Adoption 101

North American Council on Adoptable Children
970 Raymond Avenue, Suite 106
St. Paul, MN 55114-1149
651-644-3036 FAX 651-644-9848
www.nacac.org • info@nacac.org

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This adoption awareness curriculum has been designed to help adoptive parent group leaders and others train child welfare, medical, legal, education, and mental health professionals, and other community members to be more responsive to the needs of adopted children and to work more effectively with their families.

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Diane Martin-Hushman, Parent Group Coordinator
hushman@nacac.org

Janet Jerve, Writer/Editor
janetjerve@nacac.org

Adoption 101
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Introduction

Purpose of the Training

The purpose of the Adoption 101 curriculum is to give child welfare, medical, legal, education, and mental health professionals, and others in the community a deeper understanding of adoption, most specifically the adoption of children from the child welfare system who have special needs.

This curriculum was developed to provide adoption advocates with the necessary tools to lead an adoption competency training in their community. The material covers basic information for better understanding the needs of adopted children and their families. We hope adoptive parent group leaders and other child advocates will use this curriculum to help professionals in their communities learn more about adoption and apply what they learn in their work with families.

This curriculum gives an overview of the children who are adopted from the child welfare system and the parents who adopt them. It describes common early life experiences of these children, their special needs, and how their various special needs affect their lives and the lives of their adoptive families. Post-adoptive support and therapeutic services are extremely important for these children and their families. Professionals who understand adoption and the complex needs of these children can make decisions that will support these children and preserve their families.

Learning Objectives

To raise awareness and increase the knowledge base and skill set of child welfare, medical, legal, education, and mental health professionals, and others who work with adopted children and/or their families. To help these individuals learn:

- why it is important to know more about adoption
- that adoption is a different experience and a lifelong journey
- the national and local statistical profile of adopted children and adoptive parents
- qualities that help adoptive parents successfully parent children with special needs
- the core issues of adoption, how they affect each member of the adoption triad (the child, adoptive parents, and birth parents), and how those issues recycle throughout the lives of adoptees, adoptive parents, and birth parents
- more about the special needs that are more common in children adopted from the child welfare system
- that post-adoption services are necessary to help families successfully deal with their children's special needs and keep families together

Flexible Training

The training is designed to be approximately an hour and a half in length. The training has been divided into three sections (see below) with time at the end to hand out and briefly discuss resources for the participants. Feel free to modify these materials to suit your particular audience or style of presentation.

Section I
Getting to Know Adoptive Families (20 minutes)

Section II
Adoption Is a Unique Experience (40 minutes)

Section III
Qualities of Adoptive Parents that Build Successful Adoptive Families (20 minutes)

Resources for Participants (10 minutes)

Materials Needed

overhead projector
flip chart or white board with markers
overheads and handouts (see chart on the next page)

Overheads and Handouts Chart

	Overheads	Handouts
Section I **Getting to Know Adoptive Families**	**Who Are the Children?** **A1** Data on Children Adopted **A2** from U.S. Foster Care **B** Common Special Needs in Adoption **C** Helping Children Understand Adoption at Different Ages **C1** Preschool Years **C2** Elementary Years **C3** Young Adolescent **C4** Youth **Who Are the Families?** **D** Data on Adoptive Families **E** Demographics and Social Characteristics of Foster Parents **F** Transracial Adoption	**Who Are the Children?** **1** Data on Waiting and Adopted Children **2** Common Special Needs in Adoption Special Needs Fact Sheets: **3** *Attachment Disorder* **4** *Attention Deficit/Hyperactivity Disorder and Adoption* **5** *Fetal Alcohol Spectrum Disorder* **6** *Sensory Integration Dysfunction and Adoption* **7** Helping Children Understand Adoption at Different Ages **Who Are the Families?** **8** Data on Adoptive Families **9** *Seven Tasks for Parents: Developing Positive Racial Identity* by Joseph Crumbley **10** Fact Sheet: *Transracial Adoption*

	Overheads	Handouts
Section II **Adoption Is a Unique Experience**	**G** Understanding How Adoption Is Different **H** Core Issue of Adoption	 **11** Core Issue of Adoption

	Overheads	Handouts
Section III **Qualities of Successful Adoptive Parents**	**I** Qualities of Successful Adoptive Parents	**12** Qualities of Successful Adoptive Parents

Resources for Participants	**J** Positive Adoptive Language **K** Adoption Subsidy Profile	**13** Positive Adoptive Language **14** Adoption Subsidy Profile **15** *Post Adoption Services* by Vera I. Fahlberg Fact Sheets: **16** *Adoption and the Schools* **17** *Children with Special Needs* **18** *Nine Stages of Grief in Parents of RAD Kids* **19** *Promoting Family Health and Resilience* **20** *Top Ten List for Parents Caring for Children with Multiple Diagnoses* NOTE: You will also need to gather helpful local and regional information regarding post-adoption resources and services that are available in your area. (Look at the Minnesota examples to get ideas of the local and regional information that can be helpful.)

Section I
Getting to Know Adoptive Families

Method of presentation: lecture and discussion
Time: 40 minutes
Materials needed:

Overheads

A Data on Children Adopted from U.S. Foster Care (A–1 & A–2)
B Common Special Needs in Adoption
C Helping Children Understand Adoption at Different Ages (C–1, C2, C–3, & C–4)
D Data on Adoptive Parents
E Qualities of Successful Adoptive Parents
F Transracial Adoption

Handouts

1 Data on Waiting and Adopted Children
2 Common Special Needs in Adoption
Special Fact Sheets:
3 Attachment Disorder
4 Attention Deficit/Hyperactivity Disorder and Adoption
5 Fetal Alcohol Spectrum Disorder
6 Sensory Integration Dysfunction and Adoption
7 Helping Children Understand Adoption at Different Ages
8 Data on Adoptive Parents
9 Qualities of Successful Adoptive Parents
10 *Seven Tasks for Parents: Developing Positive Racial Identity* by Joseph Crumbley
11 Fact Sheet: *Transracial Adoption*

Learning Objectives

To help professionals who work with adoptive families or adopted children learn:

- why it is important to know more about adoption
- the statistical profile of adopted children and adoptive parents (nationally and locally)
- the special needs common to children adopted from the child welfare system
- qualities of successful adoptive parents
- how transracial adoption affects adopted children and their families
- that post-adoptive services are often *necessary* for families who have adopted children with special needs or have adopted transracially

Getting Started

Introduce presenters (2-3 minutes) and then ask participants to raise their hand if their life has been touched by adoption by having been adopted or adopting, or through relatives or friends who have been adopted or have adopted.

The majority of Americans are personally affected by adoption. In 1997, the Evan B. Donaldson Adoption Institute conducted a benchmark survey of 1,554 adults to examine public attitudes toward adoption. The survey found that 6 in 10 Americans have personal experience with adoption, meaning that they themselves, a family member, or a close friend was adopted, had adopted a child, or had placed a child for adoption. (Evan B. Donaldson Institute, 1997)

Make the point that professionals need to know about adoption to better understand and serve their adopted children and adoptive family clients.

Who Are the Children?

Data on Waiting and Adopted Children

Goal: To provide statistics and a profile of the children who are waiting and the children who have been adopted from the child welfare system.

Gather the most recent Adoption and Foster Care Analysis and Reporting System (AFCARS) statistics from the U.S. Department of Health and Human Services web site: www.acf.hhs.gov/programs/cb. Click on "Data and Info Systems" to find the AFCARS report. Make overheads of the current relevant statistics on adopted children child welfare system, age ranges, gender, race, etc. (See OVERHEAD A and HANDOUT 1—*Data On Children Adopted from Us Foster Care* as examples of statistical data as of September 2001.) Contact the state department of social services or provincial ministry to get current data from your state or province.

Discussion Points: Try to personalize the data by relaying the statistics regarding the adopted children in your community who may have direct contact with your participants. For example, if you are training local teachers, try to provide the demographics of adopted children who are enrolled in your local school system. Maybe you can get the demographics of the number of adoptive families in the area who potentially have access to the local clinics and hospitals for a training with local medical professionals. Look for other ways to make your material have a greater impact on your audience.

Common Special Needs

Goal: To explain to participants that most children adopted from the child welfare system have special needs. To name the special needs that are most commonly found in children adopted from the child welfare system, such as fetal alcohol spectrum disorder (FASD), reactive attachment disorder (RAD), sensory integration problems, and attention deficit hyperactivity disorder (ADHD).

These children often require developmental or psychological therapy, specialized medical care, special services at school, and more. Post-adoptive services to adoptive families are usually key to enabling parents to help their children overcome barriers and become more physically, emotionally, socially, cognitively, and behaviorally healthy.

Discussion Points: Children adopted from the child welfare system come with a variety of special needs—genetic conditions, early childhood neglect and abuse, and prenatal exposure to drugs and alcohol—some that are unknown to the adoptive parents prior to adoption. Many of these special needs affect children's social skills, thinking and reasoning abilities, impulse control, performance in school, and more.

Many of these children have multiple diagnoses and dealing with multiple special needs is even a greater challenge for families. Give real examples (describing families you know) to help participants get a clear picture of how intense the manifestation of these special needs can be, the stress this puts on families, and how post-adoptive services can preserve families. Tell personal stories about what it was like for your family and your child before services were available and how services have helped families and children that you know. Compare their lives without proper services and their lives with services.

Use OVERHEAD B and HANDOUT 2—*Common Special Needs in Adoption* to guide the discussion. Some of the special needs that are common to adopted children:

- fetal alcohol spectrum disorder
- attachment disorder
- sensory integration
- attention deficit hyperactivity disorder

HANDOUTS 3–6 discuss these special needs in greater detail. Use them to help explain how these disorders affect children and their families. In most cases there won't be time to go over these handouts in detail. They are meant as future resources for participants.

Understanding Adoption Developmentally

Goal: To explain to participants that adoption is not a single event, but rather a journey.

All members of the adoption triad grow and change and view the experience differently at various stages of life. In particular, children view adoption differently at different developmental stages.

Discussion points: Many people believe the legal act of adopting a child is a single event, when in fact the *experience* of adoption is lifelong and changes as the child:

- matures developmentally
- works through and recycles issues of grief, loss, and abandonment
- experiences events such as puberty, graduation, moving, marriage, divorce, search and reunion of a birth parent, death of a pet or family member, a medical crisis, the birth of a child, or infertility etc.

An adopted child's understanding of adoption changes as over time. They need the significant adults in their lives to talk to them about their adoption again and again throughout their lives. They may at times forget what they have been told, block early childhood memories, or inaccurately process what they have been told by their parents. It is also common for some teenage adoptees to become less receptive to talking about adoption, especially with their

parents. Professionals such as teachers or social workers, and medical professionals can play a key role for families and assist and support their efforts when they better understand how children view adoption as they mature.

Professionals who recognize a child's response to adoption based on his development, can offer more help to the family if or when they face a crisis or are struggling working through a problem. Some parents may not recognize when they or their children are struggling with issues of adoption. In this case, it can be helpful for teachers, medical professionals, or social workers to help the family deal openly with adoption issues.

Use OVERHEAD C and HANDOUT 7: *Helping Children Understand Adoption at Different Ages* as you review the developmental stages of childhood and discuss how they relate to understanding adoption. Share stories about your child or others' stories to illustrate:

- a child's normal acceptance but limited understanding of adoption at the early stages of development
- how the child's perceptions change over time
- how the adoption experience changes over time
- the communication challenges that occur for the child and the parent at different ages and stages of development

Many of your stories may be funny, poignant, or painful. Do your best to share a wide range of examples to help explain what the adoption experience is like.

Who Are the Families?

Data on Adoptive Families

Goal: To emphasize that all types of families can be successful in adoption.

Adoptive parents include older parents who have previously raised a biological family, young parents, first-time parents, neighbors and other adults who have had a significant relationship with children who need a permanent family, apartment dwellers, homeowners, and families from various socio-economic backgrounds, and all racial and ethnic backgrounds. The majority of parents who adopt children from the child welfare system are moderately educated families with modest to middle incomes. Across North America more foster parents, kin, single people, and gay and lesbian (GLBT) individuals are successfully adopting.

Discussion Points: Included in OVERHEADS D and E and HANDOUT 8 is information on who is adopting children from the child welfare system. The data shows that:

- Although single parent adoptions are growing in number, most children are adopted by married couples.
- People from all races and ethnic groups adopt, but most adoptions from foster care are by African Americans and whites.
- The majority of parents who adopt from the child welfare system are either relatives of or foster parents to the child.

· Most foster parents who adopt children from the child welfare system have a combined annual income of less than $50,000.

Share more local, regional, and national statistical data describing adoptive families. Describe some of the adoptive families you know from you community. Include examples that show the diversity of the families who are adopting.

Another important point to make is that because most families that adopt children from the child welfare system tend to have more modest incomes, the parents may not have the financial resources to pay for the services that their children often need. However, statistically these same families have some of the highest success rates raising children adopted from the child welfare system.

Successful families seem able to set realistic goals, are more accepting of small steps toward success, and have a broader vision of future vocational success that may or may not include a college education.

Transracial Adoptions

Goal: To define transracial adoptions. To describe some of the post-adoptive practices that helps the success rate of transracial adoptions. To help participants understand why families who adopt transracially benefit from receiving community support and may need post-adoption services.

Discussion Points: Transracial adoptions are defined as adoptions that join together families and children of different races.

An estimated 15 percent of the 36,000 adoptions of foster children in 1998 were transracial or transcultural adoptions. (U.S. Department of Health and Human Services, 2000)

Ask participants to think of how being transracially adopted may affect children and their families. The following questions are examples of issues that transracial families often face. Feel free to use these questions or generate some of your own to start a group discussion. The stories from real families make the greatest impact on the audience.

What is it like to be a member of a transracial family—where individuals within the family do not share the same racial identity?

Children who are adopted transracially often face two issues. One: when outsiders make assumptions and do not see the child as belonging to the family because of the difference in race. Two: when outsiders assume the child is adopted and also feel they have permission to freely discuss the child's adoption. The child may, in fact, want more privacy and wish to choose when, where, and to whom she discusses her adoption.

HOW TO HELP: Think about how you feel about belonging to your family. Think about the things you want to keep private, such as your finances, your income, and your personal problems. Think about how you would feel if strangers initiated conversations about your

personal life. Think about how you can acknowledge a transracial family, respect their right to belong together, and be sensitive to their individual needs and right to privacy.

What it is like to be given and graded on an assignment that is impossible for you to complete?

Many teachers assign students to make family trees or to research and map their genetic history, often requiring students to give a report in class or create a visual display. Most children do not want to appear different in front of their peers, especially not a public display. Most adopted children have limited access to birth family or genetic information and cannot complete these assignments. These assignments also bring up past losses and cause anxiety and stress in adopted children and their families.

HOW TO HELP: Make sure all teachers in your school are trained and aware that adopted children don't necessarily have birth family or genetic information. Help your school come up with alternative assignments that teach the same concepts but are more inclusive for adopted children.

What is it like to be asked to speak on behalf of an entire race of people? What is it like to be asked to speak for adoption or justify your identity?

Sometimes transracial adoptees are put on the spot and asked to speak on behalf of their race. Many transracial adoptees have had limited or interrupted exposure to their ethnic heritage or culture of origin. Some have genetic links to several racial or ethnic groups, but are seen by others as representing one group or even the wrong group. (For example, a child of African American and Native American descent, adopted by a Native American family was mistaken by others as Hispanic and asked to speak a little Spanish.)

Some transracial adoptees have lived with several foster families before being adopted and may have temporarily lost a connection to their racial and ethnic heritage. Some adoptees continue to learn more about their genetic and cultural heritage, and even as teens, need time to process and develop a personal connection to their heritage.

Many transracially adopted children are asked to justify their identity or how they can belong in their family. Peers might say, "They can't be your parents. You're black and they're white."

Give examples of painful or uncomfortable incidents that involved transracial adoptees and their families and ways professionals could have intervened to make it better.

How You Can Help:

- Teachers can talk in class about the many ways people build families, such as birth families, foster and kinship families, adoption, and extended families. Talk about identity, how people form an identity. Teachers, medical staff and social workers can display pictures of all kinds of families, including transracial families, in their offices and classroom. Explore how individuals form an identity and groups form an identity.

- Make it a practice to approach adoptees privately when seeking representatives for panels, teams, or leadership positions. Allow students time to think and accept the offer or refuse it without guilt.

- Recognize that most individuals are continually developing their cultural and racial identities. Some adoptees have a clearer understanding of their identity than others.

What is it like to feel socially isolated and think no one understands your life or can help you?

When families adopt children of another race, they don't just add a family member of a different race, the entire family changes to become a transracial family and each family member's life changes forever. Many families aren't prepared for the judgement, rejection, unwanted attention, and questions they will get from other people.

Some families sail through the early years with their children with ease, but later find the teenage years to be extremely difficult as their children struggle with identity issues. Some families, especially those in rural areas, may feel isolated and have few resources, role models, or mentors to help them through the experience. Other rural families say they don't experience problems in their community, but find when they leave home, their children are unprepared for the prejudice and racism they experience in the broader world.

How You Can Help:

- Give parents resources for the future. If your agency or county offers post-adoption services, make sure they include services specifically for transracial families. Look for ways to collaborate with other neighboring areas to provide post-adoption services for transracial families if your agency is small or your county's resources are limited. Teach families how to look for services outside the community if necessary. Encourage families to come together to create support for each other.

- Prepare families to understand that issues of race can change over time. For example, children of color may be accepted by the community when they are little and then treated as dangerous threats as teenagers. Children of color may be treated differently by the educational, medical, legal, law enforcement, and criminal justice systems. Transracial families need to be prepared to discuss this openly with their children and develop strategies for coping and taking action.

- Find a way to sponsor a support group for transracial families. Your agency or county might be able to provide space for their meetings, materials, and offer guidance for how to get started. Sometimes there is grant money available for agencies that sponsor parent-run groups to get started. The agency or county helps the group to get organized, but allows the group to become independent, run its meetings, and plan its own activities.

Use OVERHEAD F as you describe ways professionals can help transracial adoptees and their families.

Ask participants to:

- first of all, recognize there is an additional aspect to transracial parenting and listen to the families when they have problems or concerns
- refer families to people and places that can offer community support and resources (such as resource people that could be helpful, parent groups to join, handouts included in this section, etc.)
- post a list of support groups for transracial families in your offices, school, or clinic
- possibly provide a place for transracial families to meet for support group meetings

Ask participants to encourage transracial families to:

- seek relationships with other people who reflect the racial and ethnic make up of their family
- tolerate no racial or ethnic biased remarks
- surround themselves with supportive families and friends
- celebrate all cultures
- talk about race and culture

Ask participants who are working with transracial families (especially those that are struggling) to suggest they consider:

- a lifestyle that includes living in a racially integrated neighborhood with racially integrated schools
- participating in ethnic celebrations, attending cultural fairs, and eating a variety of ethnic foods (particularly foods reflecting the ethnicities of family members)
- building relationships with families and adult role models of a variety of ethnicities (particularly those of their children)
- adopting siblings
- joining an adoptive parent support group that includes other transracial families

Distribute HANDOUT 9 *Seven Tasks for Parents: Developing Positive Racial Identity* as a resource to give to parent clients.

Section II
Adoption Is a Unique Experience

Method of presentation: lecture and discussion
Time: 40 minutes
Materials needed:

Overheads
G Understanding How Adoption Is Different
H Core Issues of Adoption

Handouts
11 Core Issues of Adoption

Understanding How Adoption Is Different

Goal: To discuss and demonstrate how children adopted from the public child welfare system face different challenges than children living with their birth families.

Discussion Points: Many people still believe that adoption is the same as giving birth to a child. The public often does not recognize or understand how the early life experiences of abuse or neglect and prenatal exposure to alcohol and drugs has affected the lives of children from the child welfare system. These children also grieve the loss of their birth parents—a population often overlooked when we talk about adoption.

Parents who have given birth and adopted often say the experience of raising a birth child and an adopted child are the same. The love they feel for both children couldn't be any deeper. However, we have all heard stories or jokes that ended with "and then we told her she was adopted" or "you must be adopted" or "my brother always teased me and told me I was adopted". None of the statements are meant as a compliment. When a child who is adopted overhears these stories, he knows many people perceive that joining a family through adoption holds a different status than joining a family by birth. The grief of losing birth parents never goes away.

Use OVERHEAD G *Understanding How Adoption Is Different* to facilitate discussion around these differences.

Give examples of when your child felt the deep loss of his birth father. Relate stories about the problems that have come up because parents didn't know medical history or early childhood information.

Explain through a story how hard it is for a nine-year-old to bond to a parent compared to a newborn. What kinds of things do adoptive parents do, even with teens, to establish a bond?

How does prenatal exposure to drugs or alcohol affect the outcome of a child's life? What is it like for a child to understand she has FASD? What is it like for a parent to watch her child struggle with FASD?

Core Issues in Adoption

Goal: To name and define the core issues of adoption:

- loss
- rejection
- guilt and shame
- grief
- identity
- intimacy
- mastery and control

To discuss and show examples of how the core issues surface and resurface in the lives of adopted children and their families

Discussion Points: Start by asking the following questions:

How is adoption perceived?

Traditionally, adoption has been perceived as a single event, rather than a lifelong process. However, adoption affects experiences throughout the life cycle. Adoption is not pathological, it is just different.

Historically, how was adoption perceived?

Adoption was seen as a win/win situation: The adoptive parents have a child to love and raise. The child receives a new "better" life, and the birth parents are relieved of their parenting responsibilities.

Is that true?

Discuss the losses of the adoptee, birth family, and adoptive family. Many people ignore or forget about the birth parent.

When are core issues most likely to surface?

Core issues surface in different ways during developmental stages, during adolescents, around anniversaries, the birth of a child, or the death of a parent, etc.

It is important to be able to identify and integrate the core issues of adoption into:

- family dynamics, such as adoptive parents' unresolved issues
- pre-adoption education as well as post placement
- mental health treatment
- triad member experiences
- understanding isolation and feelings of helplessness and hopelessness

How do the core issues affect transracial adoptions*?*

A transracial adoption adds another layer of complexity to adoption that is extremely important to children, adoptive parents, and professionals. Transracial adoptions are more visually identifiable and because we live in a race- and culture- conscious society, transracial adoptees experience the core issues of adoption in relation to their birth parents, adoptive parents, the races and cultures of both sets of parents, and to society as a whole.

Use OVERHEAD H and HANDOUT 11: *Core Issues of Adoption* during the discussion.

Section III
Selected Qualities of Successful Adoptive Parents

Method of presentation: lecture and discussion
Time: 20 minutes
Materials Needed:

Overhead
I Selected Qualities of Successful Adoptive Parents

Handout
12 Selected Qualities of Successful Adoptive Parents

Goal: To discuss the qualities that adoption experts have found to be present in many successful adoptive families. Adoptive parents who have these qualities are the most successful in building functional adoptive families. To help professionals understand these qualities, know how to recognize them in prospective adoptive parents and adoptive parents, and to value, nurture, and encourage the development of these qualities.

Discussion Points: Many children adopted from foster care experienced deep losses, abuse, and neglect and learned not to trust adults. One of the most difficult tasks for these children is to form a loving bond with an adult. When these children enter a family, they may want desperately to be part of a family but their past has taught them to not trust. Some resist an attachment and even try to break up or interfere with close relationships others have already formed in the family.

Successful parents refuse to accept that the child who is biting, hitting, yelling, stealing, and causing chaos in the family is the true child they have adopted. They believe deep down, buried under the layers of abuse, there is a child who wants to be loved and wants to love back. The violence the child creates are acts of fear that stem from the child's history of abuse. These parents believe that with structured, patient, careful, consistent care, trust can be developed. They continually strive to reach the hidden healthy child that waits for them behind the layers of anger and violence, and teach her that she is loved and wanted.

Think of successful adoptive families you know and how they have managed to overcome difficulties raising their children with special needs. Share stories that exemplify some of the quality traits in HANDOUT 12 *Selected Qualities of Successful Parents.* If you need more examples of families who found successful strategies to turn a crisis into healing and growth, look for examples in *Parenting Your Older Adopted Child* by Brenda McCreight, Ph.D., New Harbinger Publication, Inc., Oakland, CA, 2002.

Read through handout 12 prior to the training and use OVERHEAD I and HANDOUT 12 (*Selected Qualities of Successful Parents)* to help guide your discussion on the character traits that seem to help parents successfully meet the needs of adopted children with special needs.

How You Can Help:
Professionals who understand the qualities that successful adoptive parents can better support that family in times of transition, crisis, and as the family grows and changes. For example, a professional can help remind parents of ways to "take charge of their parental role" when a new adoptee (as a way of coping or trying to stay in control) tries to sabotage relationships or destroy family unity. A professional can also help parents look for ways to find happiness or improvement in small increments. Think of stories where professionals were helpful helping parents build their strengths and succeed with their family.

Resources for Participants

Method of presentation: lecture and discussion

Materials needed:

Overheads
J Positive Adoption Language
K Adoption Subsidy Profile

Handouts
13 Positive Adoption Language
14 Adoption Subsidy Profile
15 Post Adoption Services, by Vera Fahlberg
16 Children with Special Needs
17 Adoption and the Schools
18 Nine Stages of Grief in Parents of RAD Kids
19 Promoting Family Health and Resilience
20 Top Ten List for Parents Caring for Children with Multiple Diagnoses

NOTE: To provide helpful resources for your participants, you will also need to gather local and regional information regarding post-adoption resources and services that are available in your area. (Look at the examples from the state of Minnesota for ideas of where to get your local and regional information.)

Time: 10 minutes

Goal: To help child welfare and medical professionals, educators and other professionals who work with adoptive families or adopted children become more familiar with the resources that are available in their area. To provide participants with resources to share with their colleagues, clients, and adoptive families.

Use OVERHEAD J & K and HANDOUT 13 & 14 (*Positive Adoption Language* and *Adoption Subsidy Profile)* Pass out the resource materials that are provided in the curriculum and local and regional resources you have collected. Go over them briefly. Provide names and contact information of organizations and individuals that you feel are good resources for your participants.

Overheads

OVERHEAD A–1

Data on Children Adopted from U.S. Foster Care

In September 2001, there were 126,000 children who were waiting to be adopted. 46,668 children were adopted. Below is more information on the adopted children.

Age	%	Numbers
Under 1 Year	2%	993
1–5 years	46%	22,942
6–10 years	34%	16,759
11–15 years	16%	8,075
16–18 years	2%	1,181
19+ years	0%	51

Race/Ethnicity	%	Numbers
American Indian/American Native Non-Hispanic	1%	715
Asian Non-Hispanic	1%	260
Black Non-Hispanic	35%	17,606
Hawaiian/Pacific Islander Non-Hispanic	0%	164
Hispanic	16%	8,033
White Non-Hispanic	38%	19,139
Two or More Races Non-Hispanic	3%	1,502
Unknown/Unable to Determine	5%	2,583

OVERHEAD A–2

Data on Children Adopted from U.S. Foster Care

Gender	%	Numbers
Male	50%	25,117
Female	50%	24,883

Relationship of the Adoptive Parents to the Child Before Adoption	%	Numbers
Non-relative	17%	8,699
Foster Parent	59%	29,501
Step Parent	0%	131
Other Relative	23%	11,670

Lengths of stay in foster care	Mean months	Median months
	33	19

(http://www.acf.hhs.gov/programs/cb/publication/afcars/report7.htm)

OVERHEAD B

Common Special Needs in Adoption

Adjustment Disorder

Alcohol-Related Birth Defects

Attachment Disorder

Attention Deficit Disorder (ADD)

Attention Deficit Hyperactivity Disorder (ADHD)

Bipolar Disorder

Cerebral Palsy

Conduct Disorder

Cognitive Delays

Developmental Disabilities

Emotional Behavior Disorder (EBD)

Emotional Disabilities

Educable Mental Retardation (EMR)

Fetal Alcohol Spectrum Disorder (FASD), Fetal Alcohol Syndrome (FAS), and Fetal Alcohol Effect (FAE)

Impaired Motor Skills

Impulse Control Disorder

Learning Disabilities (LD)

Oppositional Defiant Disorder (ODD)

Post Traumatic Stress Disorder (PTSD)

Prenatal Drug Exposure

Reactive Attachment Disorder (RAD)

OVERHEAD C–1

Helping Children Understand Adoption At Different Ages

Preschool Years—Ages 3–5

Children at this age:

- **are concrete**
- **learn through play**
- **are magical and egocentric thinkers (not logical)**
- **believe the world revolves around them**

Tips for professionals and caregivers:

- **Be concrete and simple. Use props such as dolls, simple drawings, and books.**
- **Stay relaxed and factual.**
- **Begin talking about adoption right away**
- **Keep in mind that children usually feel good about being adopted at this age but will still have confusion.**

OVERHEAD C–2

Elementary Years—Ages 6–10

Children at this age:

- **face many challenges inside and outside the family**
- **learn motor skills**
- **acquire academic knowledge**
- **socialize with peers (primarily same sex)**
- **become more and more independent and competent**
- **experience ordinary conflicts with parents over TV privileges, chores, clothes, bedtimes, language, movies, etc.**

Tips for professionals:

- **Respect the child's privacy in public.**
- **Notice and help kids respond to adopted-related teasing.**
- **Help kids deflect intrusive questions if they do not want to talk about adoption.**
- **Be proactive. Mention adoption and adoptive families regularly. Some children may volunteer to share about their adoption and their story. Be casual and encouraging.**
- **Support the idea that there are many kinds of families, including adoptive families.**

OVERHEAD C–3

Young Adolescent—Ages 11-15

Children at this age:

- **understand adoption and their personal story in a completely new way**
- **are maturing physically and emotionally at a rapid rate**
- **are forming their identity and sense of self; wonder what they will look like, whom they will be like, and to whom they belong**
- **are more strongly affected by the facts of their adoption, as they are able to comprehend what it means**

Tips for professionals:

- **Model the use of current adoption language. The children and families you work with may or may not use it. If they don't, help them to learn it.**
- **Avoid putting a child on the spot about being adopted or being knowledgeable about it.**
- **Mention adoption and adoptive families as one of the many ways to build a family.**
- **If youth bring up adoption concerns, provide facts and encourage parental involvement.**

OVERHEAD C–4

Youth—Ages 16–22+

Youth:

- **try to find their place in the adult world**
- **are often overwhelmed as they search for their identity**
- **feel challenged as they explore school, work, and housing options**

Tips for professionals:

- **Learn the Seven Core Issues in Adoption (see HANDOUT 12) and take them into consideration when working with adopted youth. (Remember life-changing experiences that occur throughout adulthood, such as moving, death, graduation, divorce, birth, college, etc., can trigger unresolved issues of adoption.)**
- **Mention adoption and adoptive families in your practice or work.**
- **Treat the subject of personal or family history with sensitivity and offer alternative strategies for dealing with gaps in information.**
- **Be open to listening and processing with a teen or young adult who brings up an adoption dilemma.**
- **Facilitate a referral to a counselor with parent permission.**
- **Remember a youth's desire to seek information about his birth family doesn't mean he doesn't love or need the support of his adopted family.**
- **Learn about the adoption support groups in your area and refer families to them for help.**

OVERHEAD D–1

Who Adopts from Foster Care?

The information is from the Adoption and Foster Care Analysis and Reporting System (AFCARS).

Family structure of the child's adoptive family	%	Numbers
Married Couple	67%	33,251
Single Female	30%	14,975
Single Male	2%	1,110
Unmarried Couple	1%	664

Relationship to the child prior to adoption	%	Numbers
Foster Parent	59%	29,501
Other Relative	23%	11,670
Non-relative	17%	8,699
Step-Parent	0%	131

- **82–85% of adoptive parents are either relatives or were foster parents to the child.**

OVERHEAD D–2

Foster Parents

- **More than half of the parents adopting children from the child welfare system are or were the child's foster parents.**

- **It is helpful to look at the demographics of foster parents since a high percentage of them become successful adoptive parents.**

- **Many foster families have a high rate of success adopting the children they have fostered because:**

- **they had time to bond and form a deep attachment over time before the adoption**

- **they already have a good understanding of the child's special needs**

- **they are aware of the resources that are available and already work for the child**

OVERHEAD E

Demographics and Social Characteristics of Foster Parents

(Data gathered from 539 foster families for a Spotlight on Practice *Predictors of Foster Parents' Satisfaction and Intent to Continue to Foster* by R. Denby, N. Rindfleisch, and G. Bean, Child Abuse & Neglect, Vol.23, No. 3 pp. 287–303, 1999)

Foster Mother's Age	Frequency	Percent
18–25	8	1.5
26–40	185	34.3
41–60	259	48.0
61-over	54	10.0

Foster Mother's Education Level	Frequency	Percent
8th Grade	18	3.3
Some High School	76	14.1
High School Graduate	177	32.8
Some College	176	32.7
College Graduate	42	7.8
Graduate Study	50	9.3

Foster Mother's Marital Status	Frequency	Percent
Single	60	11.1
Married	304	56.4
Separated	19	3.5
Divorced	92	17.1
Widowed	49	9.1

Foster Mother's Race	Frequency	Percent
African American	267	49.5
White	246	45.6

OVERHEAD E (continued)

Foster Father's Age	Frequency	Percent
18–25	5	.9
26–40	100	18.0
41–60	160	30.0
61-over	37	7.0

Foster Father's Education Level	Frequency	Percent
8th Grade	11	2.0
Some High School	30	5.6
High School Graduate	103	19.0
Some College	88	16.3
College Graduate	36	6.7
Graduate Study	37	7.0

Total Income	Frequency	Percent
Under $20,000	133	24.7
$20,000–29,999	114	21.2
$30,000–49,999	163	30.2
$50,000–69,000	53	9.8
$70,000 and above	25	4.6

OVERHEAD F

Helping Transracial Families

- Recognize there is an additional aspect to transracial parenting and listen to the families when they have problems or concerns.

- Refer families to people and places that can offer community support and resources (such as resource people that could be helpful, parent groups to join, handouts included in this section, etc.).

- Post a list of support groups for transracial families in your offices, school, or clinic.

- Provide a place for transracial families to meet for support group meetings.

Encourage transracial families to:

- tolerate no racial or ethnic biased remarks

- surround themselves with supportive family and friends

- celebrate all cultures

- talk about race and culture

- take their children to places where most of the people present are from his or her race or ethnic group

OVERHEAD F (continued)

When you work with transracial families who are struggling suggest that they consider:

- a lifestyle that includes living in an integrated neighborhood with integrated schools

- participating in ethnic celebrations, attending cultural fairs, and eating a variety of ethnic foods that reflect the ethnicities of their family members

- building relationships with families, adult role models, professionals, and community members of a variety of ethnicities, particularly those of their children

- adopting siblings

- joining an adoptive parent support group that includes other transracial families

OVERHEAD G

How Adoption Is Different

Many children adopted from foster care are affected by:

- **Grief and loss related to their birth**
- **Many unknowns:**
  genetic and medical history
  early life experiences
- **Multiple placements before adoption**
- **Abuse and neglect**
- **Childhood deprivation**
- **Attachment issues from early abandonment**
- **Prenatal exposure to drugs and/or alcohol**

OVERHEAD H

Core Issues of Adoption

Loss

Rejection

Guilt & Shame

Grief

Identity

Intimacy

Mastery and Control

OVERHEAD I

Selected Qualities of Successful Adoptive Parents

Successful Adoptive Parents:

- **have a tolerance for the ambivalent and/or strong feelings they feel when parenting children with special needs in extreme situations**
- **refuse to be rejected by the child and have an ability to delay the gratification of their parental needs**
- **are able to find happiness in small increments of improvement**
- **share their parental role with other key adults**
- **have a systems view of their family**
- **take charge of their parental role**
- **insist on developing an immediate relationship with the child**
- **see humor in daily life (even in crisis) and practice self-care**
- **have an open versus closed family system**

(Adapted from Katz, L. (1986). Parental stress and factors for success in older-child adoptions. *Child Welfare*, 65(6), pp. 574-577.)

OVERHEAD J

Positive Adoption Language

Use:	Don't Use:
Birth or biological Parent/brother/sister	**Real or natural Parent/brother/sister**
Birth child	**Own child**
Termination of parental rights	**Taken away, given up**
Made an adoption plan, chose adoption	**Surrendered, relinquished, gave up, put up**
To parent	**To keep**
Son, daughter, parent, mother father, mom, dad	**Adopted child, adoptive parent/mom/dad**
Child who has special needs Waiting child	**Hard to place, special needs child**
International Adoption	**Foreign Adoption**
Agency, caseworker, recruitment efforts	**The child hasn't found a family, the child moved**
(no replacement)	**Illegitimate**

In need of a family, waiting	**Available, unwanted**
Touched by adoption, adoption triad or constellation	**Adoption triangle**
Was adopted	**Is adopted**
Traditional, confidential adoption	**Closed adoption**

OVERHEAD K

Adoption Subsidy Profile
(Minnesota Adoption Assistance Example)

The child must have one or more of the following special needs:

- **The child is a member of a sibling group to be placed as one unit where at least one sibling is older than 15 months of age.**

- **The child has documented physical, mental, emotional, or behavioral disabilities.**

- **The child has a high risk of developing physical, mental, emotional, or behavioral disabilities.**

Monthly adoption assistance maintenance payment:

Ages	**0–5**	**$247**
	6–11	**$277**
	12–14	**$307**
	15–21	**$337**

Supplemental maintenance based on severity of child's disability:

Level I	**$150**
Level II	**$275**
Level III	**$400**
Level IV	**$500**

Other available support services:

- **Nonrecurring adoption expense reimbursement**
- **Respite care reimbursement**
- **Day care reimbursement**
- **Special needs camp reimbursement**

For more information on your state's profile at www.nacac.org.

Handouts

HANDOUT 1

Data on Children Adopted from U.S. Foster Care

In September 2001, there were 126,000 children who were waiting to be adopted. 46,668 children were adopted. Below is more information on the adopted children.

Age	%	Numbers
Under 1 Year	2%	993
1–5 years	46%	22,942
6–10 years	34%	16,759
11–15 years	16%	8,075
16–18 years	2%	1,181
19+ years	0%	51

Race/Ethnicity	%	Numbers
American Indian/American Native Non-Hispanic	1%	715
Asian Non-Hispanic	1%	260
Black Non-Hispanic	35%	17,606
Hawaiian/Pacific Islander Non-Hispanic	0%	164
Hispanic	16%	8,033
White Non-Hispanic	38%	19,139
Two or More Races Non-Hispanic	3%	1,502
Unknown/Unable to Determine	5%	2,583

Gender	%	Numbers
Male	50%	25,117
Female	50%	24,883

Lengths of stay in foster care	Mean months	Median months
	33	19

Relationship of the Adoptive Parents to the Child Prior to Adoption	%	Numbers
Non-relative	17%	8,699
Foster Parent	59%	29,501
Step Parent	0%	131
Other Relative	23%	11,670

(http://www.acf.hhs.gov/programs/cb/publication/afcars/report7.htm)

HANDOUT 2

Common Special Needs in Adoption

Adjustment Disorder
The development of emotional or behavioral symptoms—such as depression, anxiety, sleeping problems, inappropriate conduct, etc.—in response to an identifiable stress event that are more intense than one would expect.

Alcohol-Related Birth Defects
Physical or cognitive deficits in a child that result from maternal alcohol consumption during pregnancy, including but not limited to fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE).

Attachment Disorder
The inability of a child to form significant emotional connections with other people. Children who have experienced abuse and neglect, even when very young, will sometimes find it difficult to form significant ties. While they may be very charming, their relationship to others may be superficial. Lying, being out of control, lack of conscience development, and the inability to maintain direct eye contact are among the signs of attachment disorder.

Attention Deficit Disorder (ADD)
A child with ADD is not hyperactive but may have many of the following difficulties: has concentration problems, has difficulty following directions, has difficulty completing tasks, is easily distracted, loses things, and is overly messy or overly neat.

Attention Deficit Hyperactivity Disorder (ADHD)
A disorder that involves problems with attention span, impulse control, and activity level. Typical behaviors include fidgeting, difficulty remaining seated, distractibility, difficulty waiting for turns, difficulty staying on task, difficulty playing quietly, excessive talking, inattention, and engaging in physically dangerous activities without considering consequences.

Bipolar Disorder
A mental illness characterized by cycles of mania and depression. During manic periods, individuals may seem very happy and be hyperactive. In severe episodes, psychotic symptoms may also be present.

Cerebral Palsy
A non-hereditary condition resulting from brain damage before, during, or after birth. Children with cerebral palsy lack muscle control in one or more parts of their bodies or may experience speech and language difficulties, depending on the area of the brain damaged. Individuals with cerebral palsy can possess very normal mental functions.

Conduct Disorder
A condition characterized by a strong unwillingness to meet societal norms or expectations.

Cognitive Delays
Delays in the customary development of a person's ability to process information or think logically or analytically.

Developmental Disabilities
Often used to describe a variety of conditions, with implications ranging from mild to severe. It is usually used to describe any condition or disorder—physical, cognitive, or emotional—that interferes with a child's normal progress.

Emotional Behavior Disorder (EBD)
Children who are diagnosed with emotional or behavioral disorders have an established pattern of behavior characterized by one or more of the following:

- Severely aggressive and impulsive behaviors.
- Severely withdrawn or anxious, depression, mood swings, pervasive unhappiness.
- Severely disordered thought processes manifested by unusual behavior patterns; atypical communication styles, and distorted interpersonal relationships.
- Inability to build or maintain satisfactory interpersonal relations necessary to the learning process with peers, teachers, and others.
- Failure to attain or maintain a satisfactory rate of educational or developmental progress that cannot be improved or explained by cognitive, sensory, health, cultural, or linguistic factors.

Emotional Disabilities
Some children, due to their past history, genetics, or both must cope with emotional difficulties in their daily living. These children may require special therapeutic school programs and special living arrangements.

Educable Mental Retardation (EMR)
Mental retardation affects people in different ways. Some have educable retardation, meaning they can be educated and trained for future responsibilities. EMR classes and programs help them achieve a level of independence. Roughly 85 percent of those with retardation fall into this category.

Fetal Alcohol Spectrum Disorder (FASD), Fetal Alcohol Syndrome (FAS), and Fetal Alcohol Effects (FAE)
Conditions that result from alcohol use by the birth mother during pregnancy. Children born with FAS or FAE can have organic brain damage, low birth weight, birth defects, mental retardation, and learning impairments in varying degrees.

Impaired Motor Skills
A person who does not have the ability to use large and small muscle groups or has limited ability has impaired motor skills. Gross motor skill refers to use of large muscles in activities such as running or jumping. Fine motor skills refer to the small muscle coordination required for things like writing or buttoning a shirt.

Impulse Control Disorder
A mental disorder characterized by an individual's recurrent failure to resist impulsive behaviors that may be harmful to themselves or others.

Learning Disabilities (LD)
Some children find learning in regular classrooms difficult. Children with learning disabilities may be of average or above average intelligence, but have difficulty learning, sorting, and storing information.

Oppositional Defiant Disorder (ODD)
A disorder characterized by behavior such as frequent loss of temper, a tendency to argue with adults, refusal to obey adult requests, deliberate behaviors to annoy others, spiteful and vindictive behavior, use of obscene language, and a tendency to blame others for mistakes. Symptoms sometimes indicate the early stage of conduct disorder.

Post Traumatic Stress Disorder (PTSD)
PTSD develops when a child experiences or witnesses, an extremely traumatic event. This could include actual or threatened death, serious injury or a threat to the physical integrity of self or others. For children, sexually traumatic events may include developmentally inappropriate sexual experiences or the threat of them to the child or others. These incidents cause the child to experience intense fear, helplessness, or horror. The child may also exhibit various physical symptoms related to this disorder.

Prenatal Drug Exposure
Cocaine or other drugs used during pregnancy can significantly increase the risk of damage to the child's nervous system. Children exposed to drugs in-utero may appear stiff and rigid, have prolonged and piercing crying episodes, are easily over stimulated, and face an increased risk of Sudden Infant Death Syndrome. Long-term effects are uncertain.

Reactive Attachment Disorder (RAD)
A condition resulting from an early lack of consistent care characterized by an inability to make appropriate social contact with others. Symptoms include developmental delays, lack of eye contact, feeding disturbances, hypersensitivity to touch and sound, failure to initiate or respond to social interaction, indiscriminate sociability, and self stimulation.

(Adapted from Minnesota Adoption Resource Network's (MARN) web site: www.mnadopt.org)

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612-798-4033
www.mnasap.org

HANDOUT 3

FACTSHEET

ATTACHMENT DISORDER

Compiled by Cathy Bruer-Thompson, Training Coordinator, Hennepin County Adoption Program

(Materials from Evergreen Consultants www.attachmenttherapy.com, Daniel A. Hughes' *Adopting Children with Attachment Problems*)

Attachment disorder is a condition in which individuals have difficulty forming loving, lasting, intimate relationships. Attachment disorders vary in severity, but the term is usually reserved for individuals who show a nearly complete lack of ability to be genuinely affectionate with others. Attachment is the result of the bonding process that occurs between a child and caregiver during the first 2 years of the child's life. When the caretaker recognizes and attends to the child's needs innumerable times a year, the child learns the world is a safe place and trust develops. The emotional connection also forms. The child feels empowered in their environment, and develops a secure base from which to explore the world. Attachment is reciprocal as the baby and caretaker create a deep, nurturing connection together. It takes two to connect. It is imperative for optimal brain development and emotional health, and its effects are felt physiologically, emotionally, cognitively, and socially.

Children without proper care in the first few years of life have an unusually high level of stress hormones, which adversely effect the crucial aspects of the brain and body develop. Conscience development is dependent upon brain development and follows attachment. Therefore, these children lack pro-social values and morality as well as demonstrating aggressive, disruptive and antisocial behaviors.

There are many reasons why the development of this connection and attachment can be disrupted:

- Premature birth
- In-utero trauma, such as exposure to alcohol or drugs
- Unwanted pregnancy
- Separation from birth mother
- Postpartum depression in mother
- Severe abuse and/or neglect in the first years of life
- Multiple caretakers
- Hospitalizations
- Unresolved pain
- Painful or invasive medical procedures
- Insensitive Parenting

These children have learned at a pre-verbal stage that the world is a scary and distrustful place. This lesson has taken place at a biochemical level in the brain. For this reason, these children do not respond well to traditional therapy or parenting since both rely on the child's ability to form relationships that require trust and respect. Children who have Reactive Attachment Disorder require a different type of therapy to address these early attachment difficulties.

There is a range of attachment problems resulting in varying degrees of emotional disturbances in the child. Some of these children may have concurrent diagnoses such as Oppositional Defiant Disorder, Conduct Disorder, ADHD, Mood Disorders such as Depression or Bipolar Disorder, and Posttraumatic Stress Disorder. Unfortunately, many children with RAD are often misdiagnosed and receive inadequate therapy for years. Without proper treatment, these children and the societies in which they reside will pay a very high price indeed.

Symptoms of Attachment Disorder

The Child may have some of the following behaviors/symptoms:

- Superficially charming, acts cute to get what he/she wants
- Indiscriminately affectionate with unfamiliar adults
- Resists genuine affection with primary caregivers, on parental terms (especially mother)
- Controlling, bossy, manipulative, defiant, argumentative, demanding
- Impulsive, no "stops" on their behaviors
- Fascinated with fire, death, blood, weapons, evil or gore
- Cruelty to animals, destruction of property, aggression toward others or self
- Destructive, accident-prone
- Very concerned about tiny hurts, but brushes off big hurts
- Rages or has long temper tantrums, especially in response to adult authority, being told "no"
- Poor eye contact… except when lying will look you in the eye with the most innocent eyes
- Blames others for their problems
- Lacks self-control
- "Crazy" lying (about the obvious), steals, shows no remorse, no conscience, defiant
- Food issues- hoards or sneaks food, gorges, refuses to eat, eats strange things, hides food
- Poor hygiene: wets or soils self
- Poor peer relationships
- Underachiever
- Persistent nonsense questions and incessant chatter
- Abnormal speech patterns or language problems
- Grandiose sense of self, lacks trust in others to care for him/her

The Parents' may exhibit some of the following symptoms:

- Feel helpless, demoralized, emotionally exhausted
- Appear angry, frustrated and hostile
- Feelings of inadequacy and guilt
- May look overly controlling and rigid

Helpful Resources: www.attach.org www.attachmenttherapy.com

Adopting Children with Attachment Problems, Daniel A. Hughes, Child Welfare League, 1999.
Attaching in Adoption by Deborah D. Gray, Perspectives Press, 2002.
Theraplay by Ann M. Jernberg and Phyllis B. Booth, Jossey-Bass, 2001.
Parenting the Hurt Child: Helping Adoptive Families Heal and Grow
by Gregory C. Keck, Regina M. Kupecky, 2002

How to Parent and Help a ChildWith Attachment Disorder?

Find appropriate therapy: Traditional therapy is based on the belief that the child has the readiness and ability to form a therapeutic relationship… these kids are not capable of this. Use attachment therapy and skilled therapists with experience. Be present in the therapy!

Spend a lot of time together, be physically close, take time off work. Parents need to help their child develop a secure attachment for the first time in their life… a "psychological birth." The parents can make many of the choices for the child and provide both a sense of safety and fewer consequences for misbehavior… because there will be fewer misbehaviors, and the child is not repeatedly experiencing failure and shame.

- Parental attitude that communicates empathy, acceptance, affection, curiosity, and playfulness increases the child's ability to respond like a securely attached infant.
- Learn to parent differently. Enlarge your "bag of tricks"
- Get support for yourselves: support groups, on-line RAD parent groups.
- Use natural and logical consequences. Accept the child's choices and show empathy for the consequences, striving to be "sad for" his distress over the consequence rather than being "mad at" him for his behavior.
- The behaviors may be more frequent, more intense and last longer, so you need to hang in there!
- Use respite care; find one who understand the nature and severity of the child's attachment problems, false allegations, need to follow parent's guidelines. Take care of yourself!
- Be prepared "for the long haul since 18-24 months may be required to see significant progress.
- Get in-home supportive services a few hours a week: must be knowledgeable of attachment.

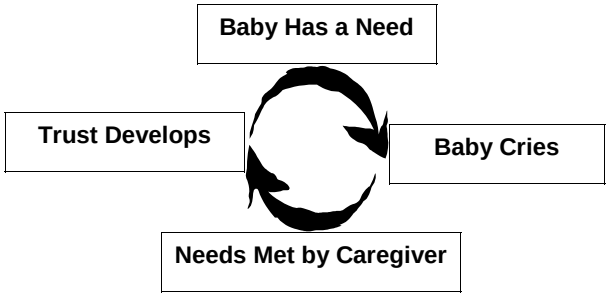
Reactive Attachment Disorder Assessment Checklist

(Cicchetti, 1989)

- How severe, chronic and pervasive were the child's experiences of neglect and abuse?
- How many caregivers did the child have? (Disrupted relationships with foster parents are likely to be experienced as rejection and abandonment. With each subsequent disruption, a child's readiness to form an attachment with the next caregiver is likely to be less.)
- Were there any positive, continuing relationships during the first 2 years of the child's life?
- Has the child begun to show any significant improvements in his current family foster home?
- Is there any selectivity in the child's attachments?
- Has the child ever shown grief over loss?
- Does the child accept help and comforting?
- Can the child enjoy, without disrupting them, close and playful interactions that are similar to the attunement interactions mothers have with their infants?
- Can the child ever directly show shame over his behaviors?
- Does the child ever show sadness over the consequences of his behaviors, rather than being enraged over the perceived unfairness? Can the child experience and give expressions to sadness and to fears?

Reactive Attachment Disorder is a very real illness. Children with Reactive Attachment Disorder are reacting to events in their early life that may include prenatal exposure to alcohol or drugs, neglect, abuse, or multiple caretakers. The brain's development may actually be altered to impair

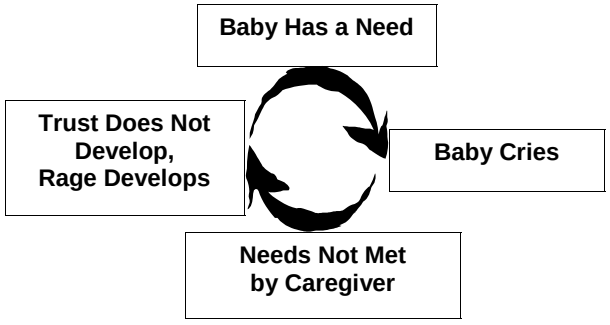
Healthy First Year Attachment



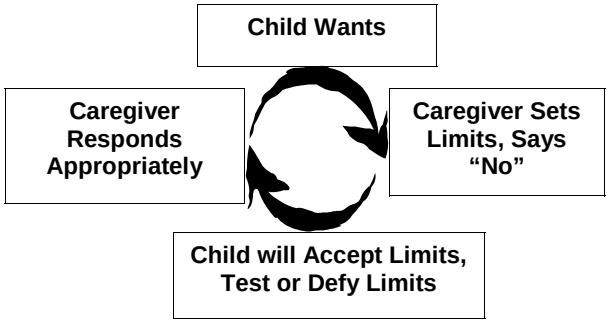
As the baby has a need and signals that need by crying, the mother (primary caregiver) comes and soothes her baby and meets her needs. If this cycle is repeated over and over again and the baby's needs are consistently met in the proper way by the same caregiver, the baby often learns to trust. She can then be able to continue on in her development.

Disturbed First Year Attachment

This time her mother (primary caregiver) does not meet the need. Sometimes the need is met, but it is not consistent, or there are different caregivers who are not *attuned* to this particular baby. Sometimes the baby's cries go unanswered as in the case of neglect or the baby's cries are met with physical abuse. Whatever the cause, the baby's need are not met in a consistent, appropriate way. This baby learns that the world is an unsafe place, that she must take care of herself, that she can trust no one to meet her needs. She learns that she cannot depend on adults. Instead of trust developing, rage develops and is internalized. She learns that she must be in charge of her life for her very survival. A child with reactive attachment disorder feels that her life depends on her ability to assume control.



Healthy Second Year Attachment Cycle



The Second Year Secure Attachment Cycle demonstrates how the child learns to accept limits on her behavior. By going through two attachments cycles (Year One and Year Two) the child learns to trust, engage in reciprocity, to regulate her emotions. During this time, she starts to develop a conscience, self-esteem, empathy, the foundations for logical thinking are laid down, etc. The breakdown of these two attachment cycles will damage all relationships she has for the rest of her life unless interventions are made.

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HANDOUT 4

FACTSHEET

Attention-Deficit/Hyperactivity Disorder and Adoption

Attention-deficit hyperactive disorder (ADHD) is probably the most controversial medical health issue of our time. While some suggest that no such disorder exists, new brain scan tests of adults diagnosed with ADHD have located a chemical imbalance in a part of the brain that uses the nerve messenger dopamine. Dopamine helps regulate attention and inhibits impulsive behavior. A public perception exists that ADHD is over-diagnosed, although the Council on Scientific Affairs of the American Medical Association recently determined that this is not the case. Adoptive parents need to be vigilant since the incidence of learning disabilities such as ADHD appears to be higher among adopted children than among non-adopted children.

ADHD brings the nurture vs. nature debate to the adoption floor. A genetic pattern of multigenerational transmission of ADHD has been documented, as well as a high incidence among children born in a crisis. The crisis may be generational and connected to addiction, depression and/or abuse. While genetic influences may offer cause-effect explanations to the diagnosis, environmental factors may also be at play. Some experts believe that the added childhood task of trying to make sense of altered life circumstances influences the learning styles of children who are adopted.

ADHD symptoms, manifested by the age of seven, include developmentally inappropriate impulsivity, inattention, and in some cases, hyperactivity. This neurobiological disorder affects three-to-five percent of school-age children. Symptoms typically continue into adulthood with a two to four percent occurrence among adults. The disorder results from parts of the brain being under-active, not hyperactive.

Three variations of ADHD exist:

* Combined (most common) – hyperactive, impulsive, inattentive
* Predominantly Inattentive – (most common in girls and adults)
* Predominantly Hyperactive/impulsive

Determining if a child has ADHD is a multifaceted process that requires separating out biological and psychological problems that mirror those exhibited by children who may not have ADHD. A comprehensive evaluation by a specialist in the field should include a clinical assessment of the child's academic, social/emotional functioning and developmental abilities. A medical exam by a physician is also important.

By federal law, children suspected of having ADHD must be evaluated at the school's expense and, if found to be eligible, provided services under either The Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973. Some of the services that could be provided to eligible children include modified instructions, assignments, and testing; assistance from a classroom aide or a special education teacher; assistive technology; behavior management; and the development of a positive behavioral intervention plan.

In order to adapt education to the needs of youth with ADHD, educators need to:

* Send clear messages and teach for understanding
* Use multi-sensory teaching techniques and active learning strategies
* Provide clear, explicit structure for class time, space, materials and course of study
* Provide frequent assignments with meaningful feedback and evaluation
* Expose and teach the skills, information and expectations hidden in the curriculum
* Offer alternative assignments, when indicated
* Involve and respect students as central partners in learning
* Intervene early and effective with individual students who have difficulty learning

Alternative schools with smaller classrooms or home schooling may suit youth whose educational needs are not being met in larger public school settings. Smaller classrooms offer less distraction compared to typical larger classes where attention strays to 30 voices, 30 faces, 30 bodies moving around.

ADHD presents some paradoxes, including:

* Psychostimulants prescribed for ADHD calm those with ADHD but can be potentially over-stimulating and even dangerous to those without the disorder
* Children with ADHD resist the structure they desperately need for symptom relief
* They love distractions, but function and feel best when hyper-focused
* They seek stimulation to stave off boredom and depression, but over-stimulation exacerbates their symptoms, causing distress
* They are capable of making connections between ideas/people at the speed of light, yet may act scattered and socially backward

Since children with ADHD often appear bright and capable, parents may find themselves arousing the suspicion of others who blame a child's behaviors on poor parenting. Child raising experts suggest that parents receive training specific to ADHD, get individual/ family counseling, investigate a medical regiment, and create interventions based on these guidelines:

* Raise the bar; don't lower it
* Make life challenging in fun ways, not less
* Keep the stakes high with individual tasks

Untreated children with ADHD are "at-risk" for potentially serious problems: academic underachievement, school failure, difficulty getting along with peers, and problems dealing with authority. In the pre-teen and teen years, youth diagnosed with ADHD may be at greater risk for substance abuse if they turn to substances to mask the negative effects. Recent research investigating the calming effects of nicotine on ADHD may explain why many who have the disorder smoke. Studies show that children who receive adequate treatment for ADHD have fewer problems with school, peers and substance abuse, and show improved overall functioning, compared to those who do not receive treatment.

RESOURCES

Adoption and the Schools: Resources for Parents and Teachers, edited by Lansing Wood and Nancy Ng. Published by FAIR (Families Adopting in Response) P.O. Box 51436, Palo Alto, CA 94303, www.fairfamilies.org

How To Reach and Teach Teenagers with ADHD by Grad L. Flick, Ph.D.
Center for Applied Research in Education: New York, 2000.

Special Kids Need Special Parents: A Resource for Parents of Children with Special Needs by Judith Loseff Lavin,
Berkley Books: New York, 2001.

Taking Charge of ADHD: The Complete Authoritative Guide for Parents by Russell A. Barkley, Ph.D.
The Guilford Press: New York, 2000.

C.H.A.D.D. (Children and Adults with ADD)
8181 Professional Place, Suite 201
Landover MD 20785
CHADD National Call Center (800) 2334050
www.chadd.org

MN ASAP
Minnesota Adoption Support and Preservation
612-798-4033
www.mnasap.org

HANDOUT 5

FACTSHEET

Fetal Alcohol Spectrum Disorder—Part 1 Diagnosis and Adoption

Minnesota has the tenth highest alcohol use rate in the nation. Consumption of alcohol during pregnancy is the number one cause of preventable mental disabilities. Alcohol consumption during pregnancy does far more damage to the unborn child than any other drug.

- Children diagnosed with **Fetal Alcohol Syndrome (FAS)** have abnormal facial features, slow growth both before and after birth, and brain injury.
- Children diagnosed with **Fetal Alcohol Effects (FAE)** may lack the outward physical appearance of alcohol damage and have some of the above characteristics. Or they may demonstrate all of the characteristics but still not have proof that the birth mother drank.

Together FAS and FAE are classified as Fetal Alcohol Spectrum Disorder (FASD), a lifetime disability that is not curable. Early diagnosis and intensive, appropriate intervention can make an enormous difference in the prognosis for the child, preventing secondary disabilities that result from primary disabilities related to FASD. Because of the brain injuries associated with FASD, individuals often have attention deficit and hyperactivity disorder (ADHD), learning disabilities, problems with daily living including poor impulse control, memory problems, sensory integration issues, relationship difficulties, an inability to understand cause/effect and thus to generalize. They also demonstrate a tendency towards high risk behaviors. **Considered "soft signs," these symptoms are not behavioral problems but rather show the permanent, unchanging damage to the brain that is out of the child's control.**

Adoptive parents need to be aware of FASD because:

Alcohol consumption during pregnancy may not appear in adoption paperwork.

- Women who use drugs during pregnancy are very likely to be using alcohol as well.
- During pregnancy, a woman may not know that she is pregnant until several months into the pregnancy. Her pre-pregnancy pattern of drinking many continue into the early stages of pregnancy when the effects of consumption are most dangerous to the fetus.
- Medical history of siblings can help determine a diagnosis of an adopted child. A woman who has delivered a child with FASD is at 70 percent greater risk of delivering additional affected children. Often younger siblings have a higher incidence rate than older brothers and sisters.
- Children with FASD are over-represented in foster care and adoption. So prevalent is the diagnosis among older "special needs" children that some adoption workers tell potential parents to assume prenatal exposure to alcohol unless there is clear proof otherwise.
- Among the 2 million adults in the U.S. with suspected FAS disorders, the combination of the primary brain dysfunction (poor judgment, lack of impulse control) and the secondary disability of alcoholism results in another risk that is not always recognized, that these individuals are very likely to have unprotected sex that results in pregnancy, and another generation of babies are at risk of damage from prenatal alcohol exposure.

The diagnosis process for FASD includes:

- A complete medical examination
- Psychological, occupational therapy and speech/language evaluations
- Evaluation of the prenatal, birth and previous medical history
- Measurement of head size and facial features
- Occupational therapy evaluation to determine motor functions and adaptive abilities.
- Speech and language evaluation to determine abilities to understand and communicate.

Adoptive parents can prepare for a diagnostic procedure by gathering all they know about their child's health and family history. They can bring photos of the child, preferably at a young age. Photos should be straight on, not smiling and without glasses.

Diagnosis

Regional FASD clinics offer team evaluations for children with significant behavior, learning or physical problems that may be related to the disorder. A treatment plan will be developed based upon the recommendations of the team. Minnesota clinics that specialize in FASD diagnosis include:

Minnesota Children with Special Health Needs
Division of Family Health
Minnesota Department of Health
85 East Seventh Place, Suite 400
PO Box 64882
St. Paul, MN 55164
651-215-8956
800-728-5420
mn-cshn@health.state.mn.us
www.health.state.mn.us/divs/fh/mcshn/directory0102.htm

University of Minnesota FAS/E Diagnostic Clinic
Pi-Nian Chang, Ph.D.
University Gateway Center
200 Oak Street SE (Oak and University Avenue SE)
Suite 160, KDWB Variety Center
Minneapolis, MN 55455
612-624-9134 or 800-688-5252

University of Minnesota International Adoption Clinic
Counsels international adopters (after viewing videos of children being considered), screens adopted children after arrival, providing follow-up and referral to specialists.
Dr. Dana Johnson
Box 211, 420 Delaware Street SE
Minneapolis, MN 55455
612-624-1164 or 612-626-2928

Health Partners Ramsey Clinic -- Child and Adolescent Psychiatry
Elizabeth Reeve, MD
640 Jackson Street
St. Paul, MN 55101-2595
651-221-3061

Mayo Clinic - Department of Medical Genetics
Pamela Carnes, M.D
200 First Street S W
Rochester, MN 55905
507-284-8208 Fax: 507-284-1067

Minnesota Indian Women's Resource Center
2300 5th Ave. S
Minneapolis, MN 55404
612-728-2018

Hennepin County Medical Center - Department of Pediatrics
Linda Thompson, M.D.
701 Park Avenue South
Minneapolis, MN 55415
612-347-2617
Works particularly with infants.

Hennepin County Medical Center
Child Behavior Learning Clinic
Rachel Trockman, M.D., Pediatric Neurologist
701 Park Avenue
Minneapolis, MN 55415
612-347-2675
Fax: 612-904-4227

Cass Lake Indian Hospital
Diane Pittman, M.D., Pediatrician
RR 3, Box 211
Cass Lake, MN 56633
218-335-2293
Fax: 218-335-2601

Abbot Northwestern Hospital - Perinatal Center
Shari Baldinger, M.S., Geneticist
800 E 28th Street
Minneapolis, MN 55407
612-863-3536
Fax: 612-863-5692

What to Tell My Child Once I Have the FASD Diagnosis

Some adoptive parents are reluctant to discuss the FASD diagnosis with their child. A solid diagnosis can be a relief for the child who can be helped to understand that many of their difficulties have a solid medical reason. Parents can begin to help the child see that their birth mother did not intentionally hurt them by drinking during pregnancy. Not all children with FASD are alike, with some displaying more of the reasoning and behavioral problems than the physical features. Each child will have individual special needs and may display varying degrees of symptoms:

Fetal Alcohol Spectrum Disorder Symptoms				
Attention and Focus	**Education**	**Social**	**Sensitivity**	**Physical**
Agitated, unable to sit down	Requires constant reminders; cannot understand abstracts	Has difficulty keeping or making friends; misses social cues	Resists change in any form	Has problems going to sleep; often smaller in stature
Difficulty playing independently	Must re-learn previously learned skills	Doesn't understand social expectations	Has low frustration level	Exhibits unusual physical characteristics
Talks incessantly	Lacks motivation to learn; does not generalize	Requires constant supervision; developmental delays; plays with younger kids	Over stimulated by public areas such as shopping centers	Experiences eating difficulties
Acts without thinking	Labeled "slow learner"	Alienates loved ones	Overly sensitive to touch, movement, sights, smells or sounds	Over reacts to under reacts to pain
Easily distracted	Has academic delays	Doesn't learn from mistakes	Over reactive to touch, movement, sights, smells or sounds	Inability to make sense of situation can lead to FAS shutdown
Unable to sit still or to calm self	Unable to understand time or money	Often aggressive and physical; is rageful	Has difficulty in regulating emotions	Exaggerated feelings with roller coaster emotions

Many people with FAS/FAE have strengths that mask their cognitive challenges

- Highly verbal
- Bright in some areas
- Artistic, musical, mechanical
- Athletic
- Friendly, outgoing, affectionate
- Determined, persistent
- Willing
- Helpful
- Generous
- Good with younger children

Resources

Minnesota Organization on Fetal Alcohol Syndrome (MOFAS)
MOFAS offers Project Seeds of Success (SOS), an education and outreach program designed for individuals who have been diagnosed with FAS/FAE and their families. Project SOS is a parent-driven, child-centered program that is designed to strengthen relationships between families and schools by building partnerships, providing resources, and improving the education system for children with FASD.
1821 University Avenue N-185 St. Paul, MN 55104
651-917-2370
Fax: 651-917-2405
www.mofas.org

Thunder Spirit Lodge
A resource center that strives to improve the wellbeing of individuals, families, and communities affected by alcohol and drug-related birth defects. Provides family support, research and training, crime prevention, advocacy, education and intervention.
4026 Central Avenue NE
Columbia Hts MN 55421
763-789-6385
TSL1234@aol.com

National Organization of Fetal Alcohol Syndrome (NOFAS)
Comprehensive resources with bookstore, legislative updates, articles of interest to families living with FASD.
www.nofas.org

Websites

FAS Alaska

Comprehensive website includes numerous links to resources around the world, training and consultations, research, connections to families, articles, homeschool resources. Focuses on intervention techniques for educators.
www.fascets.org

FASCETS- Fetal Alcohol Syndrome Consultation, Education and Training Services Inc.

Non-profit organization that provides direct services for individuals, family systems and professionals affected by Fetal Alcohol Spectrum Disorder including information, training, consultation and resources.
www.fascets.org

FAS Characteristics

Log on to view facial characteristics and a list of symptoms associated with FASD.
www.come-over.to/FAS/faschar

FAS Community Resource Center

Resources include articles of interest to parents ("When the Teen with FASD Drinks," "Teaching Kids about FASD."), research, fact sheets, web links, products, camps, lending library and homeschooling help.
www.come-over.to

Advanced Communications and Business Resources

Designed by Canadian businessman, this site offers a FASlink Archives with over 70,000 FAS related letters and articles. FASlink is a free Internet listserv that includes biological, foster and adoptive parents and caregivers as well as a wide range of professionals including those in medicine, social work, education and justice. Participants also include individuals who have FAS or FAE.
www.acbr.com/fas

ARC of Hennepin and Carver Counties

Resources for families of children with developmental disabilities include future planning, family support, respite care, assisted technology and managed care. ARC successfully connects families to the wisdom and know-how of other parents, family members and professionals understanding and living the experience throughout their entire lives.
www.archennepincarver.org

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612-798-4033
www.mnasap.org

FACTSHEET

Fetal Alcohol Spectrum Disorder—Part 2 Strategies and Interventions

Fetal Alcohol Spectrum Disorder (FASD) is permanent brain damage that results from prenatal exposure to alcohol. If your child has been diagnosed with FASD, you will need to find ways to parent and teach your child that will fit their abilities. Children with FASD typically do not learn nor respond as other children. New ways of behavior management, parenting skills, medication and teaching methods will have to be applied.

Children and adolescents with FASD act in ways that seem inappropriate to their age, but in actuality are acting within their developmental age. Educators and parents need to review the child's behavior within the context of the FASD diagnosis. Many of these behaviors continue into adulthood.

- The stubborn acting out child doesn't understand verbal directions.
- A child who keeps repeating the same mistakes in what seems like defiance can't recall what was learned yesterday or a year ago.
- Often late and disorganized, the child can't understand time since time is an abstract concept. Any type of math such as multiplications, division or fractions that have to be visualized because they can't be "touched" may not be understood.
- Squirmy and intent on bothering others, the child's brain communicates a need to move while leaming.
- Unable to be safely left alone, the child is unable to understand danger.

Methods that work with other children to help them "act their age" won't work with these children who take longer to grow up and require alternative behavior management, parenting skills, medication and teaching methods. A rule of thumb for parents and teachers is to "think younger" when a child or adolescent seems unable to complete tasks or displays inappropriate behaviors.

For those who teach and parent children and youth diagnosed with FAS, it is important to know:

- Symptoms that are based on the developmental level of the young person..
- How to get correct assessments.
- How to access educational services and community resources.
- Effective methods of parenting and teaching adapted to needs of youth with FAS.
- Support systems that bolster the family as well as the child or youth with FAS.

When an intervention is not working with a student with FAS, it is best to:

- Stop the action!
- Observe.
- Make eye contact with the child.
- Listen carefully to find out where he/she is stuck.
- Ask: What is hard? What would help?

Strategies to keep in mind are:

- Keep information concrete.
- Consider poor behavior as a physically-based unmet need.
- Maintain consistency.
- Use repetition.
- Maintain stable routines
- Keep it short and sweet.
- Be specific.
- Provide structure
- Be vigilant with supervision.
- Sensory awareness and sensory interventions work well. (See Sensory Integration Dysfunction Fact Sheet)
- Teach incorporating as many of the senses as possible.

Alternative Methods in Dealing with Children/Youth with FASD						
Concrete	**Supervision**	**Specific**	**Structure**	**Consistency**	**Repetition**	**Routine**
Talk and educate in concrete terms.	Constant supervision is the rule since the child may not understand consequences nor perceive danger.	Say exactly what you mean to help the child who has difficulty with abstractions.	Structure is the "glue" that helps the world make sense to someone with FASD.	To accommodate the inability to generalize learning from one situation to another, provide consistency.	To address short term memory problems, re-teach, re-teach, re-teach.	Provide a daily stable routine to decrease anxiety and enable learning.
Avoid double meanings and idioms such as "catch the bus."	Develop habit patterns of appropriate behavior since child may be socially inappropriate.	Avoid the abstract and generalizations.	Adjust expectations to meet the child's/youth's developmental level.	Provide an environment with few changes.	Practice teaching concepts in a variety of environments	Provide assistive technology within a routine (a watch with alarm).
Give instructions at lower age/grade level than chronological age.	FASD creates naiveté and danger, so adults need to be vigilant.	Students with FASD are unable to "fill in the blanks" when given directions.	Adapt work and study schedules to child's/youth's frustration level.	Teachers and parents need to use the same key words for oral directions.	Patiently explain step by step with external supports and lots of cues.	Allow adequate time to complete tasks within a daily routine.

Traditional interventions do not work with FASD youth who cannot associate a consequence with a behavior. The best discipline is to keep the child or youth from needing discipline. If a discipline technique is NOT working, don't try harder. Change your course of action. Redirect activity. Devise a prearranged gesture or signal as an automatic intervention to help a child understand that they need to stop whatever he or she is doing.

Without appropriate support services, youth with FASD have a high risk of developing secondary disabilities as teenagers or as young adults including mental illness; getting into trouble with the law; abusing alcohol and other drugs; and unwanted pregnancies. Families who understand the realities of this disability soon realize it requires the parents to have a life-long commitment to the son or daughter who has been diagnosed with FASD. All family members including siblings will need support, respite and coping skills.

Resources

Adoption and Prenatal Alcohol and Drug Exposure: Research Policy and Practice
by R. Barth, M. Freundlich, and D. Brodzinsky (ed.)
Addresses long-term developmental issues with counseling suggestions. Illustrates the remedial effects of a positive postnatal environment, including services and support systems.

Our Fascinating Journey: The Best We Can Be – Keys to Brain Potential Along the Path of Prenatal Brain Injury
by Jodee Kulp
Comprehensively addresses FASD interventions with topics ranging from brain basics to creating an educational environment.

The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities
by Ann Streissguth and Jonathan Kanter
Summarizes recent findings and recommendations from twenty-two experts in the fields of human services, education, and criminal justice regarding FASD.

Fetal Alcohol Syndrome: A Guide for Families and Communities
by Ann Streissguth
A leading authority on FAS draws on her life's work to give information about FAS diagnosis; brain damage; physical and behavioral manifestations; and services for high-risk mothers. Also, case studies, photos, illustrations and validated empirical research highlighting the cultural, racial and economic diversity of FAS.

The Way to Work: An Independent Living/Aftercare Program for High Risk Youth
by Amy J.L. Baker, David Olson and Carolyn Mincer
A Child Welfare League publication that presents a 15-year longitudinal study profiling successful programs serving youth such as those with FASD.

Websites

FAS Alaska
Comprehensive website includes numerous links to resources around the world, training and consultations, research, connections to families, articles, homeschool resources. Focuses on intervention techniques for educators.
www.fasalaska.com

FASCETS- Fetal Alcohol Syndrome Consultation, Education and Training Services Inc.
Non-profit organization that provides direct services for individuals, family systems and professionals affected by Fetal Alcohol Spectrum Disorder including information, training, consultation and resources.
www.fascets.org

FAS Characteristics
Log on to view facial characteristics and a list of symptoms associated with FASD.
www.come-over.to/FAS/faschar

FAS Community Resource Center

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Designed by Canadian businessman, this site offers a FASlink Archives with over 70,000 FAS related letters and articles. FASlink is a free Internet listserv that includes biological, foster and adoptive parents and caregivers as well as a wide range of professionals including those in medicine, social work, education and justice. Participants also include individuals who have FAS or FAE.
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FACTSHEET

Therapies that Help Children with Fetal Alcohol Spectrum Disorder (FAS)

by the Family Achievement Center and Minnesota Organization on Fetal Alcohol Syndrome
(Materials from Evergreen Consultants www.attachmenttherapy.com,
Daniel A. Hughes' *Adopting Children with Attachment Problems*)

Occupational Therapy Helps Children Diagnosed with FAS develop:

SELF-CARE

Assist in teaching activities of daily living

- Dressing
- Toileting
- Grooming
- Feeding
- Home care tasks
- Meal preparation

SENSORIMOTOR

Visual perception and visual-motor skills

Includes, but not limited to:

- Difficulty building with blocks as young child
- Difficulty putting puzzles together
- Difficulty drawing well with crayon or marker
- Difficulty recognizing similarities and differences in patterns
- Difficulty making letters stay within lines

Sensory integration difficulties

- Tactile- includes seeking out touch by rubbing/pushing others or objects, resisting touch of others, objects, or clothes, bed-wetting, etc.
- Vestibular- includes avoiding or seeking movement activities, becoming anxious when feet leave ground, rocking unconsciously, becoming easily car sick, etc.
- Proprioception- includes poor coordination, appearing clumsy, using too much force, using too much pressure with writing, etc.
- Oral sensory processing- includes gagging with food textures, having strong preference for certain foods, mouthing non-food objects, etc.
- Auditory- includes responding negatively to loud noises, easily distracted around a lot of noise, not responding when name is called, etc.
- Regulatory functions- difficulty sleeping, adapting to change, transitioning
- Upper extremity muscle strength
- Eye-hand coordination
- Fine-motor skills - grasp, pinch, handwriting

Cognition

Attention span

Concept learning (e.g. cause and effect)

Following directions

Memory

Sequencing

Compensatory techniques

Psychosocial

Social skills -Initiation and termination of activity, cooperative behavior, leisure interests, self-expression, coping skills, aggressive behaviors, etc.

Physical Therapy Helps Children Diagnosed with FAS develop:

MUSCULOSKELETAL

Muscle tone

Hypotonia (low muscle tone) and hypertonia (high muscle tone) are common in children with FASD. Physical therapy can perform therapeutic techniques to help normalize tone and develop strength.

Posture

Skeletal deformities and abnormal muscle tone can affect posture thus causing children to fatigue easily and use inefficient movement patterns.

Funnel chest or slouched trunk

Forward head posture and rounded shoulders

Flat feet or high arches

Hyperextension of the knees

Strengthening

Weak trunk and abdominal muscles

Poor upper body, arm and leg strength

Range-of-motion

Obtaining and maintaining full extremity and trunk range-of-motion especially in those with abnormal muscle tone and/or skeletal deformities

GROSS MOTOR SKILLS

Developmental Milestones

Children with FASD often have a difficult time obtaining their developmental milestones. Physical therapy can facilitate children to gain these skills at a more age appropriate level and in an efficient manner without compensation.

Rolling, crawling, sitting, standing, walking, etc.

Balance

Balance impairments may be the result of physical deformities, poor posture, low muscle tone, visual or vestibular dysfunctions, and/or poor coordination. – Physical therapy can help determine the cause of the balance impairment and help to facilitate improved stability and balance reactions.

Developing postural balance in sitting

Standing balance when in a stationary position and when moving

Standing on one leg or maintaining balance while weight shifting

Coordination

Hand-eye coordination

Bilateral coordination (right and left sides of the body)

Arms and legs together and in opposition

Ambulation

Learning to walk with and without assistance

Improving efficiency with walking and running activities to increase endurance levels and safety

Speech Therapy Helps Children Diagnosed with FAS develop:

EXPRESSIVE LANGUAGE

Assist with finding an effective means to communicate

Develop grammatically correct sentence structures

Express their feelings

Use symbols and/or pictures to aid in the development of sentence length and structure, assist with making choices, and provide a predictable schedule

RECEPTIVE LANGUAGE

Assist in comprehending spoken language

Use symbols, pictures, and written cues to assist them in understanding spoken language

Address the issues of:

Concepts

"wh" questions

Multi-step directions

Sequences

COGNITION

Attending

Recalling information

Problem solving skills

Reasoning

Logic

Organizing

Turn-taking (decrease impulsivity)

Understanding boundaries (personal and property)

Work collaboratively with the school, parents, and other therapists to assist in the child's environmental control to help facilitate learning.

Authors/Sources

The Family Achievement Center, 651-738-9888
www.familyachievement.com

Minnesota Organization on Fetal Alcohol Syndrome (MOFAS), 651-917-2370
www.mofas.org

Project SOS: Seeds of Success
Creating Success One Child at a Time, One Step at a Time

MN ASAP
Minnesota Adoption Support and Preservation
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www.mnasap.org

HANDOUT 6

FACTSHEET

Sensory Integration Dysfunction and Adoption

In her book, *The Out-of-Sync Child*, Carol Stock Kranowitz defines Sensory Integration Dysfunction as the "inefficient neurological processing of information received through the senses, causing problems with learning, development, and behavior." In simple terms, children diagnosed with SI Dysfunction have brains that are wired differently than their peers, making it difficult for them to make sense of messages received through any of the five senses. They are often delayed and prone to explosive outbursts. Their reactions are often out of proportion, going into a frenzy when viewing a brightly painted wall or being so much an "escape artist" that parents have to put an alarm on the child's bedroom door.

For children of adoption, SI Dysfunction rates are higher than with non-adopted children, requiring their parents to gain an understanding of the many complex skills that are required to do what seems to be a simple act such as tying a shoe or playing a board game. With such children, the interventions that illustrate "good parenting" such as setting firm limits simply do not work, causing their parents to be blamed and shamed for the child's behavior. The child may also be treated unfairly with no regard to this invisible disability. As early as preschool, the child may be labeled as a bully.

Inefficient sensory intake translates into taking in too much or too little information. With too much information, the brain is on overload and causes an individual to avoid sensory messages. With too little information, the brain seeks more sensory stimuli.

Only an occupational therapist that has been carefully trained in sensory integrative theory and treatment can properly diagnose SI Dysfunction (for a list of Minnesota therapists who specialize in SI Dysfunction, go to www.mnasap.org/pages/resources/pediatric_clinics.htm). A teacher and/or parent can learn to recognize signs that a child may be having sensory processing difficulties. The teacher can initiate an evaluation so the child may eventually receive appropriate therapy.

A high correlation exists between SI Dysfunction and Learning Disabilities (LD), with 70 percent of children diagnosed with LD having SI Dysfunction. SI Dysfunction resembles ADHD with some overlapping symptoms. The optimum treatments for the two differ. While the symptoms of ADHD may be eased with medicine such as psychostimulants, targeted occupational therapy tailored to the individual needs of the child is more helpful in cases of SI Dysfunction. An overloaded child needs less stimulation such as dimmed lights, comforting with "deep pressure" bear hugs, or a "nest" of pillows and blankets under the dining room table. An under-responsive child requires more sensory stimulation with daily activities, gentle roughhousing, and perhaps a trampoline. Therapy that is appropriate to the child's type of SI Dysfunction can ease underlying difficulties.

Kranowitz suggests that parents of a child diagnosed with SI Dysfunction do the following:

- Be a detective! Keep notes on your child's atypical behavior. Does his reaction to a sensory stimulus occur with **frequency**, **intensity** and **duration**? For instance, does the child have a heck of a time calming down after getting a splinter or being knocked down?
- Ask yourself the "WH" questions, i.e., When did it happen? Where? Who was involved? What happened or what was said? How did your child respond? After taking notes for a while, you may be able to see the pattern and find the answer to the trickier question of "Why did it happen?"
- Find an occupational therapist certified to provide SI Dysfunction treatment.

Symptoms of Sensory Integration Dysfunction

(This material is reprinted with the permission of the Childhood Apraxia of Speech Association of North America on the Apraxia-Kids (SM) Internet Resources at www.apraxia-kids.org)

Sensory	Symptoms
Auditory	Responds negatively to unexpected or loud noises Holds hands over ears Cannot walk with background noise Seems oblivious within an active environment
Visual	Prefers to be in the dark Hesitates going up and down steps Avoids bright lights Stares intensely at people or objects Avoids eye contact
Taste/Smell	Avoids certain tastes/smells that are typically part of children's diets Routinely smells nonfood objects Seeks out certain tastes or smells Does not seem to smell strong odors
Body Position	Continually seeks out all kinds of movement activities Hangs on other people, furniture, objects, even in familiar situations Seems to have weak muscles, tires easily, has poor endurance Walks on toes
Movement	Becomes anxious or distressed when feet leave the ground Avoids climbing or jumping Avoids playground equipment Seeks all kinds of movement and this interferes with daily life Takes excessive risks while playing, has no safety awareness
Touch	Avoids getting messy in glue, sand, finger paint, tape Is sensitive to certain fabrics (clothing, bedding) Touches people and objects at an irritating level Avoids going barefoot, especially in grass or sand Has decreased awareness of pain or temperature
Attention, Behavior and Social	Jumps from one activity to another frequently Has difficulty paying attention Is overly affectionate with others Seems anxious Is accident prone Has difficulty making friends, does not express emotions

Occupational therapists suggest activites to help children increase their ability to regulate themselves and to be more in control of behavior and impulses. These include working on:

- Joints and muscles—Joint compression, mini tug-of-war, roll up in a blanket
- Sense of touch—brushing, vibration, loufah sponges
- Deep pressure—squeeze hands, weighted blanket, ace bandage wrap, wet suit
- Overall movement and gravity—mini trampoline, rocking chair, roller skating
- Oral—sucking on ice, chewing, crunching, blowing cotton balls

Books

(For book ordering information, log onto www.mnasap.org)

Answers to Questions Teachers Ask About Sensory Integration
by Carol Stock Kranowitz

Challenging Behavior in Young Children: Understanding, Preventing, and Responding Effectively
by Barbara Kaiser

The Out-of-Sync Child : Recognizing & Coping with SI Dysfunction
by Carol Stock Kranowitz

The Out-Of-Sync Child Has Fun: Activities for Kids with Sensory Integration Dysfunction
by Carol Stock Kranowitz

101 Activities for Kids in Tight Spaces: At the Doctor's Office, on Car, Train, and Plane Trips, Home Sick in Bed
by Carol Stock Kranowitz

Websites

Sensory Integration International

A non-profit, tax-exempt corporation concerned with the impact of sensory integrative problems on people's lives.
310-787-8805
info@sensoryint.com
www.sensoryint.com

Learning Disabilities Association of America (LDA)

Dedicated to identifying causes and promoting prevention of learning disabilities and to enhancing the quality of life for all individuals with learning disabilities and their families by encouraging effective identification and intervention, fostering research, and protecting their rights under the law.
412-341-1515
info@ldaamerica.org
www.ldanatl.org

Developmental Delay Resources

Dedicated to meeting the needs of those working with children who have developmental delays, publicizing research and networking for parents and professionals after a diagnosis to support children who have special needs.
412-422-3373
devdelay@mindspring.com
www.devdelay.org

Apraxia-Kids

This online source provides comprehensive information about Childhood Apraxia of Speech* and is designed for families, professionals and all those who care about a child with apraxia.
**Childhood Apraxia of Speech is sometimes called Developmental Apraxia of Speech, Developmental Verbal Dyspraxia, Oral-motor Speech Disorder and other terms*
760-632-5020
helpdesk@apraxia.org
www.apraxia-kids.org

HANDOUT 7

Helping Children Understand Adoption At Different Ages

Preschool Years—Ages 3–5

Children at this age:

- are concrete
- learn through play
- are magical and egocentric thinkers (not logical)
- believe the world revolves around them

Tips for professionals and caregivers:

- Be concrete and simple. Use props such as dolls, simple drawings, and books.
- Stay relaxed and factual.
- Don't worry if children reject the explanation of being born to someone else for now.
- Begin talking about adoption right away, but remember to look for opportunities to talk about adoption in the future.
- Keep in mind that children usually feel good about being adopted at this age but will still have confusion.

Elementary Years—Ages 6–10

Children at this age:

- face many challenges inside and outside the family
- learn motor skills
- acquire academic knowledge
- socialize with peers (primarily same sex)
- become more and more independent and competent
- experience ordinary conflicts with parents over TV privileges, chores, clothes, bedtimes, language, movies etc.

Tips for professionals:

- Respect the child's privacy in public.
- Notice and help kids with adopted-related teasing.
- Help kids deflect intrusive questions if they do not want to talk about adoption.
- Be proactive. Mention adoption and adoptive families regularly. Some children may volunteer to share about their adoption and their story. Be casual and encouraging.
- Support the idea that there are many kinds of families, including adoptive families.

Tips to pass on to caregivers:

- Take advantage of your child's growing maturity and relate more details of your child's history and early life.
- Help your child distinguish between what is public information and what is private. Help your children understand that details from their past can be kept private or shared only with those they choose to share them with.
- For newly arrived older children, help them rehearse simple answers to inevitable questions. Adopted children sometimes get asked insensitive questions that they shouldn't have to answer ("Why didn't your mom want you?") and can use help thinking of ways to deal with them.
- Respect your child's comfort level regarding public exposure of her adoption. Offer opportunities for your child to participate in celebrations, cultural fairs, and school presentations but don't insist.
- Bring up the subject of adoption casually but often.
- Help your child connect with other adopted kids and families.

Young Adolescent—Ages 11-15

Children at this age:

- understand adoption and their personal story in a completely new way.
- are maturing and growing physically and emotionally at a rapid rate.
- are forming their identity and sense of self. What they will look like, whom they will be like, and whom they belong to are growing questions.
- are more strongly impacted by the facts of their adoption, as they are able to comprehend what it means.

Tips for professionals:

- Model the use of current adoption language. The children and families you work with may or may not use it. If they don't, help them to learn it.
- Avoid putting a child on the spot about being adopted or being knowledgeable about it.
- Mention adoption and adoptive families as one of many ways to build a family.
- If youth bring up adoption concerns, provide facts and encourage parental involvement.

Tips to pass on to caregivers:

- Take opportunities to clarify adoption information for your child.
- Expect that your child will have gaps in understanding or remembering the information you previously provided.
- Be particularly respectful when speaking of birth parents.
- Give as much specific information about your child's adoption as you can.

Youth—Ages 16–22+

Youth:

- try to find their place in the adult world
- are often overwhelmed as they search for their identity
- feel challenged as they explore school, work, and housing options

Tips for professionals:

- Learn the Seven Core Issues in Adoption (see handout) and take them into consideration when working with adopted youth. (Remember life-changing experiences that occur throughout adulthood, such as moving, graduation, divorce, death, birth, college etc. can trigger unresolved issues of adoption.)
- Mention adoption and adoptive families in your practice or work.
- Treat the subject of personal or family history with sensitivity and offer alternative strategies for dealing with gaps in information.
- Listen and process with teens or young adults who bring up adoption issues.
- If a youth needs help, facilitate a referral to a counselor with parent permission.
- Remember a youth's desire to seek information about his birth family doesn't mean he doesn't love or need the support of his adopted family.
- Learn about the adoption support groups in your area and refer families to them.

Tips to pass on to caregivers:

- Don't stop talking about adoption.
- Always refer to your child's birth parents with respect.
- Use news, movies, TV shows with adoption themes, school biology assignments, etc. to start a conversation about adoption.
- Be sure to listen when your teen is talking!
- Share everything you know about your child's story. It is hers to have.
- Join an adoption support group.
- Contact local or online support group or counseling for help when needed.

(Adapted from Minnesota Adoption Resource Network's (MARN) web site: www.mnadopt.org)

HANDOUT 8

Data on Adoptive Families

The information below has been taken from the Adoption and Foster Care Analysis and Reporting System (AFCARS).

Family structure of the child's adoptive family	%	Numbers
Married Couple	67%	33,251
Unmarried Couple	1%	664
Single Female	30%	14,975
Single Male	2%	1,110

Relationship to the child prior to adoption	%	Numbers
Foster Parent	59%	29,501
Other Relative	23%	11,670
Non-Relative	17%	8.699
Step-Parent	0%	131

Adoptive parents include older parents who have previously raised a biological family, young parents, first-time parents, neighbors and other adults who have had a significant relationship with children who need a permanent family, apartment dwellers, homeowners, and families from various socio-economic backgrounds, and all racial and ethnic backgrounds. The majority of parents who adopt children from the child welfare system are moderately educated families with modest to middle incomes. Across North America more foster parents, kin, single parents, and gay and lesbian (GLBT) individuals are successfully adopting.

- 82–85% of adoptive parents are either relatives or were foster parents to the child.

- More than half of the parents adopting children from the child welfare system are or were foster parents.

- It is helpful to look at the demographics of foster parents since a high percentage of them become successful adoptive parents.

- Many foster families have a high rate of success adopting the children they have fostered because:

- they had time to bond and form a deep attachment over time before the adoption
- they already have a good understanding of the child's special needs
- they are aware of the resources that are available and already work for the child

Publications/Articles
Training
Resources

Seven Tasks for Parents: Developing Positive Racial Identity

By Joseph Crumbley, D.S.W.

Each night, without fail, she prayed for blue eyes. Fervently, for a year, she had prayed. Although somewhat discouraged, she was not without hope. To have something as wonderful as that happen would take a long time. Thrown, in this way, into the binding conviction that only a miracle could relieve her, she would never know her beauty. She would only see what there was to see: the eyes of other people.

In her description, in *The Bluest Eyes*, of a young black girl who wishes that her eyes were blue so would be as beautiful as all the blond, blue-eyed children in her school, author Toni Morrison captures the struggle that many transracially and transculturally adopted children face: judging their own beauty by the standards of a culture that is not their own.

Although transracial adoption and foster care have been a controversial topic for more than a decade, the number of children entering such placements continues to increase. In 1997, approximately 17 percent of all domestic adoptions were transracial placements in which at least one of the parent's race was different from the child's. In 1998, Americans adopted 15,774 children born outside of the United States. The largest number of these children were adopted from regions of the former Soviet Union and from China. As of March 31, 1998, at least 110,000 children were in foster care, with the goal of adoption. Twenty-nine percent were white, 59 percent were African American, and 10 percent were Latino. Twenty-seven percent (3,601) of the African American children who were adopted and 7 percent of the white children were in transracial adoption. The realities of children living in transracial families raise many questions:

- How does a child develop a positive racial or cultural identity?
- What are the affects of transsracial adoption or foster care on a child and his or her family?
- What are the special needs of adopted or foster children living in tranracial families?
- What are the parenting tasks specific to transracial families? And
- What skills, attitudes, knowledge, and resources must parents in transracial families have or develop?

How Positive Racial Identity Develops

Theories on social learning, object relations, and identification are useful in explaining how a child's identities (racial, religious, ethnic, class, and gender) develop. These theories are also useful in understanding the similarities and differences in how identities develop in children from dominant groups and from children in minority groups experiencing discrimination.

Object identifications suggest than a child's identity is influenced by significant role models and relationships to which the child is consistently exposed in his or her environment (family, school, society, and the media). The child from the dominant group-the group that has power over the distribution of goods, services, rights, privileges, entitlements, and status-begins his or her identity formation by:

1. observing what group is in power
2. observing that members of the group in power are like him or her (i.e. in race, gender, or religion), and
3. assuming that because he or she is like members of the group in power, he or she has the same rights and will achieve similar accomplishments and power as members of that group.

The ultimate result of the child's identity is a sense of positive self-esteem, confidence, worth, entitlement and goals. In contrast, the child from the minority group-the group subject to the power, control, discretion, and distribution of goods and privileges by another group-begins his or her identity formation by:

1. observing what group is in power,
2. observing that group members who are like him or her are not in positions of power and control,
3. observing or experiencing prejudice, discrimination, and exposure to stereotypes, and
4. assuming that because he or she is like members in the minority group, he or she has the same limited rights, can only achieve the same accomplishments, position, and status as similar group members, and that members of the minority group are not as good as those in power.

The minority child's identity affects his or her self-self-esteem, confidence, goals, worth, self-respect, sense of entitlement, and expectations by making him or her feels inferior. This inferiority is not the result of identifying with or being a member of a minority group, but from exposure to discrimination, prejudice, and negative stereotypes about he group. A child from a minority group that is celebrated, held in esteem, or that shares power and control with the dominant group can have identities that are just as positive as a child's from the dominant group.

To counteract a minority child's formation of negative identities, he or she must see and be told:

1. that members of his or her minority group can also make positive achievements if given equal opportunities,
2. that he or she and his or her minority group should also have the same rights and entitlements as members in the dominant group,
3. that he or she and his or her group are equal to and as good as any other group,
4. that stereotypes, prejudice, and discrimination are wrong, and
5. that there is proof that prejudices and stereotypes are untrue. The child must be able to see it to believe it.

Feeling self-confident about his or her ability to cope with and appropriately respond to discrimination reinforces a child's positive self-image and identity.

This last task may be the most difficult and challenging to accomplish if the minority child's group is not in a position of power, control, and success in the child's environment. Alternatives may need to include:

1. exposing the child to historical figures and information about his or her group's accomplishments, capacities, values, and culture.
2. redefining and reframing the child's definitions of success, strengths, and accomplishments by not using standards and definitions based on those of the dominant group (e.g. highlight individual accomplishments, family commitment, group survival, spiritual and moral integrity, and civil rights activities against discrimination),
3. exposing the child outside of his or her environment to members of the minority group in positions of power and control (e.g. geographically, in other countries, through films and other media).

Parenting Tasks that Facilitate Positive Racial Identity

Because children from minority groups (Asian, Latino, African American, or Native American) who experience prejudice or discrimination are subject to developing negative racial identity, they require monitoring, with attention paid to their perception of racial identity. They should not be expected to develop positive racial identity without support

and reinforcement from their families, role models, and the community. Parents can provide support and reinforcement through the following 7 tasks.

TASK 1: Acknowledge the existence of prejudice, racism, and discrimination.

Adoptive parents must recognize not only that racism, prejudice, and discrimination exist, but that they, too, have been victims and survivors of it. By admitting the existence of inequities, parents can avoid racist, prejudicial, or discriminatory behavior. By admitting being a victim and survivor, parents are able to: 1) recognize inequities and how they affect others; and 2) elicit strategies for intervening on behalf of their child, based on personal experiences and knowledge.

While the victimization of minority groups is fairly obvious, that of members from the dominant culture and race may not be. Children in the dominant group are victims of racism by inadvertently developing superiority complexes.

Superiority complexes occur when a child:

1. observes that those in power are racially the same as he or she is,
2. observes those not in power are of a different race or color,
3. observes or is exposed to prejudicial and discriminatory beliefs and practices against a minority race,
4. assumes, therefore, that he or she and his or her race are better or without having any contact with a minority group.

Once parents understand how racism victimizes members from both the dominant and minority communities, they are prepared from the second task.

TASK 2: Explain why the child's minority group is mistreated.

Parents must explain and define racism, prejudice, discrimination, and bigotry, and why such behavior exists. Understanding the behavior exists. Understanding the behaviors beyond their simply being "good or bad" will enhance the child's coping skills. Understanding the functions and reasons for the behaviors increases the child's range of responses beyond anger or retaliation.

TASK 3: Provide the child with a repertoire of responses to racial discrimination.

Parents must work to minimize their children's feelings of helplessness. A child's identity can be more positive if he or she perceives him or herself and members of racial groups to be empowered with choices, resources, and the ability to acquire and protect their rights. This repertoire of responses may include:

1. selective confrontation or avoidance,
2. styles of confrontations (passive, aggressive),
3. individual, legal, institutional, or community resources and responses (i.e. grievances, suits, NAACP, protests)
4. priorities and timing (when to avoid and when not to avoid issues),
5. goal-oriented responses rather than unplanned reactions,
6. institutional/organizational strategies (positioning, coalitions, compromising).

TASK 4: Provide the child with role models and positive contact with his or her minority community.

Parents of a different race from their child are quite capable of modeling and helping the child develop various identities (i.e. gender, class). However, counteracting the racial identity projected by a racially conscious or discriminating society requires positive exposure to same-race models or experiences. These contacts and experiences require: 1) interacting with the child's minority community, 2) providing the child information about his or her history and culture, and 3) providing an environment that includes the child's culture on a regular basis (i.e. art, music, food, religion, school, integrated or same race community).

This task requires that the parents be comfortable with 1) being a minority when interacting in the child's community, and 2) sharing the role of modeling with members

from the child's race. Same race contacts and experiences function to: 1) counteract negative stereotypes, 2) teach the child how to implement the repertoire of responses, and 3) provide a respite from being a minority (i.e. the only child of color, the object of stares, or needing to prove one's equality).

TASK 5: Prepare the child for discrimination.

Providing the child with information on how his or her racial identity might be degraded helps him or her develop better coping skills and methods of maintaining a positive identity. Feeling self-confident about his or her ability to cope with and appropriately respond to discrimination reinforces a child's positive self-image and identity.

Same race role models may be a helpful resource for information and preparation if an adoptive parent has not experienced discrimination similar to the child's minority group (i.e. double standards, slander, interracial dating, and gender issues).

TASK 6: Teach the child the difference between responsibility to and for his or her minority group.

This task relieves the child of: 1) feeling embarrassed or needing to apologize for his or her racial identity or group, 2) not having to overcompensate or prove his or her worth because of his or her racial identity or negative stereotypes. However, the child is able to develop a commitment to both his or her individual and minority group's accomplishments, resources, and empowerment.

The Clark Doll Test suggests that children are aware of differences in race as early as four years old. This study also found that African American children became aware of stigma associated with race as early as seven years old. Although parents cannot stop the minority child's exposure to racial prejudice, discrimination, and stereotypes, parents (adoptive, birth, same or different race) of any minority child must help develop the positive racial identity necessary to counteract the effects of racial inferiority.

TASK 7: Advocate on behalf of your child's positive identity.

The purpose of this task is to provide the child an environment that is conducive to the formation of a positive identity. The parent should advocate for family, social, and educational experiences that are respectful, reflective, and sensitive to cultural diversity. Therefore, the parent may need to be prepared to correct or confront individual or institutional racism, prejudice, or discrimination that the child may encounter.

As an advocate the parent models for the child how to advocate for themselves. The child also sees and feels their parent's protection, loyalty, and commitment, which are essential in attachment and bonding. Confronting prejudice and discrimination on the child's behalf is no longer optional once a parent adopts transracially.

Joseph Crumbley, D.S.W., is in private practice as a consultant and family therapist. His most recent areas of concentration have been kinship care and transracial adoptions. This article is adapted from his book, Transracial Adoption and Foster Care*, available from the Child Welfare League of America Press.*

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North American Council on Adoptable Children (NACAC)
970 Raymond Avenue, Suite 106
St. Paul, MN 55114
phone: 651-644-3036
fax: 651-644-9848
e-mail: info@nacac.org
Feedback

National Clearinghouse on Child Abuse and Neglect Information
National Adoption Information Clearinghouse

Gateways to Information: Protecting Children and Strengthening Families

Transracial and Transcultural Adoption

Introduction

Transracial or transcultural adoption means placing a child who is of one race or ethnic group with adoptive parents of another race or ethnic group. In the United States these terms usually refer to the placement of children of color or children from another country with Caucasian adoptive parents.

People choose to adopt transracially or transculturally for a variety of reasons. Fewer young Caucasian children are available for adoption in the United States than in years past, and some adoption agencies that place Caucasian children do not accept singles or applicants older than 40. Some prospective adoptive parents feel connected to a particular race or culture because of their ancestry or through personal experiences such as travel or military service. Others simply like the idea of reaching out to children in need, no matter where they come from.

Adoption experts have different opinions about this kind of adoption. Some say that children available for adoption should always be placed with a family with at least one parent of the same race or culture as the child. This is so the child can develop a strong racial or cultural identity. These people say that adoption agencies with a strong commitment to working with families of color and that are flexible in their procedures are very successful in recruiting "same race" families. Other experts say that race should not be considered at all when selecting a family for a child. To them, a loving family that can meet the needs of a particular child is all that matters. Still others suggest that after an agency works very hard to recruit a same-race family for a certain period of time but does not find one, the child should be placed with a loving family of any race or culture who can meet the child's needs.

Despite the experts' differing opinions, there are many transracial and transcultural families, and many more will be formed. If you are or wish to be a parent in one of these families, this fact sheet will help you by answering two questions: (1) What should you do to prepare for adopting a child of a race or culture different from yours? and (2) After adoption, what can you do to help your child become a stable, happy, healthy individual, with a strong sense of cultural and racial identity?

How to Prepare for the Adoption

Preparation for adoption is important for anyone thinking about adopting a child. It is even more important for parents considering transracial or transcultural adoption because it will introduce you to all aspects of adoptive parenthood, help you learn about adoption issues, and help you identify the type of child you wish to parent. Any adoption agency that conducts and supervises transracial or transcultural adoptions should provide this important service. If you are undertaking an independent adoption, you should seek counseling and training in these areas. You should also read as many articles and books as you can on the subject. (See the resource list at the end of this fact sheet.)

National Adoption Information Clearinghouse
330 C St., SW
Washington, DC 20447
(888) 251-0075 or (703) 352-3488
naic@caliber.com
http://naic.acf.hhs.gov

The Clearinghouses are services of
The Children's Bureau
Administration for Children and Families
U.S. Department of Health and Human Services

The following sections describe some issues to consider as you prepare for a transracial or transcultural adoption.

Examine Your Beliefs and Attitudes About Race and Ethnicity

While you may think you know yourself and your family members very well, it is important to examine your beliefs and attitudes about race and ethnicity before adopting a child of another race or culture. Try to think if you have made any assumptions about people because of their race or ethnic group. There are two reasons for this exercise: (1) to check yourself -- to be sure this type of adoption will be right for you; and (2) to prepare to be considered "different."

When you adopt a child of another race or culture, it is not only the child who is different. Your family becomes a "different" family. Some people are comfortable with difference. To them, difference is interesting, wonderful, and special. Other people are not so comfortable with difference, and are scared by it. Thus, some friends, family members, acquaintances, and even strangers will rush to your side to support you, while others may make negative comments and stare. During the pre-adoption phase, you should think about how you will respond to the second group in a way that will help your child feel good about himself or herself. (We'll give you some ideas a little later.)

When your child is young, an extra hug and a heart-to-heart talk might be all it takes to help him or her through a difficult situation. While the hugs and the heart-to-heart talks never stop, as your child gets older, you and your child will need more specific coping skills to deal with the racial bias you might face together as a family. Are you ready to fully understand these issues and help your family deal with whatever happens?

Think About Your Lifestyle

Before considering a transracial or transcultural adoption, take a look at your current lifestyle. Do you already live in an integrated neighborhood, so that your child will be able to attend an integrated school? If not, would you consider moving to a new neighborhood? Do you already have friends of different races and ethnic groups? Do you visit one another's homes regularly? Do you attend multicultural festivals? Do you enjoy different kinds of ethnic foods? How much of a leap would it be to start doing some of these things?

It is important for children of color growing up with Caucasian parents to be around adults and children of many ethnic groups, and particularly, to see adult role models who are of the same race or ethnic group. These people can be their friends, teach them about their ethnic heritage, and as they mature, tell them what to expect when they are an adult in your community. Can you make these types of relationships available for your child?

Consider Adopting Siblings

It is always good for siblings to be adopted together. It is no different in the case of transracial or transcultural adoption. Siblings who are adopted together have the security of seeing another person in the family who looks like them. They are able to bring a part of their early history and birth family with them to their adoptive family, which may help them adjust better. And with internationally adopted children, being together might mean they will be able to keep up their native language.

How to Help Your Child Become a Healthy Adult

Let's say, then, that you have examined your beliefs and attitudes about race and ethnicity. You have thought about your lifestyle and considered adopting siblings. You are sure you want to adopt a child from another race or culture. What comes next?

The seven parenting techniques listed below were compiled from books and articles on adoption and by interviewing experts in transracial and transcultural adoption. Some of these "techniques" are common sense and apply to all adopted children. However, with transracially or transculturally adopted children, these techniques are especially important.

Parents in a transracial or transcultural family should do the following:

- Become intensely invested in parenting;
- Tolerate no racially or ethnically biased remarks;
- Surround yourselves with supportive family and friends;
- Celebrate all cultures;
- Talk about race and culture;
- Expose your child to a variety of experiences so that he or she develops physical and intellectual skills that build self-esteem; and
- Take your child to places where most of the people present are from his or her race or ethnic group.

The next sections provide more information on these techniques.

Become Intensely Invested in Parenting

Dr. Larry Schreiber, former president of the North American Council on Adoptable Children (NACAC), an umbrella organization for a large number of adoptive parent support groups in the United States and Canada, wrote a column about his transracial adoption experience in the Winter 1991 issue of Adoptalk,[1] the NACAC newsletter. He characterizes transracial parenting as a "roller coaster of exaggerated parenting." As a Caucasian adoptive father of African-American, Latino, Korean, Cambodian, East Indian, and Caucasian children, he describes transracial parenting as the most joyous experience of his life. He admits that he doesn't really know what it is like to endure the racially-biased name-calling that his children have experienced, but he was always there for them when they needed to be comforted and to help them get through those difficult times.

Dr. Schreiber says that transracial parenting has both complicated and enriched his life. He had to work hard to help his children develop their cultural pride and self-esteem in a world that sometimes does not understand or is unkind to people from different cultures. However, he believes his children did overcome these difficulties and were able to develop positive cultural identities, mostly because of the help his family received from adoptive parent support groups and from other adults of the same cultural groups as his children.

Ms. RoAnne Elliott is another experienced adoptive parent in an interracial family who has written about the importance of investing in parenting. An African-American woman, Ms. Elliott encourages parents in transracial families to empower themselves and believe strongly that their family belongs together. She writes, "You need the firm knowledge in your heart and in your mind that you are the best parent for your children. This empowerment is key, since you can't parent well if you don't feel confident, competent,

and entitled to do so."[2] She says that being in an interracial family is the opportunity of a lifetime, allowing you to embark on "a journey of personal transformation, growing in your ability to nurture your children along the way. This involves an alert awareness of difference and an optimistic expectation that cultural differences among us will lead to rewarding personal connections and friendships."[3]

The message, then, is that transracial parenting is not laid-back, catch-as-catch-can parenting. According to these two experienced adoptive parents, the demands are great, but so are the rewards.

Tolerate No Racially or Ethnically Biased Remarks

As adoptive parents in an interracial or intercultural family, you should refuse to tolerate any kind of racially or ethnically biased remark made in your presence. This includes remarks about your child's race or ethnic group, other races and ethnic groups, or any other characteristic such as gender, religion, age and physical or other disability. Make it clear that it is not okay to make fun of people who are different, and it is not okay to assume that all people of one group behave the same way.[4] Teach your children how to handle these remarks, by saying, for instance, "I find your remark offensive. Please don't say that type of thing again," or "Surely you don't mean to be critical, you just don't have experience with . . ." or "You couldn't be deliberately saying such an inappropriate comment in front of a child. You must mean something else."

Try to combat the remarks while giving the person a chance to back off or change what has been said. This way you will teach your child to stand up to bias without starting a fight -- which could put your child at risk. In addition, by being gracious and giving others a chance to overcome their bias/ignorance, you can help to change their beliefs and attitudes over time. Positive exchanges about race will always be more helpful than negative ones.

Surround Yourselves With Supportive Family and Friends

While you were thinking about adopting transracially or transculturally, did you find some people in your circle of family and friends who were especially supportive of your plans to become a multicultural family? If so, surround yourself with these people! In addition, seek out other adoptive families, other transracial or multicultural families, and other members of your child's racial or ethnic group. You will be surprised by how helpful many people will want to be, whether it is to show you how to cook an ethnic dish or teach you some words in their language. According to Ms. RoAnne Elliott, "You need a supportive community comprised of many races -- those who will be role models and provide inspiration, those who will stimulate your thinking, those who fill your desire for cultural diversity, and those who will challenge you in constructive and respectful ways.[5]

Celebrate All Cultures

As a multicultural family, you should value all cultures. Teach your child that every ethnic group has something worthwhile to contribute, and that diversity is this country's and your family's strength. For example, you might give your Korean daughter a Korean doll, but you might also start a collection for her of dolls of many different racial and ethnic groups.

If your child is from South America, go to the Latino festival in your town, but also visit the new Native-American art exhibit, eat at the Greek fair, and dance at the Polish dance hall. Incorporate the art, music, drama, literature, clothing, and food of your child's ethnic group and others into your family's daily life.[6] Invite friends from other cultures to celebrate your holidays and special occasions, and attend their events as well.

The area of religion brings up special concerns. You may wish to take your child to a place of worship in your community where most of the members are from the same ethnic group as your child; for example, you could bring your East Indian child to a Hindu temple or your Russian child to a Russian Orthodox church. What an opportunity to meet people of his ethnic group, find adult role models, and learn the customs of his heritage! However, before you do this, be sure you could be supportive if your child decides to practice that religion. If you have your heart set on raising your child in your own family's religion -- one that is different from the religion practiced in the place of worship you will visit -- tell your child that the visit is for a cultural, not religious, purpose or perhaps decide not to visit at all. Practically speaking, you can impose your religious practice on your child for only a few years. As an adult, your child will ultimately decide whether to practice any religion at all, and whether it will be one that people of his or her heritage often practice, your family's religion, or yet another one that he or she chooses.

While it is important to teach your child that differences among people are enriching, it is also important to point out similarities. One expert suggests that in an adoptive family the ratio should be two similarities for each difference.[7] For instance, to a young child you might say, "Your skin is darker than Daddy's, but you like to play music, just like he does, and you both love strawberry ice cream." As much as you want to celebrate your child's distinctive features, he or she also needs to feel a sense of belonging in the family.

Talk About Race and Culture

How has race or culture defined you? What is life like for a Latino person in America? What is life like for a Caucasian person? An African-American person? An Asian person? How are persons of different ethnic groups treated by police officers, restaurant employees, social organizations, or government agencies? What do you think about interracial dating and marriage? As a multicultural family, you need to address these and other racial matters.

Talk about racial issues, even if your child does not bring up the subject. Use natural opportunities, such as a television program or newspaper article that talks about race in some way. Let your child know that you feel comfortable discussing race -- the positive aspects as well as the difficult ones. On the positive side, a child of a certain race may be given preferential treatment or special attention. On the other hand, even a young child needs to know that while your family celebrates difference, other families do not know many people who are different. These families are sometimes afraid of what they do not know or understand, and may react at times in unkind ways. It can be difficult to deal with such issues, especially when your child is young and does not yet know that some adults have these negative feelings, but you have to do it. You will help your child become a strong, healthy adult by preparing him or her to stand up in the face of ignorance, bias, or adversity.

Stand behind your children if they are the victim of a racial incident or have problems in your community because of the unkind actions of others. This does not mean you should fight their battles for them, but rather support them and give them the tools to deal with the blows that the world may hand them. Confront racism openly. Discuss it with your friends and family and the supportive multicultural community with which you associate. Rely on adults of color to share their insights with both you and your child. Above all, if your child's feelings are hurt, let him talk about the experience with you, and acknowledge that you understand.

Ms. Lois Melina,[8] a Caucasian adoptive parent of Korean children and a noted adoption writer, lists five questions for you to ask your child to help him or her deal with problem situations:

- What happened?
- How did that make you feel?
- What did you say or do when that happened?
- If something like that happens again, do you think you will deal with it the same way?
- Would you like me to do something?

It is important to leave the choice of your involvement up to your child. This way, you show that you are available to help, but also that you have confidence in your child's ability to decide when your help is needed.

Expose Your Child to a Variety of Experiences so That He or She Develops Physical and Intellectual Skills That Build Self-Esteem

This parenting technique is important for all children, but it is especially important for children of color. Children of color need every tool possible to build their self-esteem. While society has made strides in overcoming certain biases and forms of discrimination, there remain many subtle and not-so-subtle color or race-related messages that are discouraging and harmful to young egos. Be alert to negative messages that are associated with any race or culture. Point them out as foolish and untrue. Emphasize that each person is unique and that we all bring our own individual strengths and weaknesses into the world. Frequently compliment your child on his or her strengths. Draw attention to the child's ability to solve math problems, play ball, dance, play a musical instrument, ride a bike, take photographs, perform gymnastics, or any other activity that increases confidence. Self-esteem is built on many small successes and lots of acknowledgement. A strong ego will be better able to deal with both the good and the bad elements of society.

As your child gets older, keep in touch with his or her needs: this might mean buying him or her a few of the in clothes or enrolling him or her on the popular teams. Stay in tune with your child's natural skills and talents, and do whatever you can to help him or her develop them at each age.

Take Your Child to Places Where Most of the People Present are from His or Her Race or Ethnic Group

If you bring your African-American child to an African-American church, or your Peruvian child to a Latino festival, your child will experience being in a group in which the number of

people present of his ethnic group is larger than the number of Caucasians present. Adoptive family support group events are other places where this might happen. Children usually enjoy these events very much. If you adopted a young child from another country, you might consider taking a trip to that country when the child is older and can understand what the trip is all about. Many adoptive families who take such a trip find it to be a wonderful learning experience.[9]

Another benefit of such an experience is that it might be one of the few times when you feel what it is like to be in the minority. This will increase your awareness and ability to understand your child's experience as a minority individual.

Other Sources of Information

Transracial adoption is a "hot" topic in the media and in adoption circles. There is quite a lot of activity in this area of adoption practice. We offer the following brief sections for your information.

Where Can I Find Out More About Transracial or Transcultural Adoption?

The National Adoption Information Clearinghouse (NAIC) often receives questions about which adoption agencies place children transculturally or transracially. The answer is twofold. Their names often signal the kinds of adoptions they conduct (for example, if they have the word "international" in their name). These agencies are marked with an asterisk in NAIC's National Adoption Directory. However, many agencies are not as open about their policy on transracial adoption because of some of the controversial issues surrounding this type of adoption. Ask your local adoption agencies about their policies in this area, especially if you are strongly considering this type of adoption.

Legislation

In 1994, transracial adoption was the subject of a bill before Congress submitted by Senator Howard Metzenbaum of Ohio. After intense debate, the Multiethnic Placement Act (MEPA) passed both houses of Congress. One positive outcome of the debate is that people who historically have been on opposite sides of the question are beginning to reach some common ground. One point that everyone agrees on is that adults of all cultures need to work together to help adopted children of all cultures reach their highest potential.

Statistics

Although available statistics are rough estimates, several sources show that the percentage of transracial or transcultural adoptions in the United States is significant. For example, one source estimates that 1,000 to 2,000 African-American children are adopted by Caucasian families each year.[10] Data from the Immigration and Naturalization Service show that U.S. families adopted 7,088 children from other countries in 1990. This means that there were roughly 8,500 transracial or transcultural adoptions in 1990. In that same year, there were almost 119,000 adoptions of all kinds.[11] Since approximately half of the adoptions in any year are stepparent or relative adoptions, in 1990 there were about 59,500 nonrelative adoptions. The percentage of transracial/transcultural adoptions (8,500 of 59,500) then, comes out to more than 14 percent.

Conclusion

Adopting a child of another race or culture can be a richly rewarding choice for many families, although there are also many unique challenges and concerns. Hopefully the information provided in this fact sheet will provide food for thought and become part of the ongoing discussion in your home. The resources listed at the end of this fact sheet should also be helpful. For more resources, visit the National Adoption Information Clearinghouse website at http://naic.acf.hhs.gov.

Written by Debra G. Smith, ACSW, Director of the National Adoption Information Clearinghouse, 1994.

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Footnotes

[1] Schreiber, p. 2.

[2] Elliott, p. 8.

[3] Elliott, p. 8.

[4] Melina, 1988, p. 2.

[5] Elliott, p. 8.

[6] Thorp, p. 36.

[7] Van Gulden, F.A.C.E Conference Workshop, 1992.

[8] Melina, 1988, pp. 3-4.

[9] Pederson, p. 42.

[10] Brooks, p. 10.

[11] Flango and Flango, p. 317.

HANDOUT 11

Core Issues in Adoption

(Adapted from work by Deborah N. Silverstein and Sharon Kaplan)

1. Loss

Adoption is created through loss. All members of the adoption triad—birth parents, adoptive parents, and adoptees—feel the loss. The hub of the wheel that connects all members of the triad is loss.

Transracial adoptees can also experience the loss of a connection to their race and/or culture of origin.

Adoptees—experience the loss of separation from their birth family and/or foster parents or first caregiver. They are aware of adoption at different developmental stages and sometimes feel as if they are learning about their adoption for the first time when they reach a new developmental stage. They don't have closure on those losses.

Birth parents—experience the loss of their genetic connector, the loss of a role, and the loss of contact with their child

Adoptive parents—experience the loss of their dream child and feel the impact of infertility.

How You Can Help

- Recognize and acknowledge all the losses and the effect loss has on their lives
- Understand that the loss is never totally forgotten; there is a conscious or unconscious awareness of the loss
- Loss is always a part of triad members' lives
- Understand and consider your own losses—how did you come to terms with losses in your life?
- Help to minimize future losses by keeping siblings together and allowing contact with grandparents and former foster parents
- Encourage adoptive parents to establish and maintain connections to the child's culture of origin and surround their child with role models from his racial or ethnic group.

2. Rejection

To be *chosen* into an adoptive family, you must first be *unchosen* by another family.

Transracial adoptees can also feel because they are perceived as "different" by their culture of origin and their adoptive culture, they don't feel fully accepted anywhere. They may also feel rejected by their culture of origin because no one from that culture chose to adopt them.

Adoptees—personalize rejection; "Why did she leave me?" is a frequently asked question, either verbally or internally. The birth parent has often chosen a lifestyle over the child. The child is confused, feels unlovable, unwanted, unworthy, or defective. The child wonders "would they

have loved me if I were cuter, taller, less demanding?" The child feels like he was "damaged goods" or she "was not good enough" for birth parents.

Birth parents—condemn themselves for being irresponsible.

Adoptive parents—struggle with issues of entitlement. Fear of rejection from a child with attachment problems. Concern about rejection as the child matures. They should not create fantasies for the adoptee about the birth family. This creates further rejection.

How Can You Help:

- Help sort out the facts about the adoption from the feelings—support and validate those feelings.
- Help build self esteem—rejection chips away at self-esteem.
- Understand the adoptee's wariness of intimate relationships because of rejection—help build intimacy through small steps.
- Don't reject or fear the child's pain—comfort the child.
- Encourage parents to maintain contacts and relationships with people from their child's past and/or establish new relationships with people from their child's culture of origin.

3. Guilt & Shame

There is tremendous guilt and shame for all members of the adoption triad.

Adoptees—believe something is intrinsically wrong with them or that their actions caused the loss to occur, often internalizes feelings, and feel shame for having been "given up".

Birth parents—feel guilt and shame because of an unplanned pregnancy and for having been sexual and intimate.

Adoptive parents—feel shame for taking someone else's child, infertility, or defective bodies. They also have guilt and shame for not making up for the losses in their children's lives.

How You Can Help

- Have a "letting go" ceremony to let go of shame and guilt. (Ex. Have client or patient write down what they feel guilty or shame about, crumple the paper and burn it in a ceremony to let go of those feelings.

- Talk about how the adoptee or adoptive parents have grown from the struggle, how they have survived.

- Acknowledge the pain of guilt and shame and share it with each other.

4. Grief

Adoptees—are often stuck in denial or anger. Understand that the developmental unfolding of cognitive processes is slow and that youth do not fully understand the impact of grief until they are adults.

Birth parents—are often told to move on and as a result deny their grief.

Adoptive parents—may grieve over the inability to bear children and/or grieve over their inability to spare their children grief from parental loss.

How You Can Help

- Discuss the stages of grief with the family. Help them to identify where they are and help them move through the stages: denial, anger, bargaining, depression, and acceptance.
- Help parents and children express grief openly, listen carefully, and offer them comfort and hope in the process.
- Help parents accept that their joy may conflict with the grief of their child.

5. Identity

Adoptees—often lack medical, genetic, religious, and historical information. Identity is defined both by what one is and what one is not. The adoptee is expected to "borrow" the identity of the adoptive family.

Transracial adoptees can have an especially difficult time with identity formation. They often wonder where they fit in. They may learn to feel comfortable in both cultures but also feel that others perceive them as not fitting into either culture.

Birth parents—can feel "I am a parent, but not a real parent" and wonder how to respond to the question: "Do you have children?"

Adoptive parents—are often made aware of the opinions of others that imply that adoptive parents are not real parents. They often have to deal with the questions: "Do you have children of your own?" or "Do you have any real children?"

How You Can Help

- Use appropriate adoption language. (Handout can be found in fact sheet: *Adoption and the Schools)*
- Children need accurate information about their past but it needs to be framed in a positive way. (Ex. Instead of labeling a birth mother as a prostitute, she is described as a person who chose an unhealthy lifestyle and made risky choices.) The child needs a way to build a positive self-image, not feel linked to negative choices of birth parent, and believe there is or was something good about the parent(s) who terminated rights.
- Children need hands-on memorabilia from their past. Do whatever you can to help get pictures of the children and encourage foster and adoptive parents to hang on to toys, a blanket, a doll or anything given to the child from the birth family. Encourage foster and adoptive families to make a scrapbook or lifebook. It is too hard for children to hold onto a past that is only an idea in their heads.
- Transracial adoptees need to stay connected to and continue to have experiences with their culture of origin—through relationships with other people, eating ethnic food, listening to or making music, dancing etc.

6. Intimacy

Other core issues impede intimacy issues.

Adoptees—may seem to hold back. A child may have a lifetime of emptiness related to longing for a birthmother the child may never see. The adoptee will most likely have attachment issues because of what did or didn't happen during the first three years of life—the period of normal child development when healthy attachments are first formed. The adoptee may have had disrupted bonding or no clear attachment figure.

Birth Parents—may equate sex, intimacy, and pregnancy with pain leading to loss.

Adoptive parents—may be challenged by the need to nurture and parent a child who has core issues. The reality that "this child is really different than me" sets in and parents may wonder "how can I love him/her?"

How You Can Help

- Counsel parents to *show* their children they were and are a choice in their parent's lives.
- Give parents attachment activities to do at every stage of development.
- Encourage families to have rituals and ceremonies to celebrate the adoption journey.

7. Mastery and Control

All members of the triad are forced to give up control.

Adoptees—are keenly aware of not being part of the decisions surrounding the adoption. The adoptee has no control over the loss of the birth family. Life altering choices were made for them. Adolescents often engage in power struggles and feel a lack of internalized self-control.

Birth parents—did not grow up thinking they would be "giving up" a child or that they would be a less-than-perfect parent.

Adoptive parents—may have parental entitlement issues, and as a result may be overprotective or controlling or rigid.

How You Can Help

Understand and recognize the inner strength and resources that many adoptees have developed to become deeper and more thoughtful people because of their struggles. These core issues are a part of the lives of the triad members, often regardless of the circumstances of the adoption. Professionals, family members, friends, and school personnel can help by being willing to engage in open dialogue and understand the core issues of adoption.

HANDOUT 12

Selected Qualities of Successful Adoptive Parents

(Adapted from Katz, L. (1986). *Parental Stress and Factors for Success in Older-Child Adoptions. Child Welfare,* 65(6), pp. 574-577.)

In families who manage to overcome all the barriers inherent in parenting disturbed children and who become parents to these children in the fullest sense of the word, a number of potent qualities stand out. Each of the following characteristics is associated with implications for placement agencies.

Successful adoptive parents:

1. ***have a tolerance for the ambivalent and/or strong feelings they feel when they parent children with special needs in extreme situations.*** For normal, healthy adults it is upsetting to experience sudden surges of rage and unpredictable fluctuations in affection for a child. Children placed in middle childhood have so many conflicts and destructive behaviors that frequently bring out these powerful feelings in adults, which can lead to painful guilt and shame in the caretakers (Gill, 1978). Well prepared, successful adopters manage not to judge themselves too harshly for these negative feelings but accept their inevitability, given the child's pathology. ("I never knew an eight-year-old child could turn me into a witch in two minutes flat!") With this comes an understanding that uncomfortable feelings will pass and they, as parents, can feel rage without acting out and hurting the child. As this pattern becomes familiar, parents and workers can use joking and humor to defuse these disturbing reactive emotions. Guilt and shame can be short-circuited before they become debilitating and set up a consequent cycle of abuse. Self-disclosure by workers and other adoptive parents is vital in normalizing these feelings.

2. ***refuse to be rejected by the child and have an ability to delay the gratification of their parental needs.*** It is a real talent to be able to persist in behaving as if one loves the child in face of constant rejection, such as "I'd rather be in jail than in this crummy family!" Instead of mutual warmth and satisfaction, the parents receive punishment. Successful adopters are stubborn, above all else, and see the child's behavior for what it is, a desperate fear of the needed closeness. When they know it has nothing to do with them as people, parents can shrug off rejection and proceed with the nurturing they know the child needs. (One father suggested a new kind of support group for adoptive parents: Parents Against Parent Abuse, or PAPA). Above all, they do not equate their own lack of gratification to failure in parenting. They realize that the child's needs can be met although they themselves are having a hard time, and they have the ability to postpone their rewards for a very long time—months, even years. Parents can be told that their role will often resemble that of the milieu therapist in residential treatment. The parents will use themselves daily, hourly, to

accomplish what is the end goal of all therapy: to change the negative worldview of the child into "I am lovable, competent, and have a safe place in this world." Kadushin (1970) described successful placements this way:

> Children were healed; behaviors changed, mistrust was dissolved and permitted regression was given up. With the parents' patience, humor, firmness in guidance, and assurances of love and acceptance, the problems were found to be surmountable. The adoptive home did the work of therapy.

3. ***are able to find happiness in small increments of improvement.*** These successful families are not focused on end goals. They have abandoned the hope of being ideal parents and they strive only to help the child achieve success in small daily tasks. Instead of laboring to remake the child, parents strive to help the child achieve success in small daily tasks. Their time perspective is especially long, and patience is possible. As one mother said, "Somehow I know he won't graduate from high school talking baby talk." By helping families focus on the present instead of dwelling on future catastrophes, workers can subtly empower parents to use the only arena they really have, the present.

4. ***share their parental role with other key adults.*** Families differ widely in dividing parenting tasks. In a study reported by Cohen (1981), one factor distinguishing successful adopters of older children (in two parent families) was the ability of one parent to perceive the signs of burnout in another parent and to move into a caretaking role for the children while the stressed out parent recovers. In families where this did not occur, disruption was attributed to the inability of the primary caregiver to continue parenting the disturbed child. An established pattern of role flexibility greatly increases a family's likelihood for success, as one partner is relieved from absorbing all the emotional battering. Single parents achieve the same result when they have trusted friends and relatives step in and help during stressful times or periodically to relieve the primary caregiver of all the duties.

5. ***have a systems view of their family.*** In explaining internal family conflicts, families differ in how much they rely on simplified cause-and-effect explanations (good guy and villain) versus a more systemic view. Families that customarily look at their total system to find answers will have a richer base for problem solving after placement than those families that label one person as *the problem*. Children placed at older ages are perfect scapegoats for families seeking a villain to relieve their distress. With a systems viewpoint, the family can work toward changes in parents' behavior, sibling roles, family priorities, etc. as a way of handling family members' reactions to the disturbed child. They thus avoid the frustrating trap of seeking someone to "fix" the child and focus instead on mobilizing all their resources the better to cope with the child. Agencies reinforce the systemic view when families are treated as a unit and placed children are not singled out as the identified patient. (Katz, 1977)

6. ***take charge of their parental role***. Some families are able to make the transition from a tentative parental stance to full "ownership" of the placed child in a short time, incorporating the child's many differences and history comfortably. For these families, sameness is not an essential ingredient in entitlement (Kirk 1984). Their own comfort in being a parent overcomes the anomalies in their situation and they are able to take charge. Preparation and education before placement can help set the stage for this (Ward, 1981). Agencies can support this adaptation by providing full background information on placed children as a right of adoptive families and by empowering them to truly act as parents with maximum authority and decision-making power in the child's life from the beginning of the placement. Just as with parents of newborns, the process of acting like a parent transforms one into a parent.

7. ***insist on developing an immediate relationship with the child.*** Successful parents of older adopted children are both somewhat intrusive and controlling, but in a caring way. They realize they have a limited timeframe to turn things around for an older child. They must be active and don't have time to hold back. Parents who stand back and allow the child to reject and exclude them soon come to feel the child is unreachable. Effective families for the disturbed child do what parents of infants and toddlers do; they are active with the child—they assume control, try to anticipate behaviors, interrupt behavior-spirals early, provide a great deal of praise, positive reinforcement, and physical affection. ("Oh boy, it feels like a storm cloud is coming. You need some lap time.") The adults take the lead in the relationship and are not deterred by the child's protest or withdrawal (Jernberg, 1979). This proactive posture helps the parents avoid feeling victimized by the child as more passive adoptive parents often feel. In addition, it gives the child the essential message, "I am your parent now and this is how I will protect and care for you." As with an infant, the parent intrudes often to gain the eye contact and body closeness upon which intimacy and trust can be built for both parent and child. Many of these techniques can be demonstrated and taught, even before placement, and encouragement to use them should continue after placement.

8. ***see humor in daily life (even in crisis) and practice self-care.*** Essential to parental survival and mental health in these placements is a refusal to accept martyrdom as the price of parenting. Humor can diffuse disturbing reactive emotions aimed at the child. Regular evenings and occasional weekends away are not regarded as selfish but necessary to keeping the parents strong and healthy enough to raise the child; maintaining outside interests and friendships serves to restore perspective, relieve tension and refresh themselves. Agencies can encourage this by providing respite care for placed children, building adoptive parent support groups into the program of services offered, and encouraging humor and venting of feelings as vital strategies in coping with stress (Gill, 1978).

9. ***have an open versus closed family system.*** Regardless of a family's basic ability, their success with a disturbed child will depend in part on how receptive their family system is to seeking and accepting help. The parents' willingness to reveal weakness and discouragement is the key to finding helpers and new solutions. By defining this very difficult kind of parenting as best accomplished through sharing with the parents, teachers, social workers, and therapists, the agency encourages each family's openness (Smith and Sherwen, 1983). The prototype for this stance must begin in an enabling type of adoption

preparation in which families open themselves up to the worker and to their own self-scrutiny, minimizing defensiveness. Successful preparation results in families committed to providing for themselves and their children the best outside help available, as an asset, not a threat, to their family unit. Group preparation can model this dynamic effectively and create an open climate (Tremitiere, 1979).

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HANDOUT 13

Positive Adoption Language

Use:	Don't Use:
Birth or biological Parent/brother/sister	Real or natural Parent/brother/sister
Birth child	Own child
Termination of parental rights	Taken away, given up
Made an adoption plan, chose adoption	Surrendered, relinquished, gave up, put up
To parent	To keep
Son, daughter, parent, mother father, mom, dad	Adopted child, adoptive parent/mom/dad
Child who has special needs Waiting child	Hard to place, special needs child
International Adoption	Foreign Adoption
Agency, caseworker, recruitment efforts	The child hasn't found a family, the child moved
(no replacement)	Illegitimate

In need of a family, waiting	Available, unwanted
Touched by adoption, adoption triad or constellation	Adoption triangle
Was adopted	Is adopted
Traditional, confidential adoption	Closed adoption

HANDOUT 14

Adoption Subsidy Profile
(Minnesota Adoption Assistance Example)

The child must have one or more of the following special needs:

- The child is a member of a sibling group to be placed as one unit where at least one sibling is older than 15 months of age.

- The child has documented physical, mental, emotional, or behavioral disabilities.

- The child has a high risk of developing physical, mental, emotional, or behavioral disabilities.

Monthly adoption assistance maintenance payment:

Ages	0–5	$247
	6–11	$277
	12–14	$307
	15–21	$337

Supplemental maintenance based on severity of child's disability:

Level I	$150
Level II	$275
Level III	$400
Level IV	$500

Other available support services:

- Nonrecurring adoption expense reimbursement
- Respite care reimbursement
- Day care reimbursement
- Special needs camp reimbursement

For more information on your state's profile, visit www.nacac.org.

We know how to minimize the chance of disruption. We know how to prepare and support parents and children to increase success. Why don't we? Wise Vera Fahlberg shares wisdom too often overlooked. – Ed.

Post-Adoption Services

by Vera I. Fahlberg, M.D.

Caseworkers often perceive placement of a child in an adoptive family as the end of the work. Although placement may signal the end of the child's sojourn within the child welfare system, in reality it is the beginning of a life-long journey that, hopefully, will lead to overcoming the effects of whatever traumas led to the child entering the system as well as the negative impact of experiences he may have experienced while in care.

Children who join adoptive families after experiencing abuse, either physical or sexual, neglect, parental separation and loss bring with them a legacy of failed family relationships. Their new family provides a new hope, and possibility, for them to more successfully experience the intricacies and benefits of family life.

Although previous life experiences may have led to emotional insults that may benefit from formalized therapeutic interventions, primary healing, if it is to occur at all, will occur within the contexts of day-in, day-out family life. It is the result of the interface between the characteristics of the child and family that leads either to healing for the child or to disruption of the placement. According to Barth and Berry the characteristics of the child, his behaviors, temperament, habits, and academic skills are important only in relation to family characteristics and patterns.

Children and parents alike come to adoption with some added risk factors when compared with children joining their permanent family at the time of birth.

Child risk factors include:

- survival behaviors which originated when they lived in dysfunctional families and a dysfunctional system
- individual vulnerabilities
- previous traumatic events
- unresolved separations or losses

Parent risk factors may include:

- lack of empowerment and entitlement
- "echoes" from their past
- unrecognized or unresolved losses -
- unrealistic expectations for child or self

Elbow identifies three facts in older child adoption that contribute to difficulty in mastering family developmental tasks.

1. distortion of family life cycle: adoptive families begin with distance and are expected to move toward closeness; birth families start with symbiosis and are expected to move toward individuation
2. stress on family boundaries caused by agency intrusiveness; by lack of family's empowerment by society and agency; and by child's conflicted loyalties.
3. individual issues of the child and echoes from the past for the parents.

Because of the nature of special needs adoption, involvement with post-placement services and mental health resources should be considered a normative part of this adoptive family's experience.

Adopted children and their families are best served when there is collaboration between the family, social service agencies, and mental health resources. Each recognize not only what they, but also what the others, have to offer.

The family:

- provides the foundation on which the child's continued development is dependent
- provides the environment for change
- provides continuity and commitment
- the fact that the family needs help in meeting the child's needs does not mean that they do not care or that they are incapable of participating in decision making.
- if the family is made to feel impotent it is harmful to the overall treatment.
- if the family is recognized as doing the best they can in difficult circumstances and as having an important role in any change process, they can be stronger partners.
- unfortunately, families may not seek help until they feel overwhelmed and desperate and at that point in time they will present themselves at their worst. Many times it is difficult to have a solid assessment at that time of the parents' long range capacities.

Social workers:

- have knowledge of how the system works
- are more likely than others to know how to access information about the child's specific past history, information that may be critical to providing adequate treatment
- can help families locate and access the specific services that they need (i.e support services, respite care, therapists knowledgeable about adoption)
- can provide information to therapists about common behaviors seen in "systems" children
- predict times that will be difficult for child and family (based on developmental information and knowledge about anniversary reactions, etc.)

Mental health professionals:

- may provide assessments of families and children, both before and after placements
- may be able to intervene early enough that they can help prevent problems from becoming entrenched
- may help families connect with support groups
- do direct work with children and families when there are ongoing problems
- provide information as to when families might anticipate future problems
- be involved in crisis intervention
- may help determine if out-of-home care is necessary and the level of care that would be most useful.

Post-adoptive services need to be provided by individuals who:

- understand adoption related issues
- understand the social service and legal systems and their impact on the child prior to placement
- are supportive of the adoptive family's role and importance in the child's life
- include the parents in the assessment, planning and treatment
- will work with parents to develop strategies for behavioral interventions
- will collaborate with others who are involved with this child and family (i.e. schools etc.)

Post-adoptive services may take a variety of forms:

- supportive services (groups for parents, children, respite care, training and educational services) can meet the needs of many adoptive families.
- services aimed at helping the child and family come together soon after placement
- intermittent preventative therapy which is instituted as children reach certain developmental levels that are likely to lead to retriggering old issues (i.e. sexual abuse, loss, identity, etc.)
- intermittent short term problem focused therapy aimed at interrupting problem behaviors
- crisis intervention with threatened families

Support services:

Families who were prepared for adoption using a group process frequently use other group members as an informal support system. Agencies may provide parent support groups; or help individual families connect with others who have had a similar problem; may provide parent education presentations. Even those families who need more intensive services, view support services as helpful. Respite care can be a very useful service, but unfortunately families are frequently left to their own devices in terms of providing it on a regular basis.

The PARTNERS project in Iowa arranged respite care for special-needs children one weekend per month at a local camp. This was combined with a week long summer camp as well.

Even those families who need more intensive services, still tend to view support services as helpful. Initial post-placement services aimed at helping the child and family come together as a unit. The emphasis is on resolving current separation and loss issues, addressing current behavioral problems and facilitating the attachment process. The focus is primarily on the present. According to Linda Katz, the client is neither the child nor the parents, but rather the relationship. During this period the provider should prepare families and children for identifying times that preventative work might be undertaken and for times that old problems are likely to re-emerge.

Preventative work:

New cognitive skills, combined with current life experiences, will lead to repeated opportunities for reintegrating the effects of earlier life experiences. Understanding the developmental tasks presented at various ages helps professionals and family members alike to understand the impact of pre-adoption events and to make use of opportunities provided to overcome these effects. When adoption issues are not addressed at these developmental times, it will be difficult for the adoptive family and young person to master the developmental tasks at hand.

Intermittent short-term problem focused therapy:

When families are faced with living with children with disturbing behaviors, they are looking for therapy with goals and timelines that they and the therapist agree to. Parents tend to abandon therapy when they are not included and when the therapy does not address the behavioral concerns that initiated the parental request for intervention.

Crisis intervention with threatened families:

Kay Donley and Maris Blechner identified threatened families as usually being those with a long-term adoptive relationship in place; with evidence of repeated self-destructive or violent behavior by the child; these episodes of problem behaviors are intensifying; the parents may have made a variety of unsuccessful efforts at obtaining help; the parents feel that the situation is out of control.

According to Pam Grabe, this is not the time to question to family's commitment, the size of their family or their motivation to adopt. It is a time to offer some initial relief that will help the family hang together until substantive improvements in the relationships can be achieved. This will include a more complete assessment and being flexible in providing services that can help this family unit.

Donley and Blechner point out that it is very important that the intervenors not mistake these families for chronically troubled families who have never experienced a period of relatively calm adjustment. Many times these are very competent parents who may have difficulty convincing others of the seriousness of the problem. They may be more skilled than the people they are turning to for help, who in turn may be intimidated by the parents.

In general these parents either didn't expect the adolescent to have as severe behavior problems as are evident or they misperceive the long-range prognosis. The family may be under a variety of current stresses. The young person's individual pathology may be becoming more evident.

Intensive adoption preservation services are called for. These include all aspects of support services, including short-term out-of-home placement. The overall goal at this time is to engage the families in treatment and to help them see the problems in a realistic context. During the provision of these intensive services, it may become apparent that the young person needs out-of-home care. It is important that this be provided in a timely enough manner that the family continues to be available as a long-term resource for the youngster.

TRADITIONAL THERAPY APPROACHES ALONE HAVE NOT BEEN PARTICULARLY SUCCESSFUL WITH THIS POPULATION

Individual non-directive therapy with the child:

- frequently never addresses the issues of abuse or neglect if the child does not introduce these topics
- rarely focuses on the behavioral issues that ultimately will determine whether the child remains in the placement
- tends to disempower the family and distance them; does not focus on family relationships
- may never identify the child's misperceptions

Traditional family therapy

- views the child's behavioral problems as a manifestation of the overall family dysfunction
- does not take into account the concept of imported pathology (child bringing pathology into family
- may view parent as more part of the problem than part of the solution

Adoptive families, who represent the source of real change and remediation, must be actively involved in the healing strategies.

BELIEFS IN FAMILY SYSTEMS APPROACH TO TREATMENT IN SPECIAL NEEDS ADOPTION

- Although the adoptive family is not the source of the child's problems, it is within the context of family relationships that primary healing occurs
- It is the result of the interface between the characteristics of the child and family that leads either to healing for the child or disruption of the placement.
- Many children are internally driven to reenact their earlier life experiences in the new family setting
- The reenactment may lead to the adoptive parents looking quite dysfunctional by the time they seek help
- It is more important that the non-helpful patterns of family interactions be interrupted and new interactional behaviors be learned than that either parent or child be seen as the "cause" of the problem
- Therapists need to empower the adoptive parents by including them in the therapeutic interventions
- When under stress, and feeling vulnerable, individuals (parents and children alike) become more defensive, resistant and frequently more rigid
- Although neither the adoptive parent nor the therapist can undo the early damage from inadequate nurturing or abuse, they can minimize the scarring and help the adopted individual compensate by learning new skills.
- Any intervention that threatens the parent-child relationship undermines the goal of preserving the family as a resource for the child.
- Although we might prefer the "best interests of the child" standard, in reality we must frequently invoke "the least detrimental alternative available" standard.
- Decisions must be made considering not only the identified child's needs, but also the interests of the family as a whole, as they will impact parents, siblings and extended family members as well.

WHEN OUT-OF-HOME PLACEMENT IS NECESSARY:

Out-of-home placement may be indicated in a wide variety of circumstances ranging from brief respite to lengthy residential treatment; from assessment to treatment. Special needs adopted children have many reasons for possibly needing the most intensive therapeutic interventions.

Out-of-home placement should not be considered an adoption failure. Indeed, it may be a strong indicator of an adoption success when the family recognizes that their young person needs more help than they alone can provide and they are willing and able to advocate that their child receive this help.

Children who are not experiencing success in any of the major arenas of their life—family, school and peer relationships—are frequently candidates for out-of-home placement. Family and professionals should also be assessing the child's functioning within the community and his/her more personal functioning. Looking at these areas in detail frequently help determine the most beneficial type of placement.

Grotevant and McRoy in their research on adopted children in residential treatment found that although adopted and non-adopted youth in residential treatment had similar behaviors and diagnoses, there were significant differences as well. When compared with the control population, the parents of adopted youth had less mental health pathology and more stable marriages. Of the 50 adopted individuals studied in 33 cases the adoption played a major role in their emotional disturbance; in 9 cases it played a minor role and in 8 cases it seemed to be playing no role.

The intensity of family life at the period when the young person is reintegrating earlier life experiences and redoing the tasks associated with individuation and identity formation may interfere with successful achievement of the tasks at hand. Some youth are able to make much better use of their family when they are not living with them. The family may be able to be more emotionally supportive, because they are less drained, in this situation as well.

Summary: The goal of all post-placement services is to aid in maintaining the long-term commitment and accessibility of the family as a positive influence in the adopted individual's life.

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This paper developed for her training workshops for child welfare professionals is related to material from Dr. Fahlberg's book A Child's Journey through Placement. Find this article and others on the internet at http://www.perspectivespress.com/ourfactsheets.html. Reprinted with permission from Perspectives Press Fact Sheets, with thanks to Patricia Johnston. Perspectives Press, P.O. Box 90318, Indianapolis, IN 46290-0318 USA * (317)872-3055

North American Council on Adoptable Children March 2003

Adoptive Parent Leadership Network

Children with Special Needs:

Helping Families Access Services and Information

An overwhelming number of foster and adopted children have a variety of special needs, and parent groups often have to address the many issues related to those special needs. As a group leader, your role is to provide group members with information on where to get reliable, comprehensive resources and where to find training opportunities from qualified experts who also understand the issues of adoption. You don't have to be an authority on attachment, fetal alcohol syndrome and effects (FASE), attention deficit disorder (ADD/ADHD), or any of the complex special needs common to adopted and foster children to help families in your group. Your group can do a variety of things to increase the effectiveness and quality of the services you offer to parents by creating a resource library and a directory of local and regional services, hosting a training for families, sending parents to training, by periodically providing current information and new resources at your meetings, and facilitating group discussions on a variety of special needs topics.

Building a Resource Library

The first step toward providing resources to your members is to have your group gather quality books, magazines, articles, videos, and materials from web sites that provide information on the most common special needs for adoptive and foster families. The most common issues that affect many foster and adopted children are attachment, FASE, ADD/ADHD, learning disabilities, and behavioral, emotional, and mental health problems. As you build your library, gather other specialty resources that reflect the specific needs of your group. For example, if a group member's child is autistic, include resources on that topic too. Listed in the insert are resources that experienced parents who have children with special needs have found useful, practical, and easy to apply to family life.

One way to build your group's resource library is to ask each member to choose a different book to donate to the group. To expand your library, you can have an annual group anniversary party where everyone brings a new resource to add to your collection. Members who have access to the Internet can make copies of some of the most useful information on web sites to share with those who are not connected to the Internet. Search out local, regional, and state- or province-wide brochures from adoption or foster care related services, support organizations, and from doctors' and therapists' offices.

As part of the library, you should create a directory that provides contact information for quality local and regional support services for:

- qualified doctors and therapists who understand the issues of adoption
- regional, state, provincial, and national advocacy organizations
- county and private agencies
- adoptive and foster parent support group information
- training on specific topics helpful to foster and adoptive families

Once your group develops your resource library and directory, organize a way to pack and carry everything when your group travels (such as a rolling suitcase). Some rural groups trade off meeting in different members' homes and need an easy way to transport the resources from place to place.

Other groups need a handy way to store and transport materials when they run a booth at a conference or other adoption or foster care events.

Developing Your Group's Training Potential

Think Broadly

It is important to widen your scope and see the training possibilities and support your group can receive outside your immediate area. Some groups get locked into thinking they have limited resources and can only take small steps toward helping the families in their area. Sometimes groups outside a major metropolitan area complain there aren't any experts in their community, when in fact experts are an hour or two away by car and would be more than willing to provide training.

One way to ensure that your group can bring in an expert from out of town is by partnering with other groups in your area. Several groups can pool their resources to plan a training in a central location and divide the costs. Gathering a larger audience for the training can make it more attractive to the speaker and more affordable for families.

Keep in touch with groups in your area, region, state, or province and discuss other ways you can unite efforts to provide services to families. Be open to learning from each other. Some groups have great tips for how to provide support to families and other groups are talented in planning strategies to access services.

This fact sheet is the seventh of a series produced by the North American Council on Adoptable Children (NACAC) through an Adoption Opportunities grant (#90CO0913) from the U.S. Department of Health and Human Services' Children's Bureau. We encourage you to reproduce and distribute this fact sheet. Under this grant, NACAC operates the Adoptive Parent Leadership Network to offer resources and support to adoptive parent groups. For more information, contact:

Diane Martin-Hushman, Parent Group Coordinator
North American Council on Adoptable Children
970 Raymond Avenue, Suite 106 • St. Paul, MN 55114
651-644-3036 • info@nacac.org • www.nacac.org

Writer/Editor: Janet Jerve

Labels are for Jars Not Children

Parents usually don't mean to talk about their children in terms of their diagnoses, but it happens sometimes when they want to quickly convey the daily problems they cope with as they parent. As a group leader, gently remind parents to avoid describing children as a series of acronyms such as RAD, ADHD, FAS, and EBD. These labels help children qualify for services and give parents a starting point for finding help, but children are much more than their diagnoses.

Choosing a Speaker

When you choose a speaker, look for an informed expert who is also a dynamic speaker and will relate to your audience. Some people have a clear understanding of the material they are presenting, but aren't good speakers. Make sure you are clear about the depth and scope of the topic you want that person to cover. You can survey your audience prior to the presentation to get accurate information on what will best meet their needs and inform the speaker in advance.

If you are unsure where to find a speaker, ask people you respect to recommend quality presenters they have heard. Survey other parent group leaders and members, call county and private agencies and advocacy organizations like NACAC to get recommendations of quality speakers you can afford. Some speakers will speak pro-bono and others will charge a fee. You will have to weigh quality with what you can afford. Sometimes speakers will trade time and skills if you can provide them with an equally valuable service.

Using Videos

When you use a video, make sure your purpose is clear and reflects the needs of the group. Set high standards and only use quality videos. Take time to preview the video first to make sure the content contains current, accurate information. As you preview the tape, create an outline of main ideas to help the audience track the important points of the video. Write a list of open-ended questions you can ask to stimulate discussion after the group watches the video. The video should teach new information, stimulate group discussion, and help develop group problem-solving skills.

Encouraging Parents to Get Information

Parent group leaders should encourage parents to get as much background information as they can about their children. This should happen before the adoption, but if it didn't, tell parents to go back to their agency and get more information. Make sure there are no gaps in the information and if there are, insist on knowing what happened during that time period. Share these questions with parents in your group:

- Where was my child during the first two years of life?
- How many moves did my child have in foster care?
- Can I talk to the foster parents to learn more about my child's past?
- Is there a history of mental illness or other medical problems in my child's birth family?
- Is there a record or signs of alcohol use or drug abuse during pregnancy?
- Was my child born prematurely?
- Were there signs of abuse or convictions for abuse against my child?

You will also want to get information on your child's educational history, medical records, and a social history from your agency.

Helping Parents Choose a Good Therapist

Set aside some group time for parents to discuss how to choose a good therapist. Allow group members who have found good therapists a chance to speak at the meeting. Facilitate group discussion and develop a list of tips for what to look for in a good therapist. Remind parents that they are in a position of power when they are choosing a therapist and they should:

- Take the time to interview more than one therapist.
- Look for a therapist who understands the seven core issues of adoption (listed below).
- Make sure the therapist values the attachment you already have with your child and is willing to nurture and reinforce it.
- Choose a therapist who knows when to work with the whole family and values the family (not the therapist's office) as a place where children heal.

Seven Core Issues of Adoption

The parent and child in an adoptive family have an unshared genetic and social history that professionals must take into account when planning intervention strategies. The most helpful therapists and experts are those who understand the seven core issues of adoption and know that they resurface often in the lives of any member of the adoption triad. The following information has been adapted from the work of Deborah N. Silverstein and Sharon Kaplan. Although their work specifically relates to adoption, much of the information can also be applied to foster children.

- Loss. Adopted children morn the loss of their birth parents, even when they are happy with their adoptive family. Their loss can feel more prominent at various developmental stages, but especially as a teenager or young adult.
- Rejection. Adopted children often feel rejected by their birth parents and subsequently avoid situations where they might be rejected or provoke others to reject them to validate their negative self-perceptions.
- Guilt/Shame. Adopted children often believe there is something intrinsically wrong with them and that they deserved to lose their birth parents, which causes them to feel guilt and shame.
- Grief. There is no ritual to grieve the loss of a birth parent. Suppressed or delayed grief can cause depression, substance abuse, or aggressive behaviors.
- Identity. Adopted children often feel incomplete and at a loss regarding their identity because of gaps in their genetic and family history.
- Intimacy. Many adopted children—especially those with multiple placements or histories of abuse—have difficulty attaching to members of their new family. Early life experiences may affect an adopted child's ability to form an intimate relationship.
- Mastery and Control. Adopted children sometimes engage in power struggles with their adoptive parents or other authority figures in an attempt to master the loss of control they experienced in adoption.

Providing Parent-to-Parent Mentoring

One group strategy to help new parents who may be struggling raising a child who has special needs is to establish a parent-to-parent mentoring program. For example, parents who have successfully helped their child bond can be partnered with parents who are raising a newly adopted child who is fearful and resisting forming an attachment. Sometimes a behavioral incident that is viewed by a new parent as being a crisis is clear evidence to the mentor that progress is being made and the child is beginning to bond, but still feels afraid. These mentoring relationships are usually mutually beneficial. Many experienced mentors enjoy sharing the wisdom they worked hard to learn but also learn valuable information from the parents they mentor.

Using Meetings to Help Parents

Talk about Child Development

It is important for parents to periodically review normal child development to understand how special needs can affect a child's development. Most children with special needs have developmental delays, learning problems, and require special care. It is important to provide group meeting time to review various special needs diagnoses, help parents realistically assess their children's developmental ages, and plan strategies for how best to deal with behavior and learning problems.

Parents can easily lose track of what is normal for their individual child. For example, new parents may notice that their recently adopted eight-year-old struggles with sharing, is clingy and staunchly independent, and continually tells lies. They may realize their child is not acting like other eight-year-olds and become overly worried about their child. A child, however, may be delayed and act more like a four-year old. It is normal behavior for four-year-olds to have trouble sharing and to experiment with lying. This is the age where children learn how to share and to distinguish between the truth and lies. Any trauma experienced when the child was four can delay learning these skills.

Parents can offer each other support for accepting children at their developmental age and share strategies for helping their children learn and grow.

Encouraging Parents to Care for Themselves

Many foster and adoptive parents focus solely on what they have to do to take care of their family. One of your roles as a leader is to help parents remember they need to take care of themselves first, because their children need them to be up to the challenge of parenting. A burned-out parent is too easily depleted of the energy needed to raise children. Think of creative ways your group can promote self-care skills among your members.

Maybe your group can begin each meeting asking what parents did during that month to take care of themselves. Award a prize to the parent who has modeled the best self-care habits during a three- to six-month period. Make a group pact to:

- surround yourselves with support by talking to friends on a regular basis and not isolating yourselves when you experience problems
- take time in your day or week to get regular exercise
- use respite care on a regular basis if necessary
- take a vacation
- protect your personal time (even if it is just a daily soak in the tub)
- set realistic expectations
- learn to say *no* and avoid adding more duties to an already busy life

Sharing Success Stories

Parents need to know their children can heal from trauma and their family can build a trusting, loving bond. Plan a group meeting where each family shares a success story. Those who are in crisis can share small steps toward resolution and peace or just listen to how things improved in other families.

Some groups write their success stories and put them in a notebook for families to read as needed. You can ask parent groups in your region to contribute stories to be compiled into a book. A wider variety of stories is more likely to strike a chord with more families. It is good to tell and celebrate the hopeful stories that demonstrate family success.

Another way to focus on the positive is to bring in adults who have lived with some of the same disabilities your children have, such as ADD/ADHD. Ask them to speak about how they learned to cope with their problems and their transformation into the person they are today. It is good for parents to see how children with special needs can make choices for their future to reach their potential.

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Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families, Terry M. Levy and Michael Orlans, Child Welfare League of America Press, Washington DC, 1998.

Building Bonds of Attachment: Awakening Love in Deeply Troubled Children, Daniel A. Hughes, Jason Aronson Inc., Northvale, NJ.

Facilitating Developmental Attachment, Daniel A. Hughes, Jason Aronson Inc., Northvale, NJ, 2000.

Fostering Changes: Treating Attachment-Disordered Foster Children, Richard Delaney, Walter Corbett Publishing, Fort Collins, CO, 1991.

When Love Is Not Enough: A Guide to Parenting Children with RAD—Reactive Attachment Disorder, Nancy Thomas, (Order from Families By Design, P.O. Box 2812, Glenwood Springs, CO.)

Raising Children Who Refuse to be Raised: Parenting Skills and Therapy Interventions for the Most Difficult Children, David Ziegler, Ph.D., SCAR/Jasper Mountain, Jasper, OR, 2000.

The Association for Treatment and Training in the Attachment of Children (ATTCh), www.attach.org

Child Trauma Academy, www.childtrauma.org

ADD/ADHD

Attention Deficit Disorder Sourcebook, edited by Dawn D. Matthews, Omnigraphics, Detroit, MI, 2002.

How to Reach and Teach ADD/ADHD Children, Sandra F. Rief, Jossey-Bass, 1993. (To order call: 800-288-4745: Item 087 6284136)

Living with ADHD: A Practical Guide to Coping with Attention Deficit Hyperactivity Disorder, Rebecca Kajander, C.P.N.P., M.P.H., distributed by Park Nicollet Health Source, Minneapolis, MN. (800-372-7776)

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), www.chadd.org

FASE

Children with Fetal Alcohol Syndrome: A Handbook for Parents and Teachers, Larry Burd, Ph.D., 1999. (Must be ordered from: Larry Burd, 1300 S. Columbia Road, Grand Forks, ND.)

Fantastic Antoine Grows Up: Adolescents and Adults with Fetal Alcohol Syndrome, edited by Judith Kleinfeld and Siobhan Wescott, University of Alaska Press, Fairbanks, AK (907-474-6389).

Fantastic Antoine Succeeds: Experiences in Educating Children with FAS, edited by Judith Kleinfeld and Siobhan Wescott, University of Alaska Press, Fairbanks, AK (907-474-6389).

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Fetal Alcohol Syndrome and Fetal Alcohol Effects, Diane Malbin, Hazelden Books, Minneapolis, MN, 1993.

Recognizing and Managing Children with Fetal Alcohol Syndrome/Fetal Alcohol Effects: A Guidebook, Brenda McCreight, Child Welfare League of America, 1997.

The ABCs of FAS/FAE: Teachers Guide and Resource Booklet, www.lcsc.edu/education/fas/FAS.html

Fetal Alcohol Syndrome, www.come-over.to/FAS/

PARENTING CHILDREN WITH SPECIAL NEEDS

A Child's Journey through Placement, Vera Fahlberg, Perspectives Press, Inc., IN, 1991.

A Parent's Guide to Understanding Sensory Integration, Sensory Integration Intervention. (Call 310-320-9986 to order.)

Adopting and Advocating for the Special Needs Child, L. Anne Babb and Rita Laws, Bergin & Garvey, Westport, CT, 1997.

Adopting the Hurt Child, Gregory Keck, Ph.D. and Regina Kupecky, L.S.W., Piñon Press, Colorado Springs, CO, 1995.

The Healing Power of Families, Richard J. Delaney, Ph.D., Wood 'N' Barnes Publishing, Oklahoma City, OK, 1995.

Helping Children Cope with Separation and Loss, Claudia Jewett, Harvard Common Press, Harvard, MA, 1994.

Grandparents as Parents: A Survival Guide for Raising a Second Family, Sylvie DeToledo and Deborah Edler Brown, The Gilford Press, New York, NY, 1995.

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Troubled Transplants: Unconventional Strategies for Helping Disturbed Foster and Adopted Children, Richard J. Delaney, Ph.D., and Frank R. Kunstal, Ed.D., Horsetooth Press, Fort Collins, CO, 1993.

Scholastic, www.teacher.scholastic.com/professional/bruceperry/index.htm (Internationally known Dr. Bruce Perry lists his published articles on topics such as brain development, attachment, and learning strategies. They are available to be copied by teachers and parents.)

VIDEOS:

Multiple Transitions: A Young Child's Point of View on Foster Care, Michael Trout, The Infant-Parent Institute, Champaign, IL.

Parent to Parent Video: A Mentoring Program, Richard J. Delaney, Ph.D., Wood 'N' Barnes Publishing, Oklahoma City, OK, 1999.

Rebuilding the Broken Bond #1: For Reactive Attachment Disorder, Nancy Thomas, P.O. Box 2812, Glenwood Springs, CO, 1998.

Rebuilding the Broken Bond #2: For Reactive Attachment Disorder, Nancy Thomas, P.O. Box 2812, Glenwood Springs, CO, 1998.

Redefining Success: Raising Children Exposed Prenatally to Alcohol, Ministry of Children and Family Development, British Columbia, Canada, 2001.

Re-Education of Foster and Adopted Children: Prospects for a Healthy Life, by Vera Fahlberg, M.D., (70-minute video & viewer's manual or DVD & viewer's manual)

Safe Environment for Foster Children Parts I & II: Managing Acting Out Behavior, (41 min. video and viewer's manual)

S*afe Environment for Foster Children Part III: A Time and Place for Healing with Dr. Vera Fahlberg*, (40 min. video and viewer's manual)

Tender Healing, by Vera Fahlberg, M.D. and Richard J. Delaney, Ph.D., (45-minute video) (To order call 800-777-6636 or www.sociallearning.com)

North American Council on Adoptable Children March 2002

Adoptive Parent Leadership Network

Adoption and the Schools

Children who are adopted or live in kinship or foster care bring with them an additional history and set of experiences when they enter the classroom. Part of that history includes many unknowns. No parent, child, or teacher would ever choose a public place like school to be a source of misunderstanding, misinformation, embarrassment, or pain for a child. Unfortunately, thoughtless remarks and exclusive assignments cause hurt feelings, tearful homework battles, confusion, and sleepless nights for many adopted and foster children and their families. Some of the common assignments that present a challenge to these children are family history projects, providing baby pictures, writing autobiographies, making family trees, genetic analyses, and student of the week displays. Sometimes first-time adoptive parents have been taken by surprise (as described in the story about David on page 2) and haven't known how to be proactive or how to avoid the pain these assignments can bring.

Many children who are adopted or in foster care don't have the information needed, or the life experiences that fit neatly into the model of a traditional family tree. Adoptive and foster parents across the country do not necessarily want teachers to stop giving assignments that examine the family unit, they simply want more variety and alternatives to the "one family fits all" format for many of these assignments. As all parents do, foster and adoptive parents want their child to fit in and to be included. Blended families who have united after divorce or the death of a spouse, single, step, and same gender parents also want the same consideration. Besides providing alternative models for the above assignments, it is absolutely crucial for educators to model positive language to appropriately name and describe various aspects of adoption. Using positive language means choosing words that show respect for birth parents, adoptive and foster parents, and adopted children. (See the inserted chart *Positive Adoption Language*.)

Adopted children often have unanswered questions about their origin and experience pain due to the loss of their birth parents, even if they are happy and thriving in their adoptive families. These feelings of loss are normal and often become more intense at various developmental ages, such as during pre-teen and teenage years. The additional pressure children feel if they have to deliver, display, or present an assignment that accentuates how they are different in front of their peers can magnify those losses.

Leah O'Leary, executive director of A Red Thread Adoption Services Inc., in Massachusetts says, "I believe kids today are extremely vulnerable in school situations, especially in any area where they feel different from other kids. Adoption is just one way in which kids can feel different because of antiquated attitudes and bias. Simple school assignments such as baby pictures, family trees and cultural heritage can raise questions and uncertainties for teachers and children alike." (www.celebrateadoption.org)

This fact sheet will:

- inform parent group members of some successful educational efforts achieved by parent groups across the country, and offer tips for how your parent group might affect a school system.
- provide parents with advocacy survival tips on behalf of their school-aged adopted children and children in foster or kinship care.
- provide examples of alternatives for problematic school assignments (handouts enclosed).

Parents as Leaders

Parents and parent groups can make a tremendous impact on how teachers, schools, and educational systems treat the individual child and the subjects of foster and kinship care and adoption. Not all school administrators or teachers are equally informed about adoption, and because of this, adoptive parents are often the ones who take the lead to educate the educators. Parents do not need to give all the personal and detailed descriptions of their child's past, but information that will help the teacher provide a more nurturing, inclusive, and thoughtfully structured learning environment is important to all concerned.

> An adoptive father in Milwaukee, Wisconsin, was concerned when his son David* was asked to bring a baby picture to school for a class project. "David joined our family as a six-year-old, first as a foster child and later we adopted him. His third grade teacher asked each child to bring a baby picture so students could try to guess which person matched each baby picture. We didn't have any baby pictures or childhood pictures at all before age six, and I worried about his feelings through this whole thing. I wish I could have warned the teacher ahead of time, but I didn't see it coming," said the father. Then he added, "We found a picture in a magazine that looked like what David might have looked like, and spiffed it up with some cool backing paper. David knew it wasn't him, though."
>
> *name has been changed

Lois Melina, author of *Raising Adopted Children*, believes parents should inform teachers and other professionals who provide services to their children. She writes [p. 87]:

> …I realized that a child's adoptive status is part of his social history and that schools need to know the social histories of their students. At the same time, parents should not expect that teachers or administrators are informed enough about adoption to know when it may be an issue for a child. So, at the same time that we inform the teacher of our child's adoptive status, we should also take a few moments to ask if the teacher has any classroom assignments coming up that deal with families or genetics. We should discuss with the teacher how he plans to handle those assignments in such a way that our child is able to complete them without being singled out as an "exception". In many cases, when children are given enough flexibility, they can come up with their own creative and insightful ways of completing the assignment so they satisfy the teacher while maintaining a sense of privacy and control.

Doug Lewis, an adoptive parent from Michigan Foster and Adoptive Parent Association (MFAPA), has been fortunate with his children and their school experiences: "I tend to head things off at the beginning of the year and explain the situation with my children. I tell the teachers the trouble spots with some kinds of assignments." Although unforeseeable situations can arise, Doug believes "it's better to deal with the issues before there is a problem than after." Doug adds, "I've personally never met a teacher who didn't care about one of my children and want to spare them pain or embarrassment."

Parents know their children better than anyone else and should follow their instincts about how to be the best advocate. One parent might initially tell the teacher that her child is adopted and forewarn the teacher about assignments that might be impossible or painful for her child to complete—then back off to let the child take the lead unless problems arise. Another parent, perhaps one with a child who has significant special needs, might want to set up regular check-in meetings with the teacher throughout the year.

Parent Groups Making an Impact on Schools

Parent groups all across North America are making an impact on how schools treat the subjects of adoption, foster care, and kinship care. Parents in these groups know this topic affects the deepest sense of self in their children. Other groups can use their resources and learn from their experiences.

Baltimore, Maryland

Jennifer Klotz, a longtime trainer on adoption and the schools from the Center for Adoptive Families in Baltimore, Maryland, helped develop and has provided

adoption awareness training in the Baltimore and Washington area schools since 1993. She says her group has continued to be successful with training because they remain flexible and have expanded their curriculum to include foster and kinship families into the scope of their training. The number of foster and kinship families has increased in the Baltimore and Washington area and has heightened the awareness of families that are built in non-traditional ways. "It's odd," she says, "but if I just mention adoption, sometimes administrators say they don't have any adopted children in their school (whether it's true or not) and therefore they feel there's no need for training. But no one can ignore the rise in kinship and foster children attending our area schools, and now they welcome our presence. We do whatever it takes to increase adoption awareness."

Jennifer adds, "Our training presentations range from 10 minutes to two hours depending on the time that is available to us. Some audiences—especially where there are high concentrations of children in adoptive, foster, and kinship families—want even more time from us." Jennifer also said that in addition to providing handouts on positive adoption language and difficult assignments, she always tells teachers to do the following three things:

- ➢ Mention adoption—If teachers mention every other kind of family but neglect to mention adoption, an adopted child will feel shame and embarrassment.
- ➢ Have at least one book on adoption in every primary classroom.
- ➢ If a child tells you he or she is adopted all you need to say is—"What a wonderful way to build a family!"—and leave it at that.

One of the keys to the success of the Center for Adoptive Families' adoption awareness program has been targeting guidance counselors. Jennifer elaborates, "We have developed a good rapport with many of our schools' guidance counselors and it has opened doors to get us on the agenda for staff meetings. Some principals now pull us in to train staff on a regular basis and also when specific adoption issues come up. There are schools that invite us to come every other year because new staff have been hired and need the awareness training." The Center for Adoptive Families has also learned that simple bulleted handouts limited to no more that 5 to 10 pages are the most helpful to teachers. Their book, *Adoption Awareness in Our Schools: A Training Manual,* is available for purchase.

Tucson, Arizona

The Arizona's Children Association received a grant from Casey Family Programs to develop a teacher training kit that focuses on family diversity with an emphasis on adoption. They created a video and training manual to train guidance counselors on the school-related issues for foster, adopted, and kinship care students. The idea for training school counselors was that the counselors can then train the teaching staff. The video and curriculum guide can be kept in the library for further use or as new teachers join the staff.

Anna Loebe, from Post Adoptive Families Together in Tucson, Arizona, also used the curriculum and video when she was an instructor in the College of Education at the University of Arizona. "The video made a tremendous impact on the student teachers. Many of them had never thought about adoption and had no clue of the impact insensitive curriculum could have on children who were adopted. The students were quite receptive and in strong support of the information they learned. Many of them were surprised they had never been made aware of this issue before." says Anna.

Anna was especially excited to be able to use Arizona's Children Association's curriculum with teachers before they started teaching. "I wanted to reach teachers before they began their careers and help them understand a more

continued on page 6

This fact sheet is the third of a series produced by the North American Council on Adoptable Children (NACAC) through an Adoption Opportunities grant (#90CO0913) from the U.S. Department of Health and Human Services' Children's Bureau. We encourage you to reproduce and distribute this fact sheet. Under this grant, NACAC operates the Adoptive Parent Leadership Network to offer resources and support to adoptive parent groups. For more information, contact:

Diane Martin-Hushman, Parent Group Coordinator
North American Council on Adoptable Children
970 Raymond Avenue, Suite 106 • St. Paul, MN 55114
651-644-3036 • info@nacac.org • www.nacac.org

Writer/Editor: Janet Jerve

While parent groups promote change within a school system, most parents will also want to advocate for their child's individual needs. The following two pages offer tips for how parents can support the learning needs of their children

Strategies for Parents to Use as Educational Advocates for their Children

- **Be prepared.** Before school starts, think about what you and your child need to talk about so that he can respond to issues that may be raised at school. Give your child the tools he needs to respond to comments from classmates. Be prepared to respond to difficult situations that may arise.
- **Be proactive.** If you want it known that your child is adopted, inform each new teacher. Meet with the teacher at the beginning of the school year. Use your judgment about how much history is appropriate to share. It is not necessary to share personal details about your child's history, but general information can be important to help get the year off to a good start. For example, if your child has experienced multiple moves it might help to explain to the teacher that your child might need extra support during transitions, such as between classes, before vacations, and at the end of the year.
- **Be an educator.** Provide teachers and administrators with positive adoption language, as well as an explanation of why it is important to use positive language. If adults in your child's school present adoption in a positive light, it will help students see it that way as well. Provide a list or donate books or movies that have positive adoption themes to the school library or your child's classroom.
- **Be realistic.** Remember that teachers are responsible for working with a classroom of children. Certainly the teacher will work to meet your child's individual needs, but at the same time that teacher is teaching a community of learners, each one having important needs too.
- **Define success**. Children develop at their own pace, sometimes excelling with high academic achievement and sometimes struggling to achieve at grade level. Be open to highs, lows, and plateaus in learning, and be prepared to support your child through all three stages. Be clear about how you and your child will define success and look for ways to celebrate that success.
- **Be an advocate.** Find out about the services that your child may be entitled to, including special education services, one-to-one or small group help from paraprofessionals, and other tutoring possibilities.
- **Be supportive.** Let your child know that you are there for her, and that you want her to enjoy school. Also make it clear that you will work with her school to increase the appropriateness of assignments, educate teachers on adoption issues, and be available to explain adoption to classmates and other families, if desired. In addition to being a strong supporter for your child at school, be sure that she knows that she can talk to you if she feels embarrassed, hurt, joyous, or confused about having been adopted.
- **Work as a team.** Establish a partnership with your child's teacher, counselor, social worker, and principal. Naturally you will be working closely with the classroom teacher, but use all available adult resources. Sometimes an adult outside the classroom can effectively help a child solve problems. A counselor or social worker can track progress through the years and help ensure consistent support from grade to grade.
- **Continue to learn.** As you live and grow with your children, new information is often revealed to you. For example, sometimes suspicions of past abuse and neglect in older adopted children may be revealed as truth. Possibly symptoms such as the characteristics of fetal alcohol syndrome or effects become evident with time in children with complicated pasts. It will be helpful to read and seek information about your growing concerns and alert the school if you feel the newly revealed information may affect your child's performance in school.
- **Join a parent support group.** If you have drifted from a group, either re-connect or find another one that suits your needs. Who better than other adoptive, kinship, and foster parents to support you as you advocate for your child in school? Use the group as a safe place to talk out school concerns and solicit help from the group. Bring a friend or group member with you to school meetings if you need support talking to teachers and working through difficult issues.
- **Plan for the future.** If you sense that your child might be moving into a difficult age, check ahead to see if there are teachers in the upcoming grade level who understand adoption. A teacher who was adopted, has adopted children, or is gifted working with adopted children or children with special needs may be the mentor your child needs. Make an administrative request to have your child placed in such a teacher's room.

Advocating for Children Who Have Special Needs

In "Adoption and School Issues," the National Adoption Information Clearinghouse reports that adopted children may be more likely than nonadopted children to have a learning disability. Although there are no known causes, there are theories for why this might be true:

- ➢ One theory points to the genetic component: that parents who choose to relinquish parental rights may also be more likely to have a learning disability.
- ➢ A detrimental prenatal environment that may have included alcohol, drugs, cigarettes, or poor nutrition is certainly a risk factor for learning problems.
- ➢ An abusive or neglectful early relationship with a birth parent could cause emotional and neurological damage that in turn could produce learning disabilities.
- ➢ Another possible reason why more adopted children are diagnosed with disabilities is that their parents may tend to be overly observant and seek professional help right away.

Whatever the reasons for a learning disability diagnosis, many adoptive parents become the educational advocates for their children with special learning needs.

Parents must first request a special needs assessment from their child's school. Once parents have signed the papers to initiate the referral, federal law requires the school district to make the assessment within a "reasonable amount of time." This time limit varies from state to state. (In Minnesota, for example, districts allow 30 school days.) Likewise, each province in Canada may vary somewhat on the allowed time. Check with your state or provincial education department for the guidelines in your area and learn about your child's and your parental rights.

After a referral, an assessment team will come together and begin to evaluate the needs of the child. This team can include all or some of the following people: principal, psychologist, counselor, social worker, special education teacher, classroom teacher, speech pathologist, and physical therapist. Depending on the needs of the child, members of this team will administer appropriate standardized tests to obtain a measurable result. One of the members of this team will also interview the parents to get background information and discuss the child's medical history.

If the child qualifies for special needs services, the parents and a team of specialists will determine the Individualized Educational Plan or IEP for a child. The IEP can include a combination of academic, physical, social, and emotional goals that best meet the current needs of the child. The IEP is reviewed throughout the year by parents, the classroom teacher, and the team of specialists, and goals are continually evaluated.

Goals initially set too high may be made more realistic if the child becomes too frustrated and the outcome seems unattainable. Goals may also be upgraded and made more challenging when the child meets a desired outcome earlier than expected. If a child is older and received services from another state or country, the new school district may require an update on testing to make sure the IEP goals for the child are an accurate reflection of the child's current needs.

All goals are in some way measurable so the child and parents can see when progress is made. Parents are an important part of this team and are the true experts regarding their child. They carry the knowledge of their children's histories, and witness daily the courage, strengths, and struggles inherent in their lives.

Questions for Parents to Ask Regarding Special Needs Services

- ➢ How will my child benefit by receiving special needs services?
- ➢ What academic, physical, social, and emotional concerns do the teachers and I have regarding my child?
- ➢ What kinds of tests will be administered to determine whether or not my child qualifies for services?
- ➢ What kind of help will my child receive? How often? From whom? In what way?
- ➢ How will my child's school day schedule be affected in order to receive help?
- ➢ How will special needs services affect my child's learning time with peers?
- ➢ Will we also discuss my child's strengths and abilities, as well as concerns?
- ➢ What areas of learning will be focused on and how will growth be measured?
- ➢ How will we be involved in the IEP plan?
- ➢ How will we all know when progress is made?
- ➢ What will be expected at home and at school?
- ➢ How will we know if things are going well or not?
- ➢ How might the IEP change over time? ✧

inclusive way of viewing the family unit. I wanted to catch them before they unknowingly left any child out."

Arizona's Children Association's teacher training kit includes a 20-minute video, a 40-page workbook with easy-to-use curriculum for individual and group training, a computer disk for handout reproduction, and examples of alternative assignments. Purchasing this kit might be a more viable alternative for a parent group than seeking a grant to produce similar materials.

Palo Alto, California

In 2001, Families Adopting in Response (FAIR) in Palo Alto, California, published *Adoption and the Schools,* a resource manual for parents and teachers. It is a 250-page manual which was funded by a NACAC mini-grant. The book, written by Lansing Wood and Nancy Ng, includes:

- ➢ the history of adoption
- ➢ school presentation suggestions
- ➢ a child's understanding of adoption at different stages of development
- ➢ special education challenges
- ➢ children's written and artistic expressions
- ➢ parent-teacher communication
- ➢ resource list
- ➢ solutions to problem assignments

This manual offers adapted assignment examples for teachers, some of which are enclosed within this fact sheet. It also contains excellent articles on all aspects of adoption, written by social workers, child development specialists, psychologists, and parents. This comprehensive resource would be valuable for any school counselor to have and share with staff. Parents and teachers are encouraged to copy articles and assignment examples from the book to hand out at parent/teacher conferences and staff development meetings. FAIR also has a 45-minute videotape entitled *I Wonder…* in which teenagers talk about being adopted, suitable for middle and high schools.

Pittsford, New York

In its quest to create training materials to train teachers on the issues of adoption, Adoption Resource Network, Inc. (ARNI) in Pittsford, New York, pulled together a team of experts that included an adoptive parent, a psychologist, a teacher, and a school administrator to write the curriculum and design an educational program.

"When we had everything ready, we approached the superintendent, but were told the school district already had more curriculum than they could cover and they didn't have the time for it," said Lisa Maynard, program director at ARNI.

ARNI's vision and work were admirable but they couldn't penetrate the system the way they had originally hoped. They did, however, continue their educational efforts on a smaller but equally important scale. Lisa and other parents from the group have had continual success talking to individual classrooms about adoption. Lisa's work in a single classroom often expands, across the entire grade level and beyond, when teachers witness for themselves the excellent, helpful information she provides to students and teachers.

Lisa regrets the superintendent's refusal to allow them to train all teachers district wide, but concedes that over time, "we have taught a lot of children and expanded the

Eleven-year-old Alex Maynard, attending fifth grade in the Pittsford School District in New York, came home one day with an assignment. "Mom, we're studying immigration and I need a passport and have to dress up like an immigrant." Alex's mother, Lisa Maynard, program director at Adoption Resource Network, Inc., was thrilled with the assignment. Alex had emigrated from Korea at 3 1/2 months old when he joined the Maynard family through adoption in 1987. "This is great." said Lisa, "You've got your passport and the clothes you wore when you came on the plane from Korea. "No, you don't get it," answered Alex. "We have to make our passport and the teachers want everyone to dress up like they came from England."

Lisa was disappointed that the teachers thought it would be easier if all the students came from the same country. Although Alex was supposed to pretend he came from England, Lisa talked to her son and he agreed that he would much rather bring his official passport and the clothes he wore when he made his journey from Korea to New York. Alex was then allowed to participate as a living example of immigration.

thinking of many teachers. The importance of this topic is revealed when the teachers see the enthusiasm of the children and hear their insightful questions." Lisa added, "Lately it has been interesting speaking to junior and senior high school classes. Inevitably a student hangs around after class, thanks me for coming and then casually confides that he or she is adopted. These students tend to be children who are adopted in a family of the same race, and often others around them aren't aware they are adopted. They are grateful that someone is taking the time to talk about adoption in school."

Ways for Parent Groups to Effect Change in Schools

- **Volunteer to speak to classes and grade levels.** Do not discount the impact of the intimate relationship that develops when a parent from the community speaks to an individual class or grade level in a local school. Each child internalizes what she has learned and becomes an automatic teacher to others. Children take a special interest in speakers who not only have first hand knowledge of a subject, but also live in their community. It helps to build a broader sense of community within a school when local experts share their talents. Some parents present in their own child's classroom and others trade off in order to not train in their child's room. Let your children guide you regarding their comfort level with having you present in their classroom.
- **Familiarize yourself with high quality published materials.** It is not necessary for all parent groups to develop their own curriculum or training manuals. Good materials already exist. Using quality materials published by other groups is a more efficient use of time and money. When parent groups share with each other, it allows all groups more freedom to expand their focus to other areas of outreach.
- **Develop a lending library.** Apply for a grant to help your group gather and organize books on the topics of adoption, foster care, and kinship care and begin to develop a lending library for community members including school personnel. Your group could organize a birthday party celebrating your first parent group meeting. Every member or family could bring a book on adoption to either use for your lending library or to donate to the school in honor of the group or adoption.
- **Target guidance counselors.** Guidance counselors have more flexibility in their day to attend training workshops than classroom teachers. They can use what they learn and teach it to an entire school staff. Counselors can efficiently use budgeted money to purchase an adoption curriculum, videos, practical lesson plans, and assignment examples to keep in a central location for all staff to share.
- **Network beyond your local school.** If you or your group has helped to make improvements within your child's school, talk to your school's guidance counselor or your most supportive teachers to try to get names of teachers and administrators from other schools. You will need contact names to get into another school or district. If a teacher or counselor who has benefited from your work makes a recommendation, you will have a better chance of getting into another school. Remember you don't have to do this alone. You can call upon all willing members of your parent support group.

> *"The adopted child knows he belongs when the reality of his life is reflected in the culture of the classroom."*
>
> *FAIR's Adoption and the Schools*

- **See teachers as team members instead of enemies.** Due to ignorance and outdated lessons, some teachers have given insensitive assignments to students and as a result parents have become defensive. At the same time, there are teachers who are well informed about adoption. In fact, some teachers were adopted or are adoptive parents who:
  - informally network to keep the rest of the staff current on adoption issues
  - continually advocate for the needs of adopted and foster children

- let parents know they understand adoption issues and can be a resource
- encourage parents and the principal to place adopted children in their classes

Seek out these teachers or find the most likely candidates to support your cause and ask them to come to one of your parent group meetings. Work together as a team to build a network of supportive adults for the entire school.

➢ **Keep it simple.** Don't expect a teacher or grade level to teach an entire adoption curriculum. Teachers are given twice as much curriculum than can be covered in a year for each subject they teach. Dumping a thick volume on their laps will only overwhelm and frustrate them. Simple bulleted handouts—with clear, concise information—are not only more manageable for teachers, they are more practical and useful. Examples of more appropriate family assignments are welcome gems and will likely be used.

➢ **Look for opportunities with student teachers.** Your parent group could make an impact on the teacher training process. Most schools use student teachers periodically throughout the year. Find out how to contact the student teacher supervisor(s) at local colleges or universities. Form a panel of adoptive parents and possibly children who have been adopted, and offer to present a panel discussion for student teachers. If the college isn't receptive to adoption alone as a subject, broaden your focus to include foster and kinship care representatives as well. If forming a panel is out of the question, try to get a copy or have the college purchase a copy of Arizona's Children Association's video on adoption. Provide student teachers with easy-to-use assignment handouts. Once your group has an inroad to the college, you will reach teachers before they begin their career.

➢ **Sponsor a booth at a regional or state educational association convention.** Share your knowledge and expertise beyond your local boundaries. It can be energizing to meet others who are willing to immediately take up your cause, and sometimes it takes broadening your boundaries to find these people. ✧

Resources

Arizona's Children Association's training kits, entitled, ***Family Diversity in the Classroom: The Adopted Child***, are available for $60.00. Contact:

Arizona's Children Association
2700 South 8th Avenue
Tucson, AZ 85713
800-947-7611

Center for Adoptive Families' training manual, ***Adoption Awareness in Our Schools: A Training Curriculum***, is available for $25.00. Contact:

Center for Adoptive Families
5750 Executive Dr., Suite 107
Baltimore, MD 21228
410-869-0620 or 301-439-2900
caf@adoptionstogether.org
www.centerforadoptivefamilies.org

FAIR's ***Adoption and the Schools*** manual can be ordered for $25.00 plus $5.00 shipping and handling. The video ***I Wonder…*** can be ordered for $32.50 plus $5.00 shipping and handling. Contact:

Families Adopting In Response
P.O. Box 51436
Palo Alto, CA 94303
650-328-6832
info@fairfamilies.org • www.fairfamilies.org

Staff from **ARNI** are available to answer questions about adoption and the schools. Contact:

Adoption Resource Network, Inc.
P.O. Box 178
Pittsford, NY 14534
716-586-9586
info@arni.org • www.arni.org

Web Sites for More Information

Center for Adoption Support and Education: www.adoptionsupport.org/safe.html (provides information on school support for adoptive parents and educators)

LD Online: www.ldondline.com (provides information on learning disabilities and IEPs. etc.)

National Adoption Information Clearinghouse: www.calib.com/naic (contains information on all aspects of adoption)

National Information Center for Children and

Positive Adoption Language

From the North American Council on Adoptable Children's
National Adoption Awarenes Month Guide, *published July 2001.*

Don't use:	*Because:*	*Instead say:*	*For example:*
Real, natural parent or brother/sister	Implies that adoptive relationships are artificial, tentative.	Birth or biological parent or brother/sister	"The four boys are brothers; two have the same birth parents and are biological siblings." *Not* "Only two are real brothers."
Own child	Suggests that adoptive relationships are less important than biological relationships.	Birth child, child by birth	"She has one child by birth and two by adoption." *Not* "One of three children is her own, the others are adopted."
Taken away, given up	Denotes that children are stolen or forgotten rather than adopted legally and with forethought.	Termination of parental rights	"Following the termination of his birth parents' parental rights, he was adopted by his foster parents."
Surrendered, relinquished, gave away, put up	Does not accurately describe the birth parent's decision-making process and responsible choice.	Made an adoption plan, chose adoption	"She chose adoption for her baby." *Not* "She put her baby up for adoption."
To keep	Children are not possessions and birth parents always "keep" feelings for their children.	To parent	"She chose to parent her baby." *Not* "She chose to keep her baby."
Adopted child, adoptive parent/ mom/dad	In most contexts, qualifiers are not needed. Adoption creates a full, permanent relationship.	Son, daughter, parent, mother, father, mom, dad	"This is my son." *Not* "This is my adopted son." However, at a support group, it would be appropriate to say, "I am an adoptive parent."
Hard to place, special needs child	Labels the child and unfairly places blame on him or her for needing an adoptive family.	Child who has special needs, waiting child	"She has special needs and is waiting for the right family." *Not* "She is hard to place because she is a special needs child."
Foreign adoption	While more acceptable in the past, today "foreign" has negative connotations.	International adoption	"The parents are completing an international adoption in China."
The child hasn't found a family, the child moved	Children are not responsible for their own recruitment efforts nor their moves through placement.	The agency, caseworker, recruitment efforts	"The caseworker's recruitment efforts have not yet located an appropriate family."
Illegitimate	Children born to unmarried parents should never be labeled or stigmatized.	No replacement	
Available, unwanted	Waiting children are wanted—the right family just has not been found—and they are not available to whomever is interested.	In need of a family, waiting	"He is waiting for a forever family." *Not* "He is available for adoption." *Or* "He is an unwanted child."
Adoption triangle	Adoption involves more than just three individuals.	Touched by adoption, adoption triad or constellation	"All the members of the adoption constellation were affected when the adoptee and birth parents were reunited."
Is adopted	Adoption is a one-time event, not a definition of a person.	Was adopted	"She was adopted at age six." *Not* "She is adopted."
Closed adoption	Implies that the experience of adoption—rather than just contact between parents—is over.	Traditional, confidential adoption	"The adoptive and biological parents wanted a confidential adoption; they did not meet or correspond with one another."

ADOPTION *Appropriate Curriculum*

DEVELOPMENTAL AGE:	UNDERSTANDING OF ADOPTION:	SUGGESTED ALTERNATIVE CURRICULUM:	RESOURCES: (SEE PAGE 6 FOR MORE INFO)
Early Childhood: Pre-school kindergarten Theme: "I am the world."	Charmingly egocentric, children believe that if they are adopted, then all children must also be adopted. They enjoy hearing their adoption stories, but the word "adoption" is still a vague concept.	Role play going to the airport to meet a newly adopted sibling. Reshape the family tree diagram to include new types of families in a Family Forest, a Loving Tree with heartshaped fruit, or a rooted tree where birth family can be roots and branches the adoptive or step parents.	*Tell Me Again About the Night I was Born* Jamie Lee Curtis *A Mother for Choco* Keika Kasza *I Love You Like Crazy Cakes* Rose Lewis
Early grades - Ages 6-7 Children come to see firsthand as they come in contact with nonadopted children that their story differs from most others.	In understanding that most of their peers were born into their families, children begin to explore how they came to be adopted.	Karen Halvorsen Schreck in *Lucy's Family Tree* suggests unlinked FAMILY HOUSES, showing how blended families have members who may live in different houses. Design a wheel in which the child is in the center and caring people are portrayed by nested circles. These can be color coded to represent whatever the child wishes.	*Happy Adoption Day* John McCutcheon *Lucy 's Family Tree* Karen Halvorsen Schreck For Children in Open adoptions... *Pugnose Has Two Special Families* Karis Kruzel
Middlers Ages 8 -11 Superficially sophisticated, middlers are gauging themselves with peers, quietly comparing their family with others. The perplexing question for children of this age is: "When I look in the mirror, do I like what I see?"	Children realize that to gain a family through adoption, they left their family of origin. They try to understand why they were relinquished, using advanced reasoning. As concrete thinkers, they may think they are faulty or to blame for their life situation.	Trace your left and then your right hand. On the hand you write with, list characteristics you share with family members. On the other hand, write down attributes that are "on loan" from friends and relatives. Compile a list of famous adopted persons and categorize them by area of fame: sports, music, politics etc.	*W.I.S.E. Up PowerBook* The Center for Adoption Support and Education, Inc. (C.A.S.E.) www.adoptionsupport.org *Look Who's Adopted* Michael S. Taheri and James F. Orr *Lucy's Feet* Stephanie Stein *Anne of Green Gables* Lucy Maud Montgomery
Teens Raiding the Identity Refrigerator Just as teens raid the refrigerator,voraciously picking foods they like and passing up others, adopted teens are busy sifting through three distinct identities: 1. Adoption 2. Birth 3. The "me" that is separate from both.	Teens explore huge questions of identity: "Who am I? Where do I belong? What can I do or be? What are my beliefs?" Puberty and advanced reasoning aid the teen in the process of emancipating from birth family (who may be unknown) and adoptive families. Both tasks are necessary for adopted teens to complete as they stretch towards adulthood.	Explore multi-images that teens present to peers, to best friends and to adults. Then create three masks portraying 1) yourself as others see you, 2) as you see yourself and 3) who you see yourself becoming. Write a letter to a caring person who contributed to who you are now and who you are becoming.	*The Face in the Mirror: Teens and Adoption* Marion Cook *How It Feels to Be Adopted* Jill Krementz *Filling in the Blanks: A Guided Look at Growing Up Adopted* Susan Gabel. M.Ed *Who Am I?... And Other Questions of Adopted Kids* Charlene C. Giannetti

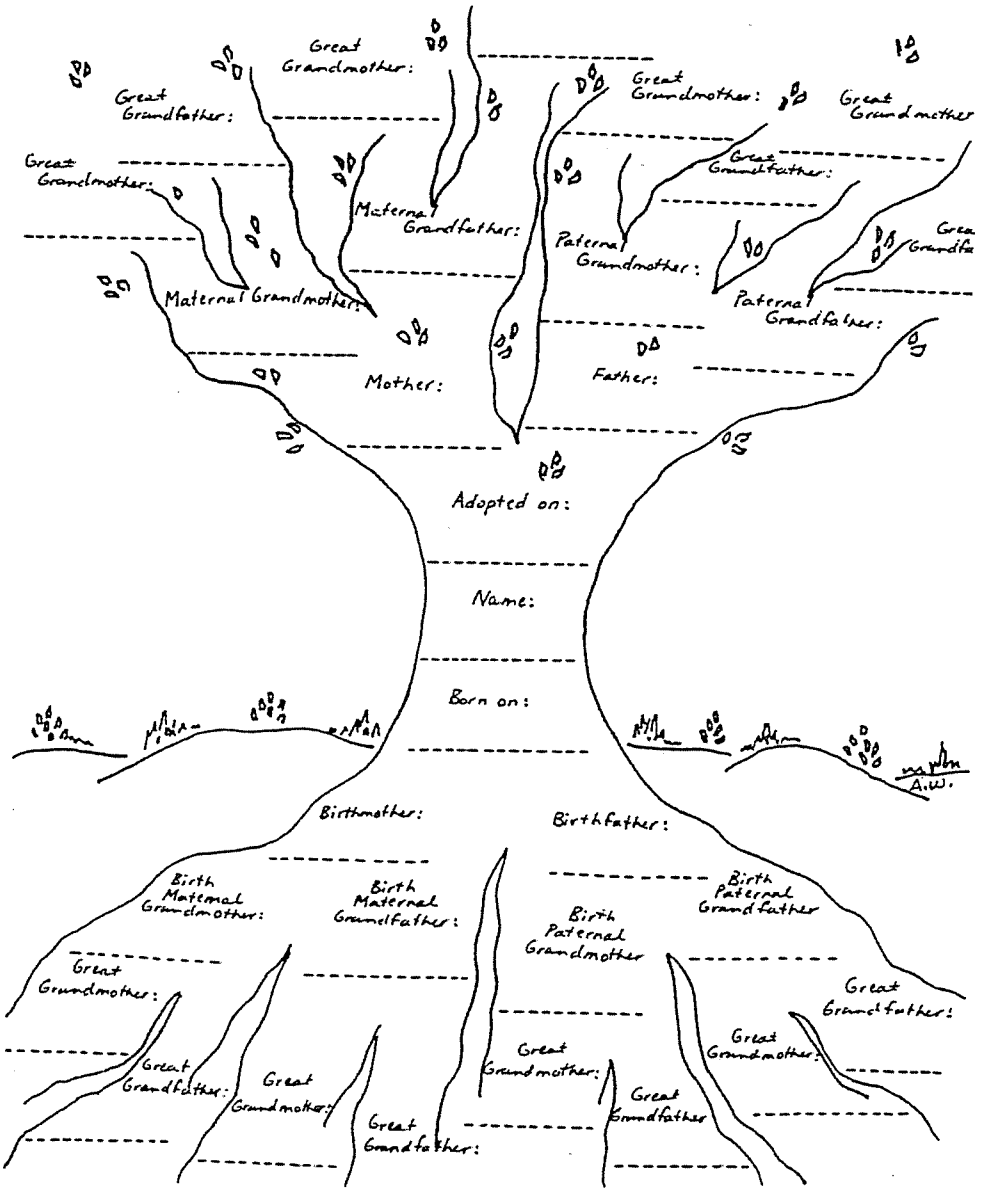
Reprinted with persmission from the Fall 2001 issues of MN ASAP Family Voices, the quarterly nwesletter of Minnesota Adoption Support and Preservation (MN ASAP). MN ASAP is a collaboration of the Minnesota Adoption Resource Network and the North American Council on Adoptable Children, funded by the Minnesota Department of Human Services.

A Forest of Family Trees (cont'd)

History Tree

Older Elementary and Middle School Trees

A family tree may be used to trace family history over time, noting important relationships and memorable events. Understanding one's family history is useful in forming a personal identity. It can be especially useful to the adopted student and his family when approached with sensitivity and a respect for privacy.

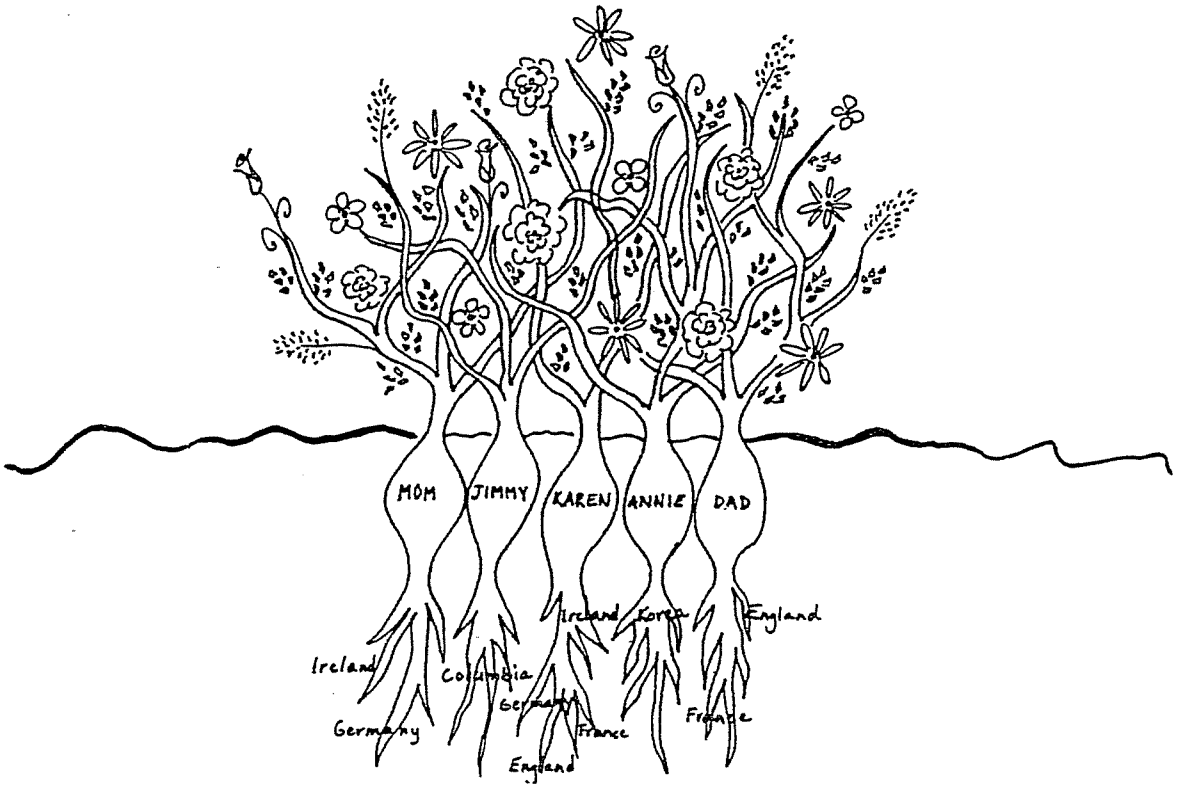


A Forest of Family Trees (cont'd)

The Peony Bush

Elementary and Middle School Trees

Cheri Register, author of *Are Those Kids Yours?*, suggests a charming alternative to the traditional family tree. She writes, "What we did was reconstruct our family as a peony bush. We probably took some liberties with horticulture to make the metaphor work, but here is how it goes: Each member of the family is a peony bulb with roots that go down into the soil and perhaps entwine with the roots of other bulbs. Grace's and Maria's roots are marked with the word 'birthparents' and a South Korean flag. We marked the other family members' ethnic roots, too, making ourselves a multi-heritage family. The bulbs are clustered together, nestling against the bulbs with whom the share the closest relationships. Our peony bush is different from the standard variety in that the bulbs do not all produce the same color of blossom. The peony bush was not an arbitrary choice. It was suggested, first, by the name Keun Young and was already an operative symbol of my family's continuity. After my grandmother Grace's death, some of her children and grandchildren dug up peony bulbs in her yard and transplanted them in our own as a memorial. Grace and I turned in the assignment feeling quite proud of our ingenuity. I was also very satisfied with the metaphorical import of the family-as-peony-bush. Planted separately, we would probably thrive all right, but planted together in common ground we bloom in greater abundance and splendor."

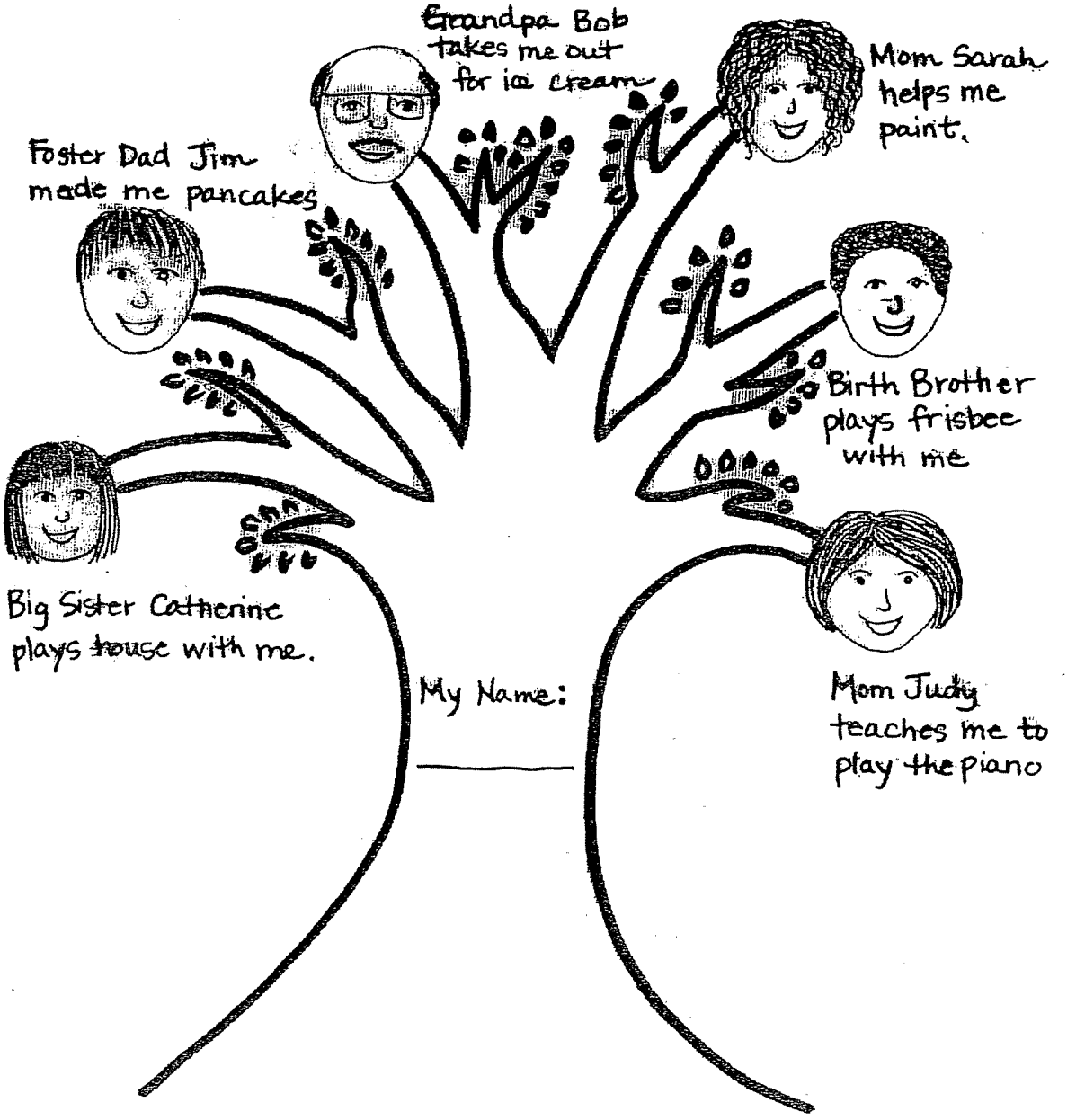


A Forest of Family Trees (cont'd)

Caring Tree

Preschool/Kindergarten Trees

The Caring Tree might be used to recognize the particular role each individual plays or played in a child's life. Matching the young child's view of his world, the adults circle around her as the center of importance.



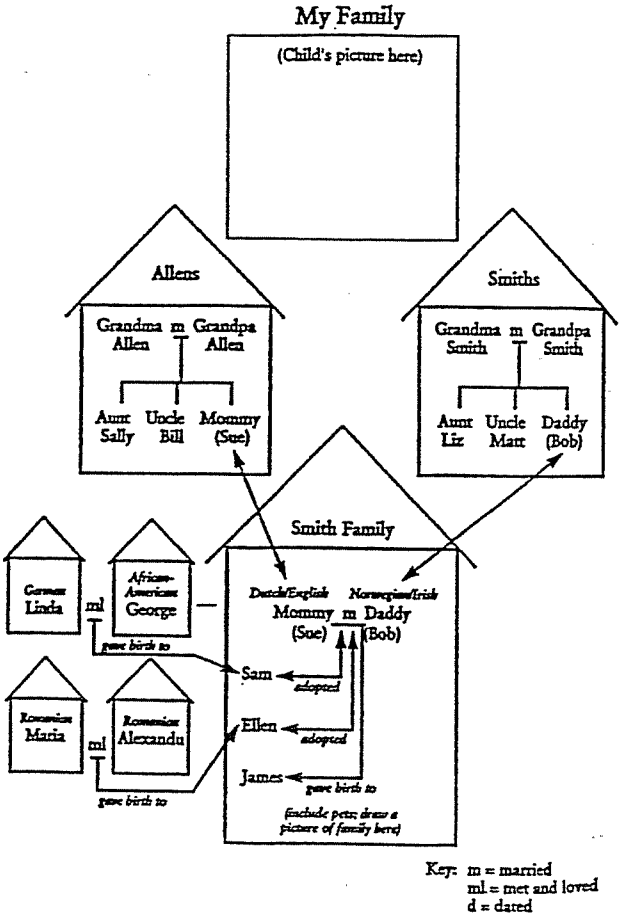
A Forest of Family Trees (cont'd)

My Family

Older Elementary and Middle School Trees

Holly van Gulden writes: "One way to make genetic lines easier to comprehend and represent graphically is to use houses instead of a tree. By using houses, you also show that other family members, such as parents, have left one home to start a new a home with new members. Before your child hands in a family "tree" drawn out with houses, however, you should first contact the teacher to explain why your child is taking a different approach to the exercise. Should the teacher insist that your child complete the assignment as assigned (though we expect that most teachers will have no objections), help him as best you can to do so. When he is done and you have a little more time, sit down with him and repeat the exercise using houses to ensure that he understands how his own genetic lines and family relationships fit together."

Excerpted with permission from *Real Parents, Real Children: Parenting the Adopted Child* by Holly van Gulden and Lisa M. Bartels-Rabb.



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HANDOUT 18

FACTSHEET

The Nine Stages of Grief in Parents of RAD Kids

by Monica Acord

(*Reprinted from the KC Connections newsletter with permission from the author)*

The stages of grief, as modeled by Kubler-Ross, are usually associated with those recovering from the loss of a loved one; however, these stages are weathered by anyone experiencing a loss of any kind. A person can grieve over many things, such as the loss of a job, marriage, health, or even a material possession. In each case, a loss is experienced. Depending on the severity of that loss combined with the personality of the individual involved, the stages of grief can last only a few minutes or the duration of a lifetime. This grieving process is extremely difficult for new adoptive parents of children with Reactive Attachment Disorder, because it begins almost instantly before there has been an appropriate lapse in time for parents to sufficiently bond with their new child. The bonding is delayed due to the emotional distancing of the RAD child. Parents have conflicting emotions between sorrow for the child and his/her past and then those for himself in his loss of enjoying and controlling a stable home environment. Parents must decide whether they can endure parenting a child who lacks the inner resources to reciprocate their love by becoming a willing participant in the family. Whether parents choose to finalize or disrupt the adoption, a loss is experienced. The following is a variation of the Kubler-Ross model of the Stages of Grief, which has been conformed to the loss that parents of RAD children find themselves as they progress to the final level of adjustment.

*** SHOCK** After a brief honeymoon period, full of excitement and idealistic dreams, one has the realization that his child is unhealthy. Even when parents have been told of their child's past behaviors, many do not understand the full realm that the accumulation of those behaviors entail until after they have experienced life with that child. One may have feelings of bewilderment and numbness.

*** DENIAL:** Denial protects our emotional well being from shock. One may make excuses for the child's behaviors such as: the child didn't understand my instructions. He/she needs more time to adjust. I am expecting too much too soon. I probably didn't perceive that situation correctly.

*** ANGER:** Outrage towards the obstinate child, biological family, Child Protective Services, court system, or anyone who played an intricate part in causing the damage to their child. One may also be angry at their spouse for lack of support or even certain family members for their lack of acceptance and understanding. Often these feelings of fury are surprising to the person experiencing them.

*** DEPRESSION:** Anger without any solutions can lead to feelings of isolation and despair. One is emotionally paralyzed. One many feel as if he were an outsider observing the stranger within his own household. Conversations with friends seem shallow and frivolous. Support is needed.

*** PHYSICAL SYMPTOMS OF DISTRESS:** The most common symptom is the preoccupation of thoughts directed towards the child. No matter how hard one ties to think about something else, the unhealthy child always dominates his mind. Other symptoms of distress can include: ulcers, headaches, nervousness, lack of sleep, shortness of breath, digestive problems, lack of appetite, or uncontrollable eating.

*** INABILTY TO RENEW NORMAL ACTIVITIES:** The RAD child will not permit the family to pursue their routine activities without turmoil. Parents may also find that their marriage is suffering from lack of quality time with one another. Many are without babysitters who are capable of managing an emotionally disturbed child.

*** GUILT FEELINGS:** One feels guilt for his lack of parenting skills in not being able to bring about the proper results in his child. A parent may also feel guilty for his feelings of ambivalence towards the child, and wonder what is missing from his own character that causes him not to feel more bonded. A deep examination of ones own role in the relationship eventually leads to forgiveness of self and decision.

*** GRADUALLY OVERCOMING GRIEF:** The decision to take action either by disrupting or finalizing the adoption. Either way, new hope for the child and ones homelife begins. If finalizing, techniques to control the child's behaviors are administered, adjusted, and emotional counseling usually begins. Parents' emotional equilibrium gradually returns.

*** READJUSTMENTS TO NEW REALITIES:** Acceptance and willingness to invest in a whole new reality. A reality where you are stronger because most of our parenting skills, relationships, and inner resources have been thoroughly tested.

New parents of RAD children can find support in knowing that these stages are a normal part of the adjustment period. Parents will also have a better understanding of their child as he/she too must go through these same stages of grief and loss before reaching their final level of adjustment as well.

Monica may be reached at macord@mastnet.net

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HANDOUT 19

FACTSHEET

Promoting Family Health and Resilience

by Judith M. Levy, MSW, MA

(Reprinted with permission from the author)

Having a child with a disability or chronic health condition is a significant life event. It can be a mixed blessing, a joy as well as a challenge. Some of the more stressful issues involve emotions coupled with the reality and cost of daily special circumstances. Parents wonder how to find time for other children in the family and for themselves. Any of these issues can contribute to individual and family stress and a decline in coping and resilience.

In a research study conducted in Finland, parents who demonstrated strong coping abilities had accepted the situation quickly and held optimistic attitudes toward the future. These parents also thought family values had changed for the better, kept their individual activities or developed new ones, shared household chores and child care, and had an extensive social support network. These findings suggest that certain coping strategies promote family wellness and may decrease the likelihood of debilitating stress.

Take Care of Yourself First

The Finnish research found that "high-coping" parents considered their own needs as well as those of their children. The tendency of most parents is to consider themselves last or not at all. Think of an airplane emergency in which in order to help their children, parents must be able to breathe, so they are instructed to put on their own oxygen masks first. This allows parents a chance to think and act logically, rather than just react. Caring for your own needs requires familial and social support and cooperation, though it is often the most difficult task.

Rest, Relaxation and Recuperation

Roadblocks to caring for yourself include limited time, no sitter and no money. Parents have the tendency to think that other family members come first or that they don't deserve to do something for themselves. It is important to take the time for regular, planned opportunities to do something fun; activities don't have to be expensive. Having an event to look forward to makes it possible to cope more easily with what comes up every day. To make this possible, make sure everyone understands how important down time is, make plans and keep them. Remember that nurturing important relationships and developing hobbies is part of caring for oneself.

Practice Resilient Behaviors

Resilience can be defined as, "the capacity to confront and make the best of a difficult situation and to develop methods to reduce stress." Parents can promote resilience in themselves and their families by:

- Promoting developmentally appropriate activities.
- Promoting independent thinking and action in children so that they learn to monitor and control themselves.
- Encouraging the entire family to anticipate future needs.
- Practicing family rituals such as meals, celebrations, vacations and conversations.
- Using positive and logical coping strategies.

Dealing with Anger and Guilt

Anger and guilt make the coping process difficult. Although common and understandable, these feelings interfere with relationships, work and the ability to think logically. Negative emotions use up precious energy that could be used more productively. Persistent guilt may lead parents to treat the child with a disability, as well as siblings, in ways that are detrimental such as excessive pampering or setting few behavioral limits. To prevent this, talk with trusted friends, family or clergy. Finding a parental support group may also ease tensions. (See www.mnasap.org for parent support groups.) If these things do not help, see a mental health professional.

Coping with Differences

Parents, the child with special needs and siblings must cope with the stigma of being different. The parents' ability to cope with their own feelings and the reactions of society in a constructive way will make it easier for children to do so. Normalize your family in your mind. You have more things in common with other parents and families than differences. Communicate this optimistic idea to your children daily. For example, in any family one child will always require more attention than the other children. Help the child with the disability as well as their siblings to understand the condition and talk about it with others. This will give them a sense of confidence because they are gaining the tools to deal with their sibling's disability independent of their parents. Try to spend time as a family with friends and relatives who are comfortable with the child who has special needs.

Siblings

Try to put your child who has special needs into perspective among all your children. Give them normal responsibilities for their age and development, including, when possible, the child who has special needs. Make sure that siblings know that you take pride in their accomplishments. Set aside time for them and their individual activities. Involve them in the care of the child with the disability in small ways.

Take their cues for information. Be prepared to listen and answer their questions. Occasionally, take them to doctor and therapy appointments so they can learn appropriate information directly and ask questions, but don't force them to go. Always take their concerns and feelings seriously, and try to see situations from their point of view. Allow them to have their own feelings about their family, including the child with special needs.

Stress Inventory

Another proactive practice involves taking an inventory of your stress triggers. Keep a journal of your positive and negative experiences. Identify your own personal warning signals, those physical, emotional and behavior symptoms that let you know you're under high stress alert. You'll have to accept some situations, but others you can change. Fighting unchangeable circumstances uses a lot of energy. Pick the stressor that bothers you most, identify what would make you feel better, and see what you can do to make it a reality. If you are having a hard time, ask a trusted family member or a friend to help you look at things objectively.

Finally, Humor

Humor is an important tool in reducing stress and promoting family wellness. Try to see a circumstance as funny whenever possible. For example, if whining is a trigger for you, give your children the opportunity to whine without parental judgment for two minutes. Make it a game. Who can whine the longest and loudest? Join them. There are probably things you'd like to whine about too.

As parents, you have many options available to you to assist in parenting your child with special needs. The suggestions discussed here have been found by many to be beneficial. Hopefully you will find them to be so too.

-Judith M. Levy is Director, Department of Social Work and the Chair of the Ethics Committee at Kennedy Krieger Institute in Baltimore. *This article is reprinted with her permission from the February, 2003 issue of Exceptional Parent Magazine.*
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HANDOUT 20

FACTSHEET

Top Ten List for Parents Caring for Children with Multiple Diagnoses

by Paul Buckley, Licensed Marriage and Family Therapist

Children with a mental health diagnosis typically display behaviors and responses to their life-space environment that create problems for them and difficulties for their caregivers as well. These problems cause significant distress in the form of discomfort and/or developmental delays. For example, a child might weep due to depression or be failing in school due to oppositional defiant behaviors. While all children cry and are oppositional, children with mental health diagnoses have more severe and persistent symptoms.

A dual diagnosis translates to a child meeting two or more diagnostic categories of a mental disorder. If your child has a dual diagnosis, don't panic. It's not uncommon. Statistics show that in 40 percent of cases, a child with ADHD will have a co-occurring diagnosis.

While families of children with multiple diagnoses can use similar parenting techniques that would work for any child, three general rules of thumb are:

- Increase structure in all settings
- Create nurturing moments
- Make sure as caregivers to get support and provide self care

The following top ten list is based on the experiences of many families and solid research findings. If one or two ideas resonate with you, focus on those.

1. Expect and accept setbacks, failures, embarrassment. Remember, difficult children often make very good parents look and feel bad. Keep in mind that over time the gradual shaping influence of your efforts is a tremendously important and convincing force.
2. Read to your children at times when they will accept your nurturing presence such as bedtime or mornings. Few activities have such a positive effect on the learning and emotional life of young people as reading.
3. Make use of empathy and natural consequences as often as possible. "Oh no, I'm sorry you spent all your allowance. I guess it'll be hard to go see that movie now."
4. Go to funny movies.
5. Use the child's diagnosis to your benefit. Use the treatment plan as a road map to assess services and as a guiding document to help you better understand your child's behaviors.
6. Make as few rules as possible, but increase the importance of those rules by posting them in writing. Regularly use and chart rewards and consequences.
7. Join your child's world now and then, using curiosity, empathy and lack of criticism. Too often a child's behaviors teach parents to be chronic critics, causing the child to not hear the criticism. Bake, play catch, listen to your child's favorite CD.
8. Blend your efforts with those of other adults such as coaches, educators, and clergy. The more adults who share a perspective about the child's problems, the greater the child's chances are for internalizing life lessons.
9. Develop consistent chores, routines and rituals. These elements of family structure should emerge from your core values and principles.
10. Bolster your support system, recreation and respite resources. One of the greatest risk factors for difficult children is that as they wear out parents and caregivers, problems cascade into even more difficulties.

RESOURCES

EP – ***Exceptional Parent magazine*** – Monthly periodical has information and support for the special needs community
Psy-Ed Corporation dba Exceptional Parent Magazine
65 East Route 4
River Edge NJ 07661
www.eparent.com

ADHD

Driven to Distraction by Edward M. Hallowell, MD and John J. Ratey
Eurkee the Jumpy, Jumpy Elephant by Cliff Corman, MD and Esther Trevino
Taking Charge of ADHD: The Complete, Authoritative Guide for Parents by Russell A. Barkley, PhD
How To Reach & Teach Teenagers with ADHD by Grad L. Flick, PhD
www.chadd.org - Children and Adults with ADD, 800-233-4050
www.add.org National ADD Association, 847-432-2332

Attachment

Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families by Terry M. Levy
Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioral Change in Foster and Adopted Children by Daniel A. Hughes
Attaching in Adoption: Practical Tools for Today's Parents by Deborah D. Gray
When Love is Not Enough: A Guide To Parenting Children with RAD – Reactive Attachment Disorder by Nancy L. Thomas
www.attachmentdisorder.net
attachmentdisordersite@hotmail.com

FAS/FAE

Fantastic Antone Series by Judith Kleinfeld, Barbara Morse & Siobhan Wescott
Our FAScinating Journey by Jodee Kulp
The Best I Can Be: Living with Fetal Alcohol Syndrome or Effects by Jodee Kulp and Liz Kulp
www.betterendings.org Better Endings New Beginnings, 763-531-9548
www.mofas.org Minnesota Organization of Fetal Alcohol Syndrome, 651-917-2370
www.nofas.org National Organization on Fetal Alcohol Syndrome, 202-785-4585

Sensory Integration Dysfunction

The Out-Of-Sync Child by Carol Stock Kranowitz, MA
www.sinetwork.org Sensory Integration Resource Center

Multi-Diagnoses

Adopting the Hurt Child: Hope for Families with Special-Needs Kids by Regina M. Kupecky and Gregory C. Keck
Parenting the Hurt Child: Helping Adoptive Families Heal and Grow by Regina M. Kupecky and Gregory C. Keck
Special Kids Need Special Parents by Judith Loseff Lavin

Oppositional Defiant Disorder

Your Defiant Child: A Parent's Guide to Oppositional Defiant Disorder by Douglas A. Riley
The Explosive Child by Ross W. Greene, PhD
www.aacap.org American Academy of Child and Adolescent Psychiatry, 202-966-7300