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Treatment Considerations For Adoption-related Complex Trauma

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CERTIFICATE OF APPROVAL

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Abstract

The western culture holds many assumptions related to adoption; however, it is clear based on the research provided that adoption and the circumstances leading up to being adopted often leave the child traumatized. Many adopted individuals and adoptive families seek mental health services in order to help address some of the symptoms that have manifested through traumatic events. However, the services they are receiving are reportedly lacking in basic knowledge related to adoption and have, at times, done more harm than good. As clinicians, it is important to acknowledge one's scope of clinical competence and to only treat individuals that fall within that scope. Adoption-related training is rare, unless one seeks out specific training to become a certified adoption-competent therapist. There are numerous treatment modalities and interventions that have been and can be adapted to use with the adopted population, however it is highly recommended that therapists become competent in working with adopted individuals and families prior to treating adoption-related complex trauma.

TREATMENT CONSIDERATIONS FOR ADOPTION-RELATED COMPLEX TRAUMA

DEDICATION

This dissertation is dedicated to all of the other wolves in the herd of sheep that have remained true to themselves and continue to fight the good fight. This is also dedicated to my parents who have continued to be my biggest fans through all of my endeavors, thank you for always seeing my abilities even when I couldn't.

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I would like to acknowledge Dr. Christina D. Brown for the continued support throughout my graduate program and for the time and dedication you have put into helping this project come to fruition in the midst of chaos.

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"What does an adopted baby know? She knows her mother, she knows her loss, sadness and hurt, she knows that those who hold her today may be gone tomorrow and that she will be the only one left to pick up the pieces that no one seems to think are broken."

– Karl Stenske, 2012

Overview of Adoption

Adoption is defined as the "legal placement of abandoned, relinquished or orphaned children within an adoptive family" (Juffer & van Ijzendoorn, 2007, p. 1067) and can be characterized as an experience or situation that has both risk and protective factors embedded within. Adoption may help individuals who cannot conceive their own biological children to fulfill a biological drive to be a parent and care for a child (Gibson, 2009). With respect to the reasoning behind putting a child up for adoption or relinquishing a child, there are an abundance of elements that lead individuals to choose this route such as an unwanted or unplanned pregnancy, a lack of financial resources or support to care for a child, chronic/terminal illnesses or diseases that may prevent proper care, substance addictions, severe mental health issues, and being a single parent (Grotevant, 1997).

Adoption can be viewed as a personal act, a legal process or an act of social service (Grotevant, 1997; Zamostny, O'Brien, Baden, & O'Leary Wiley, 2003). In regard to being a personal act, adoption can involve three sets of participants known as the adoption triad or the adoptive kinship network (AKN) – the adoptee, the birth family, and the adoptive family – and is now thought of as a lifelong process rather than a single event. The legal process of adoption is defined as the method provided by law to establish the legal relationship of parent and child

between individuals who are not biologically related or related by birth. Adoption can be portrayed as an act of social service because it addresses the needs of the adoption triad members throughout the entire adoption process, in addition to providing post-placement and post-adoptive support services.

There are a few different types of adoption, which include domestic and international adoptions. Within each of those types, there are further classifications of adoption. Domestic adoptions are defined as adoptions of American children or the adoption of a child within their country of origin (Jones & Schulte, 2012; U.S. Department of State; Zamostny et al., 2003). Domestic adoptions can either be a public/child welfare adoption or conducted through a private agency. Children who are involved in a public adoption often are coming from the child welfare system and cannot be returned to their birth families for safety or other reasons. Private domestic adoptions are usually arranged through non-profit agencies that are licensed by the state or through independent adoptions that involve a third party who assists the birth family and the adoptive family with the direct placement of the child. International adoption is defined as the adoption of children from other countries by U.S. citizens with the intention of bringing the child to live in the United States (Jones & Schulte, 2012; Zamostny et al., 2003).

Adoption can further be broken down by different classifications of adoptions (e.g., transracial, related, and special needs), as well as varying levels of adoption openness (e.g., closed vs. open adoption). *Transracial adoption* refers to adoptees that have either been involved in a domestic or international adoption and are placed with adoptive parents of a different race or ethnicity than them (Jones & Schulte, 2012; Zamostny et al., 2003). Related adoptions refer to adoptions of a spouse's child, stepparent adoptions, and other adoptions involving children who are related to the adoptive parents, such as the adoption of a niece or nephew (Zamostny et al.,

2003). It is important to note that this subsection of adoptions is not usually included in the research and therefore little information regarding the effects of adoption on this population is known. Special needs adoptions refer to adoptions of children who are typically older than five years old at the time of the adoption, members of a minority group or a sibling group, or those who have physical, emotional, and/or developmental issues (Zamostny et al., 2003).

In respect to all forms and classifications of adoption, adoption openness is a key component in navigating the adoption experience. In the literature, adoption openness is defined as the "range of preplacement and post-placement contact between birth and adoptive families including accessibility to and exchange of information either directly or through a mediator, participation by birthparents in selection of adoptive parents and placement arrangements, and indirect or face-to-face interactions between birth and adoptive families" (Zamostny et al., 2003, p. 653) Adoption openness is often referred to as an open adoption and can occur within a spectrum of engagement (Jones & Schulte, 2012; Zamostny et al., 2003), and the opposite is referred to as a closed adoption where no contact is made between the birth family and the adoptive family.

Unfortunately, adoption is not always a success and at times disruptions and dissolutions can occur. Disruptions are defined as difficulties before the child has been legally adopted and the child is returned to (or entered into) the child welfare system or a new placement with new adoptive parents (Damashek, Drass & Bonner, 2014; Zamostny et al., 2003). Disruptions can also happen after the adoption is finalized where the adoptive parents experience difficulties with the child and/or finding support and resources (Casey Family Services, 2003). The primary risk factors associated with a higher rate of disruptions are: older age when adopted, existing emotional and behavioral issues, strong attachment to the birth mother, being a victim of pre-

adoptive sexual abuse, lack of social support from relatives surrounding the adoption, unrealistic expectations surrounding the adoption and the child, and inadequate preparation and support prior to the adoptive placement (Casey Family Services, 2003; Damashek, Drass & Bonner, 2014; Zamostny et al., 2003).

Dissolutions or breakdowns are generally used to describe an adoption in which the legal relationship between the adoptive parents and the adoptive child is severed, either voluntary or involuntarily, and results in the child's return to (or entry into) foster care or a new placement (Casey Family Services, 2003; Damashek, Drass & Bonner, 2014). Although the rates of disruptions or dissolutions are relatively low, about 10% for disruptions and about 1-5% for dissolutions or breakdowns, it is imperative to acknowledge the existence of these outcomes that could negatively impact the psychological functioning of the adoptees (Casey Family Services, 2003; Damashek, Drass & Bonner, 2014; Zamostny et al., 2003).

History of Adoption

Adoption was not always as complex as it is today. In fact, the concept of adoption began in the ancient Roman society, where the father of a child had five days after the birth to decide to keep the child (only if he had one or two children already). If the father decided that the child was unwanted, then they would "expose" the child by placing the baby in a cradle or pot and place it near a public place or "exposure wall," as they were referred to. The baby would then ultimately die of hunger and neglect unless they were rescued by Harpies. However, if the child had any physical defects, there was high chance the child would not be rescued, and death was certain (Mellema, 2014). Harpies would only rescue children that appeared to be promising and could raise them to be slaves. The act of selling children to become slaves was illegal until Constantine came into power in 313 A.D (Rhodes-Confession, 2012). Surprisingly, being sold as

a slave was connected to the hope of buying their freedom at some point in the future (Mellema, 2014). Exposure walls were utilized up until 374 A.D. when their use was legally forbidden.

The idea of the unwanted child is referenced in the Bible book of Exodus (*The Holy Bible*, 1999), which includes the story of an orphaned Moses, who was separated from his ancestry as an infant after the Pharaoh of Egypt commanded that all Hebrew male infants be killed. His mother took a risk and hid her son for three months and then set him adrift on the Nile in a small basket in hopes that he would able to find refugee and a better life elsewhere. Despite being unwanted, Moses ultimately led "his people" (other Hebrews) out of bondage to their homeland where he felt he belonged (Jago Krueger, & Hanna, 1997). The Babylonian Code of Hammurabi, which is one of the oldest known set of written laws, specifically states that if an adoptee pursued the search for their biological heritage, they would be blinded (Jago et al., 1997). This notion may have heavily influenced later created laws regarding closed adoptions and sealed records.

The concept of adoption was then seen again in history when the Saint Dymphna of Belgium advocated for unwanted mentally ill children and adults because she felt as though there was no such thing as an unwanted child and that their lives must be protected. She was the inspiration for a hospital and orphanage in Gheel, Belgium that has continued to operate even now (Mellema, 2014).

Beginning in the Middle Ages and continuing into the 18th and 19th centuries, Christian missions and foundling homes provided safe, anonymous ways to care for abandoned children. The "foundling wheel" was a manmade opening or flap on the outside wall of a building that opened to a soft, warm bed where an infant could be left, and a bell rung to let the caregivers at the building know a baby had arrived (Revuelta-Eugercios, 2013).

At the end of the 19th century, international adoption took hold after children were orphaned by World War II and then later by the Korean War. Many of these adoptions were considered to be altruistic and intended to provide permanent families to children whose parents had died in those wars. The Korean adoptions to the United States marked the beginning of organized, systematic international adoption. Babies who were born to American military men and Korean women during and after the Korean war were negatively impacted by the lack of social and financial governmental and nongovernmental support for unwed mothers and biracial children, and this ultimately led to the children being placed for adoption (O'Leary Wiley, 2003). This outcome led to the development of the "international adoption industry" by Harry Holt in 1956, where the adoption process turned children into orphans, and orphans into adoptees, as part of the adoption industry process (O'Leary Wiley, 2003). The child's past, including birth certificates and adoptive records, was deliberately sealed as part of what was believed to be a beneficent act and in the best interest of the child. Adoptive families were instructed not to tell their children about their adoptions, with the belief that the children and families would be better served by maintaining secrecy (Jago et al., 1997). Traditional or closed adoptions remained the standard of practice in agencies in the United States until the 1980s when the trend moved towards open adoptions (Jago et al., 1997).

By the 1950s, the availability of adoptable children in the United States had decreased as artificial birth control measures became available (Hollingsworth, 2002). However, there were still forms of the "foundling wheel" available, now termed "baby hatch" or "baby safe haven" where infants could be left anonymously in a safe, warm place with the necessary caregivers and resources. The overall decrease in the relinquishing of children for adoption during this period was also due to the declining numbers of White women placing children for adoption, which had

been partially explained by the 1973 legalization of abortion and the lessening stigma of single parenthood (Hollingsworth, 2002; Zamostny et al., 2003).

Adoption is still utilized as a form of creating a family, specifically within the United States. However, it is important to acknowledge other forms of relinquishment that are being practiced currently around the world in place of adoption. Infanticide is an unfortunate consequence of forcing parents to keep unwanted children and leads to the murder and death of infants (Bello & Hoyer, 2014). Female infanticide, defined as the intentional murder of infants that are born female, is practiced in India where having a boy is ideal (Mohanty, 2012). In India, sex-selective abortion is also practiced: abortions are conducted when the fetus is identified as being a female and make up about ½ million of the yearly abortions (Mohanty, 2012). In France, women can have their babies in the hospital and if the child is unwanted, she can leave the child behind with no questions asked (Mohanty, 2012). Across the world, thousands of babies are abandoned in public places or left in trash bins, so therefore baby hatches and safe havens are still implemented in hopes of increasing the children's rate of survival. It is uncertain exactly why an individual abandons their child, but one of the reasons may include the intense social stigma unwed mothers face.

Assumptions about Adoption

As with most processes that stray from society's ideal path, adoption has been subject to both positive and negative assumptions related to the adoptive triad and the effects adoption has on the individuals involved. Because of the vast array of themes found in the literature, a compilation of six main assumptions has been developed for this review: a) adoption is a joyous event for all involved; b) adoption parallels genetic birth experience and a biological family life; c) once adopted, all of the child's problems disappear and there will be no additional challenges;

d) creating a family through adoption is "false," only biological families are "real"; e) the adoptive life is better than the biological life the child had or would have had; and, f) closed adoptions are in the best interest of the child. Popular media has reinforced negative messages about adoption and many negative myths and stereotypes regarding adoptive families and birth parents (Zamostny et al., 2003).

Adoption is a joyous event for all involved. Adoption has been portrayed in society as a joyous event that brings competent parents together with children in need of a home.

Adoption parallels genetic birth experience and a biological family life. Encouraged by the adoption policies and procedures, society has believed that the experience of adoption is parallel to the genetic birth experience and the biological family life. It has been believed that once the adoption placement is complete, the adoptee and adoptive parents bond and therefore the adopted child becomes indistinguishable from a biological child, the adoptive family life ultimately proceeds as it does in biological families, and the birthparents move on with their lives (Zamostny et al., 2003). In alignment with this assumption, adoption is seen as a way to enable adoptive parents to have a healthy child and raise her as their own, similar to a biological family life (Grotevant, 1997).

Once adopted, all of the child's problems disappear and there will be no additional challenges. Once adopted, the child will grow up to be a well-adjusted individual and loyal to their adoptive family (Grotevant, 1997). For example, in the movie *Annie* (Huston, 1982), a young girl goes from living in an orphanage to being adopted into a wealthy home and ends up living happily ever after. Delving farther into the origins of the movie, it was found that the film was based on a poem written by James Whitcomb Riley in 1885 about an orphan, named Mary Alice Smith, who lived with the Riley family. The poem was about a bad child who was

snatched away by goblins as a result of her misbehavior. The underlying moral and warning in the poem are that children should obey their parents and be kind to the unfortunate or they will suffer a similar fate. The movie rendition of the poem displayed an orphan living in extremely poor conditions in an orphanage, depicting both the struggle of being part of the child welfare system and the desperation involved in waiting to be adopted. Annie, the main character, holds on to hope that her biological parents will return for her, which some adopted children can intensely relate to. The movie also depicts adoption as being a positive life-changing event in which all of one's previous struggles disappear.

Another example in the media is the AdoptUSkids campaign ads that portray the messages, "You don't have to be perfect to be a perfect parent," "You don't have to know it all to be a perfect parent," "Thousands of teens in foster care will love you just the same," and "There are no perfect parents. But for the thousands of teens in foster care, they'll love you just the same" (Raising Awareness of the Need for Adoptive Families, 2017). These ads send the message that adopted children will come with few or no challenges, and even if there are challenges, these children will love the adopted parents unconditionally solely for adopting them. However, this is a blanket statement and will not apply to all of the adopted population. Prospective adoptive parents may be adopting children under the premise that they can do no wrong in these children's eyes because they are ultimately saving them from the foster care system.

Creating a family through adoption is "false," only biological families are "real." In the western culture, biological kinship is seen as superior and real, whereas adoptive kinship is regarded as fictive or false (Petta & Steed, 2005).

The adoptive life is better than the biological life the child had or would have had. Research has suggested that society views adoption as an improvement over letting the child be raised by their birthparents or in an orphanage and therefore, that the adopted child will grow up to be well-adjusted and loyal to their adoptive family (Grotevant, 1997; van Ijzendoorn, Juffer & Poelhuis, 2005). Individuals putting their children up for adoption and the potential adoptive parents may therefore assume that the adopted child will be better off in numerous ways (psychologically, socially, and economically) than if raised by a single, perhaps impoverished birthparent (Grotevant, 1997).

Closed adoptions are in the best interest of the child. In the mid-twentieth century, most American adoptions were closed; no contact was made between the children's birth and adoptive families, and it was believed that the best interests of the child were served when the adopted child could experience a "clean break" from their family of origin and focus solely on adjusting to their new adoptive family (von Korff & Grotevant, 2011). Without access to their information, it was believed that each individual involved was spared the shame, specifically the adoptee was spared the shame of illegitimacy and the connotation of "bad blood" (Jago et al., 1997). Sealing the records was perceived as an act of kindness towards the adoptive triad, and individuals were told that they would eventually forget about the adoption all together (Jago et al., 1997).

Challenging Assumptions about Adoption

The aforementioned assumptions have created a positive and effective societal perspective of adoption, where one would assume that adopted individuals are well-adjusted once adopted and therefore do not continue to struggle. However, the reality found in the research is that adopted individuals seek mental health services two to five times more than the

general population and are at a higher risk for emotional problems (Brodzinsky, Schechter, Braff, & Singer, 1984; Brodzinsky, 2013; Grotevant, 1997; Pearson, Curtis, & Chapman, 2007).

Brodzinsky et al. (1984) conducted a study to show the reality of the effects of adoption on children. Their study consisted of 260 children (130 adopted, 130 nonadopted), 50% female and 50% male, with age of placement ranging from 3 days old to 3 years and 6 months of age. All adopted children had previously been made aware that they were adopted. The adoptive families were recruited from New Jersey, Eastern Pennsylvania, and New York City areas from adoption support groups, adoption agencies, newspaper advertisements and word-of-mouth (Brodzinsky et al., 1984). Non-adoptive families were recruited from five central and northern New Jersey school systems and through newspaper advertisements. Individuals were administered the Child Behavior Profile (CPB) and the Hahnemann Elementary School Behavior Rating Scale (HESB) (Achenbach, 1978, 1979; Achenbach & Edelbrock, 1979; Spivak & Swift, 1975). This study was conducted on the premise of the Freud's (1920) psychoanalytic theory that suggests the experience of adoption sets the stage for disturbances in personality and identity development, especially for the doubt surrounding the true circumstances of one's birth and having two sets of parents and the difficulty choosing which one to identify with.

The results of the study showed that adopted children manifested more aggressive and acting-out problems as well as learning difficulties when compared to their non-adopted peers. Adopted children also displayed higher levels of hostility, dependency, physical tension, and fearfulness (Brodzinsky et al., 1984). Overall, the results suggested that adopted children are more vulnerable than other children to emotional, behavioral, and educational problems. However, this was only shown in children who were adopted by incompetent parents, which was defined in the study as parents who were unable to cope with the role of being adoptive parents

and the differences between nonadoptive families and adoptive families, in addition to engaging in ineffective communication among the family members with regard to significant adoption-related issues (Brodzinsky et al., 1984).

The authors reported an existing lack of research in this area, specifically longitudinal studies that focus on the factors influencing the underlying adoption adjustment (Brodzinsky et al., 1984). The authors cautioned against over interpreting and overgeneralizing the data because they reached no firm conclusions regarding the issues of developmental changes in adoption adjustment. Limitations of this study include the inclusion of only 6 to 11-year-old children, which limits the generalizability of the results to younger or older adoptees. The sample also lacked diversity between the adoptees and adoptive parents in regard to race, ethnicity and culture, and therefore did not assess the impact these factors could have on identity issues. Another limitation was that there was not a separation of ages when the children were told they were adopted and the impact on the child's overall adjustment was not assessed in relation to adoption openness (Brodzinsky et al., 1984). The study excluded children who experienced a significant family disruption (divorce, separation, or death) within a year of the study, which is important because these specific family dynamics can negatively impact the adopted child's psychological well-being and adjustment.

In conclusion, the stereotypical view of adoption should be confirmed for children who were adopted soon after birth to competent, affectionate parents and these children should not pose a risk for developing psychological problems in the future. However, the rate of adopted individuals seeking mental health treatment exceeds the number of individuals adopted by competent parents. As adults, adopted infants who were brought into loving, competent homes

often seek therapy for dysfunctional relational patterns and attachment difficulties (Heller & LaPierre, 2012). So what are we missing?

Despite the research on adoption and mental health being relatively limited, six themes have been illuminated as significant in the literature and bear acknowledgment in challenging the assumption that adopted individuals are well adjusted and do not experience any challenges related to their adoptive status. The themes are broken down as follows: a) prenatal trauma/genetic makeup; b) preadoptive risks, effects, outcomes; c) postadoptive risks, effects, outcomes; d) protective factors, effects, outcomes; e) overall outcomes of being adopted in general; and, f) long-lasting effects into emerging adulthood/adulthood.

Prenatal trauma/genetic makeup. Risks can be found in adoptees' genetic, prenatal, and preadoptive backgrounds. Prenatal psychological trauma can significantly impact adopted individuals in regard to their upcoming psychological functioning (Heller & LaPierre, 2012). Babies can experience prenatal malnutrition, prenatal exposure to drugs and alcohol, and prenatal exposure to chronic stress (Brodzinsky, 2013). Adverse prenatal experiences have been shown to negatively affect both the structure and functioning of the brain. These experiences have the potential to undermine the development of attachment security, emotion regulation, impulse control, social interaction, executive functioning, and overall learning ability (Brodzinsky, 2013). Genetic factors clearly contribute to alcohol and drug addiction, as well as to some mental disorders (Gibson, 2009). Approximately 55% of educational performance is explained by genetic factors; the number of years of school an adoptee completes is significantly related to how many years their genetic mothers completed (Gibson, 2009).

Pre-adoptive risks, effects, and outcomes. Pre-adoptive risk is often related to adoptive family characteristics such as adoptive parent-child relationships (Roskam et al., 2016). Children

who are available for adoption may come from backgrounds that already put them at risk for maladjustment due to poor prenatal care, drug or alcohol exposure, or other health factors (Grotevant, 1997). An estimated 60% to 80% of the children in foster care come from families affected by drug or alcohol abuse (Casey Family Services, 2003). There may have a been a psychiatric disorder in the birth family, birth complications, or deprivation in the adoptee's home, including malnutrition, neglect and abuse (van Ijzendoorn et al., 2005).

A meta-analysis of 66 previous studies showed that adopted children had higher levels of maladjustment, externalizing disorders, and academic problems than non-adopted children (Grotevant, 1997). Some of the pre-placement factors that increase the risk for adopted children's later adjustment difficulties include: early deprivation through inadequate parenting, neglect or institutional rearing, trauma, multiple placements and relationship disruptions prior to adoption, exposure to caregiver psychopathology and domestic violence, and inadequate adoptive parent preparation, education and support (Brodzkinsky, 2013). Severe deprivation associated with orphanage life is linked to abnormalities in brain volume, metabolism, neural connectivity, limbic system regulation, and neuroendocrine stress reactivity, all of which increase the chances for long-term negative developmental outcomes (Brodzinsky, 2013).

In general, adopted children are more likely than other children to be referred for mental health treatment even controlling for the extent of their problems and are more prone to externalizing disorders as a result of a complex blend of genetic, as well as pre-, peri-, and postnatal environmental factors (Casey Family Services, 2003; Keyes, Sharma, Elkins, Iacono, & McGue, 2008; Miller, Fan, Christensen, Grotevant, & van Dulmen, 2000). Higher rates of problems are found in later-placed boys and girls, especially those identified as having special needs, than in those adopted early in life (Brodzinsky, 2013; Jones & Schulte, 2012).

Post-adoptive risks, effects and outcomes. Natural selection has designed psychological mechanisms to protect parents from investing in unrelated offspring. This has been termed discriminative parental solitude (DPS) or the "Cinderella effect" (Gibson, 2009). This concept has been posed as a possible post-adoptive risk for the adopted child and the adoptive family, specifically their ability to bond and attach to one another effectively. However, the research in this domain is very limited as it relates to adoption and the related trauma.

Protective factors, effects and outcomes. Adoption can mean a positive change or offer protective mechanisms for the children who are adopted. They move from a deprived institutional setting or from an overburdened biological family to an adoptive family. A trajectory that was bound to show cumulative risk factors (maltreatment, neglect, under stimulation) is changed to a positive direction, one with a greater likelihood of healthy adjustment (Rutter, 1990). Family sense of coherence attenuates the adverse impact of child maltreatment, and therefore can buffer the impact of the pre-adoptive risks (Roskam et al., 2016). Adoptees who have experienced maltreatment prior to adoption show a significantly lower risk for depression when they are growing up in adoptive families with high levels of coherence.

If adoptive families can respond to and cope effectively with the family stressors and crises, they can ultimately help to protect their vulnerable adopted children, thereby promoting resilience and a healthy adjustment (Roskam et al., 2016). Adoptive parents were more likely to provide preschool, private tutoring, summer school, cars, rent, personal loans, and time with sports to their adopted children (Roskam et al., 2016). However, these positive investments were associated with negative outcomes for adoptees (Gibson, 2009). For example, summer school and private tutors were often remedial, and the fact that adopted children were more likely to receive them suggests they required them more often than genetic ones. However, being raised in

a stable and nurturing home, with parents who are well-adjusted and emotionally attuned to their child's needs, often protects the child from developing serious psychological problems and/or facilitates developmental recovery in those who have been impacted by earlier adversities (Brodzinsky, 2013).

Overall outcomes of being adopted. Domestic adoptees are more likely to have externalizing disorders when compared to international adoptees (Casey Family Services, 2003; Hardwood, Feng, & Yu, 2013). Studies have also shown that adopted children often lag behind in physical growth, school performance and language abilities, in addition to showing more attachment difficulties (Brodzinsky, 2013; Gibson, 2009; Juffer & van Ijzendoorn, 2007; Miller et al., 2000). Adoptees reported higher participation in academic clubs, less positive attitudes about school and more frequently skipping school without an excuse than non-adopted adolescents (Miller et al., 2000). Substance use comparisons showed higher smoking and drinking scores for adopted adolescents than for their non-adopted peers (Gibson, 2009; Miller et al., 2000). Adoptees reported lower self-esteem and future hope, in addition to more emotional distress. There is a higher risk of diagnoses of attention deficit and learning disorders, depression and chemical dependency for adopted children than for children who were raised by their biological families (Brodzinsky, 2013; Casey Family Services, 2003).

Long-lasting effects into emerging adulthood and *adulthood*. By adulthood, most differences between adopted and non-adopted individuals are less prominent, although adoptees still show higher rates of adjustment problems (Brodzinsky, 2013). Adult adoptees' mental health tends to be less satisfactory than those who are not adopted. Adoptees tend to have lower levels of self-esteem, but their life satisfaction is comparable to their peers (Sanchez-Sandoval & Melero, 2018). Findings also suggest that there are more psychological difficulties and licit

substance consumptions in domestically adopted adults than in the general population (Sanchez-Sandoval & Melero, 2018; Zamostny et al., 2003).

Emerging adulthood is a transition period that being at the end of adolescence and ends at "true" adulthood (18 years old to late 20s). Emerging adulthood presents with five distinct features: identity exploration, heightened instability because of the numerous changes before more permanent life decisions, self-focus, feeling in-between and possibilities or optimism (major life changes in social roles and contexts) (Zamostny et al., 2003). Adulthood comprises the following tasks: becoming integrated in a working world, selecting a partner, learning how to live with a partner, having one's own family, bringing up children, being responsible for a home, assuming some civic responsibilities, and finding a stable social group (Zamostny et al., 2003). In addition to the changes involved in adulthood, adoptees have to face the loss of their biological family, wondering about their identity, and searching for their origins. Some childhood and adolescent factors may predict adult psychopathology, such as maltreatment, a history of neglect or abuse, a non-intact family structure, and parental psychological problems (Zamostny et al., 2003). Adopted adults scored higher on measures of depression than non-adoptees but lower than did clinical samples.

Other symptoms with greater prevalence in adopted adults compared to nonadopted adults included anxiety, personality disorders, behavioral disorders and neuroticism. Research has found that as adults, adoptees look for psychological advice to a greater extent than non-adoptees (Sanchez-Sandoval & Melero, 2018). They were also found to have higher levels of obsessive-compulsive symptoms, lower levels of self-esteem, fewer instances of being securely attached and more employment problems (Zamostny et al., 2003). Adoptees have shown more difficulty establishing themselves relative to genetic individuals and experience higher rates of

divorce, which suggests they have difficulty staying established (Gibson, 2009). Adults are more likely to seek counseling when they are starting a family or struggling with questions about their biological and cultural background (Pearson et al., 2007).

Statement of the Problem

In the United States, there are around 267,000 adoptions each year, with the majority of the adoptions involving children under the age of two (U.S. Department of State, 2016). In the American society, adoption has been portrayed as a joyous event that brings competent parents together with children who need a family. It has been assumed that by adopting a child and providing them with a stable environment will guarantee that the child will be better off psychologically, socially and economically. However, many adopted individuals seek therapy as adolescents and adults due to significant interpersonal difficulties. Unfortunately, a number of these individuals will not receive therapy that delves deep enough into the true etiology of their difficulties, which may be related to their individual birth and adoption experiences. Therefore, these individuals will not be able to truly heal until those areas are addressed.

Purpose of the Study

The purpose of this literature review is to address the gap in the current research regarding the clinical considerations in treating adoption-related complex trauma. Adopted individuals seeking psychotherapy as adolescents and adults due to suffering from significant interpersonal difficulties may not be receiving treatment that delves into the origin of the problem. These individuals need to be treated from a biopsychosocial perspective in order to receive effective and lasting treatment. The reason behind this review is to educate clinicians on the complex etiology of the trauma associated with adoption, provided clinical considerations in treating this population and therefore increasing the efficacy of the treatment that this population

receives. The information provided within the review will help adopted individuals seeking treatment got received a higher level of care that addresses the true origin of their struggles. It is important that clients are being treated in the most effective manner, and without acknowledging these core issues related to adoption, clients' struggles might persist into the future.

Research Procedure

This literature review was conducted using the following databases: ProQuest, Ebsco, Elsevier and Science Direct. The inclusion criteria for the literature search consisted of: adopted individuals (children, adolescents, adults); varying classifications of attachment (secure, insecure, disorganized, unresolved, anxious/ambivalent); nature of adoption (closed, open, international, foster care, transracial, domestic, private agency, related, special needs); age of adoption (birth to adolescence); interpersonal difficulties (problems initiating a relationship, maintaining a relationship, difficulty communicating effectively, family conflict, disconnect from adoptive parents); view towards adoption (adoption openness); knowledge about adoption (age they were told they were adopted, how they were told, did they seek out biological parents or not?); adopted parents (attachment, grief, knowledge of child's issues prior to adoption, sought services); core issues of adoption (loss, grief, shame, identity issues, attachment, sense of self, low self-esteem, externalizing disorders, internalizing, mental health services); and genetics (oxytocin, epigenetics, dopamine, DRD4, serotonin 5-HTTLPR allele, amygdala). The exclusions were slim to none solely because the research is so limited within the adoption population, however studies on well-adjusted adoptees were excluded.

Research Questions

In order to address the gap in the research previously mentioned and to aid in providing clinicians with clinical considerations for treating adopted individuals, three questions must be answered. The research questions are as follows:

R1: What is adoption-related complex trauma?

R2: What are the long-term effects of adoption-related complex trauma?

R3: What are the treatment considerations for working with individuals who have experienced adoption-related complex trauma?

CHAPTER II: UNDERSTANDING ADOPTION-RELATED COMPLEX TRAUMA

When reviewing the research literature in regard to adoption and related psychological effects, the term "adoption-related complex trauma" is not used when discussing etiology of symptoms and behaviors. It is more common to see terms such as "developmental trauma" or "complex trauma" to describe the psychological presentations found within the adopted population.

Complex Post-Traumatic Stress Disorder

Within the psychological field, the terms complex trauma and complex post-traumatic stress disorder have been used to describe the experience of multiple and/or chronic and prolonged, developmentally adverse trauma events, most often of an interpersonal nature (e.g., sexual, physical, verbal abuse, war, community violence) (Herman, 1992). These exposures often occur within the child's caregiving system and include physical, emotional, and educational neglect and child maltreatment beginning in early childhood.

Developmental Trauma Disorder (DTD). Chronic trauma interferes with the neurobiological development and the capacity to integrate sensory, emotional, and cognitive information into a cohesive whole. DTD was developed by Bessel van der Kolk (2018) in order to understand the trauma-related responses to subsequent stress leading to increases in the use of medical, correctional, social, and mental health services. Some of the noted developmental impacts of childhood trauma are the complex disruptions of affect regulation, the disturbed attachment patterns, the rapid behavioral regressions and shifts in emotional states, the loss of autonomous strivings, the aggressive behavior against self and others, the failure to achieve developmental competencies, the loss of bodily regulation in the areas of sleep, food and self-care, the altered schemas of the world, the anticipatory behavior and traumatic expectations, the

somatic problems, the apparent lack of awareness of danger and resulting self-endangering behaviors, the self-hatred, self-blame, and chronic feelings of ineffectiveness (Kolk, 2018).

Isolated, singular traumatic incidents often create subtle conditioned behavioral and biological responses to reminders of the trauma, which are captured within the PTSD diagnosis in the DSM-V. However, the PTSD diagnosis is not developmentally sensitive and does not adequately describe the impact of exposure to childhood trauma on the developing child (Kolk, 2018). There are currently no other diagnostic entities that describe the pervasive impact of trauma on child development included in the present diagnostic manuals.

Adoption-Related Complex Trauma. Because of the complex trauma etiology specific to adopted individuals, this concept warrants its own designation. That being said, adoption-related complex trauma can be conceptualized as encompassing the traumatic events and psychological effects that adopted individuals endure beginning as early as prenatal development, spanning into adulthood, that can be traced back to their earliest attachment disruption with their biological mother. “Biological mother” is specifically designated because the child’s first attachment is ultimately created within the womb of their birth mother, not with intention of disregarding the biological father or other family members.

Despite the research not using the term adoption-related complex trauma, there have been studies with results that support my conceptualization. The American Academy of Pediatrics (2013) stated that early toxic stress and trauma are nearly universal to adopted individuals, which is a direct link to the theory of developmental trauma described above, therefore implying that the specific long-term effects from trauma are significant and should be further explored. Triggering events could include a change of status from a foster child to an adopted child,

whereas behavioral dysregulation and other trauma-related symptoms may be observed (Hartinger-Saunders et.al., 2016; Kaplow et al., 2006).

The often hidden nature of prenatal trauma and early developmental trauma has frequently led adopted individuals to seek therapy later in life presenting with symptoms that resemble complex post-traumatic stress disorder (CPTSD), such as depression and withdrawal, significant social deficits, higher levels of internalizing and externalizing behaviors and patterns of destructive and aggressive behaviors (Hartinger-Saunders et al., 2016; Heller & LaPierre, 2012). However, without the individual having any conscious knowledge of the early trauma, it is often not brought up in therapy or investigated as a possible origin source for the individual's presenting issues.

While adoption can offer benefits to an individual and the family, research also suggests that adoption is associated with many challenges and complications, specifically in the lives of the adopted children and the adults who parent them (Brodzinsky, 2011). The experience of adoption exposes the family to a unique set of psychosocial problems that may complicate meeting normative developmental family tasks and therefore decrease the level of family cohesiveness, which can result in higher levels of conflict between family members (van Ijzendoorn et al., 2005). It is not the adoption status itself that typically leads to serious adjustment difficulties, but rather the adverse circumstances that pre-dated the individual's final adoption placement: prenatal trauma, neurobiology/genetics, pre-adoptive/post-natal risks, and post-adoptive risks.

Prenatal Trauma. Prenatal trauma is still a relatively new concept in research in general, let alone in regard to the adopted population, so the effects of trauma in utero are still uncertain. The existing literature defines prenatal trauma as any traumatic event, such as the biological

mother not emotionally attaching to her child during prenatal development, that causes the womb to become a "toxic and threatening" place instead of a place of comfort and growth (Heller & LaPierre, 2012, p. 133). Some examples of what may cause the womb to become toxic and threatening include the use of substances, lack of prenatal care and medical attention, an inability or disregard for attaching to the fetus while in utero, and chronic stress experienced by the birth mother. Early trauma in the womb has been shown to be implicitly held in the individual's brain and body and therefore can be triggered later in life, such as in adulthood (Heller & LaPierre, 2012). Because this trauma would be unconscious to the individual seeking therapy, it would not be processed therapeutically in a complete manner.

Kim, Fonagy, Allen, and Strathearn (2014) found that biological mothers with unresolved trauma were more likely to have infants who displayed profoundly disorganized attachment because the child's survival and growth hinges upon the biological mother's innate neuroanatomy and naturally occurring endocrine changes during the pre- and post-partum periods of time. If they have unresolved trauma, the child is exposed to the mother's dysregulated systems. Exposure to biological parents, both mother and father, with elevated depressive symptoms during the prenatal period has been shown to negatively shape the functioning of the hypothalamic-pituitary-adrenal (HPA) axis, which is the neuroendocrine system that affects one's responsiveness to socially relevant stressors. Children are then born with suppressed HPA activity and are placed at a higher risk for internalizing disorders (Laurent et al., 2013). These individuals are also at a higher risk for blunted abilities to meet interpersonal challenges and take in relevant information (Laurent et al., 2013).

There is the risk of prenatal exposure to substances, which increases the risk for a premature birth, low birth weight and cognitive impairments. Low birth weight has been

associated with the development of attention problems later in childhood, and prenatal substance abuse and drug exposure have been associated with neuropsychological deficits in children (Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007). High rates of foster care youth (60% in some states) enter care directly or indirectly due to parental substance use and many of them were prenatally exposed to drugs (Blake, Tung, Langley, & Waterman, 2018). Adopted youth who were prenatally exposed to drugs are at risk for behavioral problems, depression, and prenatal drug exposure has been found to indirectly effect adopted children's adjustment and the family's sense of coherence (Ji, Brooks, Barth, & Kim, 2010).

Neurobiology/Genetics. Adoptive parents' home environments have only a modest effect on adopted children's cognitive development, whereas heredity and environment of the birth parents exert a profound influence and therefore should be included in the assessment of an adopted individual (van Ijzendoorn et al., 2005). The IQ of adopted children has been found to become more similar to the IQ of their birth parents with increased age, and in adulthood the correlation between the IQ of the adopted children and that of their adoptive parents appears to be much lower than the correlation with the IQ of the biological parents (van Ijzendoorn et al., 2005).

Lewis et al. (2007) found that early adverse caregiving experiences, such as abuse, neglect, and separation from caregivers, may be associated with long-term alterations in the ability to regulate behavior and physiology of the brain. Placement instability (numerous placements prior to a finalized adoption) increases children's risk for later problem behaviors. Neuroanatomical and imaging studies suggest that inhibitory control capabilities are dependent on the prefrontal cortex to some degree, which significantly develops during the preschool years of one's life and is susceptible to early environmental effects (Kim et al., 2014). Inhibitory

control also includes the brain structures, hippocampus and amygdala. The amygdala has been recognized as a primary locus of change in the aftermath of trauma and is thought to be the crucial mediator of the long-term socio-emotional sequel of trauma. Blunted emotional responses (emotional numbing, dissociation) have been reported in cases of prolonged, recurrent, early-onset trauma (Kim et al., 2014).

Conditions such as high levels of stress, maltreatment, and separation from caregivers have been associated with deficits in the prefrontal cortex development. The Polyvagal Theory states that the most advanced branch of the autonomic nervous system (ANS) is the social engagement system that fosters social communication and maternal bonding through facial expressions, vocalization, and listening (Porges, 2011). When an individual is under a threat and cannot be rescued or escape, the social engagement system, which is the most recent section of the ANS from an evolutionary stand point, shuts down and the sympathetic nervous system (SNS) is automatically activated. If it is not feasible for the individuals to defend themselves, then the SNS shuts down and the most primitive form of the ANS, the parasympathetic nervous system, is activated and initiates a freeze response or a general shutdown of the body that leads to immobilization and/or dissociation. Repetitive neural activation caused by repeated exposure to threatening stimuli causes sensitization of the nervous system. The effect of traumatic exposure on the brain overall and decreased hippocampal volume may explain the increased patterns of externalizing behaviors in adopted individuals (Hartinger-Saunders et al., 2016).

Lewis, Dozier, Ackerman, and Sepulveda-Kozakowski (2007) found that separations from caregivers have also been associated with dysregulated neuroendocrine functioning, which has been connected to atypical brain development. High cortisol levels can compromise normal brain development through processes such as accelerated loss of neurons, delays in myelination

and the inhibition of neurogenesis. Low cortisol levels can also cause neuronal damage through neuroendangerment and may result in decreased stress reactivity and damaging over activity of the immune system. The lack of a stable caregiving environment undermines the developmental of the prefrontal cortex and the development of both inhibitory control and behavioral self-regulation skills. Inhibitory control deficits in preschool and school-age children have been associated with hyperactivity, conduct problems, aggression, social incompetence and diagnoses of ADHD (Lewis et al., 2007).

Waters (2016) stated that chronic traumatic stress has a long-term effect on memory and the brain structures affiliated with memory processes (hippocampus, amygdala, prefrontal cortex, corpus callosum). Stress leads to the deactivation of certain critical structures in the brain that encode and consolidate memories into the conscious memory system, accounting for memory problems and dissociative responses. When attempting to remember a traumatic event, extra synaptic $GABA_A$ receptors promoted subcortical, but impaired cortical, activation during memory encoding of the fearful event. The brain then reroutes the memory using a completely different molecular pathway and neuronal circuit to store the memory (Waters, 2016)

Pre-adoptive/Post-Natal Risks. Potential post-natal risk factors can include the duration of exposure to the inadequacy of the birth parent's care, children's experience of the maltreatment, children's preexisting behavioral problems, and/or the experience of multiple caregiving disruptions (Lewis et al., 2007). Nancy Verrier (1993) stated in her book *The Primal Wound* that because of the series of the sensations and events that begin in utero and are stored as memories in the baby's psyche and cells, the child is able to immediately recognize their biological mother at birth. Some of the experiences that are included are: breast feeding, familiar odors, eye-contact, touching, and familiar sounds (heartbeat, voice). Some psychologists in the

field believe that these experiences are stage-specific and if they are delayed, such as an adopted child being separated from their biological mother early on, both the child and the mother will experience grief related to that attachment (Verrier, 1993). Maternal responsiveness to infant distress is also central to the formation of the infant attachment security (Verrier, 1993). Mothers with unresolved trauma may evidence a specific failure of attunement during moments of infant distress. Rather than comforting and soothing their infants, these mothers may look away more and their look-look away pattern may be less predictable than that of secure mothers. The look-look away pattern is where the mother looks at the infant and sees that they are in distress, however quickly look away from the situation without consoling the child. They may be less likely to coordinate their touch with that of their infant's and the mother's lack of attunement to distress may be underpinned by a weakened limbic signal, permitting an atypical response to be triggered (Kim et al., 2014). The mothers with unresolved trauma are more likely to have infants who display profoundly disorganized attachment and appear frightened and alarmed in the presence of their traumatized mother (Kim et al., 2014). Being frightened or alarmed frequently can lead to higher activation rates of the body's stress response and cortisol levels (Kim et al., 2014).

Other pre-adoptive/post-natal risks include different forms of adoption and the preplacement adverse experiences that occurred prior to the adoption being finalized, as well as the child's age at adoption (Hardwood et al., 2013). In 2013 it was estimated that more than 80% of internationally adopted children into the United States spent some of their preadoption time in an institutional setting (Hardwood et al., 2013). It has been found that time spent in an institutional setting before being adopted and the few opportunities to acquire or practice new skills afforded in these settings are related to deficits in physical growth, sensory processing

difficulties, internalizing, externalizing and attentional problems, delays in social skills, speech, language and learning deficits, lower cognitive scores, and general development impairment (Castle et al., 2009; Hardwood et al., 2013; van Ijzendoorn et al., 2005). Children in orphanages or institutional settings are often confined to a crib, experience malnourishment, and have few chances to play with toys, interact with adults or practice locomotion (van Ijzendoorn et al., 2005).

Adoption at an early age may be considered a protective factor in relation to cognitive achievement because the positive effects of the adoptive environment may have a greater impact during the child's crucial developmental periods. However, preadoption neglect or abuse is still a major risk factor that appears to affect adopted children's school achievement even if the child is adopted into a less deprived social context (van Ijzendoorn et al., 2005). For some adopted children, school performance never reaches the expected level because of the socioemotional problems (disinhibited attachment relationships, cognitive impairment, and inattention or over activity) related to their adoption status decreases their ability to concentrate on school work (Hardwood et al., 2013). Exposure to preadoption adversity, including the length of time the exposure lasted, rather than the child's age at the time of the exposure per se, is said to be the driving force of the negative outcomes later on in the child's life (Hardwood et al., 2013). International adoptees that have experienced a more profound preadoption adversity tend to exhibit more behavioral problems than international adoptees who have experienced less preadoption adversity. Within the United States, child maltreatment and prenatal substance exposure remain of significant concern to potential adoptive parents as sources of preadoption adversity. Those who have suffered physical abuse during their childhood tend to have more

psychological problems in adulthood in comparison to those who have not suffered the abuse (Sanchez-Sandoval & Melero, 2018).

The special health care needs status has been linked to higher risk for receipt of mental health services, attachment disorders, and diminished school performance (Hardwood et al., 2013; Howe, 2001). Children with special health care needs find themselves placed into the foster care system at higher rates than other children. In particular, the stress of having a special health care needs child combined with other family factors may produce a greater likelihood of an abusive situation, thus precipitating the removal of the child and placement into the foster care system (Hardwood et al., 2013). Potentially traumatic preadoption experiences could predispose adopted children toward a higher risk for special health care needs status. Children across adoption types who had documented or suspected prior maltreatment and/or prenatal substance exposure were more likely to be identified with special health care needs (Hardwood et al., 2013).

Youth who enter foster case are twice as likely as the normative population to later meet criteria for substance abuse or dependence, stemming from being early victims of abuse or neglect (Blake et al., 2018). Some children are immediately detained at birth due to prenatal substance exposure, whereas other children remain with their biological parents for years in a chaotic, abusive, and/or neglectful caregiving environment prior to being removed and placed into foster care. Upon entry into foster care, some children receive nurturing care from the foster caregivers, while others continue to be maltreated (Howe, 2001). Some children move between foster homes (placement instability), some reunify with their biological parents once their home environment/caregivers are deemed safe, and others are adopted into stable, permanent placements. Children adopted from foster care are often older at the time of placement and have

experienced greater pre-placement adversity than children who were placed as infants, and they display more problem behaviors in adolescence (Brand & Brinich, 1999). These factors can make it more difficult for the adoptive parents to integrate these children into their family, facilitate stable and secure attachments, and support the child's grief work (Brodzinsky, 2013). Children who have experienced multiple foster care placements prior to adoption are more likely to exhibit symptoms of Attention Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) than children who had a stable placement from the beginning (Lewis et al., 2007). Placement instability has also been associated with a higher risk of incarceration among adolescents, increased severity of Conduct Disorder (CD) symptoms in both male and female adolescents, and greater maltreatment of their own children later on (Lewis et al., 2007). These children may also exhibit poor inhibitory control and higher levels of oppositional behavior, which places them at risk for maladjustment to the demands faced in other environments such as school. In addition to the aforementioned difficulties, with placement instability comes additional attachment disruptions with surrogate caregivers and an added layer of grief and loss to the already complex attachment presentation (Hartinger-Saunders et al., 2016; Howe, 2001; Lewis et al., 2007).

One preadoption factor that has been shown to be a significant predictor of long-term outcomes among adopted individuals, and is the most commonly studied pre-adoptive risk, is the age of placement into the adoptive home (Hardwood et al., 2013; Ji et al., 2010). There has been a recognized association between adopted children's age at placement and their psychosocial development (Howe, 2001). Children who are adopted within the first year of their life show a minimal difference in development when compared to their environmental peers (van Ijzendoorn et al., 2005). If adopted as babies, some adoptees may show a slight increased risk for socio-

emotional problems that could manifest in poor peer relationships, parent-reported problems at home, and higher referral rates to child psychological and psychiatric services (Castle et al., 2009; Howe, 2001). However, most children adopted before the age of 12 months are likely to show a complete catch-up than later adopted children in physical height, quality of attachment with caregivers, and school achievement (Hardwood et al., 2013). Adoption after the age of six months serves as a marker for increased behavior problems at a later age and more pronounced developmental impairments in emotional and social development (Brand & Brinich, 1999; Castle et al., 2009; Hardwood et al., 2013; Howe, 2001).

Later adoption (after the first year of life) appears to be associated with a significant delay in school achievement (van Ijzendoorn et al., 2005). Adoption after 18 months of age has been associated with the development of more serious behavior and attention problems, and problems that persist into adolescence and adulthood (Hardwood et al., 2013; Sanchez-Sandoval & Melero, 2018). Children who are adopted internationally at later ages (24 months) are more likely to exhibit behavioral problems in general. Exposure to preadoption adversities or deprivation underlies the association between the age at adoption and later outcomes because the age at adoption serves as a proxy for the length of deprivation or exposure to the pre-adoption adversity (Hardwood et al., 2013). Older age adoptions are associated with less positive parent-child relationships, which in turn is associated with poorer school performance, increased behavioral problems, and the receipt of mental health services and later diagnoses of PTSD and/or attachment disorders (Hardwood et al., 2013; Ji et al., 2007).

Post-adoptive Risks. Post-adoptive factors can also influence the adjustment of adoptees, with the adoptive family environment the adopted child is raised being the most influential factor (Ji et al., 2010). In regard to adoptive parents' mental health, early exposure to a parent's

depressive symptoms influences a child's risk for dysregulated cortisol levels. Independent of both birth mothers' depressive symptoms and HPA activity, adoptive parents' postnatal depressive symptoms predicted young children's cortisol levels and associated affective/anxiety symptoms (Kim et al., 2014; Laurent et al., 2013). Parental depressive symptoms have been associated with lower child cortisol levels, which in turn, have been related to an increase in symptoms related to internalizing problems. These symptoms and lower cortisol levels may be seen as an attempt to adapt to moderately stressful conditions by downregulating the HPA activation and thus the overall sensitivity to the social environment (Brennan et al., 2008; Laurent et al., 2013). However, the downregulation of the HPA axis comes at the cost of blunting the child's ability to meet interpersonal challenges and take in relevant information. It is important to acknowledge that being exposed to parental (biological or adoptive) depressive symptoms during the sensitive developmental periods of the HPA axis (prenatal and postnatal) may continuously manifest over the first several years of the child's life and may not be fully apparent right away (Kim et al., 2014). Laurent et al. (2013) found that depressogenic HPA patterns differed in early (prepubertal) versus later developmental, with cortisol hypoactivity more commonly found in early development and a shift toward hyperactivity coinciding with puberty. These HPA patterns have been shown to manifest as internalizing symptoms in adolescents with higher cortisol levels, but earlier (starting in childhood) symptoms related to lower cortisol levels (Laurent et al., 2013).

The quality of parent-child relationships in the adoptive home can mediate associations between pre-adoption adversity and child outcomes (Hardwood et al., 2013). Children with a greater history of adversity may have more difficulty establishing positive relationships with their adoptive parents, and thus show poorer outcomes, whereas children with less pre-adoptive

adversity may develop better relationships with their parents and show more positive outcomes (Hardwood et al., 2013). The existence of special health care needs can affect child outcomes both directly through cognitive and emotional issues that may arise either as a result of or in concert with a significant diagnostic condition, or more indirectly through the impact that child's special health care needs can have on the mental health of their adoptive parents. Transracially and internationally adopted individuals may experience discrimination related to their adoptive status (Askeland et al., 2018) and the perceived discrimination by the adoptive parents is a significant post adoptive risk factor for this group of adoptees (Lee, 2010). Perceived discrimination is as pertinent to the development of problem behaviors as experiencing preadoption adversity. Some unique challenges for internationally adopted individuals include but are not limited to a greater likelihood that attention to language acquisition may be needed to facilitate optimal school performance, as well as a presenting history of extensive deprivation and symptoms related to that prolonged exposure to adversity prior to adoption (Hardwood et al., 2013).

Research has shown that transracial adoptees are more likely to suffer from a weaker ethnic identity or from identity confusion when compared to their same-race counterparts (Boivin & Hassan, 2015; Lee, 2010). Ethnic identity has been defined as a "part of one's self-concept that includes ethnic group identifications, belongingness feelings and positive attitudes towards these groups" (Boivin & Hassan, 2015, p. 1085), and also refers to the acquisition and practice of the ethnic group's behaviors and customs. The most influential variable for psychological adjustment among international adoptees is not the identification with their birth versus adoptive parents' culture, but rather the degree of identity integration or clarity versus confusion regardless of ethnic/cultural identifications (Boivin & Hassan, 2015). International

adoptees have a higher risk for mental health problems and a larger increase in these problems during adolescence when compared to non-adopted peers. Adolescents who are adopted internationally report more symptoms of mental health problems, such as inattention, hyperactivity, and depression, which are directly related to an increased risk for substance use. As adults, international adoptees have demonstrated higher risks of being diagnosed with or hospitalized for substance abuse or dependence (Askeland et al., 2018). In regard to transracially adopted individuals, these adoptive parents appear to make fewer attempts to address racial biases and may not recognize the prevalence of racism in their adopted child's life (Morgan & Langrehr, 2018). However, experiencing racial prejudice has been linked with negative psychological outcomes and behavioral difficulties. It is common for adoptive parents to face a variety of explicit and implicit messages that challenge the legitimacy of their parental identity. Some transracial adoptive parents have reported that their visible status as adoptive parents serve as a marker for strangers to approach them and ask intrusive questions or make hurtful comments related to their adoptive status. That being said, this is a typical, if not daily, experience for transracially-adopted children and without guidance or parental colorblindness (where their parents do not acknowledge the differences within their races), they may be ill-equipped to navigate the discriminatory remarks and behaviors (Brodzinsky, 2013; Koskinen et al., 2015; Lee, 2010; Morgan & Langrehr, 2018; Wiley, 2003).

Research has shown direct associations between perceived racial/ethnic discrimination and physiological stress responses including higher blood pressure, hypertension, coronary heart disease, cardiovascular diseases, and releases of cortisol. There have also been associations found between perceived racial/ethnic discrimination and depressive symptoms, anxiety, cynicism and hostility, and overall psychological distress (Koskinen et al., 2015). Difference in

physical characteristics may generate feelings of appearance discomfort and can complicate a positive racial/ethnic development of the individual (Reinoso, Pereda, Van der Dries, & Forero, 2013).

Not only do adoptees face challenges related to the type of adoption they are involved in, they also face challenges related to the level of openness one's adoptive family allows or engages in. In the era of closed adoptions, children were thought to be "subtracted" from their family of birth and "added" to their family of adoption, implying a clean break between the two families and was thought to be what was best for all parties involved. Individuals who firmly supported closed adoptions believed that continued contact between the adopted child and birth parents would impede the attachment and bonding between the adoptive parents and the child (Ge et al., 2008). It was also believed that contact would interfere with the grieving process that is essential to the mental health of the birth mother (Ge et al., 2008).

Since the late 1970s, there has been a clearly defined trend toward open and fully disclosed adoptions, which involve contact, communication, and/or information sharing between a child's adoptive and birth families (Grotevant, McRoy, Wrobel, & Ayers-Lopez, 2013; von Korff, Grotevant, & McRoy, 2006). The 2007 National Survey of Adoptive Parents revealed that 68% of private domestic adoptions involved some form of postadoption contact with birth family members. Proponents of open adoption suggest that adoptive parents benefit from the information about the birth family that comes from ongoing communication, which can include medical and mental health histories, ethnic and cultural backgrounds, and reasons for adoption (Ge et al., 2008). Open adoptions can vary widely in type, frequency, and directness of contact, as well as the specific family members from both the biological and adoptive families involved. The type of contact can include the exchange of pictures or gifts, communication via email,

letters, Skype, telephone, or face-to-face meetings. Frequency of contact can vary from initial contacts made only around the time of the adoptive placement to frequent, ongoing communication. Frequency and type of contact can ebb and flow over time as the participant's life circumstances change. Contact can be direct, which means involving sharing identifying information, or indirect, where the contact goes through the adoption agency without sharing any identifying information. Contact with birth relatives, particularly face-to-face contact, creates opportunities for adoptive family members to talk about adoption and topics related to adoption (Grotevant et al., 2013; von Korff et al., 2006). Open adoption requires a shift in thinking and an acknowledgement of the notion that adoption creates an adoptive kinship network (AKN), where the child connects both their biological/birth family and their adoptive family. Neither the adopted child nor their birth parents forget about one another; they may remain physically and/or psychologically present to one another in varying degrees over their lifetime (Grotevant et al., 2013). Satisfaction with the contact rather than the existence or type of contact predicted less externalizing behavior among adoptees in adolescence and into emerging adulthood (Grotevant et al., 2013). Most adoptees report that contact with their birth family has a positive effect on their self-concept, self-esteem, and their overall relationships with others (von Korff & Grotevant, 2011).

Psychodynamic theory on openness and adjustment (von Korff et al., 2006) provides the initial framework anticipating the association between openness and adjustment of adoptees. The theory suggests that children, adopted or not, often fantasize about losing parents to internalize a sense of self that is separate from the parents. Adoptees are thought to enter this process with a disadvantage, that being the knowledge of being "unwanted" by their biological parents and therefore losing those parents, is real and not fantasy. Externalizing behaviors often increase in

confidential closed adoptions when compared with open ongoing fully disclosed adoptions. However, in some studies the results have showed that there are no significant differences in externalizing behaviors between adolescents who never had contact with their birth relatives and those who had ongoing contact since early childhood (Grotevant et al., 2013). Open adoptions appear to pose no additional risks to the adoptees in regard to an increase in externalizing behaviors. Regardless of whether a child grows up in a traditionally closed or open adoption arrangement, what is primary for healthy psychological adjustment is the creation of an open, honest, nondefensive and emotionally attuned family dialogue not only about adoption related issues but in fact about any issue that impacts the child's and family's life (Neil, 2009).

Another added layer to adoption openness and adjustment is the concept of reunions, or communicating with one's biological parents/family in some way after a former cease in communication. Adoptees who felt that their adoptive family was supportive of the reunion included their adoptive family in the reunion relationship. Adoptees who felt that their adoptive family was not supportive felt compelled to withhold information about the reunion and ignore their adoptive parent's objections to the reunion (Petta & Steed, 2005). These adoptees proceeded with the reunion at the risk of being estranged from their adoptive family. Alternatively, some adoptees described abandoning or limiting the reunion process to avoid conflict and protect their adoptive parents (Petta & Steed, 2005).

The reunion relationship appears to have four emotional stages for the adopted individual including paralysis, emotional eruption, mourning the various losses inherent in the adoption process, and final resolution and self-acceptance (Affleck & Steed, 2001). Adoptees are sensitive to their adoptive parents' responses and this in turn affects their own process during the reunions (Ge et al., 2008). When searching for the biological parents is instigated by the adoptee, the

initial reaction for the majority of adoptive parents includes numbness, apprehension, and a sense of needing to be poised for what was about to occur. Searching has been viewed by the majority of adoptive parents as an internal need for the adopted individual and has been regarded as very important (Petta & Steed, 2005).

Many adoptive parents report not understanding the complexity of adoption and the numerous risk factors that comes along with adopting a child. Some adoptive parents have stated that they were ill-prepared, if at all, for some of the issues they have faced as adoptive parents, specifically issues that emerged as their children negotiated identity in late adolescence and participated in reunions. The lack of training, undisclosed physical, emotional and behavioral problems of the children coming into adoptive homes, the lack of governmental and social service oversight of post adoptive placements have been noted as significant issues for adoptive families (Wiley, 2003). Adoptive parents may still be grieving the inability to have biological children and may not be able to attune to the adoptive child's needs in an adequate manner, possibly recreating the lack of attunement pattern found in the child's biological family. Adoptive parents may have unrealistic expectations of their adopted children's potential and therefore become disappointed or frustrated that their children are not meeting those standards (Castle et al., 2009). Skinner-Drawz, Wrobel, Grotevant, and von Korff (2011) found that adoptive parents tend to fall into two groups in regard to acknowledging their adoption status: they either acknowledge the difference between the experience of adoptive parenthood and biological parenthood, or they do not. Rejection-of-difference has been shown to inhibit the development of an empathic and trusting family atmosphere, whereas parents who have accepted that adopting a child is not the same as having a biological child are be more likely to maintain an open attitude and form a mutual trust with their child. Acknowledgment-of-difference parents

are more likely to develop channels of empathy, communication and trust, which are then reciprocated by their children and the level of communicative openness within the family increases. A lack of flexible communication in the adoptive family regarding adoption-related issues has been thought to negatively impact the adopted child's development (Skinner-Drawz et al., 2011).

Adoptees raised by single parents are no different than their counterparts living with biological parents (Feigelman & Finley, 2004). However, there have been reports of significantly higher rates of female adoptees running away from home and experiencing depression when they live with one adoptive parent over their biologically related counterparts (Feigelman & Finley, 2004). There are higher rates of widowhood among parents of adopted children, which is consistent with the realities of adoption occurring when the parents are older and have spent many years attempting to conceive biological children and failing to produce desired results. Adopted daughters of widows or widowers are more likely to be very depressed after being triggered by the death, as compared to daughters of biological children who lost a parent through death (Feigelman & Finley, 2004).

Although many adopted children have experienced trauma and adversity before their adoptive placement, protective factors within the adoptive family context may serve as moderators, buffering the ill effects of the aforementioned risk factors and resulting in catch-up and resilience in these adopted individuals (Juffer & van Ijzendoorn, 2007). Resilience may be co-constructed by the adopted children interacting positively and cohesively with their adoptive family. Higher levels of cohesiveness have been shown to significantly lower the risk for depression in adoptees who have experienced maltreatment prior to their adoption (Ji et al., 2010). It has been suggested that even when contact with birth families is impossible, adoptive

parents' openness in communicating with their child about their adoption makes significant contributions to the well-being of the adopted individual (Grotevant, Rueter, von Korff, & Gonzalez, 2011). Adoptive families that can respond to and cope effectively with family stressors and crises can help protect their vulnerable children, thereby promoting resilience and healthy adjustment in adopted youth (Ji et al., 2010).

As a concept based on the foundations of CPTSD and DTD, adoption-related complex trauma encompasses all of the traumatic experiences that an adopted child has or will endure within their lifetime related to their adoption process. Prenatal trauma, neurobiology and genetics, pre-adoptive risks, and post-adoptive risks impact the adoptees' overall psychological adjustment and development. Individuals who have experienced significant early adversity prior to their adoption are at a higher risk for developing adoption-related complex trauma and therefore endure the long-term effects related to the core factors of adoption into their adulthood, which are further explained in the next chapter.

CHAPTER III: EFFECTS OF ADOPTION-RELATED COMPLEX TRAUMA

Building on the assertions in the previous chapter and research that supports the conceptualization of adoption-related complex trauma, this chapter details specific domains that are affected throughout the entire life-span of adopted individuals and are key components of the adopted individuals' presentation and functioning. Some of the areas significantly affected are: 1) attachment; 2) internal working models; 3) identity formation; 4) biopsychological effects; 5) substance abuse; 6) loss and grief; 7) shame, rejection, and guilt; and, 8) general symptoms.

Attachment

Attachment has been defined as the affective bond that develops between an infant and a caregiver; a pattern of emotional and behavioral interactions that develops over time as the infant and the caregiver interact, particularly in the context of the infant's needs and desires for attention and comfort (Egeland & Sroufe, 1981). Attachment theory, created by John Bowlby and Mary Ainsworth, states that children who have been subjected to separation, loss, and/or maltreatment may be particularly sensitive to issues concerning social interactions and therefore find interpersonal conflicts especially disturbing. Since then, it has been found that one of the main areas to be significantly affected by early trauma is the child's ability to form secure attachments with their caregivers. Secure attachments have been found in parent-child dyads where the caregiver is sensitive and comforting when the infant calls for comfort, allowing for the child to continue to reach out to their caregiver for support and comfort when distressed (Egeland & Sroufe, 1981). Insecure or inadequate attachment occurs when the caregiver is unreliable, inconsistent, insensitive or rejecting when their child seeks contact, therefore teaching the child to not seek contact when distressed or to seek comfort only in an ambivalent manner in an attempt to not alienate the already unreliable caregiver (Egeland & Sroufe, 1981). Inadequate

attachment, especially during the first six months of a child's life, has shown to be traumatic for the individual (Heller & LaPierre, 2012).

Considering attachment theory as a general statement about inadequate attachment, it is to be assumed that this identified traumatic event would have occurred earlier in adopted individuals' lives and become more complex as they went through the adoption process. For adoptees, the prenatal bond of attachment may be broken as infants are separated from their biological mother, and the loss experienced in this separation has been termed the "primal wound" by Nancy Verrier (1989). Adoption involves the breaking and making of affectional bonds, and therefore secure attachments and related self-esteem may be more difficult to develop in adoptees than in non-adopted children (Juffer & van Ijzendoorn, 2007).

Howe (2011) stated that the initial primary selective attachment figure of children placed for adoption as babies before the age of seven months will be their adoptive parents. Children who are adopted as very young babies are more than likely able to develop an initially secure attachment style and will be able to cope best with the emotional challenges related to adoption in adulthood. Children who are placed for adoption at an older age have already developed initial patterns of attachment that reflect their attempts to cope with and adapt to uncertain, rejecting, helpless or hostile caregiving. Adopted individuals may not only feel cut off or separated from their biological parents, they may also feel rejected by them. Children who have suffered rejection, maltreatment and numerous placements are more likely to develop insecure attachment styles (i.e., avoidant and disorganized) (Howe, 2011). A study conducted by Farr, Grant-Marsney, and Grotevant (2014) found that within the adopted child population they were researching, 85% of the individuals had insecure attachment styles.

Adoptees who have avoidant and disorganized attachment styles are often adopted into their new families "ill-equipped for eliciting or responding to sensitive, involved care" (Howe, 2011, p. 233). This suggests that these adopted children do not know how to respond to the new form of caregiving and run the risk of replicating negative or traumatic pieces of their prior caregiving experiences. As a result, their behavior could lead to their adoptive parents feeling rejected and therefore interact with their adopted children in an increasingly disengaged way (Howe, 2011). Children with insecure attachment styles tend to resist any affection from parental figures through controlling and defiant behavior or becoming completely withdrawn (Boyle, 2015). Other symptoms related to insecure attachment styles include but are not limited to hyperactivity, sleep issues, bed-wetting behaviors, and overeating or hoarding food (Boyle, 2015).

Children adopted at older ages appear more likely to experience an insecure attachment relationship with their adoptive mother (Howe, 2001). Those placed in adoptive families at older ages are most likely to report that they did not feel they belonged in their adoptive families growing up, did not feel loved by their adoptive mother, were least likely to remain in high frequency contact with their adoptive mother and were least likely to remain in high frequency contact with their birth mother (Howe, 2001).

The security of attachment during infancy predicts aspects of social development during childhood and adolescence, such as empathy, social competence, and behavior problems, with insecure attachment predicting behavioral and interpersonal difficulties. Adopted individuals may experience difficulties initiating relationships, maintaining relationships, enduring familial conflict, and may have possible disruptions with their adoptive families (Dorahy, Shannon, & Corry, 2009).

In emerging adulthood, adopted youth may be leaving home and beginning to make their own decisions about contacting their birth relatives. In young adulthood, the adopted individual's family of orientation often expands with the addition of committed relationships and children (Grotevant, Wrobel, Fiorenze, Lo, & McRoy, 2018). However, in relationships, adoptees often use projective identification as a means of communication, in addition to being utilized as a defense mechanism. This is often used by adoptees to communicate what they truly feel inside because they lack the emotional language to describe their feelings, as these feelings originated prior to their development of language and communication skills (Verrier, 1993). Adoptees then expect their partner to know what they need or want without having to say anything to them directly; in other words, they expect their partners to be mind-readers. Adoptees may face intimacy with trepidation, may avoid closeness and commitment with others, or may consciously or unconsciously sabotage or restrain emotion in relationships (Dorahy et al., 2009; Verrier, 1993). Struggles with intimacy can then result in depression, substance abuse, marital troubles, or problems with family and children.

A close attachment bond with a primary caregiver may serve as a protective factor for children in regard to effective functioning in the face of adversity (Egeland & Sroufe, 1981; Juffer & van Ijzendoorn, 2007). There have been observed difficulties in attachment within the adopted adult population where they have exhibited difficulties in relationship boundaries, lack of trust, social isolation and issues in regard to perception and responses to others' emotional responses (Grotevant, 1997). Some of the other symptoms reportedly observed in adult adoptees were high rates of depression, emotional dysregulation, hyperactivity, aggression and learning disabilities (Brodzinsky et al., 1984). Attachment relationships may have long-term effects on an

individual's overall functioning by influencing the course of biological development, including one's brain development (Egeland & Scoufe, 1981).

Internal Working Models

Internal working models (IWMs) are mental representations of the self, others, and the relationship between self and others that are formed based on the individual's earliest relationships and attachments (Bowlby, 1982; Egeland & Sroufe, 1981; Pace & Zavattani, 2010). Development of these working models is an unconscious process based on the child's expectations about how the physical world operates, how their mother and other significant people may be expected to behave, and how all of them can interact with each other (Waters, 2016). As the infant develops and encounters the world beyond those first few relationships, their internal working models guide their behavior and expectations in subsequent relationships. They make plans on how to respond to their parents (which factors in their attachment style and related behaviors) based on their perceptions of how accessible, responsible, and acceptable they are to them (Bowlby, 1973). These internal working models also play a role in affect regulation, social competence, cognition and understanding relationships and attachment (Pace & Zavattani, 2010). If the individual displays a secure attachment style, their internal working model will lead them to see others as reliable and compassionate and will see themselves as worthy of this kind of attention (Egeland & Sroufe, 1981). If the individual displays an insecure attachment style, their internal working model will lead them to see others as untrustworthy and potentially rejecting, and they will see themselves as not deserving of reliable and sensitive care (Egeland & Sroufe, 1981). Adoptees often hold this idea that "I was unwanted, therefore I am unworthy" and therefore sabotage anything good that may be happening in their lives (Verrier, 1993).

Having been relinquished may add a basic overall negative dimension to the adoptee's world of representations. Older placed children's' attachment histories and internal working models established in their relationship with their initial caregivers may remain active in the relationship with the new caregivers despite different caregiving styles (Howe, 2001; Priel, Kantor, & Besser, 2000). Object relations theorists suggest that adoptive parent representations are construed on the basis of organized memories of real interactional sequences, as interpreted by the child (Priel et al., 2000). The representations of the birth parents may not be grounded in actual experiences, but may be affected by experiences with (and the representations of) the adopted parents, the knowledge of having been adopted, and the associated fantasy related to reuniting with their birth parents (Priel et al., 2000). At times, young children cannot tolerate being angry at their birth parents who have "deserted" (Priel et al., 2000, p. 130) them and displace their anger onto the adoptive parents, allowing the birth parents to remain the idealized figures in the child's life. The idea that these children did not have any control over any factor in the adoption process lends to the notion that these adoptees may have a lack of perceived control over other issues in their lives and therefore feel helpless in numerous situations (Reinoso et al., 2013).

Identity

Identity development builds on processes originating in childhood, becomes intensified during adolescence, and lays the foundation for adult psychosocial development (Erikson, 1950, 1968; von Korff & Grotevant, 2011). The identity development process involves active choices and creating meaning about "givens" in one's life, such as gender, race, or being adopted. The definition of an adoptive identity includes who that person is as an adopted individual, what being adopted means to them, and how this identity fits into their understanding of themselves,

relationships, family and culture (von Korff & Grotevant, 2011). Creating this identity involves the construction of coherent stories in order to create and communicate a sense of meaning and identity that links one's past, present and future.

Adoption theorists have identified middle childhood and adolescence as key developmental periods for adoptees' adjustment (von Korff et al., 2006). Individual and family dynamics related to adoption can have profound effects on the child's self-esteem and identity, as well as on the parent-child relationships, that often lead to adjustment difficulties (Brodzinsky, 2011). It is important to review the child's internal working models and acknowledge the way the child interprets the information they are given, the manner in which their understanding changes with age, and how their evolving knowledge and curiosity about adoption can impact their adjustment, self-esteem and identity (Brodzinsky, 2011).

When children are three to five years old, they are able to label themselves as being adopted and can talk about having biological parents (Brodzinsky, 2011). Sometimes they can identify that they were born to individuals other than the parents who are raising them and may learn fragments of their adoption story. At this time, children often learn the language and terms related to adoption and begin to talk about being adopted in general without truly understanding the depth of that reality (Brodzinksy, 2011). Adoptive parents often hear their children talk about being adopted and/or about their birth families, which can lead them to assume that their child has a relatively clear understanding of their adoption and end all future adoption-related discussions that are pertinent to their child's creation of their adoptive identity (Brodzinsky, 2011).

During middle childhood, ages six to 12 years old, children's capacity for problem solving becomes more sophisticated and they often realize that their birthparents may have had

other options besides placing their child up for adoption (Brodzinsky, 2011). These children may then reject or challenge their adoptive parents' explanations regarding their adoption circumstances. This is a period of development where adoptees may begin to question whether they were ever wanted by their birthparents in the first place, recognize biological connections among family members and questions the authenticity of their family membership, therefore undermining their view of themselves and their origins. During this period, logical thought also begins to emerge, and these children now recognize that having been adopted not only means gaining a new family, but it also means having been separated or taken from their previous one (Brodzinsky, 2011). Sensitization to the reality of adoption-related losses during this developmental period can help explain why there tends to be an emergence of increased adjustment difficulties at this stage. Adoptive parent's openness to the native culture may play an important role for transracial adoptees' identity clarity (Boivin & Hassan, 2015). Confusion of conflict around heritage culture may be more deleterious to adoptees' identity integration than identifying to one or the other ethnic or cultural groups. Positive family relationships are highly important in the process of cultural identification (Basow, Lilley, Bookwala, & Mcgillicuddy-Delisi, 2008).

In adolescence, individuals are developing abstract thinking and the capacity for understanding the meaning and implications of their adoption deepens. These individuals now understand the legal permanence associated with their adoption, which for some during early childhood, anxiety was observed regarding being returned to or reclaimed by their birth families. In addition to understanding the legal permanence, these teenagers are developing the capacity for understanding other people's thoughts and feelings and therefore can conceptualize adoption within a societal perspective (Brodzinsky, 2011). They are now able to recognize the role of

adoption as a social service system that is geared towards bettering the lives of many children; however, on the flip side, they are now aware that many people view adoption as a second-best alternative to creating a family and can begin to question their value to their family and the way others view them. Like all teenagers in this developmental stage, adopted adolescents are also in the process of trying to define themselves and find their place in the world. However, for adoptees it is more complicated because they are attempting to integrate their connections to two families within their identity. Parents who are open, supportive and empathic in their communication about adoption and adoption-related issues are more likely to have children who are able to integrate aspects of both families into their lives and develop a positive sense of self. Access to information about one's biological family and the circumstances regarding the adoption, as well as contact with the birth family, generally facilitates positive adoptive identity development (Brodzinsky, 2011). Coherent adoptive identity narratives are likely to make it easier for adolescents to negotiate changing family communication patterns and new adoption-related experiences as they enter into adulthood. That being said, the identity classification of adopted individuals during adolescence has been found to significantly predict levels of internalizing behavior, but not externalizing behavior, during emerging adulthood (Grotevant, Lo, Fiorenzo, & Dunbar, 2017).

Adversities experienced prior to early adoptions may manifest in adulthood as internalizing problems such as anxiety and mood disorders (Cubito & Brandon, 2000). Predictability of internalizing but not externalizing behavior is likely due to the notion that adoptive identity development in adolescence is primarily an internal process; as children attempt to integrate all their information into their sense of self, they may end up ruminating over adoption-related domains (Grotevant et al., 2017). Adjustment difficulties that have been

associated with identity development appear to persist over time and may not be alleviated through maturity into adulthood alone.

More frequent conversations about adoption between adoptive parents and their children is likely to be very important during adolescence when they are entering Erickson's stage of identity formation (Pearson et al., 2007). At this stage of life, they want to be like everyone else, are recognizing numerous differences, and feeling the harsh impact of being adopted on multiple levels. The frequency of adoption-related conversations within the adoptive family has been found to mediate the association between contact with the birth relatives and adoptive identity formation during adolescence, and the effects of contact and adoption-related conversation on adoptive identity extends into emerging adulthood (von Korff & Grotevant, 2011). Such conversations helped adoptees to construct, organize, and interpret the meaning of adoption in their lives.

Contact with birth relatives plays a significant and meaningful role in a child's immediate relational context with implications for subsequent adoptive identity formation. The tendency to search for birth parents is influenced by a number of factors, one being the divorce of adoptive parents. The divorce of adoptive parents will ultimately raise questions in the adoptees' mind about their birth parents, and possibly negatively influence adoptee's relationships with one or both of their adoptive parents thereby increasing a desire to contact birth parents (Tieman, van der Ende, & Verhulst, 2008). The more negative the perceived relationship with the adoptive parents, the greater the degree of searching. There are two groups of searchers: one whose searching is unrelated to the atmosphere of the home and one whose searching derives from attempts to meet needs that have been unfulfilled in their adoptive family relationships. Searchers usually have more problems with their dissimilarity from their adoptive parents,

specifically in relation to intellectual and psychological differences (Tieman, van der Ende, & Verhulst, 2008).

Biopsychological Effects

Ricker, Corley, Defries, Wadsworth, and Reynolds (2018) found that long-term stress has the potential to negatively impact both one's brain structures and brain function. Stress experienced in childhood and adolescence might be especially detrimental to brain regions with long postnatal development or organizational periods, high density of glucocorticoid receptions, and/or brain regions (amygdala, hippocampus, prefrontal and frontal cortices) that undergo neurogenesis during these developmental periods. In addition, negative and widespread changes to one's gray matter have been found in adolescent brains that have been exposed to moderate and chronic childhood adversity (Ricker et al., 2018). Stress experienced during these sensitive periods of development can influence cognitive abilities dependent on these regions, as well as long-term changes in these abilities later in life. The perception of stress can invoke a host of involuntary responses associated with negative outcomes, including but not limited to intrusive thoughts, ruminations, and physiological responses such as increased cortisol levels in response to social stressors (Ricker et al., 2018).

Chronic and persistent stress has also been linked to fluctuations in glucocorticoid levels. Fluctuations in glucocorticoid levels and increased stress over prolonged periods of time have been associated with hypothalamic-pituitary (HPA) axis dysregulation with subsequent neurobiological consequences (Ricker et al., 2018). Early life separations or adoptions from families or origin may pose an increased risk for altered stress functioning and cognitive performance in adulthood. The age of separation or adoption may be a moderator, such that very early infant adoption may mitigate or lessen the risk of altered stress and cognitive functioning,

wherein HPA alterations can return to normative functioning with very early adoptions and positive maternal behaviors are increased above what would be expected (Ricker et al., 2018). Smaller hippocampal volumes have been observed for early and late adoptees when compared with nonadopted individuals but was most salient for later adopted individuals. Prefrontal cortex volume differences were observed for all aged adoptees when compared to nonadopted individuals. Both the prefrontal cortex and hippocampal volume differences suggest that adopted individuals may have different trajectories of memory and perceptual speed functioning throughout their lives, with stress influencing the effects (Ricker et al., 2018).

Substance Abuse

Adverse family environments in childhood can increase one's susceptibility to later substance abuse (Blake et al., 2018). In substance-abusing families, child maltreatment is highly prevalent and neglect commonly occurs as the needs of the child often become second to the needs of the substance-addicted parent. Maltreatment generates enduring behavioral consequences by altering the architecture of the developing brain and dysregulates the same neurobiological stress systems implicated in substance abuse, namely the HPA axis. The same neurobiological mechanisms underlying internalizing problems in maltreated youth influence stress responses in foster youth who have experienced multiple disrupted placements. Placement instability also creates alterations to the HPA axis that dysregulate individual's stress response systems.

Older-adopted children often engage in greater substance use, which implies that later adoption signifies a longer chronicity of maltreatment (Blake et al., 2018). The dysregulation of the frontolimbic systems of the brain may lead to substance use through behavior disinhibition or unstable affect regulation. Domains of externalizing behavior that can both result from

cumulative stress and predict later substance use include impaired effortful control, aggression, and neurobehavioral disinhibition. Cumulative stress heightens risk-taking traits overall, including response disinhibition, impulsivity, and risky decision-making, that can manifest as externalizing behavior in childhood and then continues as substance use problems in young adulthood (Blake et al., 2018). Youth with higher levels of pre-adoptive risk are more likely to engage in substance use as a means of regulating heightened negative emotions that they have experienced chronically throughout their lives, more so than an outlet for behavioral dysregulation. Reliance upon substances to regulate emotions can provide a short-term alternative to self-regulation strategies, however it simultaneously undermines long-term self-regulatory capabilities, which is undesirable because their emotion regulation skills may already be compromised from childhood adversity. Mental health issues often precede substance abuse in adolescence, and therefore substance abuse can be seen as a form of coping with their mental distress (Askeland et al., 2018).

Loss and Grief

In regard to adoption-related loss, there are numerous ways in which individuals in the adoptive kinship network may experience loss or grief, including the loss of birth family, loss of ethnic and culture connections, and loss of stability in relationships (Reinoso et al., 2013). The variability in the ways in which adopted individuals experience loss are linked to a range of intrapersonal, interpersonal, experiential and contextual factors, including age, cognitive level, temperament, pre-placement history, relationship history, and current support systems (Brodzinsky, 2011). The first and most obvious loss experienced by adopted children is the one associated with the separation from their birth parents (Brodzinsky, 2011; Jago et al., 1997). In addition to losing their birth parents, they are also deprived of their health information, social

history, cultural history and status (Pearson et al., 2007). For those children placed for adoption as babies, this sense of loss emerges slowly as they begin to understand the meaning and implications of being adopted. At around age six or seven the adopted child may realize that they have been relinquished or given up and then fully experience the perceived loss and abandonment by their biological parents, especially their biological mother (Brodzinsky, 2011; Grotevant, 1997; Rushton, 2010). For children who were placed for adoption at older ages, the loss of birth parents, siblings, and extended family are more likely to be acutely traumatic because they involve severing known relationships, some of which may have afforded the child a relatively decent degree of emotional security.

In middle childhood, for some adopted children struggling with the loss of their birth parents and the burden of grief, progress through school may be slowed down (van Ijzendoorn et al., 2005). Adopted children may also experience status loss when they recognize that their peers and other individuals may have negative attitudes towards adoption or about them as a person because they were adopted (Brodzinsky, 2011). This can lead to accentuating feelings of difference, a diminished self-esteem and a confused identity. Overall, unresolved loss is associated with intrusions and ruminations that limit the ability to focus on the tasks at hand. When loss is unrecognized by others, the risk is that the individual will feel ignored, misunderstood and unsupported, in other words experience disenfranchised grief and increase their risk for adjustment difficulties (Brodzinsky, 2013). Adopted-related loss can be difficult to resolve because of the lack of information most individuals have about their past, the ambiguous nature of the loss, and the lack of recognition and support for the loss (Brodzinsky, 2013).

Adoptees who have experienced loss may try and avoid any future abandonments by strengthening their social abilities (Juffer & van Ijzendoorn, 2007). Loss often leads to grief,

especially if the adoptees have little contact with their biological parents (Pearson et al., 2007). Grief tends to result from feeling unwanted and abandoned, as well as from the numerous losses endured. In children, unresolved grief may affect concentration, academics, self-esteem, identity and peer relationships (Pearson et al., 2007). The process of grief becomes more complex and abstract later in middle childhood as the adopted individuals grieve not only the loss of their birth parents and origins, but also the loss of part of themselves (Tieman et al., 2008). The stages of grief can describe the shock and denial that can manifest in withdrawn or aggressive behavior that is often towards adoptive parents or foster caregivers (Boyle, 2015). The final stage of acceptance is where the child comes to terms with their loss and begins to form attachments with their new families. However, the full impact of grief may not be recognized until adolescence or adulthood when delayed or unexpressed grief can result in depression, delinquency, substance abuse, and aggressive behavior (Pearson et al., 2007).

Shame, Rejection & Guilt

Adoptees have been found to blame themselves for their relinquishment and may hold the belief that they were not worthwhile enough for their birth mother to keep them (Juffer & van Ijzendoorn, 2007). Fear of rejection and disapproval places a sense of shame in the child and can manifest into perfectionistic behaviors that help ease the child's fear of abandonment (Kaufman, 2013). This fear can also manifest as resentment of the birth family, increased shame, lowered self-esteem, and self-concept (Pearson et al., 2007). In interpersonal relationships, the fear of rejection may become so overwhelming that adopted individuals withdraw from all interpersonal relationships, often rejecting others before it can happen to them or they become over controlling to ensure that abandonment doesn't happen again (Brodzinsky et al., 1984). Change then becomes related to abandonment and uncertainty, which can manifest into anxiety, depression,

and externalization of behaviors stemming from the child's internal working models (Brodzinsky et al., 1984; Case, 2005; Grotevant, 1997). Rejection may also be experienced by the adoptive mother when the traumatized infant cannot securely attach, leading the mother to withdraw and thus increasing the child's insecure attachment (Heller & LaPierre, 2012). Adoptees may also experience discriminatory legal, social and institutional practices such as receiving differential treatment in health care settings because of their lack of information about their biological relative's medical history (Lansford, Ceballe, Abbery, & Stewart, 2001). The fear of rejection in the workplace is often accompanied by a fear of success or an inability to believe in one's competency or expertise. There is a kind of self-rejection of one's own talents and capabilities, which sometimes results in sabotaging one's own success (Verrier, 1993).

The shame associated with adoption is often unrecognized by the members of the adoption triad, yet feeling ashamed is a common feeling for adoptees (Pearson et al., 2007). Shame reflects how individuals feel following appraisals of themselves during or after a traumatic event (Dorahy et al., 2009). Shame is one of the primary regulators of social relations, and fear is the primary regulator in circumstances where social structures for maintaining peace have been broken down and social relations are ruled by violence and neglect (Herman, 2007). Major disruptions in the attachment system can produce fear, but by the second year of a child's life they tend to react to more subtle disruptions in attachment with shame (Herman, 2007; Schore, 2003). Shame is mediated by the parasympathetic nervous system and serves as a sudden "brake" on excited arousal states. The subjective experience of shame is an initial shock and flooding with painful emotion in which speech and thought are inhibited. Shame is also an acutely self-conscious state in which the individual feels small, ridiculous, and exposed. Chronically traumatized individuals feel shame not only for what has happened to them, but for

who they are (Dorahy et al., 2009). Because shame originates within the primary attachment relationship, it often generalizes to become an emotion that serves to regulate all peer relationships, social hierarchy, and all the basic forms of social life (Dorahy et al., 2009; Schore, 2003). When shame states cannot be resolved, they are often expressed as symptoms. Shame evokes a physical withdrawal from cues that elicit painful affect and a psychological withdrawal (dissociation) from the painful affect (Dorahy et al., 2009). However, it is important to understand that shame is a normal reaction to disrupted social bonds and individuals should be encouraged to explore and express their shame in attempt to mend the internal working models.

Symptoms in General

Psychoanalytic literature suggests that adoption may have a potentially disruptive effect on one's overall development (Priel et al., 2000). Adoption-related impairments are related to the child's sense of security and identity, the channeling of aggression, and the resolution of age-appropriate developmental tasks. There is a reported high incidence of acting out problems such as aggression, stealing, lying, and oppositional behavior (Priel et al., 2000). Adoption has been related to an increased risk in academic difficulties, externalizing behaviors, psychological maladjustment, and other negative outcomes. Foundations of clinical dissociation are often forged in early relationship inconsistencies and distress, which is then exacerbated by interpersonal trauma (Dorahy et al., 2009). Dissociation in late adolescence has been significantly related to the nature of caregiver communication, availability, and attachment in early life (Dorahy et al., 2009). Those with higher levels of dissociation are likely to experience uncertainties, fears, and ruminations about future relationships (Dorahy et al., 2009).

After thoroughly reviewing the literature, it is clear that the effects of adoption are life-long and extremely complex. The domains, including attachment, internal working models,

identity, biopsychological effects, loss and grief, and shame, rejection and guilt, that have been negatively affected by adoption warrant a highly-skilled clinician that is willing and able to effectively treat the related symptoms.

CHAPTER IV: TREATMENT CONSIDERATIONS FOR ADOPTION-RELATED COMPLEX TRAUMA

Due to the variety of domains negatively impacted by adoption, it is important to acknowledge that there is not one specific evidence-based treatment that can address all the facets of adoption-related complex trauma. However, adoption has been recognized in some theoretical orientations. Numerous interventions and treatment models have been adapted for working with adopted individuals and can be used in conjunction with one another in order to effectively treat the adopted client's most pressing concerns.

Theoretical Perspectives on Adoption

Zamostny et al. (2003) conducted a literature review that compiled numerous theoretical perspectives on different facets of adoption, which include attachment difficulties, behavioral concerns, and overall family dynamics. The following section is not a comprehensive explanation of each theory, and more research needs to be done in this area, but it allows one to see the theory's conceptualization on adoption-related issues.

Psychodynamic theory. Psychodynamic theory suggests that the adoption triad or adoption kinship network often encounters unconscious conflicts that can have detrimental effects on their individual development and their family relationships (Zamostny et al., 2013). This perspective is focused on the dynamic issues related to the narcissistic wounding of infertility within the adoptive family, the overreliance on splitting defenses in the adoptees in order to maintain some semblance of a connection with their biological parents, and the object relations issues that impeded development of trust in infancy and then create problems for identity development at later stages (Zamostny et al., 2013). The splitting defenses become apparent when the loving adoptive family attempts to attach to the adoptee, but the adoptee splits

herself into the "artificial self," or good adoptee, and the "forbidden self," or bad adoptee (Zamostny et al., 2013). The psychodynamic perspective has elicited three distinct phases that the adoptive triad members go through: 1) navigating the dynamics of loss and grief; 2) the separation from the biological mother and the disruption in attachments while attempting to attach to their new family members; and finally, 3) the emerging identity search within the adoption experience.

Social role theory. This perspective has been the first systemic articulation of the differences between the adoptive and biological family systems in the research literature thus far. This specific theory details the role of loss in the adoptive family relationships and the conflicts inherent in adoptive parenting roles given biological parenthood is the standard of comparison. In addition, this perspective acknowledges that the stress created for the adoptive families because of society's stigmatized viewpoint on adoption (Zamostny et al., 2013). As mentioned in previous chapters, adoptive families often cope more effectively with the handicaps inherent in adoptive parenting when the family members openly communicate and acknowledge the differences and losses associated with adoption, as opposed to rejecting the differences.

Family systems theory. The family systems theoretical perspective is rooted in the viewpoint that adoption unites the adopted child, the birth family, and the adoptive family in a lifelong kinship network (Broderick, 1993). It focuses on the interactions of emotional and behavioral subsystems within the adoptive families. In addition, this theory acknowledges that adoptive families experience significantly different stressors than biological families and therefore have unique developmental concerns in regard to a family as a whole unit. Family systems theory is similar to the social role theory in that they both recognize that adoptive

families and biological families differ in numerous ways and therefore should be treated from a different perspective.

Attachment theory. The research has used attachment theory to understand the adjustment processes within adoption, such as bonding and loss (Zamostny et al., 2013). In addition, there is a focus on the higher disruption rates of adoption in special needs situations. Transracial adoptees that have been placed within the first few months of their life were able to securely attach to their adoptive mothers. However, there is a strong correlation between attachment difficulties, prolonged institutional care, and preadoptive histories of abuse and neglect (Zamostny et al., 2013). Attachment theory also suggests that adoptees' attachment styles likely influence their desire to search for their birth parents if they are involved in a closed adoption.

Stress and coping theory. Another perspective that addresses the specific difficulties of adoption adjustment is the stress and coping theory, however, it focuses more on the infancy stage. This theory is based on the belief that adoption involves challenges that often test the adoptees' coping resources/responses and places a major emphasis on the mediational role of cognitive appraisal in determining the outcome of adoption-related stress (Zamostny et al., 2013). Cognitive appraisal is an individual's personal interpretation of a situation that influences the extent to which the situation is perceived as stressful. This theory considers the individual's biological (genetics); individual (cognitive level, personality, attachment style); and environmental (preadoption history, family, environment social support, cultural and societal constraints) factors that can directly affect cognitive appraisal, which then in turn affects the individual's coping and subsequent adjustment (Zamostny et al., 2013). Unique to the stress and coping theory, the impact of adverse societal adoption attitudes, such as stigmatization, is

included in the development of adjustment difficulties. Most theories ignore the important social context variables and therefore do not account for a major piece of the adoptees' adjustment.

All of the theories described above encompass one or more of the core issues related to adoption and can help clinicians begin to conceptualize their adopted clients within an adoption-related trauma framework. Psychodynamic theory focuses on the individual's adoptive identity development stemming from their ability to process the loss and grief, the separation from the biological mother, and the subsequent disruptions in attachment. Social role theory highlights the discrimination and stigmatization surrounding adoption and how the stress of those experiences impacts the adoptive family development. Family systems theory allows for the difference between adoptive family development and biological family development to be accounted for when assessing the level of stress within the adoptive family network. Attachment theory helps to explain the symptoms manifesting in transracially and internationally adopted individuals, as well as adoptees' desire to search for their biological families later in life. Stress and coping theory include factors from the previously mentioned theories, however this theory also accounts for the social context variables that can impact adoptee's adjustment. Taken all together, or viewed separately, all of these theories speak to the significant difficulties that adopted individuals face during their development and may be the reasons behind their motivation to seek therapeutic services.

Why Adopted Individuals May Seek Services

The most commonly reported post-adoption need by adoptees and adoptive families was for mental health services with qualified adoption-competent mental health professionals (Casey Family Services, 2003). However, many of these families reported having to teach or educate the professionals about the basic issues of adoption. Areas in which therapists were viewed as

especially insensitive or lacking in adoption knowledge included attachment, trauma, loss, and use of appropriate language (Brodzinsky, 2013). Some individuals have reported experiences with mental health professionals that they felt damaged their families (Brodzinsky, 2013). Some of the unhelpful information, guidance, and actions that have been reported by adoptive parents and adoption professional include but are not limited to failing to validate or believe the client's experiences, blaming parents for their child's problems, pathologizing adoption and viewing the family as pathological, questioning the parent's motives for adoption, advising parents not to talk about adoption with their children because it will cause distress, seeing children with attachment issues without parental presence or input, telling parents to give their children back to the state, and failing for gather information about the child's history and/or address the impact of previous maltreatment on their current presentation (Brodzinsky, 2013).

Therapists often discount the role of adoption when providing therapy to adoptive family members and therefore it becomes imperative that training on adoption dynamics be increased (Zamostny et al., 2003). Individuals may seek help with interpersonal relations, integration of adoption experiences, struggles around adoption, healing processes, grief and loss, and preparing for reunion with a birth parent, and therefore professionals must be prepared to address those issues (Pearson et al., 2007). Isolation and intimacy issues were the highest reported concern among individuals who sought psychological help, with shame and guilt issues being the lowest reported concern (Pearson et al., 2007).

In some states, in order to receive necessary inpatient psychiatric or residential mental health treatment, adoptive parents have to relinquish custody to the public child welfare system or juvenile justice system (Casey Family Services, 2003). Given many adopted individuals' past

history of abandonment and possible multiple relationship disruptions, the action of returning the child to state custody is highly contraindicated.

When adult adoptees seek out psychotherapeutic services, the most common presenting concern is interpersonal relationship difficulties (Verrier, 1993). In most cases, the original abandonment and substitution of the mother figure is rarely considered as a significant factor in the client's current presentation. Many adopted individuals, if they have not completely withdrawn emotionally, describe feelings of panic and fear related to recent separations and losses. However, these emotions are usually not truly connected to the present circumstances. Rather, these feelings are triggered from the archaic memory traces of their original abandonment and perceived life-threatening experience. Each impending or perceiving threat of abandonment sets up a domino effect of other issues that inhibit the normal ebb and flow of relationships, including their creation, deepening, and ending.

Adoption Competent Therapy

What is an Adoption-Competent Therapist?

An adoption-competent therapist can be defined as a mental health professional who has been specifically trained in treating adoption-related issues. Meeting the needs of individuals and families involved with adoption also requires specialized training in assessment, diagnosis and the use of appropriate interventions (Brodzinsky, 2013). These professionals have been trained in understanding adoption in general and how they can best attend to the needs of adopted individuals (Grotevant et al., 2017; Pearson et al., 2007). These clinicians understand that adoption is one of the many ways to create a family, that the process is life-long, and that it involves unique experiences, feelings, and perceptions. They recognize that parenting relationships and family connections are the singly most therapeutic element in the life of a child over time. They are aware of the common developmental challenges that come with the adoption experience. These clinicians help adoptive families promote secure attachments and healthy relationships despite the challenges by collaborating with the parents towards helping the child heal.

It is important to view adoption from a culturally competent family perspective and to understand the power dynamic of the adoption triad relationships. During the therapeutic process, the clinicians help the adoptive parents honor their adopted child's past and have conversations about separation, loss and feelings about their birth parents, reiterating the importance of openness and communication about adoption-related issues. Supporting the adoptive parents in assuming parental entitlement and authority may empower them to feel confident in making decisions when it comes to their child (Casey Family Services, 2003; Pearson et al., 2007). Individual counseling with adoptees should address issues including but

not limited to anxiety, grief, control, depression, and suicide. Support and therapy groups may be beneficial for adoptees because it allows them to come out of isolation and reduce the stigma attached to being adopted.

Adoption issues are rarely addressed in doctoral psychology training programs, despite the fact that 90% of a sample of doctoral-level psychologists stated that they needed additional education related to adoption (Zamostny et al., 2003). The average time spent teaching about adoption at the graduate level was eight minutes per semester, as compared to three to ten times that amount on subjects that impact far fewer people, such as autism (Brodzinsky, 2013). The Center of Adoption Support and Education (CASE) offers adoption related mental health services for individuals, groups and families, but it also offers specific adoption-competency training for mental health professionals. The Donaldson Adoption Institute also seeks to raise the level of awareness among mental health professionals about the nature and importance of adoption clinical competence (Brodzinsky, 2013). Mental health professionals are encouraged to acquire extra training in international adoptions and the specific challenges that these individuals and families face, as it is an added challenge in their development.

Assessment considerations. Clinicians will benefit from maintaining a bio-ecological perspective when working with adoptive families. The lives of these adopted children and their parents, as well as their birth parents, are influenced by a host of interacting contextual factors, including but not limited to: multiple family and extended family systems, the legal system, the child welfare system, the mental health system, the special education system, and the medical system (Brodzinsky, 2013). When clinicians can understand the etiology of adoption and integrate this perspective into their therapeutic work, they are more likely to be successful in developing effective intervention strategies that facilitate healthier individual and family

functioning (Brodzinsky, 2013). Adopted children, especially those placed from the child welfare system and internationally are especially at risk and vulnerable because they come with histories that include prenatal complications, institutional deprivation, neglect, child abuse, and/or relationship disruptions. Special attention must be paid to assessment for the potential of neuro-developmental problems, attachment difficulties, and other trauma-related symptoms.

Diagnostic considerations. Traditional diagnostic systems within the mental health field are often inadequate for capturing the complexity of the problems and concerns manifesting in foster and adopted children (Brodzinsky, 2013). Many adopted children are diagnosed with an attachment disorder, PTSD, ADHD, CD, and Major Depressive Disorder (MDD) (Brodzinsky, 2013). However, for many, these diagnoses (whether given alone or in comorbidity with another diagnosis) do not adequately reflect the severity of the children's problems, the challenges facing their adoptive parents, or the most effective ways to treat these individuals. Mental health professionals need to be more aware of the limitations of the current diagnostic systems and maintain a more nuanced perspective in their assessment treatment planning with this specific population (Brodzinsky, 2013).

General treatment considerations. Blaming the victim is often a phenomenon of trauma, however being separated from their birth mothers and handed over to strangers (their adoptive parents) in the adoption process is the only trauma recognized at this time where the victims are expected by society to be grateful. However, these individuals are not always grateful, they are grieving, and the original abandonment and loss are sources of other issues that the adoptee presents with (Verrier, 1993). Therefore, a major treatment consideration when working with adopted individuals and complex trauma histories is the notion that these individuals often demonstrate potentially challenging combinations of impulsivity and reactivity

that makes them more vulnerable to suicidal and dangerous risk-taking behaviors. These individuals should be carefully assessed for any suicidal or risky behaviors and monitored closely if these symptoms are present (Hartinger-Saunders et al., 2016).

One of the challenges for adoption-competent therapists is to become more aware of racial and ethnic discrimination related to one's adoption and to recognize the detrimental impact it can have on international adoptees' psychological functioning and well-being (Koskinen et al., 2015). It is important for therapists to acknowledge the role that social support plays in dealing with discrimination because it may in fact buffer the harmful effects and impact on psychological well-being. During the treatment planning process, interventions should involve all levels of society involved in the client's life and therefore include policy, social activism and social change.

Another consideration for working with adopted individuals is to address the concept of shame directly within the psychotherapy relationship. Normalizing shame reactions and by giving the client's a relational framework for containing and understanding those reactions can ultimately facilitate the therapeutic work (Herman, 2007). Dorahy et al. (2009) found that therapeutic work surrounding the feelings individuals have about themselves may begin to rectify their unacknowledged shame, and therefore provides a foundation for greater progress in relation to intimate relationships. In highly traumatized individuals, it is not the affect attached to shame that negatively impacts their relationships, it is the responses to coping with those feelings. While the affect needs to be processed directly, early psychoeducation around responses to shame may buffer against ruptures within the therapeutic relationship in the form of withdrawal and avoidance. Dissociation is often associated with more complex presentations of

PTSD, higher levels of shame, greater withdrawal from shame-evoking situations, and higher psychological preoccupation with relationships.

Clinicians working with adopted individuals will benefit from understanding the complexity of adoptive sibling relationships, specifically how siblings' feelings about adoption and the involvement with the birth family contact may relate to the adoptees' adoption perceptions (Farr, Flood, & Grotevant, 2015). Siblings can play a role in adoptees' positive adoption experiences and contact, as these relationships appear to constructively contribute to adoptees' better overall adjustment over time.

For adoptees seeking treatment for interpersonal difficulties, the therapist will need to recognize the client's issues of abandonment, fear of intimacy, and splitting as possible different etiologies than someone who is suffering from a personality disorder (Verrier, 1993). This difference is not always respected by clinicians to the detriment of the therapeutic process and therefore the client is not able to heal effectively.

Treatment interventions. It is necessary to tailor interventions so they are personalized to address the unique issues related to adoption (Grotevant et al., 2017). Some clinicians have found that utilizing a person-centered approach and focusing on the specific adoption-related aspects has elicited conversations and therapeutic work around the underlying issues of the individual's maladaptive psychological adjustment. Many of the interventions listed below have been created for the use with children and adolescents, however most of the components within the models can be utilized with adults as well.

Attachment and biobehavioral catch-up (ABC). ABC engages the adopted child and the adoptive parents in specific competencies and has been found to help young children to develop regulatory capacities (Hartinger-Saunders et al., 2016). This approach is conducted in a time-

limited format with ten sessions in the home of the family. The sessions focus on attending to parent's own issues that may interfere with their ability to provide nurturing care to their children. There are three areas of focus: 1) teaching parents how to provide nurturance to distress even when their children do not elicit it and when it doesn't come naturally to the parents; 2) following the child's lead with delight; and, 3) behaving in a non-frightening manner (Hartinger-Saunders et al., 2016). This approach has been effective in enhancing parent's sensitivity; increasing their brain activity in response to infant stimuli; and improving children's attachment quality, cortisol production, emotional expression, and executive functioning skills (Dozier, Meade, & Bernard, 2014).

Attachment, regulation and competency (ARC). Based on developmental, attachment and trauma theory, ARC uses a variety of psychoeducation, somatic, cognitive behavioral, relational and psychodynamic interventions (Brodzinsky, 2013). The ARC model addresses three core domains impacted by exposure to chronic, interpersonal trauma including attachment, self-regulation, and developmental competencies (Brodzinksy, 2013). The primary attachment system provides the security and safety necessary for the children to master a variety of competencies including the ability to self-regulate, develop positive relationships, and acquire cognitive skills relevant to learning (Arvidson et al., 2011). This therapeutic model is flexible and involves the child, the family, and the system around the family. The attachment domain focuses on the ability of the caregiver to recognize and regulate the child's emotional experience utilizing attunement, consistent responses, and routines. Self-regulation specifically teaches the caregivers and children to identify and label their affect and then modulate and express their feeling in a positive and effective manner. The competency domain includes techniques to help the child increase their executive functioning skills in order to effectively engage in problem solving,

anticipation and planning. Within this domain, self-development and identity target the development of a sense of self that is unique and positive and incorporates experiences from the past and the present. At the end of treatment, the trauma experience integration interventions focus on integrating the variety of skills that the child and caregiver have learned in order to help support the child in building a coherent and integrated understanding of their self and engage in a more fully present life. Specific to trauma-related interventions, this phase targets traumatic memories and reminders, triggers of arousal and freeze states, and trauma-related self-attributions and cognitions. This approach has been shown to significantly improve children's behavior and emotional functioning, and a 50% reduction in young children's PTSD related symptoms (Brodzinsky, 2013; Vaughan, McCullough, & Burnell, 2016).

Attachment-based family therapy (ABFT). Originally, ABFT was developed for depressed and/or suicidal adolescents and based in attachment theory and structural family therapy (Diamond, Diamond, & Levy, 2015). Attachment-based family therapy was then specifically adapted for children who were adopted or fostered and aims to strengthen the parent-child relationship (Hughes, 2006, 2007). The approach focuses on teaching authoritative parenting skills that promote affect regulation within their adolescents, in addition to rebuilding secure attachments in adolescence.

Briere's integrated treatment of complex trauma (ITCT) for children and adolescents. Briere and Lanktree (2013) developed a guidebook for ITCT for clinicians to follow and can be found for free on John Briere's website, however it is not specifically adapted for the adopted population. This approach focuses on the multidimensional complex trauma reactions and comorbidities, in addition to socioeconomic resources, racial discrimination, and unsafe communities and their impact on the individual's functioning. Within this model, the

development of a trusting therapeutic relationship is the most important component related to successful treatment (Briere & Lanktree, 2013). The domains on which the interventions focus are safety, psychoeducation about trauma, distress reduction, affect regulation training, cognitive processing, titrated exposure to the traumatic memories, trigger identification and reduction, identity issues, and relational processing (Briere & Lanktree, 2013). There have been two different versions of this model, one being better suited for adolescents (ITCT-A) and one for children (ITCT-C), however both models include the caretakers and family members involved in the individual's life.

Child-parent relationship therapy. This is a structured, time-limited variation of filial therapy that trains caregivers to be therapeutic change agents for their children (Brodzinsky, 2013). This approach is typically used for children ages three to ten years old. It promotes feelings of safety, acceptance, love and connections through play interactions. A main assumption of this approach is that relationship (attachment) problems can most effectively be dealt with in the context of the dyadic (parent-child) interventions rather than in individual therapy. In addition to training the caregivers to be an agent of change, there is a noted decrease in parental stress and disruptive behavior in their children, as well as increased parental empathy (Brodzinsky, 2013).

Dyadic developmental psychotherapy (DDP). DDP is grounded in attachment and intersubjectivity theories and has been shown to be effective for individuals suffering from trauma-attachment disorders (Becker-Weidman, 2006; Brodzinsky, 2013). This is a specific treatment used with families with adopted or fostered children who have experienced neglect, abuse, and have suffered from developmental trauma. The sessions focus on exploring the experience, rather than specific behavioral change. The interventions focus on helping rebuild

positive relationships between the child caregivers, in addition to increasing the child's sense of safety and feelings of connectedness through developing healthy patterns of relating and communicating (Becker-Weidman, 2006).

Family adoption communication model (FAC). The family adoption communication model (FAC) posits three phases of communication about adoption encountered by adoptive families over the course of their family life cycles. Adoptive parents may provide unsolicited information to their children about their adoption and birth families, then address the children's growing curiosity by responding to the questions that they may have, and finally adoptees may begin seeking information independently of their parents if they wise to do so.

Communication privacy Management theory highlights the dynamic nature of privacy choices during the three phases of the family's adoption communication life cycle. During the first phase, adoptive parents set a privacy boundary which defines what information to share with their child and when to share it. Privacy boundaries evolve as adoptees mature and adoptive parents create linkages by increasingly including their children in the ownership of private information. Finally, when adoptees seek information independently, they own the adoption-related information and grant or deny access to others, including their adoptive parents, influenced by the perceived risk in sharing that information. Although adoptive parents are assumed to provide unsolicited information to their young children in the first phase of the FAC model, information seeking activity by the adoptees as an adult during the third phase may also facilitate adoptive parent disclosure of information thus creating a moment of heightened dialogue and additional family relationship development. Emerging adulthood is a time when adoptees have begun to independently seek out information about their adoptions and birth

families and are less reliant on adoptive parents for fulfilling curiosity and information needs (Skinner-Drawz et al., 2011).

Multidimensional Family Therapy. This therapeutic approach was originally developed as a strategy for adolescents with substance abuse and associated mental health and behavioral problems (Brodzinsky, 2013). The therapeutic tasks are to assess and intervene not only at an individual level and family level, but to consider extra-familial sources of influence such as peers, school, child welfare, and juvenile justice, which is applicable for the adopted population as a way to engage all of the systems involved in their lives.

Narrative Therapy. Narrative therapy was founded on the story of Oedipus and the paradigm of storytelling and the healing process involved (Homans, 2006). The therapeutic approach is based on the belief that the stories people use to describe their lives often restrict them from overcoming their personal difficulties (Brodzinsky, 2013). The linkage of adoption to trauma is complex because the process of relinquishing an infant is not only like a trauma, it has itself been called a form of trauma, as mentioned in previous sections. Many adopted individuals act out or display externalizing behaviors rather than consciously recalling their abandonment or relinquishment experience. That being said, the goal in therapy is to have the individual articulate and narrate their unconscious experiences (Homans, 2006). By eliciting clients' stories verbally, in written form, through pictures or other means, the therapist can help the individuals reframe their life narratives, find alternative ways of integrating difficulties into their lives, identify and support personal strengths, and develop healthier relationships with others (Brodzinsky, 2013).

At each stage of adoptees' development, they attempt to construct a meaning system in which the pain of loss from their adoption experience can be grieved (Jago et al., 1997). The

formulation of the adoption narrative provides an initial foundation from which to begin the search for identity. The adoptees' first narrative provides the meaning for the adoption, in which they struggle to determine the reasons behind their current situation and life thus far. For the adoptee who begins their life in a world of uncertainty, the attainment and enhancement of meaning becomes a matter of significant importance. Existential counseling may be appropriate and helpful to construct an authentic and fulfilling meaning system in congruence with their own unique character. This may help the adoptee determine the necessity or importance of searching for their birth family in the future. The searching adoptee's journey to self-awareness may be wrought with anguish, anxiety and uncertainty as they navigate uncovering defenses they have developed in order to cope with their existence. The reality of the search process and the potential reunion often uncover a significant amount of unsuspected and unexplored affect regarding their adoption (Jago et al., 1997).

Neuro-Physiological Psychotherapy (NPP). NPP is considered to be a wrap-around approach involving multi-disciplinary, neuro-sequential, attachment-focused interventions for children and families who present with multiple, clinically significant emotional and behavioral difficulties (Vaughn et al, 2016). Children and younger people demonstrated significant changes in executive functioning, attachment strategies, and emotional and behavioral presentations as reported by their parents and teachers after engaging in NPP. This model integrates sensory, somatic body work and regulation techniques that focus on empowering the individual to become aware of their own physiological state, specifically hyperarousal, and teaches them strategies to return to a baseline state. The change in their capacity to self-regulate is a necessary precursor to any other progress. Early adopted children with attachment difficulties appear to develop alternative, more secure representations of their adoptive caregivers over time. Through

a focus on emotional physiological regulation and the creation and building of the attachment relationship, the child is able to develop new ways to managing their trauma-related fears and alternative templates for relationships, including alternative perceptions of others.

Parent-Child Interaction Therapy (PCIT). PCIT was originally developed to treat disruptive behavior problems in children between the ages of two and seven years old. However, since its creation it has been researched and found to be an effective intervention for numerous behavioral and emotional issues (Hartinger-Saunders et al., 2016). This therapeutic approach focuses on improving positive parenting skills and techniques, reducing parenting stress, and in turn reducing externalizing and internalizing behaviors in children (Hartinger-Saunders et al., 2016). This treatment model is constructed into two phases: child-directed interaction (CDI) and parent-directed interaction (PDI), in which the therapists help instruct and coach the caregivers in play therapy and operant conditioning skills (Hartinger-Saunders et al., 2016). The goals of the CDI phase are to encourage warm, secure, caregiver-child relationships by learning foundational skills including praise, verbal reflection, imitation, behavioral disruption, and enjoyment. The goals of the PDI phase is then to increase child compliance and decrease disruptive behaviors through the use of positive interactions between the caregiver and child (Lieneman, Brabson, Highlander, Wallace, & Mcneil, 2017).

The Incredible Years. The Incredible Years training series is targeted at parents, teachers, and children (ages two through eight years old) and focuses on promoting parent competencies and strengthening the family as a whole (Webster-Stratton & Reid, 2003). This approach has resulted in a reduction in children's behavioral difficulties (Hartinger-Saunders et al., 2016).

Theraplay. Theraplay was developed in the 1960s as a form of focused therapy designed to enhance attachments between parents and children. Theraplay combines traditional play and family therapy with psychoeducational parenting strategies in an effort to build attachment, self-esteem and more positive interactions among parents and their children (Brodzinsky, 2013).

Trauma Systems Therapy (TST). TST is grounded in the latest knowledge about child traumatic stress and factors in how ongoing stress affects children's abilities to self-regulate emotional states. In addition, TST acknowledges that factors in the social environment can support or hinder children's ability to self-regulate and therefore recover from their trauma (Saxe, Ellis, & Kaplow, 2007). This approach integrates individual interventions with services at home, school and all other community levels involved within the client's life. The interventions focus on building emotional regulation skills, higher level cognitive processing skills, and collaboratively working with others.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT focuses on psychoeducation about trauma in general, increasing positive parenting skills, increasing relaxation and coping strategies, affective modulation training, cognitive coping skills, trauma narrative with gradual exposure, cognitive processing of the traumatic event, and integration into the present (Cohen & Mannarino, 2008). Within the research there has been positive evidence showing that TF-CBT used with children is effective when there is a single incident trauma (Vaughan et al., 2016). However, Brodzinsky (2013) found that foster and adopted children with known trauma histories, especially those with PTSD symptoms, benefit from engaging in TF-CBT work.

Trust-Based Relational Intervention (TBRI). TBRI is a relationship-based model that has three guiding principles: empowerment, connection, and correction (Purvis, Cross,

Dansereau, & Parris, 2013). The empowerment domain focuses on the physiological (internal/physical) needs and the external (environmental) needs of the child. The connection domain focuses on self-awareness, attachment, and relational needs. Finally, the correction domain is focused on the behavioral needs of the child, including teaching self-regulation skills and how to create and maintain healthy boundaries. These interventions are done with both the child and their caregivers in order to decrease trauma-related symptoms and behavioral problems (Hartinger-Saunders et al., 2016).

Video-Feedback Intervention to Promote Positive Parents (VIPP). VIPP fosters increased parental sensitivity and responsiveness to children's cues through short-term (three to six) sessions, home-based, video feedback of parent-child interactions and instructions on sensitive discipline (VIPP-SD) (Brodzinsky, 2013). This approach ultimately enhances attachment security in high-risk infants and young children. It has resulted in significantly lower rates of disorganized attachment when compared to individuals who have not received treatment. Sensitive discipline training has resulted in a reduction of externalizing behaviors in children who have been identified as having a specific genetic marker associated with motivational and reward mechanisms and ADHD (Brodzinsky, 2013).

Despite there not being a gold-standard of treatment specifically for treating adopted individuals or for adoption-related complex trauma, there is a wide variety of interventions and models that can be used to effectively treat the core issues related to adoption across the lifespan. Some of the interventions and treatment models can be adapted for the use with adults and therefore can be utilized with adult adoptees seeking psychotherapy for numerous concerns. More information about these treatment modalities can be accessed through the reference list.

CHAPTER V: DISCUSSION

Adoption has been defined as a legal process that connects a child who needs a family with prospective adoptive parents who can provide a life where their needs are met. Adoption can occur within numerous different contexts (domestic, international) and involve varying classifications (open vs. closed, related adoptions, special needs adoptions). The concept of adoption began early in the ancient Roman society and has been acknowledged throughout history as a way of abandoning unwanted children in hopes of providing them with a better life. The western culture has held assumptions regarding adoption which include regarding the actual adoption process as a joyous event for all parties involved, that the adoptive family experience parallels biological family development, all preceding issues disappear once the adoption is finalized, adoptive families are considered "false," and closed adoption are in the best interest for the adopted child. However, the research has since disproved these assumptions by indicating that adopted individuals seek mental health services two to five times more than their nonadopted peers.

Collectively, there are six themes found in the research that challenge the stereotypical assumptions surrounding adoption, which include exposure to prenatal trauma, genetic predisposition, preadoptive risks and experiences, post-adoptive risks, protective factors, overall symptoms present in adopted children, and long-lasting effects related to adoption. Adopted individuals appear to be seeking therapy as adolescents or adults due to significant interpersonal difficulties, however a large number of these individuals are not receiving therapy that delves deep enough into their pre-adoption and adoption experiences. The purpose of this literature review was to address the gap in the current research regarding the clinical considerations for treating adopted individuals. In hopes of minimizing the gap, the information provided should

help educate clinicians on the complex etiology of the trauma associated with adoption, provide clinical considerations for treating this population, and therefore increase the efficacy of the treatment being provided. In order to address the current gaps in the research the following questions were answered: 1) What is adoption-related complex trauma? 2) What are the long-term effects of adoption-related complex trauma? And, 3) What are the treatment considerations for working with individuals who have experienced adoption-related complex trauma?

With the influence from complex post-traumatic stress disorder (CPTSD) and developmental trauma disorder (DTD), adoption-related complex trauma has been conceptualized as encompassing all of the traumatic events and psychological effects that adopted individuals endure beginning as early as prenatal development and lasting into their adulthood. The themes found in the research that challenge the stereotypical assumptions (prenatal trauma, neurobiology, pre-adoptive/post-natal risks, and post-adoptive risks) all have a major impact on the development of adoption-related complex trauma. Prenatal trauma is defined as any traumatic event that causes the womb to become an unsafe and threatening place instead of a place of comfort and growth. The effects of early trauma in the womb are implicitly held in the individual's brain and body, and therefore can be triggered later in life. Parental depressive symptoms have been found to impact the child's ability to create a secure attachment, in addition to altering the child's development and functioning of the HPA axis. These factors place the child at a higher risk for developing internalizing disorders, blunted abilities to meet interpersonal challenges, and the ability to take in relevant information. Low birth weight and prenatal substance abuse/drug exposure has also been connected with the development of attention problems, neurophysiological deficits, behavioral problems, and depression. Heredity

and the environment of the birth parents have a large impact on the child's cognitive development, more specifically their IQ.

Early adverse caregiving experiences have been associated with long-term alterations in an individual's ability to regulate behavior and the overall physiology of their brain. Conditions involving high levels of stress, maltreatment, and separation from caregivers have been associated with deficits within the development of the prefrontal cortex. The effect of traumatic exposure to threatening stimuli causes sensitization of the nervous system and may explain the increased patterns of externalizing behaviors in adopted children. Separations from caregivers have also been associated with dysregulated endocrine functioning, which has been connected to atypical brain development. Pre-adoptive or post-natal risks can include the duration of the exposure to the inadequate care from their birth parents, children's experience of the maltreatment, children's preexisting behavioral problems, and/or the experience of multiple caregiving disruptions (placement instability). In addition to those risks, the duration of the time the child spent in an institutional setting has been related to deficits in physical growth, sensory processing difficulties, internalizing, externalizing and attentional problems, delays in social skills, speech, language, and learning deficits, lower cognitive scores, and a general impairment in one's development. If the child is involved in a special needs adoption, there is a higher risk for having to receive mental health services, attachment disorders, and diminished school performance.

The age of placement into an adoptive home has been the most commonly studied pre-adoptive risk and there have been associations found between the age of placement and the child's overall psychosocial development. Adoption after the age of six months serves as a marker for increased behavioral problems and more pronounced developmental impairments in

emotional and social development. Adoption after 18 months of age has been associated with the development of more serious behavior and attention problems that persist into adolescence and adulthood.

In regard to post-adoptive risks, the quality of the parent-child relationships and the environment have the most impact on the adoptee's development and adjustment. Children with a greater history of adversity prior to being adopted may have more difficulty establishing positive relationships with their adoptive parents and therefore show poorer outcomes overall. Transracially and internationally adopted individuals may experience discrimination related to their adopted status and visible physical differences between their adoptive parents and themselves. Perceived discrimination may lead the adoptee to develop a weaker ethnic identity or experience identity confusion. There have been direct associations shown between perceived racial/ethnic discrimination and physiological stress responses including higher blood pressure, hypertension, cardiovascular diseases, and releases of cortisol. There have also been associations found with higher levels of depressive symptoms, anxiety, cynicism and hostility, and overall psychological distress.

In addition to those risk factors, there are challenges related to the level of openness one's adoptive family allows or engages in. As open adoptions have become the norm, the levels of openness within adoptive families has increased, however satisfaction with the contact with their birth parents rather than the existence or type of contact predicted fewer externalizing behaviors among adoptees. Adoptive parents themselves have reported not understanding the complexity of adoption and the numerous risk factors that come with adopting a child. Many felt ill-prepared for the issues that they had to face as adoptive parents and therefore did not effectively manage the distressing situations. Protective factors within the adoptive family context may serve as

moderators that buffer the ill effects of the aforementioned risk factors. Higher levels of cohesiveness within the adoptive family has shown to significantly lower the risk for depression in adoptees who have experienced prior maltreatment. Adoptive families that can respond to and cope effectively with family stressors and crises will help to protect their vulnerable adopted children, therefore promoting resilience and healthier adjustment in these youth. When looking at all of the factors that impact adopted individual's adjustment and functioning, it is clear that this population endures their own type of trauma related specifically to their adoption and the experiences prior to being adopted.

In addition to the more immediate negative impact of adoption reviewed above, there are significant negative long-term effects of being adopted which include attachment issues, the development of faulty internal working models, identity confusion, biopsychological effects, higher rates of substance abuse, loss and grief, and shame, rejection, and guilt. Bowlby's (1982) attachment theory suggests that children who have been subjected to separation, loss, and/or maltreatment may be particularly sensitive to issues concerning social interactions and find interpersonal conflicts overwhelming. For adoptees, the prenatal bond of attachment may be broken when separated from their biological mother, therefore making the creation of secure attachments and related self-esteem much more difficult for adopted individuals. Children who have been placed for adoption at older ages usually have already developed initial patterns of insecure attachment and therefore do not know how to respond to their adoptive parents' sensitive and involved care. Children with insecure attachment styles tend to resist any affection from parental figures through the use of controlling and defiant behaviors or by becoming completely withdrawn. The security of attachment during infancy predicts aspects of social development during childhood and adolescence, such as empathy, social competence, and

behavioral problems, and therefore predicts later issues related to initiating relationships, maintaining relationships, enduring familial conflict and possible disruptions with their adoptive families. Adoptees may engage in intimacy with trepidation, may avoid closeness and commitment with others, or may sabotage or restrain emotions in their relationships. These relationship difficulties can result in depression, substance abuse, marital troubles, or problems with their families and children.

Along with difficulties forming secure attachments, these individuals often form faulty internal working models that guide their behavior and expectations in all other relationships. These internal working models play a role in affect regulation, social competence, cognition, and understanding relationships and attachment. Therefore, if children have insecure attachments, they will view others as untrustworthy and potentially rejecting, in addition to viewing themselves as undeserving of reliable and sensitive care. If people view themselves as deserving of inconsistent, unreliable, and at times hostile attention and care they may develop overall negative identities.

Internationally and transracially adopted children have an added layer of complexity involved in their identity formation, which is influenced by the way their adoptive families handle discrimination and the level of openness in communication within the family about adoption-related issues. Internalizing behaviors may become apparent during adolescent development as they are attempting to construct their adoptive identity and integrate all of the information into their sense of self. Adjustment difficulties that have been associated with identity development appear to persist over time and may not be alleviated through maturity into adulthood alone. An adoptee's identity development can ultimately lead the individual to search for their biological parents/families, in hopes of being able to construct a cohesive self-identity.

Adoption not only affects adoptees' psychological adjustment and development, it also has a profound impact on their biological and neuropsychological abilities. Multiple studies have shown that exposure to long-term stress has the potential to negatively impact one's brain structures and brain functioning. Stress experienced during sensitive periods of development can negatively influence cognitive abilities, as well as long-term changes in these abilities later on in life. All of these factors increase the risk of adopted individuals' developing substance abuse issues, especially for adoptees who experienced early adversity prior to being adopted. Maltreatment elicits the same neurobiological stress systems that are affected in substance users, mainly the HPA axis. Placement instability can also create alterations in the HPA axis that can dysregulate the individual's stress response systems.

Attachment, internal working models, and biological changes vary between individuals, however there are some core issues or themes that present in the majority of adopted individuals. Loss and grief often begin extremely early for these individuals when they are separated from their biological parents, or the biological mother failed to psychologically attach to the fetus while in utero. However, there are other numerous conditions that can impact one's experience of loss, such as the loss of the entire birth family through adoption, the loss of ethnic and cultural connections, and the loss of stability in relationships. In addition to those factors, adopted individuals are deprived of their health information, social history, cultural history, and status as a biological child. Over the course of their childhood and adolescence, these individuals become aware of the losses they have endured and at times struggle to navigate the idea of being abandoned and losing all of those aforementioned domains. As the child or adolescent processes the loss, grief may become apparent and the adoptee's school or academic performance may decrease, and externalizing behaviors may increase.

With these losses comes the notions of shame and rejection: the adopted individual may feel shameful for being adopted, guilty for not being "good enough" to keep, and ultimately feel rejected from their biological parents and families. These feelings can then manifest into anxiety, depression, and further externalization of behaviors. Shame related to adoption is almost never acknowledged by other members of the adoption triad, however it is of significance to process with the adopted child. Overall, the psychoanalytic theory suggests that adoption has a potentially disruptive effect on one's development, specifically in domains related to the child's sense of safety and security, their identity, the appropriate expression of negative emotions, and the resolution of age-appropriate developmental tasks. In addition to psychoanalytic theory, psychodynamic theory, social role theory, family systems theory, attachment theory, and stress and coping theory, help to conceptualize adopted clients from a trauma-focused perspective.

Individuals may be seeking therapeutic services for numerous reasons, including but not limited to interpersonal relationship difficulties, grief and loss, isolation, and intimacy issues. However, many clinicians have failed to effectively help these families and individuals when they seek treatment. Some families have reported that they had to educate their clinician on adoption-related issues and concerns and felt as though therapy had further damaged their families. Despite bare-minimum adoption training in most graduate psychology programs, there are adoption-competent therapists who are mental health professionals who have been specifically trained in treating adoption-related issues. These clinicians have been trained in understanding adoption in a general sense, and then on how they can best attend to the needs of the specific adopted individuals they are treating. There are also specific assessment and diagnostic considerations that need to be acknowledged for this population, including exploring all of the systems involved with the family or the individual client (the legal system, the mental

health system, the special education system, etc..) and becoming aware of the limitations of the current diagnostic system. Although there is not a specific treatment model used to treat adoption-related complex trauma, interventions from numerous models can be used in conjunction in order to address the widespan of concerns. The overall goal is for clinicians, adoption-competent or not, to provide effective treatment that delves into the true etiology of adopted individuals' struggles, which is most likely tied to their early adverse experiences and the adoption process they have endured.

Limitations and Areas for Future Research

The literature and research is significantly limited and at times outdated for this population, and this was naturally the first limitation of this literature review. There are no studies that focus on premature babies and adoption. It would be of significance to know if premature babies who spent less time in their biological mother's womb exhibited a different attachment style prior to, and after, adoption. Also, it would be interesting to know if the time the baby spends in the NICU away from their biological mother has an effect on their attachment to their biological mother and adoptive family. Further, would premature babies then be classified as special needs adoptions because of their premature births, low birth weights, and the negative consequences related to those factors? How many adopted children are being diagnosed with autism spectrum disorder (ASD) for exhibiting symptoms similar to the sensory issues and social communication deficits found in ASD that may result from their low birth weight, NICU experience, and separation from their birth mother?

Revisiting the "Cinderella effect" mentioned earlier, more research is needed to understand the psychological impact the Cinderella effect has on this specific adoptive families, and how these families compare to step-child/step-parent relationships. The Cinderella effect

may result in difficult family dynamics, conflicts, and a lack of family cohesiveness, and therefore pose barriers to meeting developmental challenges.

In regard to potential adoptive families, it would be of importance to explore the level of agreement between the two adoptive parents on their readiness and willingness to adopt, and how this level of agreement impacts their adoptive children's adjustment and development post-adoption.

Adoption research and theory needs to address the wide variability within the adoption experience and its unique developmental challenges for the adoptee and the adoptive family. The research needs to address the roles of race, culture, and socioeconomic status in adoption experience and how these factors impact the adoptee and the adoptive family's development. Existing research has mainly been conducted within the western culture and involves samples that are lacking in diversity, which can skew the results to either exaggerate or minimize a serious psychological adjustment concern related to transracial and international adoptions.

Clinical Implications and Conclusion

The research and treatment considerations in this literature review have been presented with the hope of helping clinicians and mental health professionals treat adopted individuals and adoptive families with more efficacy and care. The material presented in this review does not cover the true complexity of the adoption process and therefore more specialized training is required to be considered adoption-competent. In the future, there will hopefully be more time spent on adoption-related issues in graduate training programs, and more clinicians will become certified as adoption-competent. There is a large population of individuals, varying in age from very young children to older adults, suffering from significantly distressing symptoms related to

the abandonment process involved in adoption and seeking mental health professionals who are willing to delve deep enough and process through their trauma, the primal wound.

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