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PSYCHOEDUCATION GROUPS FOR PARENTS
ADOPTING SPECIAL-NEEDS CHILDREN

by

Korinne Knowlton Bouwhuis

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family and Human Development

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ABSTRACT

Psychoeducation Groups for Parents
Adopting Special-Needs Children

by

Korinne Knowlton Bouwhuis, Master of Science
Utah State University, 2002

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Department: Family and Human Development

This thesis evaluated training groups for adoptive parents of special-needs children. It was hypothesized that training would influence parenting stress, stress symptoms, and marital satisfaction, and that helpfulness of training sections would depend upon the status of the participants' children (i.e., foster, adopted, or adoption in process). Data were collected from 15 participants who were sampled through agencies that typically interact with adoptive parents.

Repeated measures ANOVAs were computed to compare scores on the PSI/SF Parental Distress Subscale, OQ-45, and RDAS across three time intervals. No significant differences were found. Data from a scale of helpfulness were analyzed using descriptive statistics. There was a general trend such that foster parents reported the training groups as least helpful, adoptive parents reported them as more helpful, and participants in the process of adoption reported the highest

ratings of helpfulness. Explanations for results are discussed along with implications and recommendations for future research.

(117 pages)

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Korinne Knowlton Bouwhuis

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CHAPTER I

INTRODUCTION

Any time a new member is added to a family, there is a period of transition, change, and adjustment (Helwig & Ruthven, 1990). When the new member has joined the family through adoption there are more adjustments to be made and some of the changes that occur will be different based on the nature of the new relationships (Berkowska & Migaszewska-Majewicz, 1991; Glidden, 2000; Groze, 1992; Helwig & Ruthven; Wrobel, Kohler, Grotevant, & McRoy, 1998).

Special-needs adoptions represent an even more exceptional transition period as these adoptions involve children who are typically over age five, part of a sibling group, of a minority ethnicity, or have experienced physical abuse, neglect, or sexual abuse, and have either developed emotional, physical, or cognitive disabilities, or are likely to develop such disabilities (Babb & Laws, 1997; Kramer & Houston, 1999; Rosenthal, Groze, & Curiel, 1990; Rosenthal, Groze, & Morgan, 1996). A particular aspect of special-needs adoptions that makes the adjustment and transition phase even more exceptional, and at times more difficult, is the fact that most of these children have had multiple placements (Henry, 1999; McRoy, 1999). This results not only in an increased number of significant figures in the child's life, but also an enhanced likelihood that these children will have difficulty forming new attachments (McRoy).

Further, because many special-needs children have also experienced some type of abuse (i.e., physical abuse, sexual abuse, or neglect) (Groze, 1992; Henry, 1999;

Kramer & Houston, 1999), they have developed behaviors that were beneficial and aided in coping with previous environments of the child. However, some of these behaviors, when placed in the context of a permanent adoptive family, are considered maladaptive and create more difficulty for adoptive parents (Groze; Henry; Kramer & Houston). Examples of such behaviors might include acting out, which was once a method of getting attention, or keeping distance from others and avoiding emotional involvement which once served as protection from being hurt or disappointed. However, these behaviors, in the context of an adoptive family, threaten the stability and permanency of the children's placements.

Theoretical Link

Systems theory provides a particularly suitable framework for understanding the adjustments and changes that will certainly take place within a family as the adoption is finalized. Indeed, one study examining application of attachment to adoption clearly proposes that this perspective is valuable in guiding studies of the integration of the adoptive family and adopted child (Johnson & Fein, 1991). This endorsement for the application of systems theory to adoption was made based on the idea that a family systems perspective could bring a more comprehensive understanding of family identification, motivation to adopt, attachment, and behaviors of family members (Johnson & Fein).

This idea stems from the direct relevance that many concepts of system theory have when conceptualizing adoption and the transitions that the adoptive family and the adopted child experience in the process of adoption (Johnson & Fein, 1991). The systems concept of feedback describes how families regulate the direction of changes that will (or will not) occur within their relational system. Feedback is any input that enters a system. Positive feedback is input that alters the system, bringing about change. On the other hand, negative feedback leads to maintenance of the system's current patterns of functioning (Becvar & Becvar, 2000; Hanson, 1995; Nichols & Schwartz, 2001).

For adoptive families, feedback comes from a variety of sources, including the new family member, other family members, those who have previously been involved with the adopted child, state agencies, and in some cases, the nature of special-needs the adopted child has (McRoy, 1999). These key people and associations affecting the relationships of adoptive families influence the extent to which the family will adjust to its new form and functioning, and whether the necessary changes will be successfully completed (Kramer & Houston, 1999; McCarty, Waterman, Burge, & Edelstein, 1999; Rosenthal et al., 1996).

Boundaries represent another fundamental concept of systems theory. Boundaries of a family are inter-systemic, existing between the family and other systems (families, organizations, or society in general), as well as intra-systemic, existing within the family itself (i.e., between subgroups such as parents and children, or

older and younger siblings) (Kaslow, Kaslow, & Farber, 1999; Mullin & Johnson, 1999). Boundaries may be excessively rigid (ensuring that anything outside of the family system remains separate from the family), or overly diffuse (providing no barrier between the family system and outside systems) (Nichols & Schwartz, 2001). Ideally, a family's boundaries will maintain a healthy balance of functioning as a barrier to certain aspects outside of the family, or subsystems within the family, while also allowing the presence of other aspects from outside to enter into and interact with the family or a particular subsystem of the family (Hanson, 1995; Nichols & Schwartz).

With regard to inter-system/inter-family boundaries, adoption necessitates relatively open boundaries, as a new member must be accepted as part of the family. However, flexibility is also necessitated when considering intra-family boundaries of adoptive families. This is necessary as the inclusion of a new family member requires that boundaries of subsystems within the family be redrawn so that a space for the adopted child is created (Rosenthal & Groze, 1990; Silverstein & Roszia, 1999).

Special-needs children have been described as "those who are standing in line for a birthright most of society takes for granted: a permanent family" (Babb & Laws, 1997, p. 1). Before the 1960s, children with special needs were considered "hard to place" or even "unadoptable." However, since that time, a trend of permanency planning has increased. This trend emphasizes the importance of all children having a permanent and stable family environment in which to be raised. In response to permanency planning, federal initiatives, including the Adoption and Safe Families Act

of 1997 and President Clinton's *Adoption 2000*, have resulted in an increased number of adoptions (Kramer & Houston, 1999). However, despite this legal emphasis on advancing the placement of special-needs children with families, these efforts will prove ineffectual if they are not matched with an increased focus on preparing and supporting adoptive families and children (Avery, 1999). It is encouraging that more special-needs children are being adopted in the United States (Rosenthal & Groze, 1990). What is disheartening is that the increase in this type of adoption has contributed to an increased rate of adoption disruption (i.e., terminations occurring before finalization) and adoption dissolution (i.e., terminations after adoption finalization) (Rosenthal & Groze; Rosenthal, Schmidt, & Conner, 1988).

It is uncertain what particular aspects of special-needs adoption contribute to their rate of disruption. It may be that making change and adjustments within the family system is more difficult and that the transition phase takes longer to complete in special-needs adoptions (Groze, 1992). This is particularly the case as the adopted child brings different behaviors and past experiences into the relationship. These behaviors and experiences may increase the child and family's struggle with new and changing boundaries and roles (Helwig & Ruthven, 1990).

It is equally possible that parents of special-needs children are dissatisfied as they expected relationships with the child to resemble those of other children they have had experience with, who did not have special-needs (McRoy, 1999). In either case, there is a clear discrepancy between boundary expectations.

Smith and Howard (1994) noted that the transitional crises and stress associated with adoption adjustments may be increased if services are not initiated as a preventive measure. According to this study, services designed to preserve the family's new relationships (e.g., parent education, respite, parent support) are most likely initiated only after crises have occurred. When this is the case, the stress on adoptive families is at a peak when adoption services are implemented and their potential positive effects become neutral at best (Smith & Howard).

To increase the positive effects gained from adoption services, implementation of services before crises occur, and perhaps even before the adoption occurs has been encouraged (Henry, 1999; Rosenthal et al., 1996). Services that have been suggested for preventive use include: aiding families in gaining information about the adopted child's biological family and placement history, attachment issues, impact of the adoption on the marriage and family, expectations, development, rituals, relationships with the birth family or care providers, therapeutic services, and respite care (Hughes, 1999; Kramer & Houston, 1999; McCarty et al., 1999; Mullin & Johnson, 1999; Rosenthal et al., 1996; Silverstein & Roszia, 1999).

Purpose of Study

While various disruptive factors of special-needs adoption have been documented (Rosenthal & Groze, 1990, 1991; Rosenthal et al., 1988), and calls for parent training to mediate these factors have been made (Hughes, 1999; Kramer &

Houston, 1999; McCarty et al., 1999; Mullin & Johnson, 1999; Rosenthal et al., 1996; Silverstein & Roszia, 1999), few programs with the characteristics that have been promoted are actually in place (i.e., information to be gained about the adoptive child and their birth family, attachment issues, impact on the marriage and family, expectations, development, rituals, relationships with the birth family or with care providers, therapeutic services and respite care) (Berry, 1988; Rosenthal et al., 1996). The purpose of this study was to examine the effects of a parent training program that does have the suggested content areas and foci for adoptive parents of children with special-needs. The following research questions were addressed:

1. Does preadoption parent training reduce stress in parenting roles with special-needs children?
2. Do parent training sessions decrease parents' subjective levels of distress as information about many aspects of the adoption process is gained?
3. Does marital satisfaction change with more information about the impact of adoption on the marriage?
4. Do parents' ratings of the helpfulness of parent training sections vary according to the status of their children (i.e., adopted, adoption in process, or foster)?

CHAPTER II

REVIEW OF LITERATURE

A review of literature pertinent to this study reveals information on parent training programs, as well as adoption issues and recommendations for what parent training groups for adoptive parents should include based on these issues. Topics recommended for training parents adopting special-needs children include: information to be gained about the adoptive child and their birth family, attachment issues, impact on the marriage and family, expectations, development, rituals, relationships with the birth family or with care providers, therapeutic services, and respite care (Hughes, 1999; Kramer & Houston, 1999; McCarty et al., 1999; Mullin & Johnson, 1999; Rosenthal et al., 1996; Silverstein & Roszia, 1999). Some of these recommendations are based on key areas relevant to adoption, or perceived needs of adoptive parents and families, while two particular studies examined what aspects of adoption-oriented services parents described as most needed or most helpful.

Parent Training Programs

The practice of training parents to act as therapists for their children has been used for decades (Newby, Fischer, & Roman, 1991). Parent training has primarily been applied to parents of children with behavior problems such as conduct disorder, attention-deficit hyperactivity disorder, or more typical noncompliance or acting out behavior (Newby et al.). In addition, it has been suggested that parent training and

similar psychoeducational programs enhance functioning and satisfaction in a variety of areas of parenting as well as with various aspects of relationships in general (Durana, 1997; Rabin, 1995).

Psychoeducation is a widely used service system. In psychoeducation, didactic, experiential, and process information is presented in an informal classroom-type setting with both lecture and discussion (Furr, 2000; Sprenkle & Bischof, 1994). This modality has also been described as a combination of counseling and instruction (Barth, Yeaton, & Winterfelt, 1994).

Psychoeducation is currently used with a number of topics. Psychoeducational groups have been effective for increasing satisfaction of caregivers of older adults (McCallion & Toseland, 1995), of children with mood disorders (Goldberg-Arnold & Fristad, 1999), or other mental illnesses (Dreier & Lewis, 1991), of schizophrenics (North et al., 1998), and of families of individuals with dual disorders, having been diagnosed with both a psychiatric disorder and substance use (Ryglewicz, 1991).

Another study on psychoeducation groups (Kaliski, 1997) found this approach to be helpful for caregivers transitioning violent patients from hospital to community care. An essential component of this psychoeducational program is its focus on anticipation and preparation for future living arrangements.

Other issues addressed in psychoeducational groups include marital enhancement (Durana, 1997), parenting (Kuechler & Andrews, 1996), divorce adjustment, and other situations requiring adjustment to a life-changing situation

(Cwiakala & Mordock, 1996; Pomeroy, Rubin, Van Laningham, & Walker, 1997; Taylor-Brown, Acheson, & Farber, 1993). Psychoeducation to anticipate and prepare for changes in living situations is also important when addressing the significant life changes associated with adoption (Avery, 1999). In a study by Avery, the importance of anticipating what life will really be like after adopting and what changes can be expected was identified. This study was based on a questionnaire sent to the current case-workers of children who had been waiting the longest time for a permanent adoptive placement. Because questionnaires were completed by children's current caseworkers the amount of information for each child varied, based on the length of time the caseworker had worked with that child. Similarly, responses about the children may have been biased based on the case workers' relationship and interactions with them. Seventy-seven of 100 questionnaires were returned, from these, in-depth case studies of out-of-home care histories of the 77 children were developed.

Based on this information, Avery (1999) reported that adoptive parents must be worked with to adjust expectations so they more clearly reflect the reality of changes and experiences that surround adoption. This is particularly important when the child being adopted has special needs. She also emphasized that the adjustment of parents to their child with special needs is eased if they have a clearer understanding of what the special needs will mean in their relationships and family life when the child enters their home.

Lundwell (1996) discussed a multidisciplinary approach to psychoeducation. This approach emphasizes the use of psychoeducation groups for families of mentally-ill individuals to collaborate and coordinate services that will be used in on-going care. Lundwell described psychoeducational support groups as providing education, advocacy, service coordination, and social support to families in the group.

With regard to what components should make up a psychoeducational support group, Lundwell (1996) suggested several content areas. First, she describes educational needs, as they are common for families attending psychoeducational groups. She emphasizes that families need to be provided with explanations for illness, problem behaviors, or other issues pertinent to the purpose of the group. However, she also emphasizes the need for training and modeling of effective interactions and guidelines as to how problematic behaviors should be handled.

Professional support is another component of the psychoeducational support groups described by Lundwell (1996). She cited research findings that identified that a primary difference between members and nonmembers of support groups is that families attending the support groups report that they are looking for resources beyond the support group. One suggestion for aiding families in finding the needed resources is to invite a few service providers in the community to present information to families (Lundwell). Even if these representatives do not explicitly describe their service programs, families benefit by becoming aware of the services available to them, particularly as contacts with service providers have the potential to develop into

resources that will unite with the family to plan and provide necessary services. This indicates the potential helpfulness of increasing adoptive parents' exposure to those who provide the services available to them. The need for doing so was also suggested in a study by Kramer and Houston (1999) in which parents indicated a need for assistance in navigating the service systems available to them and in understanding the policies that influence their adoption, supports, and services.

Barth et al. (1994) examined groups for foster parents of sexually abused children. Their motivation for conducting these groups was based on the assumption that the foster parent training provided by the Social Service Department could not prepare these parents with adequate knowledge and information to care for sexually abused children or to understand their behaviors in light of the past abuse.

Several areas of foster parenting, beyond the specific issues relating to sexual abuse, were considered important to include in parent training. These issues included working with biological parents, child development, and the relationship parents have with social service agencies. In these groups, it was suggested that by having fairly structured groups, parents' anxiety about attending would be decreased. Barth and colleagues (1994) also emphasized the importance of giving parents the opportunity to discuss issues and situations they experienced with their own children with other foster-parents as doing so increased content relevance and the supportive environment of the groups.

Foster parents assessed their children before and after the training groups using a self-report measure. Participants in Barth and colleagues' (1994) study unanimously stated that, after training, they felt better able to care for their child while also reporting that their understanding of foster care in general, and more particularly, of their own children, had increased. Additionally, 80% ($n = 12$) of participants stated that they would have liked a similar group to have been available to them sooner. This study supports a need for developing psychoeducational strategies for assisting foster-parents and adoptive parents as well. However, generalization of the study's findings may be limited as it consisted of a small experimental group (i.e., number of participants who received the training, $n = 15$).

In sum, parent training and psychoeducation have been effective for a variety of family situations. Much of the literature reviewed above deals specifically with effectively training families for dealing with difficulties of various family members as well as easing transitions families are to make. Psychoeducation has also been chosen as a method for the training groups because it allows an informal setting where adoptive parents can meet one another to increase their social support system. This is particularly valuable as adoptive parents of special-needs children have identified informal support systems as more helpful than formal supports (Rosenthal et al., 1996). Another benefit of this modality is that it allows for professionals from various social service providers to be involved with the adoptive parents that may need contacts with them in the future. For this reason, psychoeducation and parent training have been proposed as an

appropriate model of intervention for adoptive parents of special-needs children. Additional support for using a parent training model comes from the fact that programs of this type have also demonstrated treatment success, cost effectiveness, and lasting outcomes (Cunningham, Bremner, & Boyle, 1995).

Content of Adoptive Parent Training Programs

In a chapter on preadoption parent education, Berkowska and Migaszewska-Majewicz (1991) outline general objectives for preadoption programs. These authors identified the specific goals for parent training as follows:

1. To inform participants about the legal aspects and procedures for adoption.
2. To offer a basic knowledge about human development and help participants understand about the adjustments required when an older child comes to the family from an institution.
3. To create a realistic picture of adoptive family life and to show positive outcomes of adoptive families.
4. To help participants reduce feelings of low self-confidence and low self-esteem.
5. To try to decrease anxiety both toward the adoption process and following the adoption.
6. To create and maintain a supportive group where couples can share fears, emotions, attitudes, and values and where through discussion their outlook, if unrealistic, can be modified.

7. To meet individual psychological needs of prospective parents (pp. 197-198).

A review of child welfare parent training programs found that preparatory activities for adoptive parents are not well developed, and are the least comprehensive of training programs when compared to other aspects of child welfare (i.e., training for foster parents, case workers, etc.). Further, even at a rudimentary level, this review found that training programs for adoptive parents are rare (Berry, 1988). While no studies were found demonstrating the effectiveness of parent training for adoptive parents, one study examined service use, helpfulness, and needs of adoptive families (Rosenthal et al., 1996). This study was based on questionnaires sent to eligible participants in two states, and included 562 families who adopted children, most of whom had special needs. These services were accessed by families primarily through contact with their social worker or the Department of Human Services in their state.

This study was conducted through four adoption agencies based in Oklahoma and Iowa. Within this sample of parents, 25% of them reported on children who were assigned a special-needs status based on physical handicaps. Forty-two percent were considered special-needs because they were part of a sibling group. Thirty-eight percent were of a minority status and were consequently considered as special-needs children, based on the difficulty in finding homes for minority children. Additionally, 67% of the children of adoptive parents sampled in this study had medical or psychological difficulties qualifying them to receive medical adoptive subsidies.

Results of this study (Rosenthal et al., 1996) indicated that 60% of these adoptive families found counseling and education in the areas of adoption issues, child development, and planning for the child's future to be very helpful. One-half of these parents described help on parenting skills, and counseling resources as helpful. Further, 80% of these families also evaluated education on, and resources for respite care, as very helpful. Findings of this study also call attention to the importance of adoptive families having acquired thorough background information on the child they adopt.

Another important result of this study (Rosenthal et al., 1996), is the recognition that adoptive families tend to use informal support more frequently than formal support, and that opportunities to develop these informal support resources are helpful. These opportunities include activities such as home visits from health aids or other adoptive parents or professionals, "master" adoptive parents (i.e., parents who have previously adopted children that sponsor parents who have more recently adopted), support groups for adoptive parents and/or children, and outside time with other adoptive parents that often develops as parents become more familiar with each other through formal support services. This is evidenced in Rosenthal and colleagues' finding that 81% of parents rated time with other adoptive parents as being very helpful. This study also supports a need for the current study, as it also found that service needs were highest for adoptive parents of children with either behavioral or emotional problems. This included nearly all families that have adopted a child with special needs.

Kramer and Houston (1999) also explored the need for and use of preadoption support by families adopting children with special needs. The sample of this study may not be as representative as that of Rosenthal and colleagues (1996), due to a smaller sample of parents ($n = 17$), and because the families involved in the study live in a community established specifically for foster and adoptive parents. This community consists of single family homes so that adoptive families may reside near each other to maximize their social support network. Additionally, approximately 50 volunteers who serve as foster grandparents and volunteers live within this community. The sample of this study was purposively drawn from the community being studied (i.e., the Hope for the Children program). Questionnaires assessing needs of the adoptive families yielded results in terms of descriptive statistics.

Findings of this study (Kramer & Houston, 1999) identified similar services as being important to adoptive families as did the previously mentioned study (Rosenthal et al., 1996). More specifically, families identified a need for adequate background information, and for opportunities to increase understanding and access to counseling services. Under the heading of "additional unmet needs," families identified the need for respite care, additional training about adoption issues, and confirmation concerning how policies affecting them were applied, and how they could be navigated.

Henry (1999) examined the implications that research on resilience in maltreated children had for special-needs adoptions. Participants in her study were adolescents referred through court, probation, and welfare systems who had experienced

physical abuse, sexual abuse, or neglect as well as child care professionals with experience in the field of child abuse. Thirteen participants were interviewed (adolescents, $n = 7$; child welfare caseworkers, $n = 3$; independent living counselor, $n = 1$; foster parents, $n = 2$). Those who volunteered to participate were required to attend weekly meetings consisting of group activities, workshops, videos, speakers, and homework assignments designed to increase and assess the adolescents' independent living skills. The basis for Henry's study was that many behaviors and attitudes of maltreated children which adoptive families find difficult or confusing make sense when viewed in light of the child's previous contexts. This perspective is valuable, as what appears maladaptive in the child's new environment, may actually be what allowed the children to cope and survive in previous environments that were much less stable and supportive.

This perspective is the foundation for the current study's suggestion that adoptive parents would benefit from education in many areas (Henry, 1999). She suggested training dealing with accessing and utilizing the child's preadoption information and history, expectations for the child's behavior, connections with previous figures in the adopted child's life, and inclusion of rituals to aid families in defining the child's place in the adoptive family.

Rosenthal and Groze (1990) sent questionnaires to intact families who had adopted children with special needs. In this study, Henry's (1999) suggestion that adoptive parents could benefit from more information on their child's background, was

directly supported by the adoptive parents included in this study. Rosenthal and Groze obtained a sample of 799 parents. This sample was drawn from four years of adoption placement records at four different adoption agencies. The adoptive children of parents sampled were required to have been over four years of age at placement and 17 years old or younger at the time the questionnaires were sent. Of the participating parents, 35% reported that the adoption agency's provision of background information about their child was insufficient. These authors suggested that important information for parents to have includes medical and social histories, prior placements/residences, handicaps and limitations the child may have, significant people in the biological extended family, and interests and aptitudes of the child.

Participants in this study also rated support groups and contact with other adoptive families as more beneficial than therapy (Rosenthal & Groze, 1990). Results of this study indicated that adoptive families tend to be flexible, adaptive, and cohesive. It is interesting to note that findings of this study suggest that behavioral or emotional difficulties of the adopted child are more negatively associated with parental satisfaction than either developmental or physical handicaps (Rosenthal & Groze). This effect on parental satisfaction was even more pronounced for parents dealing with externalizing behavioral or emotional difficulties (i.e., acting-out, aggressiveness) rather than internalizing problems (i.e., withdrawn, inhibited behavior). In general, adoptive families were quite satisfied with the adoption. A majority of respondents reported good

relationships with their adopted children, and 75% of the parents in this study stated that the adoption of the special-needs child had a positive impact on their family.

Another study by Rosenthal and Groze (1991) used parental perceptions to examine behavioral problems of special-needs adopted children in more detail. Study participants, including 757 parents of special-needs adoptees, completed the behavior problems section of the Achenback Child Behavior Checklist. This is a standardized behavioral checklist that was used to compare parental perceptions of adopted children with special needs to parental perceptions of other types of child samples, including clinical and non-clinical samples. The results led them to confirm the need for parent training groups for adoptive parents to aid them in developing realistic expectations and in recognizing the length of time that will be required for the adoption transition to be made by the adoptive child and family. They reported that it is necessary that prospective parents be aware of the problems that are often encountered in special-needs adoption. Rosenthal and Groze further emphasized that parent training should focus more on externalizing behaviors than internalizing behaviors. This suggestion to focus more on externalizing behaviors was validated in their study based on two findings. First, for children between the ages of 6 and 16, scores for this type of behavioral problem were elevated to a greater extent than scores on internalizing behavioral problems. Additionally, externalizing behaviors (i.e., aggression, acting out, theft, criminal activity, etc.) were also found to be more indicative of future disruptions.

Another study examining adoption, attachment, and self-concept of adopted children suggested that intervention focusing on the adoptive family should include psychoeducation, as many of these families have high parental expectations (Groze, 1992). This suggestion was based on a two-tiered study. In the first portion of the study 197 adoptive parents of special-needs children completed a survey designed to assess the Iowa state special-needs adoption program as well as a questionnaire addressing attachment behaviors of their children.

The second tier of the study involved the special-needs children themselves (Groze, 1992). For children to be included in the study they had to be living in the home, their parents had to be receiving a subsidy for their care, and their adoption had to be finalized before February 1990. Parents were given the option of not including their child in the study, or of allowing them to be interviewed in the presence of the family or alone, or of having their child complete a questionnaire. Of the parents involved in the first tier of the study, 30% agreed to have their children participate in the second tier. This yielded a sample size of 57 special-needs adopted children. Thirty-four of these children were interviewed (60%) and 23 completed the survey by mail (40%). In tier one of the study, parents reported the frequency of child behaviors that are considered as indicative of a child's attachment style (i.e., cries a lot, withdrawn, spends time with the family). In tier two of the study, children answered an abbreviated form of similar attachment items that focused on children's self-perceptions.

Findings of this study (Groze, 1992) indicated that average scores on self-concept for adopted children were better than those for normative and clinical groups. However, looking only at mean scores does not reflect a significant group of the children involved in the study (Groze). When results were analyzed using percentile scores it was estimated that approximately 12% to almost 33% of adoptees manifested some difficulties with self-concept, depending on the subscale being examined. Another important finding of this study is that there was a statistically significant relationship between all three measures of attachment and self-concept when examined from the adopted child's perspective. Because these findings indicate that a majority of adopted children with special needs do not have self-concept or attachment difficulties, Groze suggested that effects of the trauma that many special-needs children experience before their adoptive placement can be mediated.

Groze (1992) offered suggestions for helping adoptive families aid their children in mediating the effects of previous trauma. He asserted that giving the family more information concerning the child's pre-adoptive history is one intervention to help families more realistically understand what impact that adopting a child with special needs will have on their families. This history and background information also helps the family recognize what experiences, behaviors, and expectations the child will bring to the family. Consequently, this information also aids the family in establishing more realistic expectations of the adoption and of the child that is being added to their family.

Further, as expectations between families and children become more similar, integration of the new family member occurs more smoothly. Groze (1992) also reported that this intervention will allow adopted children to more fully integrate their past and to restructure their models of caregivers and of themselves. This study also stated that structurally, adoptive families can be aided through the use of family rituals (i.e., life books, adoption "wedding" vows, family celebrations, traditions, etc.).

In light of the literature reviewed above, several themes emerge. One theme addresses the modifiability of some influences of the special-needs adoptive children's history or previous experiences on their current contexts and experiences. This flexible perspective of past traumas, or attachment disruptions implies that when adoptive families are prepared for the transitions they will need to make when adopting a child with special needs, not only does the adoption transition occur more smoothly, but in the process, the adopted child learns new ways of relating and gains a sense of security. Other key themes in the literature reviewed above include the promotion of preventive services for adoptive parents and a description of the content of parent trainings for adoptive parents of special-needs children. Content suggested for parent training groups centers around several key topics such as, attachment issues, impact of adoption on the marriage and the family, expectations, inclusion rituals, relationships with the birth family and other significant figures in the adopted child's life, therapeutic services and relationships with service providers, and respite care.

Rituals

Rituals have been found to be effective in helping families with an alcoholic member (Wolin, Bennett, & Jacobs, 1988), families with adolescents (Lax & Lussardi, 1988), families making the transitions that accompany remarriage (Whiteside, 1988) and for relationships with other transitions or changes to be made (Imber-Black, 1988; Laird, 1988; Sanders, 1988). Because adoption also involves transition and change for all members of the family system, and based on the recommendations for rituals found in adoption literature (Groze, 1992; Mason & Parks, 1995), it is inferred that rituals might also be considered effective in easing transitions for adoptive families and their biological, foster, or adopted children.

Groze (1992) also identified the importance of family rituals for adopted children's sense of self and their attachment. He states that while most families participate in traditional family rituals, when a family adopts, traditional rituals may not do enough to strengthen the family relationship. Groze proposed that adoption-specific rituals may be an effective intervention for easing adoptive families' structural transition as new family members are added. Rituals are symbolic and have the potential to be very powerful. It has been suggested that these rituals be symbolic not only for the parent adopting the child, but also for the child who is, in turn, "adopting" parents (Groze). These symbolic activities help the adoptive families and children formulate their own meaning of the adoption and essentially create the adopted child's space in the family.

Mason and Parks (1995) offered several suggestions for adoption rituals. The most well-known and frequently used adoption ritual is the creation of a lifebook. These books are similar to scrapbooks, however, they also contain information on why the adoptive child's birth parents could not care for them, why they have transitioned in the placements they have, and how the child arrived in their current situation. A similar activity to that of creating a lifebook is to collect small objects representing all the places the child has been, and people who are significant to the child.

Another adoption ritual is similar to a wedding ceremony (Mason & Parks, 1995). This ritual involves having a judge, or another adoption official, oversee a ceremony whereby the adoptive family members and the adopted child make vows and promises to each other to be "life-long" family.

Melinda (1990) described an adoption ritual for children experiencing difficulty with forming attachments. This article stated that often adopted children consider forming attachments with their adoptive family as disloyalty to previous parental and familial figures in the child's life. One ritual to help children and families feel that forming new attachments is acceptable is to take one candle, intended to represent the adopted child's love, and light other candles. Each of these other candles representing a person the child has cared about. This is symbolic as "the child is able to see that none of the light is diminished by lighting additional candles" (Melinda, p. 4).

Mason and Parks (1995) emphasized the need for adoption rituals to be developmentally appropriate for the child to understand them and to be fluid enough to

change as the child does. In this way, the adopted child can integrate more and more aspects of the ritual into their self-concept and their sense of attachment to significant figures and situations in their lives as well as to their adoptive family.

While no empirical studies addressing the effectiveness or outcomes of implementing inclusion rituals in adoptive families were found, there are many suggestions promoting the helpfulness of rituals for families making this transition. These suggestions fit circumstances of adoption as adoptive families are required to create flexible inter- and intra-family boundaries (Hanson, 1995; Johnson & Fein, 1991; Kaslow et al., 1999).

Attachment Issues

For years researchers have examined the construct of attachment (Oleson, 1996). Key researchers in the area of attachment have been John Bowlby and Mary Ainsworth. They suggested that children's relationships with their mothers serve as a model or prototype for relationships later in life (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1982). More recently, however, the significance of a child's relationship with his father or other significant people throughout their lifespan has been recognized to influence attachment (Berk, 1999; Blain, Thompson, & Whiffen, 1993). Because special-needs adoptions often involve multiple placements and attachment disruptions for children being adopted (Hughes, 1999), these significant people in the child's life typically include birth parents and relatives, case workers, a number of foster parents and relatives, as well as the adoptive parents and family.

A review of the nature of children's attachment relationships describes several factors influencing attachment security including maternal deprivation, quality of caregiving, infant characteristics, family circumstances, and parents' internal working models (Booth & Wark, 2001). In the case of many special-needs adoptees' previous experiences of abuse or neglect (Groze, 1992; Hughes, 1999; Johnson & Fein, 1991) these factors have particularly salient influence on adoptees' ability to form new, secure attachments with adoptive parents.

Johnson and Fein (1991) examined the relevance of Bowlby's theory in studying attachment in adopted children. These authors emphasize Bowlby's (1969) suggestion that while a child's confidence in attachment figures originates in early infancy, the attachment process continues to develop and is subject to change. This developmental view is consistent with ideas that treatment interventions addressing attachment are possible. Johnson and Fein again emphasized that the potency of attachment in relation to adoption is one of the challenges adopted children and their adoptive families must face to integrate the changes in the family system.

The importance of attachment in special needs adoption is also clear as a reason frequently cited for wanting to adopt special-needs children is their emotional attachment to them (Barth & Berry, 1988). Similarly, the inability of some of special-needs children to develop attachment relationships is also a frequent reason given for failures in adoption (i.e., adoption disruption or dissolution) (Schmidt, Rosenthal, & Bombeck, 1988). Hughes (1999) wrote an article reviewing the formation of attachment

as well as the effects of abuse and neglect on attachment. He also described children with significant difficulties with attachment and summarized actions needed of parents and adoption agencies to increase the probability of a successful adoption. Hughes highlighted the need for adoption professionals to understand, and communicate to parents in a way that they can understand, behaviors that may be indicative of a child's difficulty in establishing attachments. He suggested that parents must come to a fuller understanding of their child's particular attachment problems before working with professionals to determine whether or not they are able and motivated enough to continue with the adoption.

Hughes (1999) also endorsed the need for adoptive parents to have support within the adoption community. Respite services, interaction with other adoptive parents, and services aiming to increase the parents understanding and ability to access services that the child currently needs, or may need in the future, are among the resources he proposed as vital to parents and children having a successful and positive experience with the adoption.

The literature reviewed above with respect to attachment and adoption indicated that attachment styles and behaviors are not determined after a certain age, but that the processes of attachment do continue throughout life. This implies that attachment styles and behaviors can be modified over time, if the manner in which attachment figures are experienced is also modified. It has also been suggested that in cases where difficult attachment styles have been formed, the salience of past experiences makes it somewhat

more difficult for the child to alter attachment styles and behaviors based on new experiences.

These notions of attachment provide important information for the study at hand. First, this information suggests that parents need to have a clear understanding of the types of attachment styles and behaviors they may expect from adopted children with special needs. Second, this information suggests that parents would benefit from training in how to deal with their child's difficult attachment behaviors. This training might focus on allowing the child to interact with his/her adoptive parents and new attachment figures in a more secure manner. With this training, adoptive parents may be able to form an attachment relationship with their child, and the transition of the adoption and the inclusion of the new family member may occur more smoothly.

General Review of Post-Adoption Service Needs

Marx (1990) examined the family/agency experience of families who adopted from a statewide special-needs adoption agency in Massachusetts. Participants in this study were limited to families of children originally referred to the adoption agency with a primary diagnosis of developmental disability rather than other factors influencing the children's identification as having special needs concerning their likelihood of being adopted (eligible families $n = 101$). This project's findings are based on telephone surveys, completed with all participants ($n = 98$), and more in-depth interviews conducted with 20 of the participants. In her study, Marx found that over 90% of the

families listed anxiety about getting help needed. Families also reported difficulty and conflict regarding the information about the adopted child they were provided with. Several families in Marx's study also stated that the agency was too focused on the child that was to be adopted, and did not adequately consider or address implications of the adoption on the family.

A study conducted by Marcenko and Smith (1991) examined post-adoption needs of adoptive families of children with developmental disabilities. Data were collected with questionnaires completed by 125 families found using two sources. The archives of Michigan's Spaulding for Children were the first source for locating participants. Data, beginning with records of adoptive families from Spaulding's inception in 1968, was searched for eligible participants. Second, other agencies in Detroit, which were known to place special-needs children with adoptive families, were also sent questionnaires to forward to eligible families. Three hundred questionnaires were distributed, and 125 questionnaires were completed. However, because adoption agencies were simply asked to forward the questionnaires to eligible families it is impossible to know how many questionnaires were actually sent. Consequently, it was not possible for Marcenko and Smith to calculate a response rate.

Generalization of this study's results may not be appropriate, as a relatively high incidence of transracial adoptions (31%) were represented in this sample. However, these authors' findings did correspond with those of related studies indicating adoptive families' need for more support services. Again, calls were made for services that would

link adoptive families with support services. Among these services, families identified respite care, support groups, and ongoing training in how to care for the child.

Findings of this study also suggested a need for adoption agencies to work in conjunction with other agencies in the community in order to identify with the family what service needs they may encounter, and where to obtain the necessary services (Marcenko & Smith, 1991). It is important that service contacts are established for the family, based not only on current service needs, but also on anticipated needs, as needs for service will change during the life cycle of the child and family. The authors also recommended that agencies review adoptive families' expectations and provide training to ensure that these expectations are fairly realistic.

O'Hara (1991) also emphasized the need for parents and families to look at how the placement of a child with special needs will not only initially upset a family's balance, but also how it will permanently change the structure of the family. This study assessed the outcome of permanent placement achieved either through adoption or permanent foster parenting made by an agency during a five-year period from 1982 to 1987. O'Hara found that children placed in a permanent home represented less than 5 % of those received into the care of children's welfare during this time period ($n = 335$). However, it is also interesting to note that some of the children for whom permanent placement had been established were described as among the most disturbed children in public care. O'Hara reported that in contrast to the past, in the 1980s children were more likely to have spent less time in public care; experienced repeated and failed

rehabilitation efforts; been physically or sexually abused; to come from rough or "turbulent" backgrounds; been part of a sibling group to be placed; to be less than ten years old; and to have received therapy of some kind.

In light of the increasing difficulties experienced by most special-needs children and the lasting effects of such experiences, one of the biggest achievements adoptive families and agencies can make is to realize that adoption is not in itself an end (O'Hara, 1991). O'Hara called for parents to be educated about the many different ways the process of adoption and related issues will affect their lives as new stages and transitions of life are encountered.

A summary of the literature discussed above yields several themes in adoptive parents' needs for services and training. These themes emphasize the need for parent training in developmental and attachment issues, expectations for the child, parent-child relationship, and impact on the marriage and the family, rituals for inclusion of the adopted child into the family, relating with the birth family and other significant figures in the child's life, when to seek services and how to navigate the service system, respite care, and the need for information on the history of the child and their birth family. However, much of what has been described in the literature as relevant to services, needs, and training for adoptive families has not been implemented, or has not been studied in terms of outcomes. This study seeks to build on the literature by implementing a psychoeducation group for parents adopting special-needs children,

while also empirically examining outcomes of a training including the content areas promoted in the literature.

Research Hypotheses

- H1. Parent training on special-needs adoption issues will reduce stress in parenting roles. This is expected as the training sessions will focus on establishing realistic expectations for what the child's behavior may be like, and for what parents' roles with a special-needs adoptee will be.
- H2. Parent training sessions will contribute to a change in parents' subjective distress in interpersonal relationships as well as other social roles.
- H3. Marital satisfaction between adoptive parents will be influenced by parent training sections addressing a variety of factors influencing the impact of adoption.
- H4. The aspects of parent training services parents will find most helpful will vary according to the special needs of their adopted child as well as the family's stage in the adoption process.

CHAPTER III

METHODOLOGY

Research Design

This study utilizes a pretest-posttest design. This design was selected based on the absence of random assignment in the current study. Subjects were purposively sampled and all individuals meeting the criteria of the study, who were interested in participating in a preadoption group, were assigned to the experimental condition. Subjects were given the option of participating in one of two training sessions, held 3 months apart. Nine of the participants in this study came from the first group, the other six subjects in this study participated in the second group. While the style of presenting changed slightly over time, in each group the information and presenters remained the same. Because participants received the same information from the same presenters, the training sessions were considered one treatment, and participants from both groups were combined and treated as one group for the purpose of data analysis.

Subjects were tested on standardized measures (see Measures below) prior to the intervention of preadoption groups (Time 1) and again immediately following the second and final session (Time 2). Subjects were again tested on each of the three measures six months following the intervention of two group meetings (Time 3), which were held 1 week apart.

In addition to measures administered in the pretest, at the post-intervention observation (Time 2) participants were also given a questionnaire regarding their knowledge of adoption-related issues and what sections of the group meetings they considered most helpful. This questionnaire also asked for any feedback or suggestions from the participants. Using the symbol O to represent observations, or points of measurement, and X to represent the intervention, the following is a diagram of this study's design: O X O O.

Research Sample

Because subjects for this study had to meet fairly specific criteria to participate, the sample was purposively drawn. In order to participate in the parent training groups, individuals were required to have adopted a special-needs child, to be foster-parents of a special-needs child with the intent of adopting, or to have a special-needs child in their home waiting for finalization of the legal adoption.

Potential subjects were recruited using a variety of methods. The Division of Child and Family Services (DCFS) sent letters to eligible individuals in the target area of northern Utah. These letters informed 60 potential families, qualified for inclusion in the parent training groups, of the location, dates and times when training groups were to be held. Potential participants were also informed about the parent training via newsletters of organizations frequently involved with adoptive or foster parents (i.e., The Foster Care Foundation, County Mental Health Centers,

DCFS). After having an outline of the program's plan presented to DCFS caseworkers and social workers, this group was also emailed the dates and times the parent training groups would be held in order for them to recommend the training to parents going through the adoption process. Potential participants were generally middle aged, first married couples.

There were 60 people who attended at least one session of the psychoeducation groups. However, only 18 attendees completed the questionnaires at all three time intervals. This difference may be attributed to a variety of factors.

First, several parents did not attend both sessions of the training. This may be due to a variety of factors. One source of attrition was a schedule conflict with foster parent appreciation night during one group. Due to this conflict, several participants were not present for the second session of the group. Another factor influencing attrition is that a few couples who attended had one spouse come to the first training session, and the other spouse come to the second session. Similarly, in many cases, only one spouse completed the follow-up questionnaires ($n = 6$), despite several calls and messages left for those who did not return the questionnaires and repeated mailings.

This difficulty in gathering complete data for participants with questionnaires completed at all three time intervals may relate to attendees' comments that they receive several questionnaires a week relating to adoption, and that they were frustrated by this. Consequently, many who attended both groups were not willing to complete any or all of the questionnaires. This frequency of mailed surveys contributed to difficulty

obtaining follow-up data even from those parents willing to complete the mailed questionnaires, because it was difficult for them to identify which one of the surveys they were receiving related to the group they had attended, despite reminder calls and mailing the follow questionnaire a second time.

Because there was a large difference between the number of parents who attended the group sessions (i.e., attendees) and the number of parents with complete data (i.e., participants, having completed the questionnaires at all three time intervals), a two-tailed independent samples *t* test was used to test for differences between the two groups (i.e., those with incomplete data versus those with complete data). The groups were compared on their scores on the OQ-45, RDAS, and PSI Parental Distress Subscale at Time 1 (i.e., prior to the first session), as well as on the demographic variables of age, education, income, and the total number of children in the home.

Mean scores on the OQ-45 were 45.00 ($SD = 17.50$) for those who did not complete the measures at all time intervals ($n = 42$), and 39.80 ($SD = 14.25$) for those who did complete the measures at all three times ($p = .32$). On the RDAS, the difference between attendees' and participants' mean scores at Time 1 was not statistically significant ($p = .39$). The mean scores on this measure were 10.21 for attendees ($SD = 1.63$), and 5.83 ($SD = 1.51$) for participants. Attendees' mean score on the PSI/SF Parental Distress Subscale at Time 1 was 26.43 ($SD = 8.79$), while participants' mean score was 24.47 ($SD = 7.52$). A *t*-test comparing these mean scores again indicated that the difference between groups was not statistically significant ($p = .22$). With an alpha

level of .05, no significant differences between those who completed the questionnaires at all three time intervals and those who did not were found on any of the measure or demographic variables.

Completion of the instruments at all three time intervals (i.e., prior to the first session, following the second session, and a 6-month follow-up), was a requirement for inclusion in this study. This left 18 participants eligible for inclusion. However, because spouses' responses to the questionnaires would not be independent, in cases where both the husband and wife completed the instruments at all time intervals, only the husband's responses were included in the study. Data from three wives were dropped from inclusion in the study in order to maintain independent responses. This left a sample representing 15 different families, consisting of responses from 5 males and 10 females, all Caucasian. Participants ranged in age from 26 to 51 years old. All but one of the participants were in their first marriages, with the exception being a female in her second marriage. Participants came from middle- to upper- socioeconomic status. Table 1 gives an overview of additional demographic information about participants.

In addition to this information, parents were asked to provide some information about their children. Approximately 50% ($n = 8$) of participants had biological children, averaging two to three biological children per family ($M = 2.5$; $SD = 1.41$). Many of the participants had adopted children in their home ($n = 9$; 60%), again averaging about two children in the adopted status per family ($M = 2.11$; $SD = 1.27$). In addition to those

Table 1

Summary of Participant Characteristics

Characteristics	Male <i>n</i> = 5		Female <i>n</i> = 10		Total <i>n</i> = 15	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Age in years	44.40	3.13	36.10	7.31	38.87	7.32
Years in current marital status	16.20	7.19	13.50	6.55	14.40	6.64
Years of education	15.40	1.14	14.10	3.04	14.53	2.59
Income (in thousands)	74.00	26.51	69.29	43.53	70.70	37.75
Total number of children	4.40	1.95	3.00	1.63	3.47	1.75

who had finalized adoptions, four participants were in the process of adopting children, averaging one to two children in this status per family ($M = 1.25$; $SD = 0.50$). Further, four participants also had foster children in their home, with an average of two foster children per family ($M = 2$; $SD = 0.82$).

The factors of adopted or foster children which led to their classification as children with special needs were also reported by parents. Consequently, reports of children's special needs were based on adoptive parents' understanding, which is primarily based on information from case workers, therapists, teachers, and doctors, or from experiences interacting with and observing their children in the home environment. These needs ranged a variety of areas including attachment ($n = 3$), behavioral problems ($n = 2$), developmental delays ($n = 1$), ethnicity/race issues ($n = 1$), learning disabilities ($n = 5$), medical ($n = 1$), a history of abuse or neglect ($n = 2$), and drug abuse by their biological parents ($n = 1$).

Measures

The present study investigated four research questions. Each research question is listed below with its corresponding measure. Additionally, a fifth measure is described which was created to obtain demographic information on adoptive families and their children.

Research Question 1. The amount of stress experienced by adoptive parents was measured using items from the Parenting Stress Index/Short Form (PSI/SF; Abidin,

1990). The items composing the Parental Distress Subscale (i.e., items 1-12) were utilized in this study as this subscale is widely used in child services for assessing parental stress and parent-child relationships.

PSI/SF

The Parenting Stress Index/Short Form (PSI/SF; Abidin, 1990) is used to identify parent-child systems that are under stress as well as families that are at risk for parenting problems or emotional pathology. It is a standardized self-report instrument. Each item is rated by the parent on a 5-point Likert scale, ranging from strongly agree to strongly disagree. The scale is divided into three subscales: Parental Distress, Parent-Child Dysfunctional Interaction, and the Difficult Child (Abidin).

The Parental Distress Subscale indicates the level of stress a parent is feeling as a result of personal factors related to parenting (i.e., lack of social support, depression). The Parent-Child Dysfunctional Interaction Subscale examines how the parent feels that the child measures up to their overall expectations for the child. Scores on the Difficult Child Subscale indicate which behavioral characteristics of a child (i.e., temperament, defiance, noncompliance) make him or her easy or difficult to the parent. The subscales may be summed together to create a Total Stress Score, intended to represent the overall level of parenting stress the individual is experiencing.

Reliability for the PSI/SF was established over a six-month period. For this interval, test-retest reliability coefficients were .84 for the Total Score, .85 for the Parent Distress Subscale, .68 for the Parent-Child Interaction Subscale, and .78 for the Difficult Child Subscale (Abidin, 1990). Cronbach's coefficient alpha's were also calculated for the measure and were .87 for the Parental Distress Subscale, .80 for the Parent-Child Interaction Subscale, .85 for the Difficult Child Subscale, and .91 for the Total Score, (Abidin). Because Cronbach's coefficient alpha for the Total Score of this measure reached .91 it is questionable that the subscales actually measure different constructs.

Because the total measure primarily accesses a single construct, and in order to shorten questionnaire length to help in questionnaire completions by participants, only the Parental Distress Subscale was utilized in this study. Component stresses of this subscale include an impaired sense of competence in the parenting role, stresses associated with limitations placed on other significant roles in a parent's life, conflict with the child's other parent, lack of social support, and depression. This subscale was chosen rather than other subscales of the PSI/SF because addressing the individual's adjustment in the parental domain is a key purpose of the parent training groups. This subscale also maintains better reliability than other subscales of the total measure, with an alpha of .87 (Abidin, 1990).

Concurrent validity for the PSI/SF was established by correlating the test with the Parenting Stress Index (PSI). Further, validity for the subscales of the

PSI/SF was found by correlating them with the corresponding subscales of the PSI. The Parental Distress Subscale highly correlated with the Parent Domain score of the full length PSI ($r = .92$). Further evidence for this test's validity may be based on a number of studies supporting both concurrent and construct validity for the PSI (see Abidin, 1990).

Research Question 2. This question addressed the influence of trainings on levels of individual parents' distress in various aspects of their lives. This stress was measured using the Outcome Questionnaire (OQ-45; Lambert et al., 1996).

OQ-45

The Outcome Questionnaire (OQ-45; Lambert et al., 1996) was developed to measure progress in treatment as identified by a decrease in stress symptoms. The level of stress symptoms experienced by subjects is based on questions addressing three aspects of a subject's life: (1) subjective discomfort, (2) interpersonal relationships, and (3) social role performance. Progress on this measure can be inferred as scores decline, particularly if an individual scored in a range typically indicative of distress at a previous time of measurement. This test of an individual's subjective distress is particularly important when examining adoptive parents of special-needs children as the processes of placement and, in some cases, adoption finalization require many adjustments to be made which include a period of increased stress.

The OQ-45 is a paper and pencil based test designed for self-administration. The test consists of 45 items divided into subscales examining the three areas of functioning mentioned above. The instrument was designed to be a brief test and to be sensitive to change over short periods of time while maintaining high levels of reliability and validity. Internal consistency of the OQ-45 was found to be high, ranging from .71 to .93, depending on the population being examined, test-retest reliability values range from .78 to .84. These values have been based on populations of students, business people, in-patient and out-patient clinical samples, as well as a general community sample (Lambert et al., 1996).

Concurrent validity of the OQ-45 was established by correlating the instrument with a number of tests. This instrument yielded correlation coefficients in the .70s when correlated with the Symptom Checklist-90-R (.78), the Beck Depression Inventory (.79), and the State Trait Anxiety Inventory (.79). The OQ-45 was also highly correlated with several other tests. The OQ-45 correlated with the following tests with a coefficient in the .80s: the Zung Self-Rating Depression and Anxiety Scales (ZSDS & ZSAS) (.88 and .81, respectively), the Taylor Manifest Anxiety Scale (TMA) (.86) and the composite score of the Friedman Well-Being Scale (.81) (see Lambert et al., 1996).

Research Question 3. Marital satisfaction was measured using the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larsen, 1995). This instrument is widely used in the field of marital therapy.

RDAS

The Dyadic Adjustment Scale (DAS; Spanier, 1976) was developed to examine components of marital adjustment. The scale consists of four subscales measuring consensus on matters of importance to marital functioning, dyadic satisfaction, dyadic cohesion, and affectional expression. The instrument was also designed for use as a measurement of general marital satisfaction or to examine more specific aspects of marital satisfaction by using the previously mentioned subscales independently. In either case, the reliability and validity of the DAS is retained in the revised measure (Busby, Christensen, Crane, & Larson, 1995).

The Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995) was designed to improve on the DAS by adhering to the standards of construct hierarchy and removing test items of the DAS that were homogenous. Because the subscale of affectional expression was found to be quite problematic, the subscale was removed. Consequently, questions on the RDAS were structured to measure dyadic consensus, cohesion, and satisfaction, the remaining scales of the DAS.

The format of the RDAS remains very similar to that of the DAS. Both tests are self-administered paper and pencil tests. The RDAS consists of 14 items with 6-point Likert-type responses.

Busby and colleagues (1995) found the RDAS to be a good representation of the domains proposed in the DAS with less than half of the items included in the first version of the instrument. Construct validity of the DAS was established by

correlating it with the Locke-Wallace Marital Adjustment Test (MAT; Locke & Wallace, 1959) another popular measure of marital adjustment. The DAS was found to correlate with the MAT with a coefficient of .66. The RDAS improves somewhat on this validity by evidencing a correlation coefficient of .68 when correlated with the MAT.

Discriminant analyses comparing the RDAS with the DAS yielded equal ability of these measures in accurately classifying cases as distressed or non-distressed. Both measures correctly classified 81% of the cases. Internal consistency as measured by Cronbach's alpha for the RDAS was .90 (Busby et al., 1995). For the purposes of this study, only the total score from the RDAS was utilized, as each of the sub-areas have relevance to adoptive families.

Research Question 4. This question was addressed using a self-report questionnaire with responses on a five item, Likert-type scale (see Appendix C for a copy of the Scale of Section Helpfulness).

Scale of Section Helpfulness

This self-report questionnaire was developed for the current study to assess research question four. This scale included a list of the nine sections of the parent training (characteristics of successful adoptive families, attachment issues, impact of adoption on marriage and family, expectations of adoptive parents and children, inclusion rituals, relationships with birth/foster families, warning signs for seeking

consultation for the adopted child or self, receiving and evaluating therapeutic services, and respite care) and asked parents to rate the helpfulness of the section on a scale from one to five (1 = not at all helpful, 2 = minimally helpful, 3 = moderately helpful, 4 = very helpful, 5 = extremely helpful). Additionally, space was left at the end of this measure for parents to make comments on the training groups.

Reliability of Measures

Reliability coefficients were calculated for all measures, each time they were administered, in order to test for consistency within the present study. At Time 1 (prior to the first session), the OQ-45 and PSI/SF Parental Distress Subscale both obtained excellent reliability with Cronbach's alpha equaling .92 and .96 respectively. The RDAS achieved acceptable reliability with an alpha coefficient of .82.

At Time 2 (following the second and final session), the OQ-45 reached an alpha level of .88, while the PSI/SF Parental Distress Subscale reached .93. Again, reliability of the RDAS was below that of the other measures, however, at Time 2 Cronbach's coefficient alpha for this measure was .89, generally considered good reliability (Thorndike & Dinnel, 2001). The scale of section helpfulness was also administered at Time 2. Its reliability was found to be .94.

At the 6-month follow-up (Time 3), an alpha of .99 was calculated for the OQ-45, the PSI/SF Parental Distress Subscale was calculated to have a Cronbach's coefficient alpha level of .88, while the reliability of the RDAS was calculated at .84.

The section helpfulness scale decreased in reliability from Time 2 to Time 3. However, the scale did maintain acceptable reliability with a coefficient of .87.

Demographics

Information about study participants was gained using a self-report questionnaire. Ten questions were written to gain information regarding the following characteristics of participants: gender, age, number of marriages, length of the current marriage, years of education, annual family income, ethnic background, children in the home as well as their age, gender, and relationship status (i.e., natural child, adopted child, child with adoption in process, or foster child), special needs of their most recently adopted child or children, and whether or not participants had other special-needs children in the home besides those most recently adopted (see Appendix D).

Procedure

Development of Group Structure

Topics and principles discussed in two preadoption parent training groups were developed from suggestions in the literature previously reviewed. Additionally, a think-tank of professionals met over a period of one year to determine the key content areas and their components as well as other issues vital to the successful implementation of training groups for adoptive parents.

This group included marriage and family therapists, researchers and practitioners from Utah State University, and clinicians and practitioners from the

Division of Child and Family Services (DCFS), the Foster Care Foundation, the Children's Center, as well as the following county mental health centers: Bear River Mental Health, Weber Human Services, and Davis County Mental Health. A private practice psychiatrist also consulted on this project. Once the structure of the groups had been developed, the model for intervention was presented to a group of caseworkers, social workers, and agency members frequently involved in adoption processes. Their feedback was reviewed for comments relating to content and presentation. Written comments from 54 attendees revealed only positive remarks about the content and only minor suggestions on the presentation.

Group Protocol

Following the presentation of the intervention organization to professionals frequently working with adoption processes, more specific information was added to some of the topics that were covered. The preadoption groups were designed to include two 2 ½ hour sessions with a one-week interval between them (see Appendix A for an expanded outline of the groups).

Session 1. The first group session was devoted to several topics including discussion of successful adoptive families, developmental issues, impact of a special-needs adoption on the marital relationship of adoptive parents, expectations of both adoptive families and children being adopted, and the importance of inclusion rituals in providing meaning and identity for family members. Following a brief explanation of the informed consent forms and questionnaires, policies for

relating to confidentiality and participation were discussed and informed consent forms were signed (See Appendix B for a copy of the informed consent). Three assessments, the Parental Stress Index (PSI; Abidin, 1995), the Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995), and the Outcome Questionnaire (OQ-45; Lambert et al., 1996) were administered immediately prior to the beginning of the first group. Parents completed the questionnaires independently, even when their spouses were also attending the training. The student researcher on this project remained at the front of the room to assist parents when they had questions concerning the informed consent forms or the questionnaires. The group session concluded with the participants being given the assignment of developing inclusion rituals with their adoptive children and families.

Session 2. The second session began with a discussion of rituals that families had developed since the previous session and what subjects' own, as well as subjects' family members and adoptive children's, reactions were to the establishment of such rituals. This group session then proceeded to cover topics including pragmatic issues relating to adoption (i.e., medical cards, birth certificates, and social security information), as well as, attachment issues, relationships between adoptive families, children, and birth families, warning signs for when professional assistance should be sought, what therapeutic services are available, and resources to be used in obtaining respite care. Immediately following this second and final session, the measures previously mentioned (the OQ-45,

RDAS, and the PSI/SF Parental Distress Subscale) were again administered to subjects. However, at this time, subjects were also given the helpfulness scale, as well as an opportunity to provide any additional feedback. Six months following the second group, participants were mailed all questionnaires (the OQ-45, RDAS, the PSI/SF Parental Distress Subscale, and the helpfulness scale) with a letter explaining the purpose of the questionnaires as well as a stamped envelope addressed to Utah State University, where the research was completed.

The unit of measurement was the individual and not couples. This was necessary as many adoptive parents are also licensed foster parents and must obtain continuing education units (CEU's). Carol Baumann, associate director of the Division of Child and Family Services (DCFS) in Utah, stated that parents this agency works with often elect to attend different trainings than their spouses so that a greater variety of information can be obtained while investing same amount of time in trainings (personal communication, April 2, 2001). This was evidenced in responses received from the preadoption parent training sessions. In cases where both spouses completed the questionnaires, only the husbands' responses were utilized in the study, because spouses' responses were not independent, as reports related to the same child and marriage would be included more than once.

CHAPTER IV

RESULTS

Analysis of Data

The first three research questions were statistically analyzed using repeated measures analysis of variance (ANOVA) with an alpha level of .05. Stevens (1999) stated that this method "is the generalization of the *t* test for correlated samples" (p. 204). Stevens also deemed this procedure for statistical analysis appropriate when assessing trends in performance over time. In this study, performance is evaluated using scores obtained from subjects on the RDAS, PSI/SF Parental Distress Subscale, and OQ-45.

The statistical procedures used with repeated measures ANOVA, like most statistical procedures, result in both advantages and disadvantages (Stevens, 1999). One such advantage is that repeated measures ANOVA allows for blocking on variables being considered, thus removing all variability between blocks from the error term. This blocking consequently yields a more powerful test. Further, a repeated measures ANOVA allows for such thorough blocking that it is possible to remove all variability among subjects that is due to individual differences. A repeated measures design also strengthens this study, as the procedure is well suited for small samples (Stevens, 1999).

While this type of analysis is best-suited for randomized samples, a repeated measures ANOVA was selected for this study based on its ability to test for main effects as well as interactional effects between the dependent variables (i.e., scores on the OQ-45, RDAS, and PSI/SF Parental Distress Subscale). This is particularly important in the current study as it is likely that the dependent variables of marital satisfaction and adjustment, parenting stress, and individual satisfaction are interrelated. Because a repeated measures ANOVA is a robust statistic, and functions even when some of its assumptions have been violated, it was determined that the benefit and increased knowledge that would be gained from this type of analysis outweighed the disadvantage of relying on the robustness of the statistic.

Disadvantages of using a repeated measures ANOVA procedure include issues regarding how the sequence in which treatments are administered may affect findings concerning subjects' performance. This disadvantage is not of considerable importance when considering that the current study included only one intervention. Research questions and scoring procedures for measures designed to evaluate dependent variables are described below.

Research Question 1. Does preadoption parent training reduce stress in parenting roles with special-needs children? This question was addressed by examining pre- and post-intervention and follow-up scores on the PSI/SF Parental Distress Subscale (Abidin, 1990), using repeated measures analysis of variance (ANOVA), with gender as a status variable and the PSI/SF Parental Distress Subscale total for times one, two, and

three as dependent variables. Because elevated scores on this subscale indicate increased levels of distress, either a reduction of scores, or the maintenance of the status quo on this measure was desired.

The effect of the training on parenting stress was not statistically significant, $F(2, 26) = 0.10, p = .91$. Because this ratio is not significant at the stated alpha level of .05, no further data analyses were performed.

The first research hypothesis, that the parent training groups would reduce parenting stress for parents of special-needs children, was not supported. Based on the analysis in this study, there was no evidence that the training reduced parenting stress as no significant changes were observed. Descriptive statistics for the PSI/SF Parental Distress Subscale are presented in Table 2, and a summary table of results of the repeated measures ANOVA for this subscale is presented in Table 3.

Research Question 2. Do parent training sessions decrease parents' subjective levels of distress near adoption finalization, as information about many aspects of the adoption process is gained? This question was addressed by examining trends over time in total scores on the OQ-45 (Lambert et al., 1996). These trends were analyzed using repeated measures ANOVA, where the dependent variable (i.e., OQ-45 scores) was split by gender. This measure is also scored such that higher scores indicate increased distress. Consequently, when scores are elevated, a decrease in scores would be desirable for post-intervention observations on this measure.

Table 2

Descriptive Statistics for the PSI/SF Parental Distress Subscale at Each Time Interval

Time Interval	Males <i>n</i> = 5		Females <i>n</i> = 10	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Time 1	24.80	5.17	21.20	4.76
Time 2	25.20	7.01	19.70	5.42
Time 3	23.60	4.67	22.90	7.45

Table 3

PSI/SF Parental Distress Subscale ANOVA Summary Table

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>
PSI/SF Subtotal	4.47	2	2.23	0.10*
PSI/SF Subtotal * Gender	38.96	2	19.48	0.86*
Error (PSI/SF Subtotal)	587.80	26	22.61	

* $p > .05$

With an alpha level of .05, the effect of the training on participants' subjective distress and stress symptoms was not statistically significant, $F(2, 26) = 0.55, p = .58$. Because this ratio is not significant at the stated alpha level, no further data analyses were performed.

Based on the analysis in this study, there was no evidence that the parent training groups reduced subjective distress or stress symptoms of parents of special-needs children. Because no significant changes in scores on the OQ-45 were identified, the second research hypothesis, that the parent training would decrease participants' reports of distress and stress symptoms was not supported. Descriptive statistics for the OQ-45 are presented in Table 4, and a summary table of results of the repeated measures ANOVA for this scale is presented in Table 5.

Table 4

Descriptive Statistics for the OQ-45 at Each Time Interval

Time Interval	Males <i>n</i> = 5		Females <i>n</i> = 10	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Time 1	34.20	7.16	39.00	12.70
Time 2	28.40	12.20	39.50	11.32
Time 3	30.60	14.84	36.80	15.35

Table 5

OQ-45 ANOVA Summary Table

Source	SS	df	MS	F
OQ-45 Total	68.87	2	34.43	0.55*
OQ-45 Total * Gender	72.96	2	36.48	0.58*
Error (OQ-45 Total)	1,623.67	26	62.45	

* $p > .05$

Research Question 3. Does marital satisfaction change with more information about the impact of adoption on marriage? In this study, relational adjustment and satisfaction is addressed using the RDAS (Busby et al., 1995). To answer this research question, repeated measures ANOVA was again utilized, with gender functioning as a status variable, and total scores on the RDAS at each of the three time intervals serving as dependent variables. Contrary to the other instruments used in this study, higher scores on the RDAS are preferred as they indicate lower levels of distress and increased satisfaction in the relationship being assessed. Thus, it was intended that lower initial scores would increase while higher scores would remain fairly constant.

At the stated alpha level of .05, the effect of the training on participants' marital satisfaction was also not statistically significant, $F(2, 24) = 2.64, p = .09$. Because this ratio is not significant at the stated alpha level, no further data analysis was

performed. No further data analysis was performed because there was no evidence that marital satisfaction of participants was influenced by gaining information on the impact of a special-needs adoption on the marriage and family. Descriptive statistics for the RDAS over all three time intervals are presented in Table 6, and a summary of the repeated measures ANOVA results is presented in Table 7.

Research hypothesis three stated that participants' marital satisfaction would be enhanced by parent training. This influence was expected as information about the impact of adoption on the marriage and family was to be presented. No significant changes in marital satisfaction were observed, consequently, this hypothesis was not supported. Thus, based on this study, there is no evidence that parent trainings influence satisfaction in marriage.

Table 6

Descriptive Statistics for the RDAS at Each Time Interval

Time Interval	Males <i>n</i> = 5		Females <i>n</i> = 10	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Time 1	53.60	5.50	55.00	6.08
Time 2	55.40	6.54	56.33	6.10
Time 3	54.60	4.72	57.00	5.66

Table 7

RDAS ANOVA Summary Table

Source	SS	df	MS	F
RDAS Total	20.18	2	10.09	2.64*
RDAS Total * Gender	3.61	2	1.81	0.47*
Error (RDAS Total)	91.87	24	3.83	

* $p > .05$

Research Question 4. Do parents' ratings of section helpfulness vary according to the status of their children? This question was answered by calculating and plotting descriptive statistics for participants' ratings of section helpfulness according to their child's status. Because the scale of section helpfulness was completed at Time 2 and Time 3 (i.e., following the second session and at a 6-month follow-up), their ratings were calculated and plotted once for each time interval.

By plotting ratings in this way, a general trend can be seen. Foster parents' ($n = 4$) mean ratings of section helpfulness ranged between 2.67 and 3.33 across the training sections. Adoptive parents' ($n = 8$) ratings of helpfulness ranged from 3.00 to 4.25, while for participants in the process of adoption ($n = 3$) mean ratings ranged from 4.25 to 4.75. Overall, it appears that foster parents rated the sections as less helpful than did

adoptive parents, while parents with an adoption in process reported the highest ratings of section helpfulness.

Table 8 presents descriptive statistics of participant ratings of helpfulness according to the status of the child at Time 2. Table 9 presents similar statistics for parents' ratings at Time 3. Because the sample size for each child status was small (foster, $n = 3$; adoption in process, $n = 4$; adopted, $n = 8$), no further analyses were computed as the assumptions for a comparison of mean scores were violated (Thorndike & Dinnel, 2001). See Figures 1-9 for visual depictions of the helpfulness ratings on each section at Time 2 and Time 3 (i.e., immediately following the last session and at the 6-month follow-up, respectively).

It was hypothesized that the helpfulness of the parent training sections would vary according to the status of participants' children. This fourth hypothesis was somewhat supported. Based on the sample in this study, general trends in helpfulness ratings across training sections did vary with respect to the status of participants' children. However, because no mean comparison or other statistical analyses were possible, given the small sample size in each status, these differences must be interpreted with caution.

Table 8

Participant Ratings of Section Helpfulness by Child Status at Time 2

Helpfulness item	Status of Child					
	Foster <i>n</i> = 3		Adoption in process <i>n</i> = 4		Adopted <i>n</i> = 8	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Characteristics of successful adoptive families	3.33	0.58	4.75	0.50	3.88	0.83
Attachment issues	2.67	0.58	4.50	0.58	3.50	0.93
Impact of adoption on the marriage & family	3.00	0.00	4.50	0.58	3.63	1.06
Expectations of adoptive parents & children	3.00	0.00	4.50	0.58	4.00	0.93
Adoption rituals for inclusion of a new family member	2.33	0.58	4.75	0.50	3.75	0.71
Relationships with birth/foster families	2.67	0.58	4.75	0.50	3.63	0.92
Seeking consultation for the adopted child or self	3.00	1.00	4.25	0.96	4.00	0.53
Receiving and evaluating therapeutic services	3.33	0.58	4.25	0.96	4.25	0.71
Respite care	2.67	0.58	4.25	0.96	3.00	1.07

Table 9

Participant Ratings of Section Helpfulness by Child Status at Time 3

Helpfulness item	Status of Child					
	Foster <i>n</i> = 3		Adoption in process <i>n</i> = 4		Adopted <i>n</i> = 8	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Characteristics of successful adoptive families	3.67	1.15	4.50	0.58	3.50	0.53
Attachment issues	3.00	1.00	4.25	0.50	3.50	0.76
Impact of adoption on the marriage and family	2.33	1.15	4.75	0.50	3.75	0.71
Expectations of adoptive parents and their children	2.67	0.58	4.75	0.50	3.88	0.35
Adoption rituals for inclusion of a new family member	3.67	0.58	4.50	0.58	4.00	0.93
Relationships with birth/foster families	4.00	1.00	4.50	0.58	3.38	0.92
Seeking consultation for the adopted child or self	2.33	0.58	4.75	0.50	3.75	1.04
Receiving and evaluating therapeutic services	2.67	0.58	4.25	0.96	3.63	0.92
Respite care	2.00	1.00	3.25	1.26	3.38	0.92

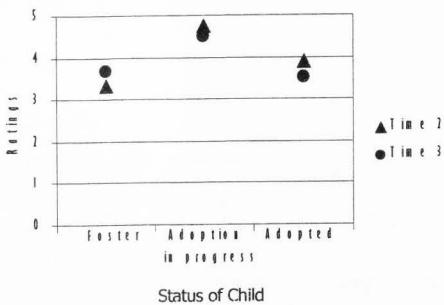


Figure 1. Helpfulness ratings for characteristics of successful adoptive families.

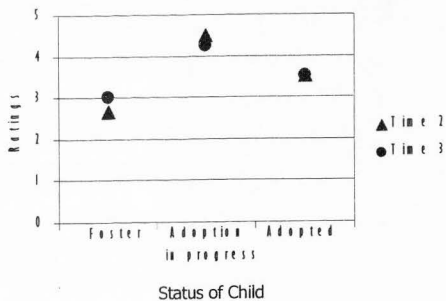


Figure 2. Helpfulness ratings for attachment issues.

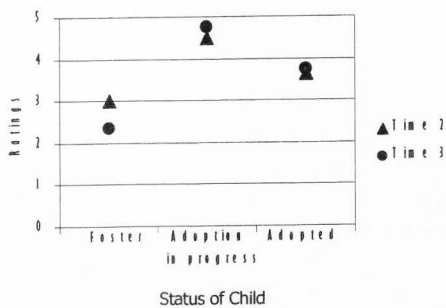


Figure 3. Helpfulness ratings for impact on marriage and family.

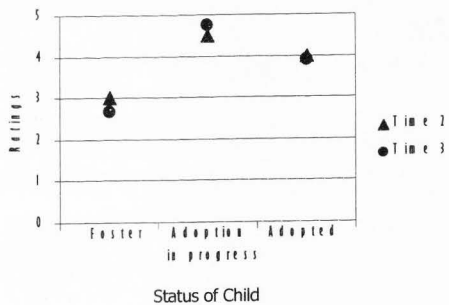


Figure 4. Helpfulness ratings for expectations.

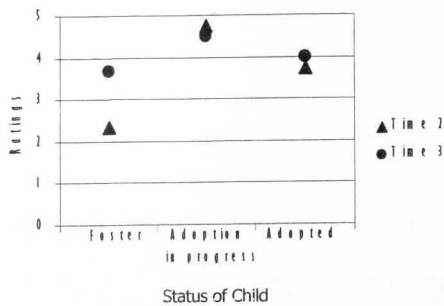


Figure 5. Helpfulness ratings for adoption rituals.

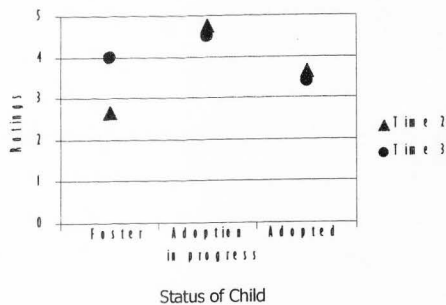


Figure 6. Helpfulness ratings for relationships with birth/foster families.

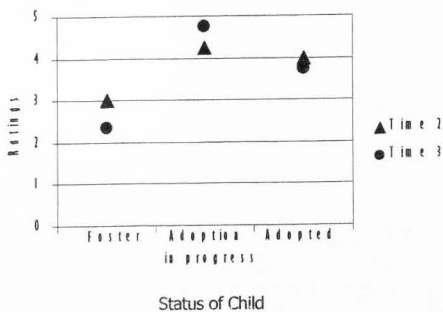


Figure 7. Helpfulness ratings for seeking consultation.

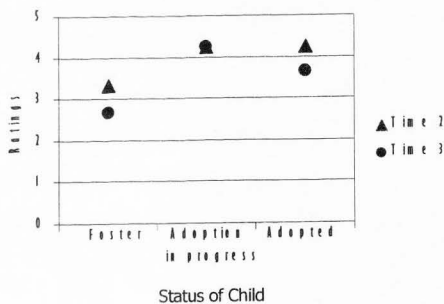


Figure 8. Helpfulness ratings for receiving and evaluating therapeutic services.

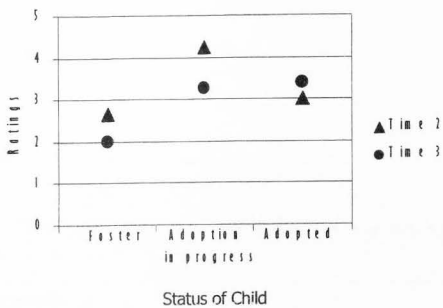


Figure 9. Helpfulness ratings for respite care.

CHAPTER V

DISCUSSION

Suggestions for providing more thorough training for adoptive parents are well documented in literature on adoption outcomes and service use and needs of adoptive families. Suggested content areas for adoptive parent training include attachment issues, impact of adoption on the marriage and family, expectations, inclusion rituals, relationships with birth/foster families, seeking and evaluating consultation and therapeutic services, and respite care (Berry, 1988; Hughes, 1999; Groze, 1992; Kramer & Houston, 1999; Rosenthal & Groze, 1990, 1991; Rosenthal et al., 1996). Because the current study included the areas documented in the literature, it was hypothesized that the parent trainings would influence parental distress, marital satisfaction, and participants' subjective distress and stress symptoms.

Based on this study, there was no evidence that the training influenced adoptive parents in these areas. It is important to note, however, that all results and possible conclusions from this study are tentative as the sample size was small ($n = 15$).

It was also hypothesized that the helpfulness of the training areas would vary according to the status of participants' children. While some trends were observed in the current study, they must also be interpreted very cautiously as the sample size was very small. Consequently, the number of participants with children

in each status was so limited (foster, $n = 3$; adopted, $n = 8$; adoption in process, $n = 4$) that mean comparison or other statistical analyses were not appropriate.

Influence of Parent Training and Research Hypotheses

The first hypothesis, that the training groups would decrease stress in parenting was not supported. Changes in this area, as measured by the PSI/SF Parental Distress Subscale were minimal for both males and females (i.e., changing by approximately one point), and were not statistically significant.

This finding creates an interesting contrast as the literature suggested that psychoeducation and parent training will benefit participants in terms of parenting stress (Barth et al., 1994; Kazdin, 1997). However, it makes sense, given that participants' mean scores on the Parental Distress Subscale were within the normal range on this subscale (males ranging from $M = 23.60$ to $M = 25.20$ across time intervals, and females ranging between $M = 19.70$ and $M = 22.90$), not indicating extremely high or low levels of distress (Abidin, 1990). Because participants were not distressed when beginning the psychoeducation groups, it makes sense that their scores did not change significantly because it is desirable for participants to remain in the normal range on the measure of parenting stress.

Another possible explanation for this null finding is that the literature has clearly identified behavior problems to be a more consistent predictor of adoption disruption and parenting stress than emotional, developmental, social, or learning

problems. The relations have been described as stronger when considering Caucasian adoptive families (Rosenthal et al., 1988, 1990; Rosenthal & Groze, 1990, 1991). The finding that no significant change in parenting stress occurred might be expected when considering that behavioral problems have been identified as a key stressor contributing to parental distress and adoption disruption in Caucasian families. However, only two of the participants (all of whom were Caucasian) reported that their child's special needs included behavioral problems. Consequently, the nature of the children's special needs was not similar to the special needs that other adoptive parents of the participants' ethnicity report having the most difficulty with (Rosenthal et al.). This may account for parents' lack of significant stress before participating in the training, as evidenced in their PSI/SF Parental Distress Subscale scores at Time 1.

Another possible interpretation for this difference is that most participants in this study have had their children for close to six months, or, in a majority of cases, the children's adoptions were already finalized. The length of time children have been in the participants' families may influence the lack of significant change in stress in parenting roles as patterns in the family have already been established (Helm & Kozloff, 1986). This coincides with the literature suggesting that services need to be accessed earlier in the adoption process, and that the period of time immediately following the transition is a particularly vulnerable time for families (Kramer & Houston, 1999; McCarty et al., 1999). With a larger sample, the

suggestion that time frame influences the usefulness and effectiveness of services could be tested as scores on the PSI/SF could be analyzed according to the status of the participants' children (i.e., foster, adopted, or adoption in process).

The second hypothesis, that the training groups would decrease parents' own subjective distress and reports of stress symptoms, was also unsupported. Mean scores on the OQ-45 for males ($n = 5$) were 34.2 prior to the first training session (Time 1), 28.4 following the second session (Time 2), and 30.6 at the six-month follow-up (Time 3). For female participants ($n = 10$), mean scores were 39.0 at Time 1, 39.5 at Time 2, and 36.8 at Time 3. Scores for males and females were well below the cutoff score (i.e., 63) for significant distress and symptoms of an impairment of functioning.

While scores on the OQ-45 (Lambert et al., 1996) did change in the desired direction over time for males and females (i.e., decreasing approximately four points), again, this change was minimal and not statistically significant. However, participants' scores indicated that they were clearly in the well-functioning range on this measure of stress at all time intervals (i.e., below 63), thus a lack of change may be desirable.

This finding is interesting because some participants are probably interested in adopting due to unique circumstances such as fertility problems, a need to help their family, as some participants may have been adopting children of a relative, or other circumstances likely to have associated stress (Helwig & Ruthven, 1990;

Levy-Shiff, Bar, & Har-Even, 1990). Because of these circumstances, and, the stress that accompanies transitions or changes of any type, it was expected that participants would be experiencing moderate to high levels of distress (Breunlin, Schwartz, & Kune-Karrer, 1997; Walsh, 1998).

However, time frame may play a key role in interpreting findings from this study. Because most participants ($n = 11$; 73%) had already made the decision to adopt and already had the children living with them, many transitional stressors may have already been adjusted to or had a diminishing impact. This level of transitional stress may have been minimal or nonexistent as many changes involved in the transition had already occurred, and the most significant point of vulnerability had passed (McCarty et al., 1999). Because of this, the measures taken at a time separated from the initial stressors by months or longer may not have been sensitive enough to identify and discriminate the types of stressors facing participants.

Further, it is also possible that participants were not stressed, and were able to adapt relatively quickly and without difficulty. This explanation fits well with literature on resiliency, referring to the processes of coping and adapting in the family (Walsh, 1998). The resilience framework also applies to the current study as participants had high income and high levels of education, which both predict stability. These characteristics promote stability as economic and other resources

buffer families against potential difficulties and minimize the effects of misfortunes when they do occur (Kliman, 1998; Walsh, 1998).

The third hypothesis was that the training groups would enhance marital satisfaction of the participants. This hypothesis was tested using measurements from the RDAS (Busby et al., 1995). Again, changes over the three time intervals were minimal and did not reach statistical significance.

A key explanation for the lack of significant change demonstrated may be that the RDAS is a global measure of marital satisfaction and adjustment (Busby et al., 1995). Consequently, it may not pick up more subtle changes in the marriage.

This finding may also be explained when considering the length of time participants had been married, and the previous consideration with respect to the length of time the child had been in the home. These factors may have influenced the lack of change in marital satisfaction as patterns in the marriage had already been established (Nichols & Schwartz, 2001; Rosenthal & Groze, 1990). Further, after adjusting to a period of change and transition, families tend to resume their typical patterns of interacting (Hanson, 1995).

Additionally, participants in this study were of higher socioeconomic status. This characteristic of the sample is noteworthy as high income and educational levels have been associated with increased marital stability and satisfaction (DeFrain & Olson, 1999). In fact, this influence has been so widely documented that in a review of research on determinants of marital satisfaction over the past

decade, economic factors were identified as a key context influencing marital satisfaction (Bradbury, Fincham, & Beach, 2000).

The fourth, and final, research hypothesis was that participants' ratings of section helpfulness would vary according to the status of their child or children (i.e., foster, adopted, or adoption in progress). By analyzing descriptive statistics and plotting them according to child status, little evidence supporting this hypothesis was found. There was a general trend indicating that foster parents found the training sections least helpful, adopted parents found them more helpful, while parents who were in the process of adoption reported the highest ratings of section helpfulness. However, due to the small sample size, it is difficult to determine whether or not the differences between child statuses are significant. Consequently, these trends must be interpreted with caution.

It is also interesting to note which sections participants with children in different statuses found least or most helpful. Foster parents' ratings on sections of attachment, inclusion rituals, relationships with birth/foster families, and respite care were the only ratings below three, which indicates that a section was moderately helpful. All other section ratings by foster parents and all ratings by adoptive parents or parents with an adoption in process were in the range between moderately and extremely helpful (i.e., between 3.00 and 5.00). The only training section that was consistently low in relation to ratings of other sections by participants in the same status was the section on respite care. That this section was consistently rated as less helpful than others might be

explained by the lack of resources for respite care available to parents (Kramer & Houston, 1999; Rosenthal & Groze, 1990; Rosenthal et al., 1996; Silverstein & Roszia, 1999). Consequently, the section focused on parents establishing their own informal and social support networks to access respite care.

Foster parents rated the section on inclusion rituals as only minimally helpful ($M = 2.33$), and gave the highest ratings of helpfulness to sections on characteristics of successful adoptive families and receiving and evaluating therapeutic services. However, foster parents still only rated these sections as moderately helpful ($M = 3.33$).

Adoptive parents rated the section on respite care as being the least helpful, reporting that it was only moderately helpful ($M = 3.00$). Like foster parents, adoptive parents also rated the section on receiving and evaluating therapeutic services as the most helpful with a mean score of 4.25, indicating that they found that section to be very helpful.

Participants who were in the process of adoption rated section helpfulness very differently than those who were foster or adoptive parenting. Those with adoptions in process, interestingly, gave the section on receiving and evaluating therapeutic services the lowest rating of helpfulness of any of the sections ($M = 4.25$). However, they still indicated that it was very helpful.

This difference is interesting, as it highlights the difference in ratings across child status because, while participants with adoptions in process reported that this section was the least helpful of any of the sections, their rating of helpfulness for

that section equaled or exceeded the ratings given by foster or adoptive parents. However, the number of participants with children in each status is very small and makes it impossible to draw any conclusions from these differences. The possible trend that participants in the process of adoption reported the trainings as most helpful overall when compared to participants with children in other status needs further evidence. However, according to this sample, those with adoptions in process ($n = 4$) had mean scores exceeding 4.00 (i.e., very helpful) on helpfulness ratings of every section.

These trends fit well with the literature addressing helpfulness of services for foster and adoptive parents. The relation of the trends in helpfulness ratings to the literature is evident as the literature suggests that adoptive parenting is qualitatively different from foster parenting, and that services are most beneficial when implemented earlier in the process of adoption as preventive measures (Berkowska & Migaszewska-Majewicz, 1991; Berry, 1988; Henry, 1999; Rosenthal et al., 1996).

In summary, based on the sample in this research study, no support was found for the hypothesis that parent training groups would decrease participants' stress in roles parenting special-needs children. There was also a lack of evidence supporting research hypothesis two, that the training would decrease participants' reports of subjective distress and related stress symptoms. The third research hypothesis, that training on the impact that a special-needs adoption has on the

marriage and family would enhance marital satisfaction was also unsupported.

These findings may all be influenced by the demographic variables of education and income. Participants in this study were primarily middle- to upper-socioeconomic status. This demographic information is important to note as it influences the external validity of results. However, these characteristics are controversial in terms of their influence on adoption outcomes (Rosenthal & Groze, 1990). Several studies suggested that these variables do not predict post-adoption outcome (Glidden, 1991, 2000), yet others have associated higher socioeconomic status with reports of less social support, and an increased rate of adoption disruption, and different service needs as these families had more access to resources (Marcenko & Smith, 1991; Rosenthal et al., 1990).

These findings are also surprising given the amount of research promoting parent training including the content areas presented as well as the expected outcomes of such trainings. However, there are very few outcome studies for the trainings and services proposed.

One study (Lee & Holland, 1991), evaluating the effectiveness of foster parent training, reported results similar to those found in the current study. While the participants in this study reported modest improvement in some of the target areas (i.e., attitudes towards physical punishment, clarification of parent and child roles, and empathy toward children's needs), none of the differences were significant. Further, this study utilized a comparison group and found that

participants' scores were not significantly different from those who received no training.

However, another study evaluated the effectiveness of adoptive training and orientation and its impact on adoptive parents' expectations about special-needs adoption (Wozny & Crase, 2001). Results of this investigation suggested a significant difference in unrealistic parent expectations of special-needs adoption when comparing pre- and post-training scores.

When examining service use, helpfulness, and need, Rosenthal and colleagues (1996) found that adoptive parents' were interested in more support and training in day to day parenting tasks, parenting skills, serious problems regarding the adoption or child, respite care, general adoption issues, and emotional supports with respect to adoptive parenting. While the training aspect of this research did not result in significant changes in parenting stress, stress symptoms, or in marital satisfaction, the function of offering support to adoptive parents was well served, as was the participants' development of more informal supports (Rosenthal et al., 1996).

The function of providing a source for building informal supports is important as the literature has documented that adoptive parents report that supports of this type are more helpful and accessed more often than formal supports. Further, the establishment of social connections enhances parent training outcomes (Barkley, 2000; Dumas & Wahler, 1983). Social connection is identified

in the literature as key because the primary functions of psychoeducational groups have been identified as education of members on the topic of the group and providing for the emotional needs of participants (Kuechler & Andrews, 1996). The emotional basis for conducting groups has been supported in research suggesting that the interpersonal needs of group participants tend to dictate the likelihood that a participant will remain in the group more than the type of educational module does (Beutler, Oro-Beutler, & Mitchell, 1979). This is evidenced by the subjective responses and comments participants and case workers reported about the parent training. The supportive element of the training groups also appears to have been successful as many participants have formed on-going monthly support groups as a result of their participation in the psychoeducational group (C. Baumann, personal communication, November, 14, 2001). Adoptive parents in these groups have continued to coordinate speakers to present more information on adoption, while also planning time for adoptive parents to discuss and socialize together.

Implications for Marriage and Family Therapy

Results of this study inform therapists by validating the need for therapists and service agencies to critically evaluate programs. This need is evidenced by the findings of this study because, while the training groups were based on consistent suggestions for training content and presentation found in the literature, in this

sample no difference was actually found by incorporating training topics and group interaction in the ways that have been promoted.

This is important because often therapists or agencies develop treatment programs based on new ideas or suggestions, without examining the full ramifications of the programs. Consequently, the programs continue despite a lack of evidence that they are effective. Similarly, programs that have been found effective in the past may not be evaluated on an on-going basis. This is important because clients' contexts change over time and influence what areas of intervention will be most effective and beneficial (Hanson, 1995).

This study also informs therapy professionals because the area of adoption is a relatively untapped area of service and training groups of this nature have rarely been implemented and evaluated (Kramer & Houston, 1999; Marcenko & Smith, 1991; McCarty et al., 1999; Rosenthal & Groze, 1990). In fact, one study reviewing parent training programs in child welfare found that, of the programs for biological, foster, and adoptive parents, those for adoptive parents were the least comprehensive (Berry, 1988). This study builds on the existing body of knowledge, consisting primarily of suggestions and themes in adoption by beginning evaluation of the research literature in terms of its application with families who are adopting.

Participants in the training group continued with similar, less structured meetings with other adoptive parents. This seeming disparity between responses to questionnaires and continued behavior of interacting with other group members

implies that those seeking services may benefit most from enhancing their informal social support system.

Results of this study provide some evidence that what is most beneficial to those seeking services will vary according to the contexts of the clients' current experiences as well as anticipated transitions. Based on the possible trends in participant helpfulness ratings by child status, the applicability of tailoring services to clients' situations to maximize their treatment efficacy may be supported. This is important as it concurs with models and ideas suggesting that therapists need to consider the developmental stages and processes experienced by each family member, and by the family as a whole (Breunlin et al., 1997; Carter & McGoldrick, 1980; Walsh, 1998). However, the support for this influence of context on helpfulness of services from this study is limited, due to small sample size, and needs further investigation.

Limitations of the Study

While the influences of the parent training on parenting stress, stress symptoms, and marital satisfaction were not significant, responses on the scale of helpfulness as well as subjective reports and comments about the group suggested that participants did find the group beneficial. This difference may be due to limitations in the research.

The limitation of this study with the largest effect on external validity is the small sample size, as the required difference to obtain statistical significance is negatively correlated to sample size (Thorndike & Dinnel, 2001). This limitation was partially addressed by comparing those who completed all of the questionnaires to those who did not. No significant differences were found between the groups, indicating that the findings of this study might be generalizeable, at least to others who attended the psychoeducation groups. However, without actual data from a larger sample, external validity is still a key concern.

Another limitation to observing significant changes in this study may be that the measures were not sensitive enough to detect short-term changes in a generally well-functioning, non-clinical sample. It is also possible that for some of the participants involved, the stressors associated with adoption have occurred far enough in the past that they were not detected at the time intervals the measures were completed.

That the effects of parent training are minimized when only one parent is involved has also been well documented in the literature (Beutler et al., 1979; Hanson, 1995; Nichols & Schwartz, 2001; Russell & Matson, 1998; Sandler, Coren, & Thurman, 1983). This trend applies to findings in this study with respect to the lack of significant changes in terms of parenting stress (H1), subjective distress and stress symptoms (H2), and marital satisfaction (H3), particularly when

considering that only three participants' spouses also participated in all of the parent training sessions and follow-up.

Other limitations in this study include extraneous variables such as extreme heat in the training room one night of the group, slight changes in the presentation styles of the group over time, differing group characteristics at different parent trainings, and participant characteristics.

Recommendations

Future research could improve on the current investigation by including more participants in the study. This might be done by utilizing multiple private and public adoption agencies in many areas, as the number of special-needs adoptive families in one area is relatively limited, or by collecting data over a longer period of time, so more families would be eligible for participation.

Additionally, further research could mitigate limitations related to questionnaires by developing measures addressing adoption issues more specifically, and utilizing fewer questionnaires or those with fewer items. Measures that were more sensitive to the types of stressors adoptive parents experience at a variety of time intervals in relation to their experiences with adoption might also improve research in this area. This might also improve participants' rates of completion for questionnaires, as many participants reported receiving several

questionnaires in the mail each week, while also reporting that the measures used in this study were too long.

The limitation of only one parent participating in the groups could be mediated by offering child care at groups, or by offering incentives for attendance of both partners. Further, the extraneous variables, such as heat, changes in presentation styles of the group over time, and differing group characteristics at different trainings, as well as other possible intervening variables, could be controlled in future research by utilizing a non-treatment comparison group, or by holding the groups in a more comfortable setting. More empirical studies outlining the influence of these variables in terms of training effectiveness and adoption outcomes would also benefit the body of knowledge in these areas.

Further, because one adoptive training and orientation found significant differences by focusing solely on parents' unrealistic expectations (Wozny & Crase, 2001), another possibility for future research is to focus on one of the content areas included in the parent training sessions in this study. Limiting the content in this way might allow increased interaction of participants. This interaction might enhance applicability of didactic information and provide participants with more ideas of what to do in situations related to adoption. This fits well with subjective comments made by participants as well, as many reported wanting to spend more time on each of the topics to gain more in-depth knowledge and training, and to be able to share more ideas between each other. In the current

study, the desire for interaction and idea sharing between parents led to the development of a monthly support group focusing on one topic each meeting.

Finally, future research might be strengthened by incorporating qualitative measures. This type of assessment has been identified as important in assessment of change in terms of preventive and early intervention programs, such as the trainings implemented in this study. This would be useful in identifying important variables as reported by participants, and in documenting and describing any change processes (Helm & Kozloff, 1986). This type of assessment is also useful in involving multiple family members and addressing a variety of areas (Deacon & Piercy, 2001). This might improve on the current study, as active involvement of multiple family members and simultaneously addressing multiple areas of participant experiences (i.e., parenting, individual distress, and marital satisfaction) have been correlated with enhanced training effectiveness (Helm & Kozloff; Nichols & Schwartz, 2001; Russell & Matson, 1998; Sandler et al., 1983).

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APPENDICES

Appendix A.
Expanded Outline of Adoptive
Parent-Training Groups

Session 1-

What Adoptive Families Need to Feel Successful-

This will cover the differences between adoptive and birth families and the potential for growth. We will provide a fact sheet on adoption, as well as a list of the types of background information parents should have or obtain about their child. A chart of normal developmental tasks in the areas of physical, social, and emotional development will be provided. It is important for parents to realize that their child's developmental age may not be equivalent to their age in years. There will also be a discussion on entitlement issues as special-needs children often feel that they have a right to be in a happy family.

Attachment Issues-

Attachment issues have lifelong implications. Since most special-needs children are past the critical attachment stage, there are special issues for adoptive families to be aware of.

Impact on the Marriage and the Family-

The addition of children always has an impact on the marriage and other relationships within a family. This will review the common problems and coping mechanisms to keep the marriage strong.

Break-

Adoptive families have often reported the helpfulness of contact with other adoptive parents. While the group is designed to promote interaction of parents attending, this time will also provide a chance for parents to socialize informally.

Expectations-

Both adoptive parents and children have expectations. Oftentimes these differing expectations do not match, may be unrealistic, or may be appropriate.

Inclusion Rituals-

There is clear evidence that rituals provide meaning and identity for family members. Types of rituals will be presented and families will be sent home to incorporate rituals that will bond the family and provide a sense of belonging for all members.

Session 2-

Ritual Report-

This will give family members the opportunity to report on what they have done and specifically how it has helped their family.

Relationship with the Birth Family-

Many of the special-needs adoptive children will have memories of their birth family. The importance of finding strengths and connections with the child's birth family will be discussed.

When to Seek Consultation-

When problems arise it is sometimes hard to know when to seek professional assistance. This will provide information on when to seek help for the adopted child, or for the parents or their marriage.

Break-

This provides another opportunity for adoptive parents to informally socialize with one another.

Therapeutic Services-

Knowing where to receive services from professionals knowledgeable about adoption is a challenge. The mental health centers are designated for treatment of adopted children. This will help parents know what questions to ask to ensure they are getting the types of services most needed. Parents will also be given information and handout regarding how their relationship with DCFS and other care systems changes when adoption is finalized.

Respite Care-

There are a variety of ways to receive respite care. Knowledge and use of these resources will decrease the stress on both parent and child.

Appendix B.

IRB Approval Letter and Informed Consent


Utah State UNIVERSITY

VICE PRESIDENT FOR RESEARCH OFFICE
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May 23, 2001

MEMORANDUM

TO: Scot Allgood
Korinne Bouwhuis

FROM: True Rubal, IRB Administrator 

SUBJECT: Pre-adoption Training Groups for Adoptive Parent's of Special-needs Children

Your proposal has been reviewed by the Institutional Review Board and is approved under expedite procedure #7.

- X There is no more than minimal risk to the subjects.
There is greater than minimal risk to the subjects.

This approval applies only to the proposal currently on file for the period of one year. If your study extends beyond this approval period, you must contact this office to request an annual review of this research. Any change affecting human subjects must be approved by the Board prior to implementation. Injuries or any unanticipated problems involving risk to subjects or to others must be reported immediately to the Chair of the Institutional Review Board.

Prior to involving human subjects, properly executed informed consent must be obtained from each subject or from an authorized representative, and documentation of informed consent must be kept on file for at least three years after the project ends. Each subject must be furnished with a copy of the informed consent document for their personal records.

The research activities listed below are exempt from IRB review based on the Department of Health and Human Services (DHHS) regulations for the protection of human research subjects, 45 CFR Part 46, as amended to include provisions of the Federal Policy for the Protection of Human Subjects, June 18, 1991.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Informed Consent
Pre-adoption Training Groups for Adoptive Parents
of Special-needs Children

Dear Participant,

Researchers from the Family and Human Development Department at Utah State University, are conducting a research study to find out more about the effects of parent training on adjustment and satisfaction of adoptive parents with special-needs children. Research on adoption has highlighted many potential benefits of parent education programs. However, despite these benefits, these types of services are rarely provided to adoptive parents. Further, when parent training programs are implemented, adoptive parent training tends to be less comprehensive than training provided to other groups. This study has been designed to have adoptive parents, or parents intending to adopt special-needs children participate in a comprehensive parent training group to determine how this may benefit parents' adjustment to, and satisfaction with, the adoption or placement. You have been asked to take part in this study based on your attendance at the parent training. However, participation in this study is not a requisite for participation in the parent education group.

Your participation is voluntary and you can choose to withdraw at any time without consequence. Deciding not to participate will not influence your relationship with USU or the Division of Child and Family Services in any way. Participation instructions are attached. You will be asked to fill out questionnaires at 2 different times. First, prior to beginning the parent training. And again 6 months following the second and last meeting of the parent training. Your participation, including time spent in the parent training groups, should take a total of about 6 hours (spread out over 6½ months), only 1 hour in addition to the time spent attending the training. To insure that all of your responses are paired together, an identification number will be put on the questionnaires. Following data collection, the master sheet will be destroyed. Please do not put your name on any paperwork. Questionnaires will be kept on file for the duration of the research project and will be destroyed upon completion (completion is estimated to be March 2002). Returning the questionnaires will constitute your informed consent. The Institutional Review Board for the protection of human subjects at Utah State University has reviewed and approved this project.

There is minimal risk in participating in this research project, although it is possible that you may experience some emotional distress information is presented and discussed. If this becomes bothersome or severe, please contact Dr. Allgood, Korinne Bouwhuis, or your DCFS caseworker for consultation or a therapy referral. There may or may not be any direct benefit to you from these procedures, although it is possible that you will

Informed Consent (Page 2)
Pre-adoption Training Groups for Adoptive Parents
of Special-needs Children

more easily make the transition of adopting by participating. The investigators may learn more about the role of parent education or parent training in making this transition. The information gained from this study may broaden knowledge about adoption adjustment and satisfaction and assist others in the future.

Your participation and contribution to this effort is greatly appreciated. If you would like a summary of the results, please contact either Dr. Allgood or Korinne Bouwhuis and we will make arrangements for you to obtain a copy of the results. We would be happy to answer any questions that you may have. This is part of a master's thesis project and you are welcome to contact either one of us. Dr. Allgood or Korinne Bouwhuis can be reached at (435) 797-7430.

Thank you for your assistance.
Sincerely,

Scot M. Allgood, P.h.D.
Principal Investigator

Korinne K. Bouwhuis
Student Researcher

Appendix C.

Scale of Section Helpfulness

Scale of Section Helpfulness

Please rate how helpful each section of the parent-training group was for you, according to the following scale:

	1	2	3	4	5
	not at all helpful	minimally helpful	moderately helpful	very helpful	extremely helpful
1. Characteristics of successful adoptive families	1	2	3	4	5
2. Attachment issues	1	2	3	4	5
3. Impact of adoption on the marriage and family	1	2	3	4	5
4. Expectations of adoptive parents and their children	1	2	3	4	5
5. Adoption rituals for inclusion of a new family member	1	2	3	4	5
6. Relationships with birth/foster families	1	2	3	4	5
7. When to seek consultation for adopted child or self	1	2	3	4	5
8. Receiving and evaluating therapeutic services	1	2	3	4	5
9. Respite care	1	2	3	4	5

Comments or suggestions: (This includes things that were very helpful or that need to be fine tuned in the future)

Appendix D.
Demographics Questionnaire

Demographic Information

1. What is your gender? Male ___ Female ___
2. How old are you? ___
3. How many marriages have you been in? ___
4. How long have you been married? ___
5. How many years of education have you had? (12 = High school graduate) ___
6. What is your family's combined yearly income? _____
7. What is your ethnic heritage? Caucasian ___ African American ___ Latino ___
Other ___ (Please list _____)
8. Please list your children, their ages, and relationship status.

Child's name	Age	Gender	Natural child	Adopted (Month/year)	Adoption in process	Foster
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___
_____	___	___	___	___	___	___

9. What type of special needs does your most recent adopted child(ren) have? _____

10. Do you have any other special needs children besides the child(ren) you just described?
Yes ___ No ___