980. (2010. Retrieved from https://www.childwelfare.gov/systemwide/laws_policies/federal/index.cfm?event=federalLegislation.viewLegis&id=22

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *The adoption and foster care analysis and reporting system (AFCARS)* report - no. 20. Retrieved from www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf

Wegar, K. (2000). Adoption, family ideology, and social stigma: Bias in community attitudes, adoption research, and practice. *Family Relations, 49*, 363–369. doi: 10.1111/j.1741-3729.2000.00363.x

Wilke-Deaton, J. (2005). Attachment and bonding: *Effective strategies that work.* Eau Claire, WI: Pesi HealthCare.

World Association for Children and Parents. (2012). WACAP named 2012 Evergreen Award Winner: Retrieved from www.wacap.org

Wulczyn, F. (2003). Closing the gap: Are changing exit patterns reducing the time African American children spend in foster care relative to Caucasian children? *Children and Youth Services Review*, *25*(5/6), 431-462. http://dx.doi.org/10.1016/S0190-7409 (03)00030-6

Wulczyn, F. (2004). Family reunification. *The Future of Children*, *14*(1), 95-110. http://dx.doi.org/10.2307/1602756

Wulczyn, F. 2009. Epidemiological perspectives on maltreatment prevention. *The Future of Children*, *19*(2), pp. 39-66.

Appendix A: Consent Form

You are invited to take part in a research study of understanding the challenges that adoptive families face after adopting a child who has experienced trauma. The study looks to gain insight from the adoptive parent's perspective in order to open the door for research to find ways in addressing these concerns. The impact of this research could cause social change within the area of adoption services. The researcher is inviting adults ages 24 to 75 who have adopted traumatized children from the public welfare system to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part. Individuals under 24; Individuals currently undergoing therapy for traumatic experiences, mental or emotional health services, and women who are pregnant do not qualify to be in this current study.

This study is being conducted by a researcher named Jacqueline Y Ford, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to understand the challenges adoptive families face after adopting a child who has experienced trauma.

Procedures:

If you agree to be in this study, you will be asked to:

- Meet with the researcher for about 15 to 30 minutes to learn more about the study
- Sign consent forms (this is done after learning more about the study)
- Take a 15 to 30 minute parental survey/assessment called Trauma Symptom Checklist which assesses various levels of trauma in children/adolescents.
- Submit to confidentially recorded interview (can take up to 2 to 3 hours depending on responses)
- Meet again with the researcher at a later date for verification of transcribe information received from the initial recorded interview

Here are some sample questions:

IQ1- How do you as an adoptive parent of a child who has experienced trauma describe the training that you received before you adopted your child?

1Q2- Do you, as an adoptive parent believe that specialize training significantly benefits in aiding your child's adjustment in their new home? If so, how?

1Q3-What unique challenges have you faced by adopting a child who has experienced trauma?

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Grace to the Nations Church or Loving Hearts Foster Care Agency will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during or after the study. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue, stress or becoming upset. Being in this study would not pose risk to your safety or wellbeing

The benefits of the study could help to improve post-adoption services and subsidies in the home, school and community settings.

Payment:

There is no financial payment for being in the study.

Privacy:

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure once gathered and scanned on to a flash drive that will be locked in a safe deposit box once the study is completed. Data will be kept for a period of at least 5 years, as required by the university.

Confidentiality:

Adoptive parents of children who have experienced trauma may indeed have knowledge of prior unreported abuse. As a mandated reporter I am obligated to report it. I do know that I have 48 hours to report in. If something comes up during the interview, I would make time after the interview to sit and call the Department of Child Safety (DCS) with you, the parent. I would also encourage you to talk with your therapist or adoption subsidy worker about their recent discovery. I will attach the required written report to the file and hold it along with all raw data documents for the required 5 years. After the five years have passed, this document will be destroyed with the others.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via Jacqueline Y. Ford at [redacted] or Jacqueline.ford@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative

who can discuss this with you. Her phone number is 1-800-925-3368, extension 1210. Walden University's approval number for this study is **10-14-14-0142620** and it expires on **October 13, 2015.**

The researcher will give you a copy of this form to keep. (Face-to-face research)

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant

_____

Date of Consent

_____

Participant's Signature

_____

Researcher's Signature

_____

Appendix B: Trauma Symptom Checklist for Young Children

Item Booklet

John Briere, PhD

Please read all of these instructions carefully before beginning. Mark all of your answers on the accompanying Answer Sheet and write only where indicated. DO NOT write in this Item Booklet.

On the Answer Sheet, please write the date and the child's name, gender, race, age, and living situation in the spaces provided. Also, please write your name, your gender, and your relationship to the child in the spaces provided.

The following items have to do with things the child does, feels, or experiences. Please indicate how often each of the following things has happened **in the last month**.

Circle 1 if your answer is *Not At All*; it has not happened at all in the last month.	(1) 2 3 4
Circle 2 if your answer is *Sometimes*; it has happened in the last month, but has not happened often.	1 (2) 3 4
Circle 3 if your answer is *Often*; it has happened often in the last month.	1 2 (3) 4
Circle 4 if your answer is *Very Often*; it has happened very often in the last month.	1 2 3 (4)

If you make a mistake or change your mind, **DO NOT ERASE!** Make an "X" through the incorrect response and then draw a circle around the correct response.

Example: 1 (~~2~~) 3 (4)

Please answer each item as honestly as you can. Be sure to answer every item. You can take as much time as you need to finish all of the items.

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1	2	3	4
Not At All	Sometimes	Often	Very Often

The following items have to do with things the child does, feels, or experiences. Please indicate how often he or she has done, felt, or experienced each of the following things **in the last month**.

1. Temper tantrums
2. Looking sad
3. Telling a lie
4. Bad dreams or nightmares
5. Living in a fantasy world
6. Seeming to know more about sex than he or she should
7. Being easily scared
8. Not wanting to go somewhere that reminded him or her of a bad thing from the past
9. Worrying that his or her food was poisoned
10. Flinching or jumping when someone moved quickly or there was a loud noise
11. Being bothered by memories of something that happened to him or her
12. Worrying that someone might be sexual with him or her
13. Not wanting to talk about something that happened to him or her
14. Not doing something he or she was supposed to do
15. Breaking things on purpose
16. Talking about sexual things
17. Having trouble concentrating
18. Blaming himself or herself for things that weren't his or her fault
19. Acting frightened when he or she was reminded of something that happened in the past
20. Pretending to have sex
21. Worrying that bad things would happen in the future
22. Arguing
23. Getting into physical fights
24. Drawing pictures about an upsetting thing that happened to him or her
25. Not noticing what he or she was doing
26. Having trouble sitting still
27. Playing games about something bad that actually happened to him or her in the past
28. Seeming to be in a daze
29. Having trouble remembering an upsetting thing that happened in the past
30. Using drugs
31. Fear of the dark
32. Being afraid to be alone
33. Spacing out
34. Being too aggressive
35. Touching other children's or adults' private parts (under or over clothes)

1	2	3	4
Not At All	Sometimes	Often	Very Often

Please indicate how often the child has done, felt, or experienced each of the following things **in the last month**.

36. Suddenly seeing, feeling, or hearing something bad that happened in the past
37. Hearing voices telling him or her to hurt someone
38. Staring off into space
39. Changing the subject or not answering when he or she was asked about a bad thing that happened to him or her
40. Having a nervous breakdown
41. Not laughing or being happy like other children
42. Crying at night because he or she was frightened
43. Hitting adults (including parents)
44. Being frightened of men
45. Not being able to pay attention
46. Seeming to be a million miles away
47. Being easily startled
48. Watching out everywhere for possible danger
49. No longer doing things that he or she used to enjoy
50. Becoming frightened or disturbed when something sexual was mentioned or seen
51. Not sleeping for two or more days
52. Not paying attention because he or she was in his or her own world
53. Making mistakes
54. Crying for no obvious reason
55. Not wanting to be around someone who did something bad to him or her or reminded him or her of something bad
56. Being tense
57. Worrying about other people's safety
58. Becoming very angry over a little thing
59. Drawing pictures about sexual things
60. Pulling his or her hair out
61. Calling himself or herself bad, stupid, or ugly
62. Throwing things at friends or family members
63. Getting upset about something in the past
64. Temporary blindness or paralysis
65. Getting upset about something sexual
66. Not going to bed at night the first time he or she was asked
67. Fear that he or she would be killed by someone
68. Saying that nobody liked him or her
69. Crying when he or she was reminded of something from the past

1	2	3	4
Not At All	Sometimes	Often	Very Often

Please indicate how often the child has done, felt, or experienced each of the following things **in the last month**.

70. Saying that something bad didn't happen to him or her even though it did happen
71. Saying he or she wanted to die or be killed
72. Acting as if he or she didn't have any feelings about something bad that happened to him or her
73. Whining
74. Not sleeping well
75. Worrying about sexual things
76. Being frightened by things that didn't used to scare him or her
77. Hallucinating
78. Acting like he or she was in a trance
79. Forgetting his or her own name
80. Getting upset when he or she was reminded of something bad that happened
81. Avoiding things that reminded him or her of a bad thing that had happened in the past
82. Acting jumpy
83. Making a mess
84. Acting sad or depressed
85. Being so absent-minded that he or she didn't notice what was going on around him or her
86. Not wanting to eat certain foods
87. Yelling at family, friends, or teachers
88. Not playing because he or she was depressed
89. Being disobedient
90. Intentionally hurting other children or family members

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Answer Sheet

John Briere, PhD

Date: ___/___/___

Child's name: _____ Child's gender: ☐ Male ☐ Female Child's race: _____

Child's age: _____ Child's living situation: ☐ Home ☐ Residential center ☐ Other (*describe*) _____

Rater's name: _____ Rater's gender: ☐ Male ☐ Female

Rater's relationship to child: ☐ Biological parent ☐ Adoptive parent ☐ Foster parent ☐ Other legal guardian
☐ Residential childcare worker ☐ Other (*describe*) _____

1. Does this child live with you? ☐ Yes ☐ No If yes, how long has he/she lived with you? _____years _____months
2. On average, how many hours do you spend in the same place (for example, at home) with him/her each week, not counting when he/she is asleep?
   ☐ 0-1 hr. ☐ 2-5 hrs. ☐ 6-10 hrs. ☐ 11-20 hrs. ☐ 21-40 hrs. ☐ 41-60 hrs. ☐ Over 60 hrs.

Fill in the information above. Follow the instructions in the TSCYC Item Booklet and enter your ratings on this sheet. Indicate your ratings by circling the appropriate number for each item.

1 Not At All — 2 Sometimes — 3 Often — 4 Very Often

1	1 2 3 4	19	1 2 3 4	37	1 2 3 4	55	1 2 3 4	73	1 2 3 4
2	1 2 3 4	20	1 2 3 4	38	1 2 3 4	56	1 2 3 4	74	1 2 3 4
3	1 2 3 4	21	1 2 3 4	39	1 2 3 4	57	1 2 3 4	75	1 2 3 4
4	1 2 3 4	22	1 2 3 4	40	1 2 3 4	58	1 2 3 4	76	1 2 3 4
5	1 2 3 4	23	1 2 3 4	41	1 2 3 4	59	1 2 3 4	77	1 2 3 4
6	1 2 3 4	24	1 2 3 4	42	1 2 3 4	60	1 2 3 4	78	1 2 3 4
7	1 2 3 4	25	1 2 3 4	43	1 2 3 4	61	1 2 3 4	79	1 2 3 4
8	1 2 3 4	26	1 2 3 4	44	1 2 3 4	62	1 2 3 4	80	1 2 3 4
9	1 2 3 4	27	1 2 3 4	45	1 2 3 4	63	1 2 3 4	81	1 2 3 4
10	1 2 3 4	28	1 2 3 4	46	1 2 3 4	64	1 2 3 4	82	1 2 3 4
11	1 2 3 4	29	1 2 3 4	47	1 2 3 4	65	1 2 3 4	83	1 2 3 4
12	1 2 3 4	30	1 2 3 4	48	1 2 3 4	66	1 2 3 4	84	1 2 3 4
13	1 2 3 4	31	1 2 3 4	49	1 2 3 4	67	1 2 3 4	85	1 2 3 4
14	1 2 3 4	32	1 2 3 4	50	1 2 3 4	68	1 2 3 4	86	1 2 3 4
15	1 2 3 4	33	1 2 3 4	51	1 2 3 4	69	1 2 3 4	87	1 2 3 4
16	1 2 3 4	34	1 2 3 4	52	1 2 3 4	70	1 2 3 4	88	1 2 3 4
17	1 2 3 4	35	1 2 3 4	53	1 2 3 4	71	1 2 3 4	89	1 2 3 4
18	1 2 3 4	36	1 2 3 4	54	1 2 3 4	72	1 2 3 4	90	1 2 3 4

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TSCYC Scoring Worksheet

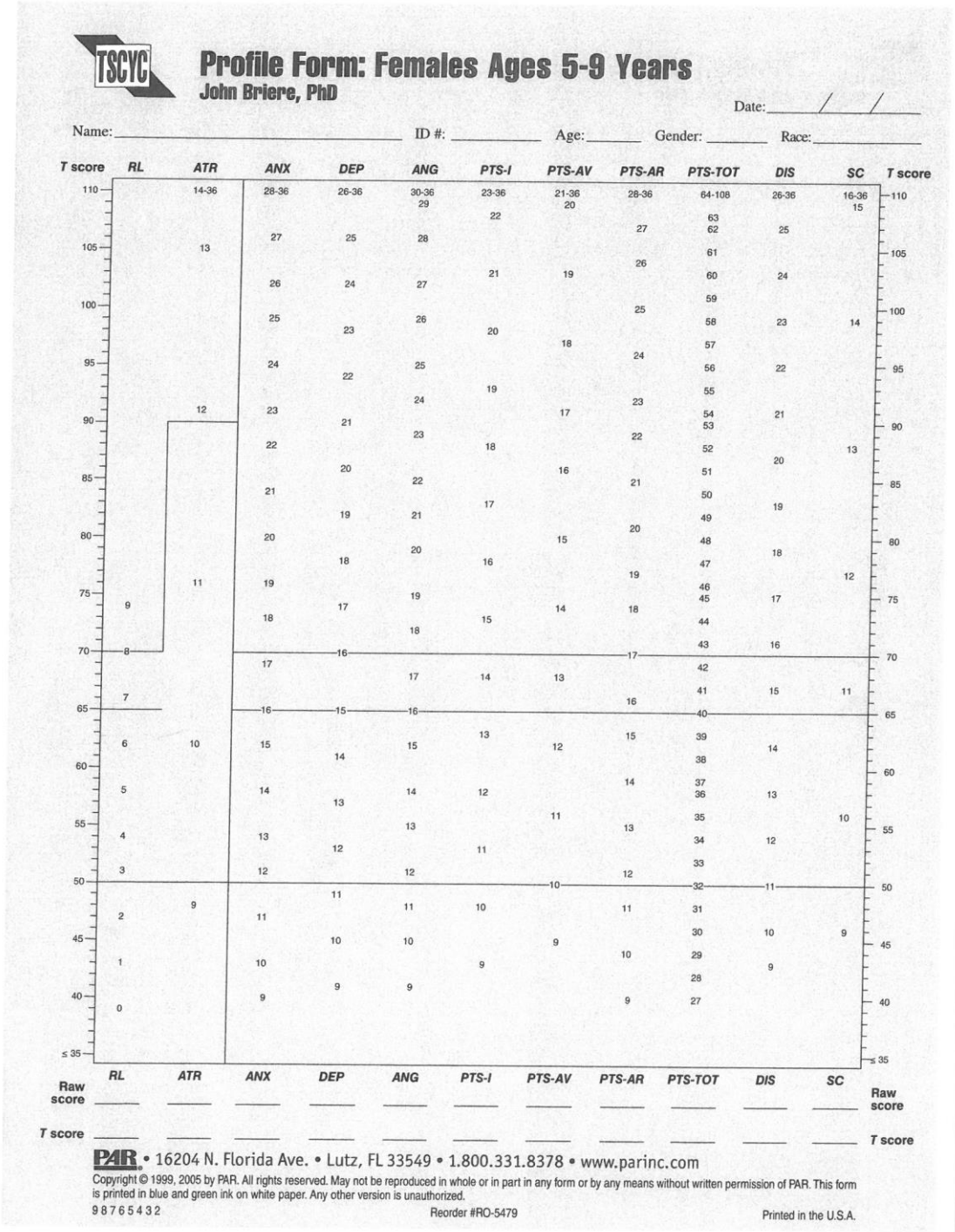
													Raw score
RL	3 ___	14 ___	22 ___	53 ___	66 ___	73 ___	83 ___	86 ___	89 ___	†Sum =	___ *RL*
ATR	9 ___	30 ___	37 ___	40 ___	51 ___	60 ___	64 ___	77 ___	79 ___	Sum =	___ *ATR*
ANX	7 ___	21 ___	31 ___	32 ___	42 ___	44 ___	57 ___	67 ___	76 ___	Sum =	___ *ANX*
DEP	2 ___	18 ___	41 ___	54 ___	61 ___	68 ___	71 ___	84 ___	88 ___	Sum =	___ *DEP*
ANG	1 ___	15 ___	23 ___	34 ___	43 ___	58 ___	62 ___	87 ___	90 ___	Sum =	___ *ANG*
PTS-I	4 ___	11 ___	19 ___	24 ___	27 ___	36 ___	63 ___	69 ___	80 ___	Sum =	___ *PTS-I*
PTS-AV	8 ___	13 ___	29 ___	39 ___	49 ___	55 ___	70 ___	72 ___	81 ___	Sum =	___ *PTS-AV*
PTS-AR	10 ___	17 ___	26 ___	45 ___	47 ___	48 ___	56 ___	74 ___	82 ___	Sum =	___ *PTS-AR*
PTS-TOT					*PTS-I* ___		*PTS-AV* ___		*PTS-AR* ___	Sum =	___ *PTS-TOT*
DIS	5 ___	25 ___	28 ___	33 ___	38 ___	46 ___	52 ___	78 ___	85 ___	Sum =	___ *DIS*
SC	6 ___	12 ___	16 ___	20 ___	35 ___	50 ___	59 ___	65 ___	75 ___	Sum =	___ *SC*

†Count the number of 1's circled.

PTSD Diagnosis Worksheet

PTSD is possibly present if each of the following criteria are met:

	Criterion met?
1. The child is age 5 years or older.	No ☐ Yes ☐
2. He or she: a. was exposed to a traumatic event (including child abuse) that involved actual or threatened death or serious injury, or some other threat to his or her physical integrity, **OR** b. witnessed a similar trauma happening to someone else, **OR** c. was exposed to a developmentally inappropriate sexual experience (e.g., childhood sexual abuse), even if there was no threat to physical integrity.	No ☐ Yes ☐
3. The event occurred at least 1 month ago.	No ☐ Yes ☐
4. The child either: a. reported or appeared to experience fear, helplessness, or horror during or soon after the event, **OR** b. demonstrated disorganized or agitated behavior, even in the absence of self-reported or observed emotional distress.	No ☐ Yes ☐
5. The parent/caretaker endorses a *PTS-TOT* raw score of **40 or greater**.	No ☐ Yes ☐
6. The child's posttraumatic symptoms appear to cause clinically significant distress or impairment in social, school, or other important areas of functioning.	No ☐ Yes ☐
Are all of the criteria met?	**Yes ☐ Possible PTSD** **No ☐ PTSD Less Likely**


TSCYC
Profile Form: Females Ages 5-9 Years
John Briere, PhD
Date: / /
Name: ID #: Age: Gender: Race:
T score RL ATR ANX DEP ANG PTS-I PTS-AV PTS-AR PTS-TOT DIS SC T score
110 105 100 95 90 85 80 75 70 65 60 55 50 45 40 ≤ 35
RL ATR ANX DEP ANG PTS-I PTS-AV PTS-AR PTS-TOT DIS SC
Raw score
T score
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Appendix C: Recruitment Flyer

ADULT VOLUNTEERS NEEDED FOR
RESEARCH STUDY ON
Challenges of Child Trauma on Adoptive Family's Social and Emotional System

Jacqueline Y. Ford, a doctoral student at Walden University, is conducting this research study as a part of her doctoral degree requirement. We are looking for adults who have adopted children from the foster care system. Volunteers will be interviewed on the challenges that they have experienced with their adopted child. The researcher desires to hear the parents' perspective on the challenges that they faced with adopting a child who has experienced trauma. As a participant in this study, you would be asked to: recall some memories from your experience in raising your adopted child and answer a few questions about them. The study will take approximately 1 to 2 hours for you complete depending on your responses.

If you are interested, please inquire here. Jacqueline.ford@waldenu.edu or [redacted]

Thank you!

This study has been reviewed and approved by the Research Ethics Review Board, Walden University Walden University's approval number for this study is 10-14-14-0142620 and it expires on October 13, 2015

Appendix D: Research Interview Questions

IQ1- How do you as an adoptive parent of a child who has experienced trauma describe the training that you received before you adopted your child?

1Q2- Do you, as an adoptive parent believe that specialize training significantly benefits in aiding your child's adjustment in their new home? If so, how?

1Q3-What unique challenges have you faced by adopting a child who has experienced trauma?

1Q4= How do you, as an adoptive parent go about finding supportive resources or training in order to help your child adjust in their new home?

1Q5- How do you describe your adopted child's stability or adjustment in their new home?

1Q6-How do you, as an adoptive parent view post adoptive treatment/services and do you find it to be essential in your family maintain permanency with your adopted children?

IQ7–What trauma symptoms have you as adoptive parents recognize in your adopted children if any? What affect have these symptoms had on developing a healthy attachment with the child? Do you consider these symptoms to be challenging? If so please explain? If not explain why not?

IQ8—Adoption in itself can be rewarding, what rewards have you as adoptive parents experienced in adopting a child who has been traumatized? And what affects has the adoption had on your family?

1Q9-What types of treatment or services do you feel are essential to have in place in order for your child to adjust in their new environment?

Research Question –con-

IQ10–Explain what you have learned about permanency and its effects on the family unit when the challenges associated with your adoption decision.

IQ11-What seems to be the most important goal that you have for your child as a member of your family unit?

IQ12-Explain what you have experienced in regards to not being the biological parent?

IQ13-Describe the child's temperament and how the child relates to their new family members.

IQ14-Did the birth order change? If so what challenges, if any, came about and how did this affect the sibling relationship?

IQ15If there are other children in the home, how do you encourage healthy relationships between them?

IQ16 –What information were you given in order to assist you in the decision making process in committing to adopting your child?

Priori of Interview Questions

Attachment

1Q5- How do you describe your adopted child's stability or adjustment in their new home?

IQ7–What trauma symptoms have you as adoptive parents recognize in your adopted children if any? What affect have these symptoms had on developing a healthy attachment with the child? Do you consider these symptoms to be challenging? If so please explain? If not explain why not?

IQ8—Adoption in itself can be rewarding, what rewards have you as adoptive parents experienced in adopting a child who has been traumatized? And what affects has the adoption had on your family?

IQ11-What seems to be the most important goal that you have for your child as a member of your family unit?

IQ12-Explain what you have experienced in regards to not being the biological parent?

IQ15If there are other children in the home, how do you encourage healthy relationships between them?

Permanency

1Q2- Do you, as an adoptive parent believe that specialize training significantly benefits in aiding your child's adjustment in their new home? If so how?

1Q4= How do you, as an adoptive parent go about finding supportive resources or training in order to help your child adjust in their new home?

1Q5- How do you describe your adopted child's stability or adjustment in their new home?

1Q6-How do you, as an adoptive parent view post adoptive treatment/services and do you find it to be essential in your family maintain permanency with your adopted children?

IQ8—Adoption in itself can be rewarding, what rewards have you as adoptive parents experienced in adopting a child who has been traumatized? And what affects has the adoption had on your family?

1Q9-What types of treatment or services do you feel are essential to have in place in order for your child to adjust in their new environment?

IQ10–Explain what you have learned about permanency and its effects on the family unit when the challenges associated with your adoption decision.

IQ11-What seems to be the most important goal that you have for your child as a member of your family unit?

IQ14-Did the birth order change? If so what challenges, if any, came about and how did this affect the sibling relationship?

IQ15If there are other children in the home, how do you encourage healthy relationships between them?

IQ16 –What information were you given in order to assist you in the decision making process in committing to adopting your child?

Decision Making

IQ1- How do you as an adoptive parent of a child who has experienced trauma describe the training that you received before you adopted your child?

1Q3-What unique challenges have you faced by adopting a child who has experienced trauma?

1Q6-How do you, as an adoptive parent view post adoptive treatment/services and do you find it to be essential in your family maintain permanency with your adopted children?

IQ8—Adoption in itself can be rewarding, what rewards have you as adoptive parents experienced in adopting a child who has been traumatized? And what affects has the adoption had on your family?

IQ10–Explain what you have learned about permanency and its effects on the family unit when the challenges associated with your adoption decision.

IQ16 –What information were you given in order to assist you in the decision making process in committing to adopting your child?

Understanding Endured Trauma

IQ1- How do you as an adoptive parent of a child who has experienced trauma describe the training that you received before you adopted your child?

1Q2- Do you, as an adoptive parent believe that specialize training significantly benefits in aiding your child's adjustment in their new home? If so how?

1Q3-What unique challenges have you faced by adopting a child who has experienced trauma?

1Q4= How do you, as an adoptive parent go about finding supportive resources or training in order to help your child adjust in their new home?

1Q5- How do you describe your adopted child's stability or adjustment in their new home?

IQ7–What trauma symptoms have you as adoptive parents recognize in your adopted children if any? What affect have these symptoms had on developing a healthy attachment with the child? Do you consider these symptoms to be challenging? If so please explain? If not explain why not?

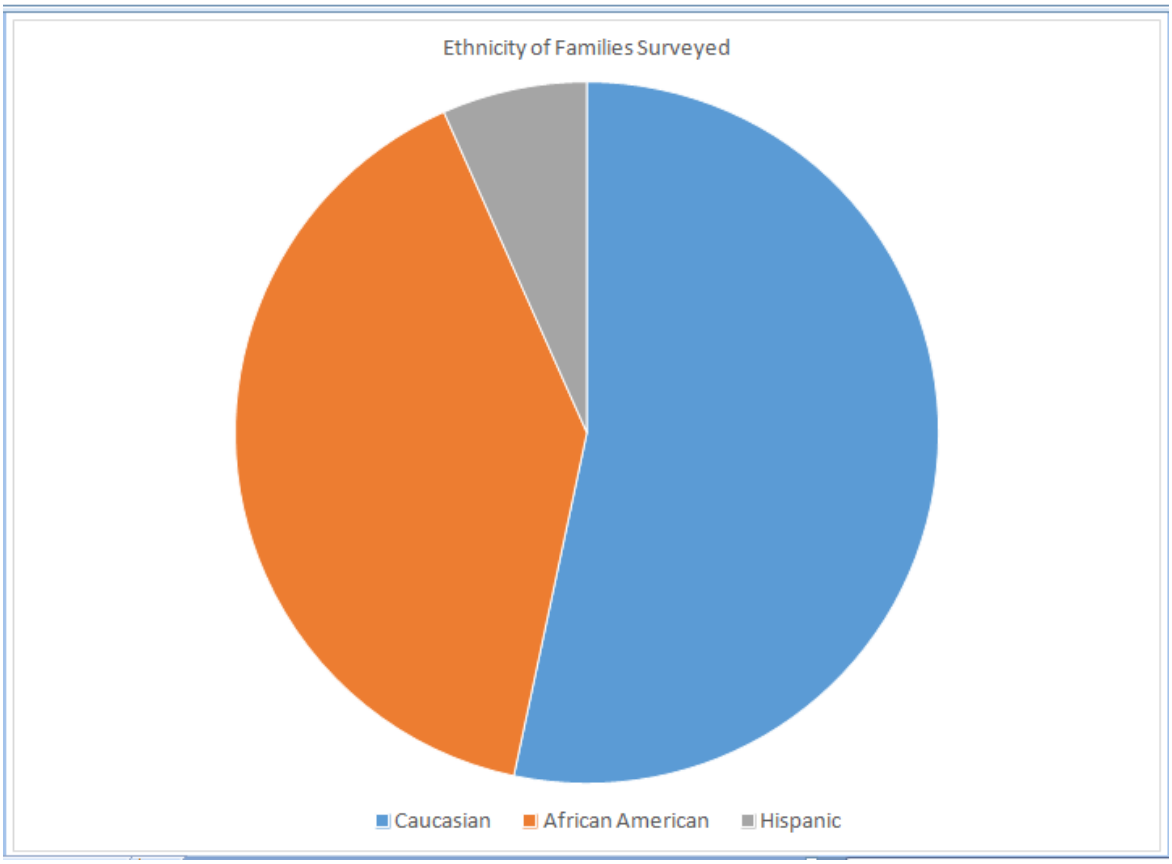
IQ8—Adoption in itself can be rewarding, what rewards have you as adoptive parents experienced in adopting a child who has been traumatized? And what affects has the adoption had on your family?

1Q9-What types of treatment or services do you feel are essential to have in place in order for your child to adjust in their new environment?

IQ12-Explain what you have experienced in regards to not being the biological parent?

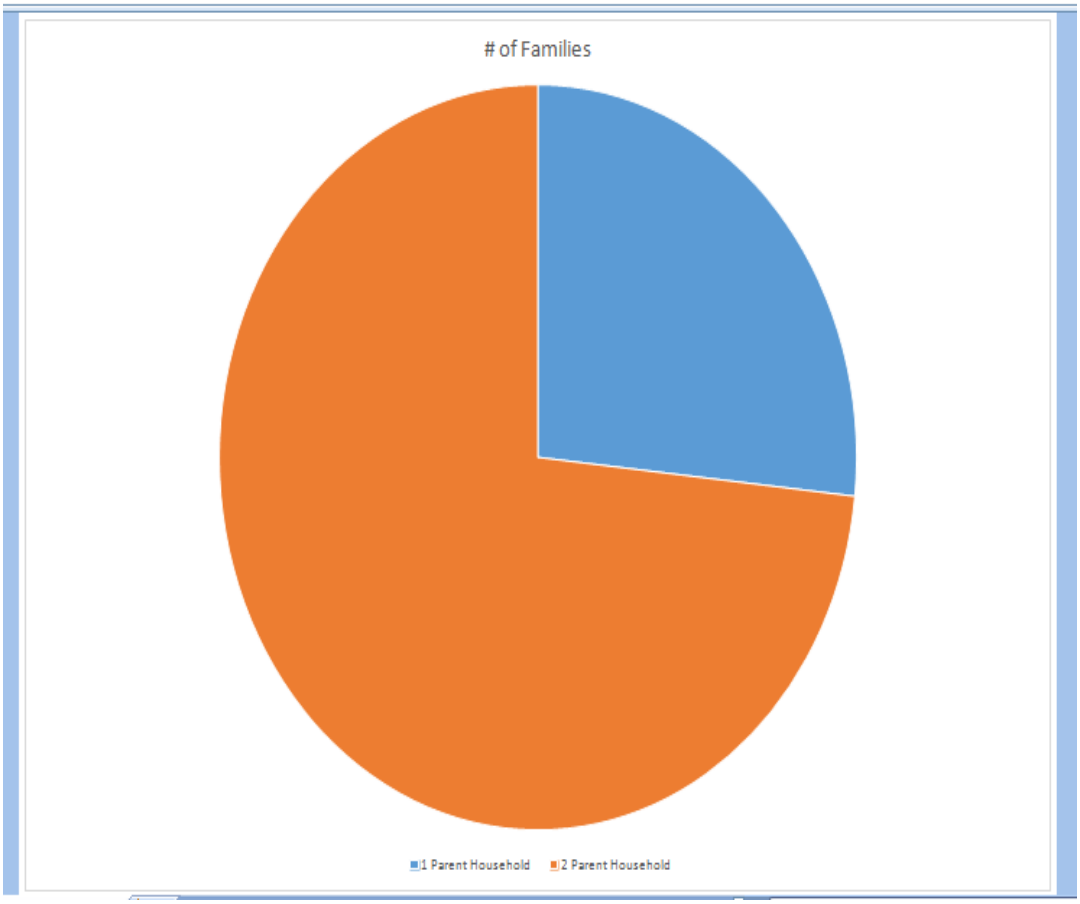
IQ13-Describe the child's temperament and how the child relates to their new family members.

Appendix E: Ethnicity Demographics



Ethnicity	# of Families
Caucasian	8

African American	6



Household	# of Families
1 Parent Household	4
2 Parent Household	11

Appendix F: Peer Reviews Comments

These are brief comments from the peer reviewers. The researcher met with the reviewers to discuss the findings which were derived from the interviews after each individual had independently analyzed the transcripts.

Dr. Marion A. Baker, Psy.D.

Marion Baker No v 2

to me

These are great. You have your answers

Major Themes:
Basic training to no training at all these parents sought out information through friends
Parents were able to recognize the trauma symptoms in their children but they were also able to understand that the behaviors are unmanaged behaviors
Self-advocating using means of online search and books
Really no information was received in assisting them in the adoption decision/process

Brittany Canfield, MS.

Brittany Canfield No v 1

to me

Thank you for sending the most recent document, it was much easier to read and to follow so that I could analyze the information.

Major Themes:

Little to no training
Recognition of trauma symptoms through unmanaged behaviors
Little to no information assisting the adoption decision/process
Self-advocating using means of online search and books

There was a great range of information and described so differently from one another that it was difficult to tease out themes. Much of the content was generally the same. It appears that an overall theme is that these families, through self-avocation, define what is occurring in their homes and internally in their own unique ways. This being a direct

result of having little to no information or training on how to understand the ways in which their homes, families, and internal lives have changed.