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Supporting families throughout the international special needs adoption process

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ABSTRACT

Due to changing trends in international adoption, a greater number of placements are now special needs. While most special needs adoptions are successful, they do present a higher risk for placement instability. Thus, adoptive parents and children are faced with an increasing need for support services. This article explores literature related to support throughout the international special needs adoption process including medical, information/education, social support and direct intervention both pre- and post-adoption. While many support strategies, both formal and informal, are utilized by families and adoption professionals, and some are promoted in policy related literature, few have been validated through empirical evidence. Findings reveal a need for further research around effective pre-adoption training programs for parents, preparation tools for children, and larger scale studies to evaluate post-placement services for each sub-group of international special needs adoptees.

1. Introduction

After decades of steady rises, the number of international adoptions to the United States reached a peak of 23,000 children in 2004 (Selman, 2012), but this dropped to 7100 international adoptions between October 2013 and September 2014 (US Department of State, 2013). There are many possible explanations for this dramatic decline. For example, in 2000, the United States passed the International Adoption Act (IAA) to implement The Hague Convention which tightened regulations and increased safeguards in an effort to protect children from abuses (IAA, 2000). Also, the US placed a moratorium on adoptions from some countries, such as Guatemala, because of concern over excessive corruption in the system (Bartholet, 2010; McCreery Bunkers, Groza, & Lauer, 2009; Yemm, 2010). In addition, some countries expanded their domestic adoption programs (Groza & Bunkers, 2014), making less children available for adoption in the US.

The decline in international adoptions is associated with certain collateral trends (Pinderhughes, Matthews, Deoudes, & Pertman, 2013). First, children are spending longer in institutionalized care, which leads to increased rates of developmental delays and behavioral problems (Julian, 2013). In fact, well over half of the approximately 7100 children adopted internationally in 2013 were over the age of three years (US Department of State, 2013). Second, some countries that still place children internationally are emphasizing or exclusively allowing special needs adoptions.

1.1. Definition of special needs

In the context of adoption, the label "special needs" refers to children who have characteristics that make them more difficult to place. Typically this includes older children and sibling groups, as well as children with a diagnosed physical, medical, or mental condition (Rosenthal, 1993). For "older children," the age at which a child enters the category of "special needs" varies greatly between countries; however, it is typically over the age of 3–4 years (Berry, 1990; Brodzinsky & Pinderhughes, 2002). "Sibling groups" refers to two or more siblings who are to be placed simultaneously in the same home.

Countries of origin determine the list of physical, medical, or mental "diagnoses" that qualify a child for special needs adoption. While there is great variability between countries, these diagnoses are typically classified as minor vs. moderate-to-major. A minor condition is potentially correctable and does not put the child at risk for long-term functional impairments, such as anemia, mild burns or scars, strabismus, a functional heart murmur, or rickets. Moderate-to-major conditions are those that require frequent and ongoing treatment, life-long management, or that impede a child from independent functioning and require the full-time care of an adult. This includes cerebral palsy, spina bifida, HIV, dwarfism, cleft palate, and Down syndrome, among others. It is important to acknowledge that common pre-adoption experiences—including institutionalization, poverty, exposure to disease, possible abuse and neglect—place essentially all international adopted children at risk for at least short-term developmental delays.

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1.2. Complications

An additional risk is inaccurate or missed diagnoses prior to adoption. The Donaldson Adoption Institute (2013) surveyed over 1000 parents, 47% of whom indicated they had adopted a child with special needs. Of those, only half the children were classified as special needs in the country of origin; the other 50% were diagnosed as having a physical, medical, or mental health condition following adoption. Further, of those classified as special needs in their birth country, 42% were later diagnosed with an additional condition following their adoption. In another study of children adopted from China, 18% of cases missed significant medical diagnoses including orthopedic issues, hearing or vision impairments, and congenital heart issues (Miller & Hendrie, 2000). Thus, even those children who initially do not fall under the umbrella of special needs may demonstrate developmental or health concerns post-adoption.

Many countries have given special needs adoptions "top priority" and loosened policies for adopting these children. For example, parental age requirements may be waived and cases fast tracked. In fact, countries often have a list of "waiting children," that is special needs children who are already cleared for adoption, so the adoption process takes considerably less time for them than for healthy infants whose adoption status has not yet been established. This situation is the reverse of the typical adoption process—the child is available and adoption agencies are seeking adoptive parents versus the traditional situation in which prospective adoptive parents await a referral of a child.

2. Outcomes of special needs adoption

Outcomes for this population are typically measured in three ways: 1) child outcomes, 2) placement failure, and 3) parental satisfaction and family functioning. Most of this literature focuses on domestic special needs adoptions, especially of older children and those with behavioral or psychosocial challenges. However, because international special needs adoptions increasingly involve older children, making the adoption environment more similar to domestic adoption, it is probable that international special needs adoption outcomes are similar to those of special needs domestic adoptions as well.

2.1. Older children

There is clear evidence that the more time children with or without disabilities spend in institutions, the greater the likelihood they will have long-term deficiencies and problems. Children reared longer than the first 6 months of life in severely deficient institutional settings (Kreppner et al., 2007) or over 2 years in more supportive orphanages (Merz & McCall, 2010; Merz, McCall, & Groza, 2013) have increased likelihood of a variety of longer-term developmental disturbances. This is considerably shorter than the usual 3–4 years taken to declare a child "special needs." In addition, the International Adoption Project (2008) found that parents whose children had spent more than one year in an institution were less likely to recommend international adoption than those parents whose children were institutionalized for less than one year. Nevertheless, children typically display substantial catch-up growth after adoption in most developmental domains including attachment, and 70%–90% of parents report mutually satisfactory parent–child relationships despite pre-adoption adversity (Groze & Ileana, 1996; Hodges & Tizard, 1989; Rushton, Treseder, & Quinton, 1995), although it may take longer to form these bonds and attachments may not be as secure as children placed at younger ages (Julian, 2013).

2.2. Siblings

A review by Hegar (2005) of sibling groups of children placed in foster care and domestic and international adoptive homes suggests that joint placements appear to be quite stable, that is, no increase in the rates of disruption or adverse child outcomes. For example, one study of international adoptions in The Netherlands found there was no difference in disruption rates 10 years after adoption between those siblings placed together versus singly (Boer, Versluis-den Bieman, & Verhulst, 1994). Note that when siblings are placed jointly, one child will be older and presumably at greater risk; nevertheless, this study does not report an increase in problem behaviors.

However, sibling placements may be less successful if biological children are present in the adoptive family (Rosenthal, 1993). The more children already in the home, the higher the rate of problem behaviors in the adopted children (Boer et al., 1994). However, problems seem more likely if all the children are close in age (Hegar, 2005), whereas placements were more successful when biological children were at least three years older than the oldest adopted child (Barth, Berry, Yoshikami, Goodfield, & Carson, 1988).

2.3. Diagnosis

In the past, children with known developmental disabilities were not considered eligible for adoption (Bohman, 1970), but more recently there has been a significant increase in efforts to place these children in "forever families" both domestically and internationally. Outcomes for children adopted with a physical, medical, or mental condition vary depending on the nature of the condition (Brodzinsky & Pinderhughes, 2002). If the condition is known, predictable or stable, and has a well-developed natural history and developmental pathway, adoptions are highly successful. Conversely, if the condition is unknown at adoption, unpredictable, varies in its course, and inconsistent or difficult to understand and predict, outcomes are less positive. Thus, predictable conditions, such as physical or cognitive disabilities, have a much lower rate of disruption than unpredictable conditions such as emotional or behavioral problems (Coyne & Brown, 1985; Partridge, Hornby, & McDonald, 1986; Rosenthal, Schmidt, & Conner, 1988). Indeed, behavior problems are the most problematic for families adopting special needs children (Nalavany, Glidden, & Ryan, 2009; Rosenthal, 1993).

These contrasting outcomes may be due in part to whether the adoptive parent is aware of the condition before the adoption. Rosenthal and Groze (1990) found greater post-placement parental satisfaction for children with major disabilities than those with milder developmental and learning issues, perhaps because parents adopting children with major disabilities were better prepared for handling these conditions prior to adoption. In fact, the majority of parents who adopt children with developmental disabilities that are diagnosed before placement are highly satisfied with the adoption (Glidden, 1991; Glidden & Pursley, 1989; Rosenthal & Groze, 1992). Even 11 years after the adoption of children with known developmental disabilities, adoptive mothers showed marital satisfaction and overall positive adjustment to the adoption (Glidden, 2000).

2.4. Placement stability

While the majority of special needs placements are successful as measured by placement stability, family satisfaction, and caseworker reports (Groze & Ileana, 1996; Pinderhughes, 1998), generally these children do present a greater risk for long-term problems and placement failure (Berry, Barth, & Needell, 1996; Brooks, Allen, & Barth, 2002). No one factor alone predicts failure, but rather an accumulation of risk factors does (Palacios, Sanchez-Sandoval, & Leon, 2006). These factors are typically classified into child characteristics, family characteristics, and support challenges.

Child characteristics include pre-adoption abuse or neglect (Rosenthal, 1993), emotional/behavioral problems (Leung & Erich, 2002), and older age at adoption (Barth et al., 1988; Berry, 1990; Palacios et al., 2006). Further, the risk of disruption rises with the age of the child; children under 12 years old have a 7–10% chance of disruption while those older than 12 years have a 13–47% chance (Barth et al.,