AN INVESTIGATION OF COUNSELOR TRAINEES' ADOPTION AND TRANSRACIAL ADOPTION PERCEPTIONS, ATTITUDES, KNOWLEDGE, AND SKILLS

by

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The purpose of this study was to examine counselor trainees' perceptions of adopted clients and explore how trainee perceptions may vary according to counselor trainees' adoption-related knowledge, attitudes, and clinical skills. This study extends the limited body of research examining mental health professionals' potential bias related to adopted clients in their approach to treatment and case conceptualization. Counselor trainees ($N = 430$) read one of six client case study vignettes that were identical except for variations on client adoption status (adopted, transracially adopted, nonadopted) and client sex (male or female), resulting in six different stimuli conditions. Group differences were examined for two independent variables (client adoption status and client sex) and dependent variables measuring counselor trainees'

perceptions of clients in four areas: (a) seriousness of treatment plan and prognosis, (b) assignment of favorable or unfavorable adjectives to clients, (c) counselor trainees' assessment of client level of functioning, and (d) diagnosis behavior. Preexisting counselor adoption knowledge, attitudes, and skills were assessed by the Knowledge, Attitudes, and Skills of Adoption Survey (KASAS) that was created and validated specifically for this study. Results of exploratory factor analyses on the KASAS revealed a cogent, three-factor structure for the measure with high factor internal consistency. The main study research questions were then addressed within the context of several univariate general linear models. Findings demonstrated that counselor trainees perceive adopted clients generally more negatively than nonadopted clients. Participants rated same-race adopted clients as lower functioning than nonadopted clients, reported having greater overall concern for adopted clients (both same-race and transracially adopted) in comparison with nonadopted clients, and rated adopted clients' problems as more severe than those of nonadopted clients despite being presented with otherwise identical presenting issues. Descriptive data revealed that 64% of trainees reported lack of preparation to deal with or no knowledge about adoption, and 89% reported wanting additional clinical training about adoption. Implications for future research and practice are presented.

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For Janet

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CHAPTER I

INTRODUCTION

Despite the prevalence of adoption in the United States and the likelihood that adoption-related themes may be a focal point in therapy, there is evidence that mental health counselors may be biased against adopted clients and might approach treatment planning and case conceptualization differently for adopted clients than for nonadopted clients (Kojis, 1990). Recent exploratory research has concluded that counselors are not adequately trained to effectively treat those directly affected by adoption and may be negatively biased against adopted clients (Kojis, 1990; Porch, 2007; Sass & Henderson, 2000, 2007). Those most affected by adoption—adoptees, birthparents and adoptive parents—are labeled "the adoption triad." Multiple researchers and clinicians have also documented that issues and clinical concerns related to adoption are virtually ignored or discounted in counselor training programs, and that there is a lack of knowledge of adoption issues among practitioners as well (Porch, 2007; Sass & Henderson, 2000, 2007). Understanding key issues in adoption and the ways in which these issues may impact clients is relevant for both individual and family counselors (Grotevant, 2003; Porch, 2007). All types of clinical intervention work (education, problem prevention, individual and family counseling, etc.) could benefit from enhanced research related to understanding counselors' and trainees' perceptions of adopted clients, and to

understanding counselors' adoption attitudes, level of knowledge, and clinical skills, and in counselor case conceptualization and treatment planning when adoption is a component of a clients' experience.

The purpose of this dissertation study is to extend the limited existing body of research on adoption. In this study, the relationships between counselor trainees' adoption attitudes, knowledge and adoption-related clinical skills, as well as counselor trainees' perceptions of adopted clients, were explored in order to increase the potential of improving counselor training and counselors' ability to effectively assess and treat members of the adoption triad. While the extant literature implies that the attitudes and behaviors of counselors may not be favorable towards adopted clients, previous research has not addressed what types of counselor variables are related to perception of clients and to subsequent clinical work, such as treatment planning. In addition, no studies have simultaneously measured counselor attitudes, knowledge and skills related to adoption, nor have they examined the relationship between these constructs and counselor perception of clients based on adoption status (Porch, 2007; Sass & Henderson, 2000, 2007).

Adoption and Mental Health Project Rationale

There are approximately one million (Stolley, 1993) to five million (Hollinger, 1998) adoptees in the United States. The 2000 United States Census was the first census in history to collect data on adopted children, and it is reported there are

approximately 2.1 million adopted children in the U.S., with 1.6 million of these being less than 18 years old at the time of data collection (U.S. Census Bureau, 2003). This indicates that at least 2.5% of all children in the U.S. are adopted. In their 1997 national survey, the Evan B. Donaldson Adoption Institute reported that 58% of Americans have had some personal experience with adoption, defined as either being a member of the adoption triad—the adoptee, biological parent, or adoptive parent—or having a close family member or friend who is a member of this triad (Evan B. Donaldson Institute, 1997).

Adopted Clients in Therapy

It is estimated that child adoptees consist of approximately 5% of all outpatient mental health referrals and 10-15% of inpatient psychiatric or residential care (Brodzinksy, 1993). Earlier adoption researchers conducted several studies whose findings indicate that adoptees are overrepresented in therapy and mental health settings (Warren, 1992; Wierzbicki, 1993). For example, in their 1990 study, Dickson, Heffron, and Parker found that 11.7% patients in an inpatient psychiatric hospital setting were adoptees. They also concluded that when compared to nonadoptees, adoptees were at higher risk (13.6% versus 7.2%) of returning to psychiatric hospitalization after discharge. In a comprehensive meta-analysis, Juffer and Van IJzendoorn (2005) found that adoptees were significantly overrepresented in mental health services, with a large effect size of .72, and were referred to mental health services at significantly higher

rates than nonadoptees. Borders, Penny, and Portnoy (2000) report that adopted adults seek counseling services significantly more often (66%) than nonadopted adult friends (44%).

However, researchers emphasize that caution must be used when interpreting these data (Brodzinsky, 1993). They suggest the underlying reason for overrepresentation is due to higher referral rates of adoptees to services, not necessarily because they are at higher risk, but because of existing bias and stigma on the part of parents or mental health professionals (Brodzinsky, 1993; Warren, 1992). Others suggest that adoptive parents might be more likely to use mental health services and seek help (Miller, Fan, Christensen, Grotevant, & van Dulmen, 2000) because they are already accustomed to working with agencies and social or mental health service settings (Brodzinsky, 1993; National Council for Adoption, 1989). They also might seek help more quickly because adoptive parents can experience a heightened level of concern or vigilance that any minor problems could be adoption-related (Brodzinsky, 1993).

Several researchers hypothesize that the role of stigmatization on adoption-related stress and adjustment, and thus resulting referrals, is largely underestimated (Brodzinsky, 1993; Wegar, 1995). Wegar (1995) posits that the overrepresentation of adoptees in mental health settings is directly related to the stigma underlying the tendency to exaggerate psychopathology in adoptive families. While most Americans report positive attitudes toward adoption as a practice, they may lack accurate

information and be biased against it (Freundlich, 2002; Zamostny, Wiley, O'Brien, Lee, & Baden, 2003). For example, in their national study with 1,554 participants, the Evan B. Donaldson Institute (1997) reported that half (50%) of the study's participants believed adoption is inferior to having a biological child, and 25% felt it is more difficult to love a nonbiological child. Without biological ties, adoptive parents can be seen as inferior or not "real" parents (Porch, 2007). Some claim that popular media promote negative stereotypes about birthparents and adoptive families (Evan B. Donaldson Institute, 1997; Wegar, 2000). A 2009 study of 309 broadcast news stories about adoption found that the majority of news stories focused only on negative events associated with adoption (i.e., fraud, crime, legal disputes, etc.) and tended to depict adoptees as "defective or unhealthy" (Kline, Chatterjee, & Karel, 2009, p. 56).

Leon (2002) posits that in addition to causing emotional challenges, stigmatization actually undermines existing strengths and erroneously minimizes adoptive families' ability to adapt and cope. However, despite a higher use of therapy and postadoption services among members of the adoption triad, researchers state that counselors may not adequately understand adoption-related issues in general, and in particular, the impact of stigma on their lives (Sass & Henderson, 2007; Wegar, 2000).

In order for counselors to be able to provide effective therapeutic interventions and support to adoptive families as they experience bias and stigma, O'Brien and Zamostny (2003) advocate for additional counselor training and preparedness. An essential precondition for any such future training is clear: An understanding of the

attitudes, knowledge and accurate client perceptions would be the important components of any such effort. To determine attitudes, levels of knowledge, and relationship to client perception represents a key and as yet incompletely understood aspect of the field (Sass & Henderson, 2000; Wegar, 2000).

Adoptive parents consistently request that counseling, both individual and family therapy, should be among the services provided by adoption agencies as part of their postadoption services (Barth, 2002; Barth & Miller, 2000). For those families that seek therapy or mental health services, the data that exist on level of satisfaction with those services are not promising. Parents are generally not satisfied with the postadoption services they receive (Barth & Miller, 2000; Smith & Howard, 1999). Smith and Howard report that many families experience dissatisfaction with postadoption counseling, noting in particular the counselor's lack of knowledge regarding adoption-related issues. Several researchers have documented cases where adoptive families actually had to teach their therapists about basic issues related to adoption (Sass & Henderson, 2000; Smith & Howard, 1999). A repeated theme observed at adoption support groups is families' level of disappointment with therapists who either possess little knowledge about adoption issues or downplay the importance of adoption in their lives (Sass & Henderson, 2007). However, researchers have not yet examined how counselor attitudes, which may include stigma and bias about adoption, can potentially impact their perception of clients and decisions regarding treatment planning and prognosis.

Professionals' Attitudes Toward Adoption

There is very little research on professionals' attitudes toward adoption. A review of the PsychINFO literature from the dates of 1985 to 2009 revealed 3,635 studies on adoption, 10 of which were related to keywords "adoption" and "psychologist." A total of eight were related to the issues of adoption and counseling, and only one of these was related to psychologist or psychotherapist attitudes towards adoption (Kojis, 1990; Sass & Henderson, 2000). None of these research articles, books or chapters explored the potential relationship between counselor attitudes, knowledge or skills on perceptions of adopted clients.

In an unpublished dissertation study, Kojis (1990) assessed psychologists' attitudes towards adolescent adoptees to see if their attitudes influenced diagnoses, choice of treatment, or prognoses. The first part of the study asked 148 psychologists to rate 13 traits of a hypothetical adolescent. When the birth status was left unspecified, psychologists consistently rated adolescent girls as having more positive traits than adopted adolescents of either sex. The theoretical orientation of the psychologists did not have an effect on their perceptions of positive or negative traits. In the second part of the study, 179 participants were presented with a vignette of a hypothetical client and asked to diagnose and indicate a treatment plan and prognosis. Results indicated that psychologists gave adopted adolescents a more serious diagnosis and a more intense treatment plan as compared to nonadopted clients, regardless of symptoms. Kojis

(1990) concluded that psychologists view adoptees differently, and may be treating their adoptive clients differently than nonadopted clients. As Kojis acknowledges, a primary limitation to her study was related to instrument construction and measurement. All measures used were questionnaires designed specifically for her study, and while the trait questionnaire designed to assess attitudes was piloted, it was not validated prior to use. Also, by only assessing psychologists, other mental health professionals and therapists from other fields were excluded from the sample population. This study also ignored different types of adoption, such as transracial adoption as a factor or variable of interest. In her conclusion and recommendations for future research, Kojis (1990) suggests that clinicians' attitudes towards transracial adoption be examined further. Finally, no data were collected regarding participants' level of knowledge or skills related to adoption issues; therefore, it was impossible to examine the relationship between attitude, knowledge and skills on treatment planning and prognosis expectations of adopted clients.

In a nonempirical article based on their clinical experience, Sass and Henderson (2007) discuss how some adoptive families have reported feeling their therapists had harmful or negative attitudes towards adoption. When working with adopted clients, families report that therapists have conveyed the attitude that adoptees should "be grateful" they were adopted (p. 315). They state that this attitude discounts feelings of loss in adopted clients, which can be nontherapeutic and even harmful. Sass and Henderson (2007) also state that adopted parents have been told by their therapists that

any problems with their adopted child can be resolved by loving or "pretending" the adopted child is their biological child. The authors emphasize that these attitudes blame client problems on adoption, ignore more complex issues, and are not therapeutic.

Perceptions About Adopted Clients

There is also very little research on professionals' perceptions of adopted clients. Only three empirical studies exist on this topic. In 1997, McDaniel and Jennings conducted an exploratory, qualitative study of 32 family therapists to assess how they considered adoption issues and conceptualized treatment plans when working with families with an adolescent who was adopted at 3 months of age. The researchers gave participants a case vignette of an adoptive family with an adopted adolescent exhibiting a range of "difficult" behaviors, and then asked participants seven open-ended questions to assess their case conceptualization and thoughts on treatment plans. Sample questions included "Tell me what you think are the important issues in this family," "Is there one issue that you consider to be more important than another?," "Tell me about your treatment approach for this family," and "Discuss your intervention."

McDaniel and Jennings (1997) acknowledge that although adoption status should not be the only key issue considered to be important, recognition of a family's adoption status "should be one of the first things noted by the therapist in their initial assessment" (p. 60). These researchers reported that 15.6% of therapists explicitly named adoption as an issue and specified it in their case conceptualization and treatment

planning. The authors interpreted this result as a "positive" indication that several therapists (5 of 32) were sensitive to the differences and unique issues facing adoptive families, and they could discuss specific ways they would address adoption-related issues in treatment. McDaniel and Jennings also reported that 40.6% of therapists did mention adoption status in their postvignette interview, but then did not include it as a relevant issue in treatment planning. Interestingly, many participants either did not mention adoption at all or discounted it as an issue. McDaniel and Jennings reported that 34.4% of respondents never mentioned adoption in their case conceptualization or treatment plans, 9.4% mentioned adoption but ruled it out as an issue, and 25% mentioned adoption once with no additional reference to it. Essentially, 43.7% of therapists did not consider adoption to be an issue at all in their case conceptualization, and 84.3% did not mentioned adoption as a consideration within their treatment planning.

Several limitations exist within this study, including a small sample size and lack of experimental conditions and control groups. Demographic information was collected on the participants' degree specialization and areas of training, but the only adoption-related demographic information revealed that three participants (9.4%) had an adopted child and none were themselves adopted. This study did not gather data on participants' attitudes, level of knowledge or self-reported skills regarding adoption and working with clients who were adopted. Also, due to the qualitative design of this study, no quantitative data were collected on how therapists perceive adoptive families

in terms of the severity of their treatment plans or level of functioning of the adopted client.

In an unpublished 1997 dissertation, Friedman-Kessler (as cited in Evan B. Donaldson Institute, n.d.-b) investigated 121 teachers' attitudes toward adopted children. While the researcher found that the teachers' judgment was most strongly affected by the severity of the wrongdoing in a hypothetical vignette, adoption status did influence teachers' perception of the child's attractiveness, aggressiveness, callousness and decisions about the intensity of the punishment. In the same study, 19 graduate students in education were asked to rate their first impressions of adopted children and all were overwhelmingly negative (Friedman-Kessler, 1997, as cited in Evan B. Donaldson, n.d.-b).

Finally, in an earlier unpublished master's thesis, Nickel (1995, as cited in Evan B. Donaldson Institute, n.d.-b) investigated the attitudes of 104 students in a Masters of Social Work graduate program on domestic transracial adoption. Results indicated that first-year students were more likely than advanced students to perceive transracial adoption as harmful for the child. The strongest finding among all students, however, was their reported belief that their graduate program did not prepare them adequately to deal with the issues inherent to transracial adoption.

Adoption Training and Skills Among Counselors

The extant literature reports that the mental health community in general (Sass & Henderson, 2000, 2007) and the field of psychology in particular (Post, 2000) has been criticized for neglecting adoption issues and members of the adoptive triad. Multiple adoption experts and researchers state that clinicians do not have adequate knowledge and skills to understand the complexities and unique issues that adoption triad members experience (Barth & Miller, 2000; Grotevant, 2003; Pavao, 1998; Zamostny, Wiley, et al., 2003).

In a 2000 study, Sass and Henderson investigated psychologists' level of training and knowledge about adoption issues. Two hundred and ten psychologists responded to the self-report survey. Eighty-nine percent reported having no undergraduate training and 65% reported having no graduate training that addressed adoption issues. Fifty-one percent rated their level of preparedness for dealing with adoption issues as "somewhat prepared," 23% rated themselves "not very prepared," and 4% reported having "no knowledge about adoption issues." Only 22% of respondents felt "well prepared" or "very well prepared." Ninety percent reported needing more training and education about adoption, with 81% expressing interest in taking a continuing education course on the topic. One half of participants indicated they do not inquire about their clients' adoption status. The authors conclude that psychologists need more education and training on adoption issues. However, this study included no information on what kind of information needs to be included in

further education and training about adoption. It also did not address any specific variables that might correlate participants' level of training and knowledge about adoption issues with adoption-related attitudes, and how these factors influence their perceptions of clients in treatment.

Adoption experts and researchers emphasize that in order to provide ethical and competent treatment, clinicians should understand the complexities and unique issues that adoption triad members experience (Barth & Miller, 2000; Pavao, 1998; Zamostny, Wiley, et al., 2003). According to Pavao (2007), a lack of training in this area can cause harm to adoptees and families. Many authors have identified the need for more training on adoption issues (Janus, 1997; McDaniel & Jennings, 1997; Porch, 2007; Post, 2000; Sass & Henderson, 2000, 2007; Zamostny, O'Brien, Baden, & Wiley, 2003). Janus (1997), for example, states that adoption counseling should be considered a professional specialty area for counselors. Others state that counselor competency in adoption-related clinical issues qualifies as a multicultural counseling competency (Lee, 2003; Porch, 2007).

Clinical Issues

As discussed earlier (and also in greater depth in Appendix A), it has been a challenge for both researchers and practitioners to avoid dichotomizing their perspectives and approaches into either overemphasizing and perhaps pathologizing adoption, or ignoring or deemphasizing its importance. In clinical and therapeutic

settings, a fundamental problem can arise when existing bias or lack of knowledge distracts from relevant clinical issues that are commonly, and perhaps uniquely, experienced by adoptees.

For example, according to Smith and Howard (1999), members of the adoption triad confront challenges and unique experiences that have the potential to complicate psychological adjustment, interpersonal relationships and developmental tasks. Silverstein and Kaplan (1998) identify seven "core issues" related to adoption: loss, rejection, guilt and shame, grief, identity, intimacy, and mastery/control. They also state, since adoption is considered to be a lifelong process, that adoptees revisit these issues as core tasks to be resolved at different developmental stages throughout their lives. Young children, for example, might feel a sense of loss, confusion or trauma upon the realization they are not biologically related to or born from their adoptive mother (Lifton, 2007). As cognitive development progresses, older children begin to consider the meaning of adoption, including thinking about the implications of having been relinquished by a birthparent. Although identity formation is a key developmental task for all adolescents, it can be particularly challenging for adolescent adoptees (Brodzinsky, Smith, & Brodzinsky, 1998; Grotevant, 1997) and even more complex for transracial adoptees (Baden, 2002). Janus (1997) reports that adolescent adoptees often seek counseling for issues related to identity development. Depending on an adoptee's age at the time of adoption, attachment issues in adolescence and later in adulthood can become more salient. There could be additional issues related to abuse, trauma,

posttraumatic stress, and attachment disorders (Pavao, 2007). Clinical issues for adults might be related to their decision to search for birthparents, ongoing identity development, or issues related to intimacy and interpersonal relationships (Janus, 1997). Adopted adults may revisit exploring their identity as "adoptees" with each major life transition such as marriage, pregnancy, adoption of their own child, death of a parent, and career transitions (Janus, 1997). To prevent against relevant issues like these being overpathologized or ignored in clinical settings, multiple adoption practitioners and researchers claim that additional training on adoption issues is needed (Janus, 1997; McDaniel & Jennings, 1997; Porch, 2007; Post, 2000; Sass & Henderson, 2000; Sass & Henderson, 2007; Zamostny, O'Brien, et al., 2003).

Training Programs

In a 2007 review of clinical and nonclinical literature, Porch discusses several types of training programs focused on increasing adoption-related knowledge and competence among professionals. According to Porch, postadoption support services are offered through public and private adoption agencies in most states, but little is known about the type, content, or efficacy of training provided to the staff members working with adoptive families. Porch highlights the Center for Adoption Support and Education (CASE) in Maryland, the Center for Family Connections in Massachusetts, and Casey Family Services in several states throughout the northeastern United States for providing postadoption services and training to both adoptive families and

professionals interested in learning more about adoption issues. In response to the identified need for increased knowledge among counselor and mental health professionals, and finding a notable lack of training at the graduate level, several schools have created adoption training programs.

According to Porch (2007), three graduate programs offer postgraduate adoption certificates, including Rutgers University, Antioch University in Seattle, and Portland State University. Porch (2007) also notes that several universities offer at least one course focused on increasing adoption-related knowledge and skills at the graduate level, including Montclair State University, Case Western Reserve University, and Galladet University. Porch (2007) states these programs could serve as potential models for additional training programs, and could inform future curriculum development. While it can be safely assumed that the purpose of each of these programs is to increase adoption-related competency among professionals, none have been examined empirically for their influence on counselor trainee knowledge, attitudes and skills related to adoption and perceptions of adopted clients.

The importance of stigmatization and bias towards adoption has been identified as a potential negative influence on adoptee and adoptive families' social and emotional adjustment (Janus, 1997; Lee, 2003; Pavao, 2007; Wegar, 1995; see also Appendix A). Negative attitudes and more serious treatment plans among psychologists towards adopted clients have also been documented (Kojis, 1990). While the extant literature implies that the attitudes and behaviors of counselors may not be favorable towards

adopted clients, previous research has not addressed what types of counselor variables are related to perception of clients and treatment planning. In addition, no studies have simultaneously measured counselor attitudes, knowledge and skills related to adoption, nor have they examined the relationship between these constructs and counselor perception of clients based on adoption status (Porch, 2007; Sass & Henderson, 2000, 2007).

Purpose of the Study

The purpose of this study was to examine counselor trainee perceptions of clients based on adoption status. In this study I (a) examined how counselors perceive adopted clients and determine subsequent treatment plans based on adoption status; and (b) explored these perceptions in relationship to their adoption knowledge, attitudes and skills. This study extends the body of research on adoption by clarifying the relationships and group differences between client variables (adoption status and sex), the counselor trainees' adoption knowledge, attitudes and skills. Results can inform counselor training related to treating clients in the adoption triad. I utilized an experimental, single-administration, posttest-only control group design. Participants, a sample of counselor trainees, were presented with one of six randomly assigned case study vignettes of a hypothetical client. Each vignette presented identical presenting problems and content, varying only in the adoption status (adopted, transracially adopted, or not adopted) and sex (male or female) of the hypothetical client.

Research Questions

The following research questions were explored:

1. Will counselor trainees perceive adopted clients (including both same-race and transracially adopted clients) in a more negative way compared with nonadopted clients, as measured by the outcome variables (concern and severity of client problems, seriousness of treatment plan and prognosis, favorable versus unfavorable adjectives, global assessment of functioning, and relevance of diagnoses).

2. Will counselor trainees perceive transracially adopted clients in a more negative way compared with same-race adopted clients, as measured by the outcome variables?

3. Will counselor trainees perceive male clients in a more negative way compared with female clients, as measured by the outcome variables?

4. Will counselor trainees perceive adopted male clients (including both same-race and transracially adopted male clients) in a more negative way compared with adopted female clients, as measured by the outcome variables?

5. Will the relationships identified in Questions 1-4 vary based on counselor trainees' adoption-related knowledge, attitudes and skills? Specifically, will counselor trainees with lower adoption-related knowledge, attitudes and skills perceive adopted clients in a more negative way compared with nonadopted clients, as measured by the outcome variables?

Two exploratory research questions were:

6. Will the relationships identified in Questions 1-4 vary based on counselor trainees' sex? Specifically, will male counselor trainees perceive adopted clients in a more negative way compared with nonadopted clients than female counselor trainees?

7. Will the relationships identified in Questions 1-4 vary based on counselor trainees' level of clinical training and professional experience? Specifically, will counselor trainees with less clinical training and less professional experience perceive adopted clients in a more negative way compared with nonadopted clients?

CHAPTER II

METHODS

In this study I used a quasi-experimental, posttest-only, control group design (Cook & Campbell, 1979) to explore the relationships between counselor trainees' perceptions of adopted versus nonadopted clients. More specifically, in this study I randomly presented different hypothetical case scenarios to participants (one per participant) that served as stimuli on which participant responses were examined. Participants received hypothetical client case scenarios that were identical in all ways except for variations in client adoption status and in client sex. Six different client scenarios resulted: (a) a female nonadopted client, (b) a male nonadopted client, (c) a female same-race adopted client, (d) a male same-race adopted client, (e) a female transracially adopted client, and (f) a male transracially adopted client.

The first independent variable is client adoption status with three levels: (a) not adopted, (b) adopted, and (c) transracially adopted. The second independent variable is client sex with two levels: (a) male and (b) female. This resulted in six primary conditions, as shown in Table 1.

Participants were then assessed on their perceptions of the client presented to them in the hypothetical case scenario they received. Participant perceptions of clients

TABLE 1. Conditions by Independent Variables

Sex	Adoption Status		
	Nonadopted	Adopted	
	Nonadopted	Same-Race Adopted	Transracial Adopted
Female	Condition 1	Condition 3	Condition 5
Male	Condition 2	Condition 4	Condition 6

were assessed by examining the following outcomes: (a) the level of concern and severity as measured by the Case Study Questionnaire; (b) the seriousness of the treatment plan and prognosis as measured by the Case Study Questionnaire; (c) participants' assignment of number of favorable and unfavorable adjectives used to describe the client, as measured by the Adjective Checklist (ACL; Gough and Heilbrun, 1983); (d) participants' assessment of the client's overall level of functioning, as measured by scores from the Global Assessment of Functioning scale (American Psychiatric Association, 2000); and (e) diagnoses that participants gave to the client, as measured by the Case Study Questionnaire, which I describe in greater detail in the Measures section.

Similarly, I gathered data on counselor trainees' adoption-related knowledge, attitudes and skills. This information was collected in a measure designed and validated for this study. Knowledge, attitudes and skills were analyzed as a covariate in the

group-comparison tests among the six conditions corresponding to the six case scenarios presented.

For analysis, I utilized a factorial design to evaluate the two factors of sex and adoption status simultaneously. The advantages of using a factorial design was that two independent variables were studied at the same time, and allowed for detection of both main and interaction effects.

Procedures

Participants in counselor training graduate programs were recruited nationally over the Internet for an online study on "counselor training issues." Over 350 emails were sent to individual program or training directors affiliated with counseling-related graduate programs across the country, including masters and doctoral programs representing a range of areas of specialization (Counseling Psychology, Clinical Psychology, Marriage and Family Therapy, etc). The names of program faculty and their email addresses were obtained in two ways: (a) from local and national email listserves targeting training directors of counseling-related programs; and (b) through an extensive Internet search of counseling-related training programs nationally, and individual program websites. The emails included (a) a request to program faculty to forward the email to their graduate students; (b) a brief description of the study, including the requirements to participate and the estimated length of time it would take to complete the survey; (c) a statement of participants' chances to win one of five $50

gift certificates to Amazon.com; and (d) a web-based link connecting them to the survey web pages located at PsychData.com.

The email also included a list of requirements for participation. In order to participate, they were required to be (a) enrolled in a counseling-related graduate program, (b) over the age of 18, and (c) able to read and write English.

If participants clicked on the web link in the email, they were taken to the online survey located at PsychData.com, a secure and confidential website that was created specifically for data collection for the social sciences community. Once there, each participant was taken to the online consent form document (Appendix C). If they agreed to participate, they were randomly assigned to one of the six vignette scenarios. After reading their assigned case vignette, participants completed the measures designed to assess the outcome variables in the following, specific order: a case study questionnaire, a modified version of the Personality Adjective Checklist, the Global Assessment of Functioning Scale, the Marlow-Crowne 2(10) Social Desirability Scale, and the Knowledge, Attitudes and Skills of Adoption Survey (see Appendix D for a list of all measures used; see Appendix E for a copy of the online survey as administered to participants).

Upon completing the survey, participants were given the option of providing their email address in order to be included in the drawing to receive the incentive. They were notified that each participant had an opportunity to win one of five $50 gift certificates to Amazon.com.

Power Analysis

Cohen's (1977) multipurpose power tables for analysis of variance demonstrates that in order to detect a small effect size with a statistical power of .80 at the $p < .05$ level, I needed to recruit a minimum of 105 participants per cell. Considering that the primary cells in the design are adopted (same-race and transracial) versus nonadopted, and male versus female, I knew that in order to detect a small effect size, I would need to recruit a minimum of 420 participants. So, the actual obtained sample size of this study ($N = 430$) is more than adequate to detect a small effect size for the primary experimental manipulations.

Participants

The final sample consisted 430 participants, with 346 females (80.4%) and 84 males (19.5%), reflecting the makeup of counselor and related training programs nationally. Demographic data are presented in Tables 2 and 3. The mean age of participants was 29.66 ($SD = 8.23$). Eighty-four percent of participants identified as White or European American; 5.1% as multiethnic; 4.6% as Asian or Asian American; 4.6% as Hispanic; 3% as Latino or Latina; 3% as Black or African American; and 2.3% identified as "Other" (such as Portuguese, Mediterranean, German, or Appalachian). Twenty-nine percent of participants were in a Ph.D. program; 26.5% Master of Arts (MA); 21.1% Master of Science (MS); 6.5% Psy.D.; and 9% "Other" (such as Master of

TABLE 2. Demographic Information for the Sample

Variable	Mean	SD
Age	29.66	8.23
	n	%
Gender		
Female	346	80.4
Male	84	19.5
Total	430	100
Race/ethnicity		
White or European-American	362	84.1
Multi-ethnic	22	5.1
Asian or Asian-American	20	4.6
Hispanic	20	4.6
Black or African-American	13	3.0
Latino/a	13	3.0
Native American or Alaskan Native	11	2.5
Middle Eastern	9	2.0
Chicano/a	3	0.7
Other	10	2.3
Type of Degree		
Doctor of Philosophy (PhD)	128	29.7
Master of Arts (MA)	114	26.5
Master of Science (MS)	91	21.1
Doctor of Psychology (PsyD)	28	6.5
Master of Education (MEd)	28	6.5
Master of Social Work (MSW)	2	0.4
Other	39	9.0
Primary Emphasis or Specialization		
Marriage or Couples and Family Therapy	115	26.7
Counseling Psychology	114	26.5
School Counseling	68	15.8
Clinical Psychology	66	15.3
Counselor Education	19	4.4
Rehabilitation Counseling	3	0.6
School Psychology	1	0.2
Other	44	10.2

TABLE 3. Additional Demographic Information of the Sample

Variable	*N*	%
Have Begun to See Practicum Clients?		
Yes	284	66.0
No	146	33.9
Year in Current Graduate Program		
First Year	148	34.4
Second Year	150	34.8
Third Year	60	13.9
Fourth Year	32	7.4
Fifth Year	27	6.2
Sixth Year or More	13	3.0
Number of Clients Seen		
None	147	34.1
1–5	47	10.9
6–10	30	6.9
11–20	56	13.0
21–30	36	8.3
31–40	22	5.1
More than 40	92	21.1
Participants in the Adoption Triad		
Adoptee (Same-Race)	10	2.3
Transracial Adoptee	3	0.7
Birthmother	1	<0.01
Birthfather	2	<0.01
Adoptive Parent	6	1.4
Total # Adoption Triad	21	5.0
Participants Who Know an Adoptee	370	86.0
Primary Theoretical Orientation		
Behavioral	12	2.7
Cognitive Behavioral	97	22.5
Interpersonal	32	7.1
Humanistic/Existential	53	12.3
Integrative	48	11.1
Eclectic	60	13.9
Psychodynamic/Psychoanalytic	14	3.2
Systems	53	12.3
Other	61	14.1

Counseling [MC], Master of Marriage and Family Therapy [MMFT], or Doctor of Marriage and Family Therapy). Participants' reported area of specialization included 26.7% Marriage or Couples and Family Therapy; 26.5% Counseling Psychology; 15.8% School Counseling; 15.3% Clinical Psychology; and 10.2% "Other" (such as Mental Health Counseling, Nature Therapy, Neuropsychology, or Community Counseling; see Table 2).

Information was also collected to better understand participants' level of educational and clinical experience and theoretical orientation. See Table 3 for additional demographic information related to level of experience. Sixty-four percent of participants reported their highest degree completed at the time of the survey was a bachelor's degree, 33.9% a master's degree, and 1.8% had completed their doctoral degree at the time of the survey. Thirty-four percent of participants reported being second-year students in their program, 34.4% were first-year students, 13.9% were third-year students, 7.4% were fourth-year students, and 9.2% were fifth-year students or beyond. At the time of the survey, 34% had not yet worked with clients in direct clinical contact, while 21.1% had reportedly seen more that 40 clients.

A total of 22 participants, or 5% of the total sample, identify as members of the adoption triad: Thirteen participants identify as an adoptee (10 same-race adoptees and three transracial adoptees); one participant identifies as a birthmother (defined as having completed an adoption plan in the past), two as a birthfather, and six identify as adoptive parents. I do not control for participant adoption status in subsequent analyses

due to the low number. Overall, 86% of participants report that they know at least one person who identifies as an adoptee (either same-race or transracial).

At the time of the survey, 66% of participants had begun to see clients as part of their graduate training. Thirty-four percent had not seen any clients at the time of the survey, while 21.1% had reportedly seen more that 40 clients. Of the participants with clinical experience, 42% report having worked with clients who identify as a member of the adoption triad. Therefore, 27% of all participants have reportedly worked with at least one client who is a member of the adoption triad.

Two questions were asked regarding trainee clinical experience. First, trainees were asked how many clients they had seen in supervised practicum training. The response options were the following: "none," "1-5," "6-10," "11-20," "21-30," "31-40," or "more than 40." Thirty-four percent of the sample had not seen any clients at the time of the survey. The remaining trainees were roughly equally dispersed across the remaining categories. Trainees were also asked how many total years of counseling experience they had. This response field was open-ended. Several responses were deleted because they were outside of the plausible range of experience for the trainee's age (i.e., 150, 60, 76, and 40 years). Overall, there were 34 missing values. The mean number of years of experience was 2.4 ($MD = 2.0$, $SD = 2.78$, Min = 0, Max = 25). The distribution was positively skewed (Skewness = 2.72, $SE = .118$), indicating that there were more participants with little to no direct clinical experience, and fewer with many years of clinical experience (see Table 3).

Finally, participants identified their primary theoretical orientation as follows: 22.5% Cognitive Behavioral; 13.9% Eclectic; 12.3% Humanistic/Existential; 12.3% Systems; 11.1% Integrative; 7.1% Interpersonal; 3.2% Psychodynamic or Psychoanalytic; 2.7% Behavioral; and 14.1% "Other" (such as Narrative, Feminist, Adlerian, Multicultural, Solution-Focused, or Unknown or Not Sure).

Measures

All measures used in the study to assess the dependent variables and related constructs are discussed in this section. Table 4 lists all measures, and copies of the instruments appear in Appendix D.

Case Study Questionnaire

After reading the vignette about the hypothetical client, participants were asked to complete the Case Study Questionnaire, which was created specifically for this study. The Case Study Questionnaire was designed to assess participants' perceptions of clients by having them identify their level of concern, severity of client problems, their proposed treatment plan and prognosis, and diagnoses. I developed the Case Study Questionnaire based on other, similar thesis and dissertation studies (Barrett, 1997; Kemp, 1993; Kojis, 1990; see also Barrett & McWhirter, 2002). The questionnaire was vetted multiple times in research groups consisting of doctoral students in counseling

psychology. Response options to the items utilize a 5-point, Likert-type scale to assess participants' perceived severity of the clients' presenting issues.

TABLE 4. Description of Study Constructs and Measures

Variable	Measure	# of Items	Variable Type
Perceptions of Client			
Level of concern	Case Study Questionnaire	1	Continuous Range = 1–5
Severity of problem	Case Study Questionnaire	1	Continuous Range = 1–5
Seriousness of treatment plan and prognosis	Case Study Questionnaire	1	Continuous Range = 1–5
Diagnoses	Case Study Questionnaire	8	Continuous Range = 1–5
Favorable or Unfavorable	ACL	150	Categorical
Level of functioning	GAF	1	Continuous Range = 1–100
Participant Variables			
Social Desirability	MCSD 2(10)	10	Categorical
Adoption Knowledge, Attitudes, and Skills	KASAS	30	Continuous Range = 1–6
Trainee Demographics	Demographics Questionnaire	7	Categorical
Sex			
Clinical Experience			

After reading the vignette about a hypothetical client, participants completed several questions in the Case Study Questionnaire assessing their level of concern, perception about the client's severity of problems, their proposed treatment plan, and prognosis. The first question asked participants to rate their overall level of concern for the client (1–5 rating scale ranging from "1 = no concern" to "5 = very concerned"). The second question asked participants to rate the severity of the client's problems (1–5 rating scale ranging from "1 = not severe at all" to "5 = very severe").

Treatment planning was assessed with a single item asking the participant to assess the number of individual counseling sessions that would be necessary to assist this client. In the case where several participants entered ranges of sessions into this field (e.g., 10–20), these were averaged for the analysis. Other participants responded with verbal phrases such as "unsure," "variant," "don't know," "20 weeks," "cannot say," "whatever needed," "indefinite," "1 week," "unknown," "variable," "6 months," and "not sure."

Client prognosis was measured by a single item asking the participant about their prediction for the course and outcome of treatment (1–5 rating scale ranging from "1 = poor" to "5 = excellent").

Adjective Checklist (ACL)

Developed by Gough and Heilbrun (1983), the Adjective Check List (ACL) contains 300 items and 37 scales originally developed for commercial testing. Two of the 37 general subscales assess the number of favorable (75 possible) or unfavorable (75 possible) adjectives selected. These two scales were used in this study. Participants were asked to select adjectives they believed best described their hypothetical client in the case vignette provided.

Applications of the ACL have ranged from descriptions of stereotypes to observer protocols to historiographies. The original ACL was normed on students, psychiatric patients and adults (Gough & Heilbrun, 1983). Median Cronbach alpha

coefficients for all subscales were reported to be $r = .76$ for males and $r = .75$ for females. For the Favorable Items Checked subscale, the reliability coefficients were $r = .95$ for males and $r = .94$ for females, with a 1-month test-retest coefficient of $r = .62$ for males and $r = .60$ for females. Reliability coefficients for the Unfavorable Items Checked subscale, alphas of .92 for males and .91 for females were reported, with one-month test-retest coefficients of $r = .65$ for males and $r = .76$ for females. Gough and Heilbrun (1983) reported that the intercorrelation between the Favorable Items Checked and Unfavorable Items Checked subscales for males and females was $r = -.68$. Sample items within the Favorable subscale include "insightful," "warm," and "friendly." Sample items within the Unfavorable subscale include "dependent," "rigid," and "moody."

Global Assessment of Functioning (GAF)

The Global Assessment of Functioning Scale (GAF) was created by the American Psychiatric Association (2000) for use in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised* (*DSM-IV-R*) multiaxial diagnostic system. The GAF is a global assessment scale that allows clinicians to synthesize different aspects of a patient's social and mental functioning into a single, clinically meaningful rating. The GAF is a standard method for representing a clinician's judgment of a patient's overall level of psychosocial functioning.

The GAF scale value range is 1 to 100 and is divided into 10 equal intervals (e.g., 1–10, 11–20, etc.). A score of 1 represents the most severe symptomology (e.g., "Persistent danger of severely hurting self . . ."), and 100 represents the highest level of functioning and an absence of symptomology (e.g., "Superior functioning in a wide range of activities . . ."). Hilsenroth et al. (2000) investigated the reliability and convergent validity of the GAF compared to the Global Assessment of Relational Functioning Scale (GARF) and the Social and Occupational Functioning Assessment Scale (SOFAS), and reported all three scales exhibited excellent interrater reliability (.87 to .94).

The GAF was chosen for this study due to its accepted familiarity with clinicians and the likelihood that counselor trainees have received training on the use of this scale in assessment courses. For the purposes of this study, the GAF score represent participants' perception of the client's overall level of functioning.

Social Desirability Scale

The Marlowe-Crowne 2(10) Social Desirability Scale [MC 2(10)] is a 10-item self-report, true-false inventory of personal and interpersonal behaviors that assesses participants' tendency to give responses thought to be socially desirable. The MC 2(10) is a short form of the original 33-item instrument (Crowne & Marlowe, 1960). Scores on the short form have been found to be closely related to the longer version (r = .80 to

.90; Strahan & Gerbasi, 1972). The 10-item version also had equal Kuder-Richardson formula reliability to the original scale (Strahan & Gerbasi, 1972).

With a recent increase in attention to multicultural competencies in counselor training programs, it is possible that counseling trainee participants might attach high social desirability to evaluating adopted and transracially adopted clients positively. The use of the MC2(10) Scale is intended to assess participants' tendencies towards socially desirable responses.

Knowledge, Attitudes and Skills of Adoption Survey (KASAS)

The Knowledge, Attitudes and Skills of Adoption Survey (KASAS) is a 30-item, 6-point Likert-type measure with responses from "1 = strongly disagree or very limited" to "6 = strongly agree or very aware" that I created and validated specifically for this study in order to measure counselor adoption-related attitudes, knowledge and skills. No current measure exists to measure counselor training, attitudes, knowledge, or skills related to adoption or adopted clients. I developed the KASAS based on the well-validated Multicultural Awareness, Knowledge, and Skills Survey—Counselor Edition—Revised (MAKSS-CE-R; Kim, Cartwright, Asay, & D'Andrea, 2003).

Thirty items measure three scales: Adoption Knowledge, Adoption Attitudes, and Adoption Skills. Sample items measuring Adoption Knowledge on a scale of "1 = Very Limited" to "6 = Very Good" include "At the present time how would you rate your understanding of the following terms and concepts: 'Adoption triad,' 'Ethnic

identity development for transracial adoptees,' and 'Adjustment issues related to adoption'?" Sample items measuring Adoption Attitudes on a scale of "1 = Strongly Disagree" to "6 = Strongly Agree" include "Transracial adoptees can be raised in European American families and predominantly European American communities with little impact on their identity development," "Adoptees are at higher risk for psychological and behavioral problems than people who are not adopted," and "Promoting an adopted client's sense of gratitude for having been adopted by a good family is usually a safe goal to strive for in most counseling situations." Sample items measuring Adoption Skills on a scale of "1 = Strongly Disagree" to "6 = Strongly Agree" include: "At the present time, how would you rate your confidence in being able to provide 'adoption sensitive' counseling?" and "How well would you rate your ability to effectively assess the influence adoption has had on your client's life, without overemphasizing or minimizing it in treatment?"

Piloting of this measure began by consulting with two research groups in August 2007 to discuss the development of the KASAS. One group consisted of six researchers who are members of the American Psychological Association Adoption Research and Practice Special Interest Group (SIG) within Division 17's Society of Counseling Psychology. The second group consisted of five researchers and psychologists attending a Continuing Education workshop on Adoption Research and Practice at the Annual Meeting of the American Psychological Association, 2007. Information and feedback gathered (see Appendix B) from these two research groups consisting of

experts in the field of adoption research and practice has been integrated into the survey construction. From these groups, it appears the KASAS Survey takes approximately 5–10 minutes to complete. Factor analyses, reliability analyses, and concurrent and discriminant validity analyses are described in more detail in Chapter III.

Trainee Demographic Information

Background information was collected via a questionnaire created for this study that included the following demographic information: sex, age, ethnicity, graduate program degree and specialty, number of months of counseling experience, approximate number of clients treated in therapy, trainees' adoption status, and their level of exposure to adoption issues or training.

Online Pilot of the KASAS Instrument

The purpose of the pilot study was to assess the factor structure and internal consistency reliability of the KASAS instrument. First, I created items for the measure based on theory and then initially validated the measure by consulting with a research group consisting of experts in the field of adoption research and practice who modified, edited, and added items that were theoretically and clinically important to include in the measure. Second, I utilized an exploratory factor analysis to empirically examine the scale that was developed in conjunction with this group of experts. In this factor analysis, I used pilot data to evaluate and confirm the presence of the three theoretically

driven and measurement-derived subscales of adoption-related attitudes, knowledge, and skills. Factor analysis results provided information about which items clustered together and helped to identify items with high and low item-to-scale correlation. Factor analysis was used to identify the number of separate measurement dimensions or factors in the measure and to determine which items load most highly on each factor. Results of the factor analysis also allowed me to reduce the total number of items by eliminating items that loaded poorly on any particular subscale. Third, I assessed for item and factor reliability and report Cronbach's alpha coefficients and interitem correlations as a reflection of the overall reliability of each subscale. Results of the factor analysis are discussed in detail in Chapter III.

CHAPTER III

RESULTS

In this chapter, I present the study findings in the following order: preliminary analyses, results from the factor analysis of the KASAS measure, and finally, the results of main study hypothesis testing. The results of the hypothesis testing are presented in the order of the outcome variables. To analyze data and explore study results, I utilized SPSS, version 14.0.

Preliminary Analyses

I followed data-screening guidelines outlined by Mertler and Vannatta (2002) for the preliminary analyses. Prior to conducting the factor analysis and the main study analyses, I screened the data for errors in data coding, univariate and multivariate outliers, normality and linearity. I also conducted screening to check for outliers, examined skew and kurtosis. Overall, 15 participants stopped responding to the survey once they reached the Adjective Checklist. In situations where only a few data points were missing, the remainder of the survey data was used for analysis, and exceptions are noted below. The presentation of preliminary analyses results are organized and presented according to each measure.

Case Study Questionnaire

On the Case Study Questionnaire assessing participant level of concern, perception about the client's severity of problems, proposed treatment plan, and prognosis, there were 5 or fewer participants who did not answer a specific question, and 20 missing data points on the treatment planning question, and distribution of scores was normal.

Level of concern was assessed with a single item asking participants to rate their overall level of concern for the client (1-5 rating scale ranging from "1 = no concern" to "5 = very concerned"). There were 5 missing data points ($M = 3.77$, $MD = 4.00$, $SD = .75$) and the distribution of scores was normal.

Severity was assessed with a single item asking participants to rate the severity of the client's problems (1-5 rating scale ranging from "1 = not severe at all" to "5 = very severe"). There were 5 missing data points ($M = 3.43$, $MD = 3.00$, $SD = .65$) and the distribution was normal.

Treatment planning was assessed with a single item asking the participant to assess the number of individual counseling sessions that would be necessary to assist this client. In the case where several participants entered ranges of sessions into this field (e.g., 10–20), these were averaged for the analysis. Other participants responded with verbal phrases such as "unsure," "variant," "don't know," "20 weeks," "cannot say," "whatever needed," "indefinite," "1 week," "unknown," "variable," "6 months,"

and "not sure." Verbal responses were treated as missing and there were 20 missing data points (M = 15.68, MD = 12.00, SD = 10.70, Min = 0, Max = 112).

Client prognosis was measured by a single item asking participants about their predictions for the course and outcome of treatment (1–5 rating scale ranging from "1 = poor" to "5 = excellent"). There were 5 missing data points (M = 4.01, MD = 4.00, SD = .76) and the distribution was normal.

The Case Study Questionnaire also provided a list of eight diagnoses, and participants were asked to rate how relevant each was to the hypothetical client they just read about (options were "very relevant," "potentially relevant," or "not relevant"). The percentage of respondents that endorsed each category for each of the eight diagnoses is presented in Table 5.

TABLE 5. The Number (%) of Respondents Who Thought Each Diagnosis Was Relevant

Variable	Relevance		
	Not relevant	Potentially relevant	Very relevant
Major depression	28 (6.3)	220 (49.3)	198 (44.4)
Dysthymic disorder	71 (15.9)	220 (49.3)	155 (34.8)
Depressive NOS	33 (7.4)	238 (53.4)	175 (39.2)
Attachment-related disorder	69 (15.5)	224 (50.2)	153 (34.3)
Generalized anxiety	128 (28.7)	246 (55.2)	72 (16.1)
Other anxiety-related disorder	144 (32.3)	258 (57.8)	44 (9.9)
Dependent personality	230 (51.6)	189 (41.1)	27 (6.1)
Adjustment-related disorder	65 (14.6)	247 (55.4)	134 (30)

Adjective Checklist

For the first subscale, 75 favorable adjectives, there were 15 missing data points (M = 6.60, MD = 4.00, SD = 9.31, Min = 0, Max = 75). Also, there were four large

outliers (participant numbers: 13, 133, 169 and 170). Three of these large outliers were removed because they had checked all of the positive adjectives or a very high number, and I was not confident that they were paying attention to the task. With outliers removed, there was a total of 19 missing data points ($M = 5.98$, $MD = 4.00$, $SD = 6.69$). For the second subscale, 75 unfavorable adjectives, once outliers were removed there were 19 missing data points on this subscale ($M = 10.49$, $MD = 7.00$, $SD = 11.65$).

Global Assessment of Functioning

For the Global Assessment of Functioning (GAF) some participants ($n = 9$) entered a range for this variable (e.g., "51–60"), and when this occurred the average of the range was calculated for a single score. There were 19 missing data points ($M = 56.56$, $MD = 55.00$, $SD = 8.42$, Min = 22, Max = 87). The distribution was normal.

Social Desirability

For the Marlowe-Crowne 2(10) Social Desirability Scale [MCSD 2(10)] there were 15 missing data points ($M = 4.33$, $MD = 4.00$, $SD = 2.32$, Min = 0, Max = 10). Scores were normally distributed.

Table 6 presents the correlations of the MCSD 2(10) and the primary variables. MCSD 2(10) scores were positively correlated with the knowledge and skills scores from the KASAS, although the correlation coefficients were very low. This suggests that participants who tended to respond in socially desirable ways also rated themselves

higher in knowledge and skills. Higher scores on social desirability were also related to lower ratings of the length of treatment necessary to treat the client. However, these correlation coefficients were also very low. In summary, there were no substantial correlations between the primary dependent variables and the MCSD 2(10), suggesting that social desirability is not a significant factor in influencing participant responses and in understanding study findings.

TABLE 6. Correlations (*r*) Between the MCSD 2(10) and the Primary Dependent Variables

Diagnosis	MCSD2(10)
KASAS—Attitudes	-.02
KASAS—Knowledge	.12*
KASAS—Skills	.10*
Concern and severity	.06
Number of unfavorable adjectives	-.01
Number of favorable adjectives	-.01
GAF	.05
Treatment planning	-.12*
Prognosis	.01

*$p < .05$.

Results of Measurement Development: The Knowledge, Attitudes and Skills of Adoption Survey (KASAS)

Because I developed this measure for this study and it has not been validated in past research, I analyzed the factor structure and reliability data for this scale prior to using it in subsequent analyses. Results of this analytical process are presented here. The Knowledge, Attitudes and Skills of Adoption Survey (KASAS) was initially

developed as a 30-item, Likert-type scale to measure counselor trainees' adoption-related Knowledge (9 items), Attitudes (13 items), and Skills (8 items). This measure was very closely modeled after the Multicultural Awareness, Knowledge and Skills Survey—Counselor Edition—Revised (MAKSS-CE-R; Kim et al., 2003) and in fact, includes items that were only slightly modified from the original MAKSS-CE-R measure. For instance, instead of the original items related to multicultural knowledge, such as "At the present time how would you rate your understanding of the following terms: 'Ethnicity,' 'Culture,' or 'Racism'?," the KASAS measure asks an almost identical question related to Adoption knowledge, which reads, "At the present time how would you rate your understanding of the following terms and concepts: 'Adoption triad,' 'Transracial adoption,' or 'Adoption-sensitive counseling"? Participants responded to each of the 30 original items on a 6-point, Likert-type scale ranging from "1 = very limited" to "6 = very good." Items 1–13 were written to make up a construct that closely reflects "Attitudes" about adoption, items 14–22 were written to make up a construct that closely reflects "Knowledge" about adoption, and items 23–30 were written to make up a construct that closely reflects "Skills" related to working with adopted clients (See Appendix F for a description of the original, prefactor analyzed 30-item measure; See Appendix G for the final version of the KASAS postfactor analysis). While the three hypothesized constructs of Attitudes, Knowledge and Skills should be distinct constructs, they are and should be theoretically related.

Factor Analysis Results

Twenty-eight (28) participants had a large amount (i.e., more than 75%) of missing data from their responses to this measure and were therefore removed from analysis. This left a sample size of 430 for the factor analysis. Preliminary analysis of the items revealed no substantial deviations from normality. The eleven reverse-scored items in the original measure were reversed coded before analysis.

For the factor analysis, I submitted the original measure to three sequential factor analyses, and after each analysis employed specific criteria for retaining items, deleting items, and refining resulting factors. For each analysis I conducted a principal axis factor analysis, with oblique rotation. Three different criteria were used to decide which items to keep in the KASAS. The first criterion was to identify potentially poor items by examining interitem correlations. The second criterion, based on the results of the factor analysis, was to identify items that did not contribute to any individual factor (that is, items that loaded below .32 on any factor) and items which loaded on more than one factor (i.e., cross-loadings) with a loading of .32 or greater on more than one factor (Tabachnik & Fidell, 2001). The third criterion for maintaining and removing items from the measure was to consider the face validity of the items. I kept items that met the first and second criteria, but that also linguistically clearly appeared to measure one of the three primary theoretical constructs of interest.

The first factor analysis was conducted with all of the original 30 items from the measure. I utilized the factor eigenvalue criterion (with eigenvalues larger than one) as

the primary criterion for extracting identifiable factors from the analysis. Results of this first factor analysis revealed a seven-factor solution for all items, accounting for 64.15% of total explained variance. Tables 7 and 8 reveal the overall factor-loading matrix, factor eigenvalues, percentage of variance explained by each factor, and overall variance explained by the seven-factor model.

TABLE 7. Eigenvalues and Percentage of Variance Explained for the Entire KASAS Scale

Factor	Initial Eigenvalues			Extraction SS Loadings			SS Loadings
	Total	% of variance	Cumulative %	Total	% of variance	Cumulative %	Total
1	8.55	28.52	28.52	8.24	27.46	27.46	6.62
2	3.44	11.47	39.98	2.94	9.81	37.27	2.49
3	2.04	6.81	46.79	1.65	5.51	42.78	6.10
4	1.95	6.49	53.28	1.42	4.73	47.50	1.45
5	1.16	3.88	57.16	.73	2.44	49.94	2.06
6	1.08	3.59	60.75	.52	1.73	51.67	2.31
7	1.02	3.40	64.15	.43	1.43	53.10	1.52

Note. Principal axis factor analysis with oblique (oblimin) rotation.

Items with no strong factor loadings (that is, items with factor loadings that were less than .32 on any factor; items 6, 13, 24), items that cross-loaded on more than one factor (items 2, 4, 16, 17, 29), and items with particularly low communality (item 10) and low interitem correlations were removed from the measure before subsequent re-analysis. This resulted in the dropping of a total of 9 items from the original 30 items. Items 18 and 22, which had a very strong loading on one factor and a moderate loading on another, were retained at this stage.

TABLE 8. First Factor Analysis: Partial Factor Loading Matrix for All Items

Item	Factor						
	1	2	3	4	5	6	7
20	.91	-.04	.03	.07	-.02	-.04	.00
21	.88	-.00	.09	.02	-.05	-.12	-.06
19	.78	-.08	.10	.03	-.04	.04	.06
18	.66	.03	.02	.08	-.33	.00	-.03
17	.59	.01	.01	-.05	.15	.03	.36
16	.58	-.03	.02	.03	-.47	.06	.01
22	.57	-.39	.22	.08	-.05	.13	.06
5	-.04	.75	.02	-.09	-.04	.14	.08
3	.01	.68	-.01	-.04	.00	.00	-.02
1	-.16	.53	-.01	-.02	-.02	.20	.07
2	-.01	.43	.01	.27	.04	-.05	-.08
4	.01	.43	.08	.35	-.05	.01	-.10
6	-.11	-.17	.13	.10	-.11	-.08	.04
26	-.10	.05	.88	-.05	.01	-.08	.12
27	-.02	.05	.84	-.02	-10	-.01	.11
25	-.01	-.08	.76	.06	.00	.09	.02
30	.17	.11	.71	-.07	-.02	-.08	-.05
24	.31	-.06	.61	.03	.09	.06	.09
23	.10	-.13	.53	-.08	-.01	.14	-.08
28	.02	.07	.47	.11	-.13	-.10	-.22
29	.40	.07	.44	-.08	.16	-.03	.17
12	-.01	.01	-.01	.59	-.02	.02	-.05
11	.10	.03	-.07	.56	.02	.05	-.02
10	-.05	-.11	.03	.36	-.10	-.16	.26
15	.30	.07	.09	-.03	-.73	.11	.07
8	-.11	.09	-.01	.04	-.09	.80	-.07
9	-.06	.05	.03	-.03	.11	.73	-.07
7	.04	.01	-.02	.01	-.06	.46	.06
13	.06	.07	.12	.14	.07	.15	.03
14	.27	.07	.17	-.08	-.17	.00	.47

For the second factor analysis conducted with the remaining 22 items, a five-factor solution emerged that accounted for 64.67% of the total variance. Tables 9 and 10 present the results of this second factor analysis, with factor loading matrix, factor eigenvalues, percentage of variance explained by each factor, and overall total variance explained by the factor analysis. All item-to-factor loadings above .32 are bolded.

TABLE 9. Eigenvalues and Percentage of Variance Explained for the Reduced-Item Set

Factor	Initial Eigenvalues			Extraction SS Loadings			SS Loadings
	Total	% of variance	Cumulative %	Total	% of variance	Cumulative %	Total
1	6.38	30.39	30.39	6.03	28.73	28.73	5.21
2	2.94	13.99	44.39	2.51	11.97	40.69	2.10
3	1.75	8.33	52.72	1.40	6.67	47.36	4.73
4	1.45	6.90	59.61	.80	3.81	51.17	.88
5	1.06	5.06	64.67	.56	2.67	53.84	2.04

TABLE 10. Factor Loading Matrix for the Reduced-Item Set

Item	Factor				
	1	2	3	4	5
20	**.96**	-.03	-.06	.10	-.02
21	**.90**	-.01	.00	.12	-.09
19	**.86**	-.06	.02	.04	.05
18	**.66**	.05	-.01	-.22	.01
22	**.66**	-.02	.15	.10	.12
14	**.48**	.08	.19	-.19	-.05
15	**.46**	-.04	.17	.18	.08
5	.03	**.83**	.02	-.02	.03
3	.04	**.64**	-.03	.03	-.01
1	-.10	**.57**	.00	.05	.13
26	-.05	.04	**.94**	-.16	-.09
27	.04	.02	**.87**	-.05	-.01
25	.02	-.09	**.74**	.02	.09
30	.16	.06	**.65**	.02	-.04
23	.10	-.08	**.48**	.00	.12
28	-.03	.03	**.47**	.27	-.07
12	-.04	.01	.03	**.54**	-.02
11	.09	.05	-.04	**.48**	.00
8	-.10	.07	.01	.07	**.84**
9	-.08	.13	.02	-.06	**.66**
7	.09	.00	-.02	-.02	**.44**

Note. Figures in bold type indicate item-to-factor loadings above .32.

Examination of the factor loadings revealed a simple factor structure for the Knowledge and Skills subscales. These two factors were also correlated at $r = .55$. The eight items composing the original Attitude scale loaded onto three separate factors. There were only two items that loaded highly on factor 4 (items 11 and 12) and three items that loaded highly each on both factor 2 (items 1, 3, 5) and factor 5 (items 7, 8, 9). Because each of these three factors contained only a few items, with factor 4 considered unacceptable as a unique factor with 2 items and factors 2 and 5 considered only borderline acceptable as factors with 3 items each (Tabachnik & Fidell, 2001), their clarity in accounting for unique factor variance is not defensible. In short, factors 2, 4 and 5 were not robust as distinct factors. This result, along with the strong theoretical support for a three-factor solution structure for this measure, led me to limit the third and final factor analysis to a three-factor solution. So, for the subsequent (i.e., third) and final factor analysis, I limited the analysis to a three-factor solution but did not drop the items that previously loaded on factors 2, 4 and 5.

For the third factor analysis, a preset three-factor solution resulted in three distinct factors, each with eigenvalues greater than 1.0 and which accounted for 52.71% of the total variance. Tables 11 and 12 present the results of this third factor analysis. In this three-factor solution, items 11 and 12 did not load onto any factors above .32 so they were removed from the measure. The solution revealed a simple and cogent factor structure with no cross loadings of items. For all items, 6 items fell into what clearly represents the "Attitude" factor or subscale, 7 onto the "Knowledge" factor or subscale,

and 6 items onto the "Skills" factor or subscale, summing to 19 total items in the final KASAS measure.

TABLE 11. Eigenvalues and Percentage of Variance Explained for the Three-Factor Solution

Factor	Initial Eigenvalues			Extraction SS Loadings			SS Loadings
	Total	% of variance	Cumulative %	Total	% of variance	Cumulative %	Total
1	6.38	30.39	30.39	6.01	28.64	28.64	5.27
2	2.94	13.99	44.39	2.38	11.31	39.95	2.38
3	1.75	8.33	52.71	1.38	6.56	46.51	4.44

TABLE 12. Factor Loading Matrix for the Three-Factor Solution

Item	Factor		
	1	2	3
20	**.97**	-.04	-.07
21	**.90**	-.09	.00
19	**.88**	-.02	.00
22	**.69**	.08	.14
17	**.64**	.02	-.04
15	**.48**	.03	.17
14	**.48**	-.01	.15
8	-.02	**.74**	-.01
5	-.02	**.73**	.02
9	-.02	**.66**	-.02
1	-.12	**.63**	.00
3	-.01	**.56**	-.02
7	.13	**.38**	-.04
11	.08	.08	.03
26	.02	-.13	**.87**
27	.10	-.06	**.84**
25	.10	-.06	**.72**
30	.09	-.05	**.63**
28	.20	-.03	**.48**
23	.01	-.05	**.45**
12	-.01	.03	.10

As a final confirmation, I submitted these remaining 19 items to a fourth and final factor analysis. In Tables 13 and 14, I present the findings of this final factor analysis, including the eigenvalues and percentage of variance explained by each factor, as well as the total variance explained by the final model. In Table 14, I additionally present item loadings, means, and *SDs* for each item by each of the three factors.

TABLE 13. Eigenvalues and Percentage of Variance Explained for the Final Three-Factor Solution

Factor	Initial Eigenvalues			Extraction SS Loadings			SS Loadings
	Total	% of variance	Cumulative %	Total	% of variance	Cumulative %	Total
1	6.37	33.52	33.52	6.00	31.59	31.59	5.27
2	2.93	15.42	48.93	2.37	12.46	44.06	2.37
3	1.73	9.10	58.03	1.37	7.23	51.29	4.78

The oblique rotation of the final factor structure revealed a substantial correlation between the knowledge and skills factors, but minimal correlations between these factors and the attitudes factor. The knowledge and skill factors were correlated $r = .51$, and the attitude factor was not correlated with the knowledge ($r = .04$) or skills factors ($r = .11$).

Reliability Analysis

Internal reliability analyses were conducted using Cronbach's Alpha. In general, an alpha coefficient of .7 or higher is considered adequate for scale reliability. The

TABLE 14. Factorial Solution for the Knowledge, Attitudes and Skills of Adoption Survey (KASAS; $N = 430$)

Item # and item	Mean	*SD*	Item-factor loadings		
			1	2	3
Factor 1: Knowledge					
20. Developmental issues related to adoption	2.61	1.29	**.98**	-.04	-.07
21. Adjustment issues related to adoption	2.82	1.37	**.90**	-.09	.00
19. Adoption-sensitive counseling	2.57	1.30	**.88**	-.02	.00
22. Adoption-sensitive language	2.75	1.35	**.68**	.08	.14
17. The "seven core issues" of adoption	1.57	0.95	**.65**	.02	-.04
15. Transracial adoption	3.58	1.50	**.47**	.03	.17
14. Adoption triad	2.14	1.27	**.47**	-.01	.15
Eigenvalue = 6.37; Total variance explained = 33.52%					
Factor 2: Attitudes					
8. Adoptees are at higher risk for psychological and behavioral problems than people who are not adopted.	3.71	1.10	-.02	**.74**	-.01
5. When counseling an adopted adult, it is generally safe to assume their racial and ethnic identity development is similar to other members of the same racial or ethnic group who were not adopted.	4.38	1.56	-.02	**.71**	.02
9. In particular, transracial adoptees are at higher risk for psychological and behavior problems than biological children and adoptees who are the same race as their adoptive parents.	3.54	1.06	-.02	**.66**	-.02
1. In general, if an adopted person comes to counseling, it is likely that their presenting issue is related to being adopted.	3.95	1.16	-.12	**.63**	.01
3. When counseling international adoptees, it is generally safe to assume they have experienced early trauma or neglect in orphanages or institutions.	4.38	1.2	-.01	**.55**	-.02
7. In families with a biological child and an adopted child, it might be challenging to love and treat them equally.	3.62	1.32	.13	**.37**	-.04
Eigenvalue = 2.93; Total variance explained = 15.42%					
Factor 3: Skills					
26. How well would you rate your ability to accurately assess the mental health needs of all members of the adoption triad?	3.06	1.25	.02	-.13	**.92**
27. How well would you rate your ability to accurately assess the mental health needs of transracial adoptees?	3.03	1.20	.10	-.06	**.88**
25. At the present time, how would you rate your ability to recognize resilience and positive coping skills within adoptive families?	3.90	1.27	.09	-.05	**.75**
30. How well would you rate your ability to effectively assess the influence adoption has had on your client's life, without overemphasizing it or minimizing it in treatment?	3.23	1.20	.20	-.03	**.66**

TABLE 14. (Continued)

Item # and item	Mean	*SD*	Item-factor loadings 1	2	3
28. At this time in your life, how would you rate yourself in terms of understanding how your cultural background influences the way you think and act?	4.69	1.09	.01	-.05	**.49**
23. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of an adopted client or member of the adoption triad?	3.84	1.55			**.48**
Eigenvalue = 1.73; Total variance explained = 9.10%					

Attitudes (alpha = .77, mean interitem correlation = .37), Knowledge (alpha = .90, mean interitem correlation = .55), and Skills subscales (alpha = .86, mean interitem correlation = .51) all showed adequate internal reliability (see Table 15).

TABLE 15. Reliability Analysis for the KASAS

Subscale	Alpha	Mean interitem correlation
Attitudes	0.77	0.37
Knowledge	0.90	0.55
Skills	0.86	0.51

Main Study Analyses and Experimental Results

After reviewing the five main study hypotheses and two additional exploratory hypotheses, I will discuss my analytic approach. For organizational purposes, after I present results of the correlation analysis, the results for each hypothesis will be discussed separately. This is a summary of findings before the detailed discussion of results in Chapter IV.

Hypotheses

The five primary hypotheses under analysis are that Counselor Trainees will perceive differences between clients in the following ways:

1. Counselor trainees will perceive adopted clients (including both same-race and transracially adopted clients) in a more negative way compared with nonadopted clients, as measured by the outcome variables (concern and severity of client problems, seriousness of treatment plan and prognosis, favorable versus unfavorable adjectives, global assessment of functioning, and relevance of diagnoses).

2. Counselor trainees will perceive transracially adopted clients in a more negative way compared with same-race adopted clients, as measured by the outcome variables.

3. Counselor trainees will perceive male clients in a more negative way compared with female clients, as measured by the outcome variables.

4. Counselor trainees will perceive adopted male clients (including both same-race and transracially adopted male clients) in a more negative way compared with adopted female clients, as measured by the outcome variables.

5. The relationships identified in Hypotheses 1–4 will vary based on counselor trainees' adoption-related knowledge, attitudes and skills. Specifically, counselor trainees with lower adoption-related knowledge, attitudes and skills will perceive adopted clients in a more negative way compared with nonadopted clients, as measured by the outcome variables.

Additionally, I examined the following two exploratory hypotheses in this study. I expected the relationships identified in Hypotheses 1–4 to change based on the counselor trainees' sex and level of clinical training and professional experience:

6. The relationships identified in Hypotheses 1–4 will vary based on counselor trainees' sex. Specifically, male counselor trainees will perceive adopted clients in a more negative way, compared with nonadopted clients, than female counselor trainees.

7. The relationships identified in Hypotheses 1–4 will vary based on counselor trainees' level of clinical training and professional experience. Specifically, counselor trainees with less clinical training and less professional experience will perceive adopted clients in a more negative way compared with nonadopted clients.

Correlation Analyses

To begin analyses, I conducted a Pearson product-moment correlation among all dependent study variables. I ran a second Pearson product-moment correlation among each of the diagnostic categories that were presented to participants. Results of these correlational analyses are presented in Tables 16 and 17, respectively.

Results of these correlation analyses demonstrate that the only substantial correlations between the primary dependent variables were between participants' "ratings of concern" for the client and participant-identified "severity of problem" for the client ($r = .63$). Ratings of the relevance of a particular diagnosis showed only moderate correlations. However, the relevance ratings for the anxiety-related disorders

are highly correlated ($r = .72$). Because the ratings of concern and severity are so highly correlated, they will be averaged in the subsequent analyses for simplicity of modeling.

TABLE 16. Correlations Between the Primary Dependent Variables ($N = 430$)

	Concern	Severity	Prognosis	Treatment plan	Unfavorable adjectives	Favorable adjectives	GAF
Concern	1						
Severity	.63**	1					
Prognosis	-.02	-.09*	1				
Treatment plan	.07	.19**	-.11*	1			
Unfavorable adjectives	.02	.05	-.07	.07	1		
Favorable adjectives	-.04	.05	.08	.03	.35**	1	
GAF***	-.29**	-.35**	.09	-.11*	-.12*	-.01	1

Note. GAF = Global Assessment of Functioning.

*$p < .05$. **$p < .01$.

Given the very high correlation between the relevance ratings for the "general anxiety" and "other anxiety disorder" diagnostic categories, these two categories were averaged for subsequent analysis for simplicity of modeling. Based on the overall low correlations between dependent variables, it will be appropriate to conduct separate analyses to examine the effects of the experimental conditions on the outcome variables.

TABLE 17. Correlations Between Diagnostic Ratings for the Diagnostic Categories ($N = 430$)

	Major Depression	Dysthymia	Depression NOS	Attachment Disorder	Generalized Anxiety	Other Anxiety	Dependent Personality	Adjustment Disorder
Major Depression	1							
Dysthymia	.30**	1						
Depression NOS	.35**	.48**	1					
Attachment Disorder	.15**	.18**	.24**	1				
Generalized Anxiety	.25**	.08	.17**	.17**	1			
Other Anxiety	.28**	.11*	.19**	.25**	.72**	1		
Dependent Personality	.18**	.09	.14*	.31**	.45**	.43**	1	
Adjustment Disorder	.18**	.21**	.25**	.28**	-30**	.30**	.26**	1

*$p < .05$. **$p < .01$.

Univariate Analysis

The research questions were addressed within the context of several univariate general linear models (GLM). The independent categorical variables in the model were adoption status and sex. Continuous variables representing trainee knowledge, attitudes, skills, sex and experience were included as continuous independent variables. Interactions between the categorical and continuous variables will also be included to address specific hypotheses. The interaction effects corresponding with Research Questions 5–7 will be evaluated at $\alpha = .01$ instead of $\alpha = .05$ to minimize alpha inflation and the reporting of Type-I errors.

Analysis Assumptions

I explored the distributional properties of the variables of interest by examining frequency distributions and bivariate scatterplots before proceeding with statistical tests. The continuous variables showed minimal skewness with no substantial univariate outliers. Bivariate scatterplots were also used to assess the adequacy of using the correlation coefficient as a measure of relationship between continuous variables of interest. All relationships appeared to be linear in nature and no bivariate outliers were identified. One of the primary assumptions of the univariate GLM is that of homogeneity of variance (i.e., equal variance at each level of the categorical independent variables). This was a concern given the sample sizes at each level of the categorical variables were not equal, which would have assured that the ANOVA was

robust against violations of the homogeneity assumption (Tabachnik & Fidell, 2001). Therefore, the standard deviations were inspected for each level of the categorical variables, and Levene's test of the equality of variances was used to test for violations of homogeneity. The homogeneity assumption was not violated in any of the univariate GLMs reported below.

Main Study Results

A review of each univariate test is provided below and organized according to each hypothesis.

Hypothesis 1

The first hypothesis was that "counselor trainees would perceive adopted clients (including both same-race and transracially adopted clients) in a more negative way compared with nonadopted clients, as measured by the outcome variables (concern and severity of client problems; seriousness of treatment plan and prognosis; favorable versus unfavorable adjectives; global assessment of functioning; and relevance of diagnoses)." With respect to perceived concern and severity of client problems, there was a significant main effect of adoption status: $F(2, 407) = 5.32$, $p = .005$, $\eta^2 = .03$. After controlling for trainee knowledge, attitudes, skills, sex and experience, nonadopted clients ($M = 3.45$) were rated as significantly lower in concern and severity than same-race ($M = 3.66$) and transracially adopted clients ($M = 3.68$) combined, $p =$

.001. This means that as hypothesized, participants viewed adopted clients differently from nonadopted clients. Table 18 shows the adjusted mean concern and severity ratings for the clients in each experimental condition.

TABLE 18. Adjusted Mean Concern and Severity by Experimental Condition

	Nonadopted	Same-race	Transracial	Total
Male	3.34 (.09) $n = 49$	3.70 (.07) $n = 78$	3.68 (.07) $n = 73$	3.57 (.05) $n = 200$
Female	3.55 (.07) $n = 82$	3.62 (.08) $n = 72$	3.67 (.08) $n = 65$	3.61 (.04) $n = 219$
Total	3.45 (.06) $n = 131$	3.66 (.05) $n = 150$	3.68 (.05) $n = 138$	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

In addition, for the diagnosis outcome variable of attachment disorder, there was a significant main effect of adoption status: $F(2, 405) = 18.38$, $p < .001$, $\eta^2 = .083$. After controlling for trainee knowledge, attitudes, skills, sex and experience, attachment disorder was rated as significantly more relevant for same-race adoptees ($M = 2.36$) and transracially adopted clients ($M = 2.26$) combined, as compared to nonadopted clients ($M = 1.90$), $p < .001$. The adjusted mean relevance of attachment-related disorder for each experimental condition is presented in Table 19. There were no other significant effects comparing nonadopted and adopted clients (i.e., same-race and transracially adopted clients combined).

TABLE 19. Adjusted Mean Relevance Ratings for Attachment-Related Disorder by Experimental Condition

	Nonadopted	Same-race	Transracial	Total
Male	1.79 (.09) $n = 48$	2.30 (.07) $n = 77$	2.25 (.08) $n = 73$	2.11 (.05) $n = 198$
Female	2.01 (.07) $n = 82$	2.42 (.08) $n = 72$	2.27 (.08) $n = 65$	2.23 (.04) $n = 219$
Total	1.90 (.06) $n = 130$	2.36 (.05) $n = 149$	2.26 (.06) $n = 138$	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

Hypothesis 2

The second hypothesis was that "counselor trainees would perceive transracially adopted clients in a more negative way compared with same-race adopted clients, as measured by the outcome variables." For the outcome variable level of functioning, there was a nearly significant main effect of adoption status: $F(2, 403) = 2.70$, $p = .07$, $\eta^2 = .013$. After controlling for trainee knowledge, attitudes, skills, sex, and experience, nonadopted clients ($M = 57.62$) had a higher mean GAF score than same-race ($M = 55.32$), $p < .05$, but did not significantly differ from transracially adopted clients ($M = 56.95$). This means that counselor trainees rated same-race adopted clients as lower functioning than nonadopted clients. See Table 20 for the adjusted mean GAF for each experimental condition.

TABLE 20. Adjusted Mean GAF Ratings by Experimental Condition

	Nonadopted	Same-race	Transracial	Total
Male	58.73 (1.21) $n = 49$	55.68 (.96) $n = 77$	56.52 (.99) $n = 73$	56.98 (.61) $n = 199$
Female	56.51 (.93) $n = 82$	54.95 (1.00) $n = 71$	57.37 (1.07) $n = 63$	56.28 (.58) $n = 216$
Total	57.62 (.76) $n = 131$	55.32 (.70) $n = 148$	56.95 (.73) $n = 136$	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

A significant main effect of adoption status was found with the diagnosis outcome variable of major depression: $F(2, 405) = 3.78$, $p = .02$, $\eta^2 = .018$. After controlling for trainee knowledge, attitudes, skills, sex, and experience, major depression was rated as less relevant to transracially adopted clients ($M = 2.27$) as compared to same race ($M = 2.43$) and nonadopted clients ($M = 2.46$), $p < .05$. The adjusted mean relevance of major depression for each experimental condition is presented in Table 21.

Furthermore, a significant main effect of adoptions status was found with the diagnosis outcome variable of dependent personality disorder. After controlling for trainee knowledge, attitudes, skills, sex, and experience, there was a significant main effect of adoption status: $F(2, 405) = 3.40$, $p = .034$, $\eta^2 = .017$. This diagnosis was rated as significantly lower for transracial adoptees ($M = 1.42$) as compared to same-race adoptees ($M = 1.61$), $p = .01$. The adjusted mean relevance of dependent personality

disorder for each experimental condition is presented in Table 22. There were no other significant effects comparing same-race adopted clients with transracially adopted clients.

TABLE 21. Adjusted Mean Relevance Ratings for Major Depression by Experimental Condition

	Nonadopted	Same-race	Transracial	Total
Male	2.33 (.09) $n = 48$	2.35 (.07) $n = 77$	2.20 (.07) $n = 73$	2.29 (.04) $n = 198$
Female	2.59 (.07) $n = 82$	2.52 (.07) $n = 72$	2.35 (.07) $n = 65$	2.49 (.04) $n = 219$
Total	2.46 (.05) $n = 130$	2.43 (.05) $n = 149$	2.27 (.05) $n = 138$	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

TABLE 22. Adjusted Mean Relevance Ratings for Dependent Personality Disorder by Experimental Condition.

	Nonadopted	Same-race	Transracial	Total
Male	1.44 (.09) $n = 48$	1.54 (.07) $n = 77$	1.41 (.07) $n = 73$	1.46 (.04) $n = 198$
Female	1.65 (.07) $n = 82$	1.67 (.07) $n = 72$	1.43 (.08) $n = 65$	1.58 (.04) $n = 219$
Total	1.55 (.06) $n = 130$	1.61 (.05) $n = 149$	1.42 (.05) $n = 138$	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

Hypothesis 3

The third hypothesis was that "counselor trainees would perceive male clients (adopted and nonadopted) in a more negative way compared with female clients, as measured by the outcome variables." There were several significant and nearly significant effects within the relevance-of-diagnosis outcome variable. Counselor trainees rated the following diagnoses as more relevant for female clients than male clients: major depression, attachment-related disorder, adjustment disorder, and dependent personality disorder. Specifically, after controlling for trainee knowledge, attitudes, skills, sex, and experience, trainees rated major depression as more relevant for female clients ($M = 2.49$) than male clients ($M = 2.29$): $F(1, 405) = 10.89$, $p = .001$, $\eta^2 = .026$. The adjusted mean relevance of major depression (*MD*) for each experimental condition (trainee knowledge, attitudes, skills, sex, and experience) is presented in Table 23.

The main effect of sex was also nearly significant for attachment-related disorder: $F(1, 405) = 3.46$, $p = .064$, $\eta^2 = .008$, with female clients ($M = 2.23$) receiving higher relevance ratings than male clients ($M = 2.11$; see Table 24).

The diagnosis of dependent personality disorder was also rated as more relevant for female clients ($M = 1.58$) than male clients ($M = 1.46$): $F(1, 405) = 4.10$, $p = .044$, $\eta^2 = .010$ (see Table 25).

TABLE 23. Adjusted Mean Relevance Ratings for Major Depression by Experimental Condition

	Nonadopted	Same-race	Transracial	Total
Male	2.33 (.09) *n* = 48	2.35 (.07) *n* = 77	2.20 (.07) *n* = 73	2.29 (.04) *n* = 198
Female	2.59 (.07) *n* = 82	2.52 (.07) *n* = 72	2.35 (.07) *n* = 65	2.49 (.04) *n* = 219
Total	2.46 (.05) *n* = 130	2.43 (.05) *n* = 149	2.27 (.05) *n* = 138	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

TABLE 24. Adjusted Mean Relevance Ratings for Attachment-Related Disorder by Experimental Condition

	Nonadopted	Same-race	Transracial	Total
Male	1.79 (.09) *n* = 48	2.30 (.07) *n* = 77	2.25 (.08) *n* = 73	2.11 (.05) *n* = 198
Female	2.01 (.07) *n* = 82	2.42 (.08) *n* = 72	2.27 (.08) *n* = 65	2.23 (.04) *n* = 219
Total	1.90 (.06) *n* = 130	2.36 (.05) *n* = 149	2.26 (.06) *n* = 138	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

And finally, the diagnosis of adjustment-related disorder was also rated as more relevant for female clients ($M = 2.22$) than male clients ($M = 2.10$): $F(1, 405) = 3.67$, $p = .05$, $\eta^2 = .009$. See Table 26 for the adjusted mean relevance of adjustment-related disorder for each experimental condition (trainee knowledge, attitudes, skills, sex, and

experience). There were no other significant effects comparing male and female client conditions.

TABLE 25. Adjusted Mean Relevance Ratings for Dependent Personality Disorder by Experimental Condition

	Nonadopted	Same-race	Transracial	Total
Male	1.44 (.09) *n* = 48	1.54 (.07) *n* = 77	1.41 (.07) *n* = 73	1.46 (.04) *n* = 198
Female	1.65 (.07) *n* = 82	1.67 (.07) *n* = 72	1.43 (.08) *n* = 65	1.58 (.04) *n* = 219
Total	1.55 (.06) *n* = 130	1.61 (.05) *n* = 149	1.42 (.05) *n* = 138	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

TABLE 26. Adjusted Mean Relevance Ratings for Adjustment-Related Disorder by Experimental Condition

	Nonadopted	Same-race	Transracial	Total
Male	2.05 (.09) *n* = 48	2.09 (.07) *n* = 77	2.14 (.08) *n* = 73	2.10 (.05) *n* = 198
Female	2.15 (.07) *n* = 82	2.26 (.08) *n* = 72	2.25 (.08) *n* = 65	2.22 (.04) *n* = 219
Total	2.10 (.06) *n* = 130	2.19 (.05) *n* = 149	2.19 (.06) *n* = 138	

Note. Figures represent adjusted means (followed by *SE*). Means are adjusted for trainee knowledge, attitudes, skills, gender and experience.

Hypothesis 4

The fourth hypothesis was that "counselor trainees would perceive adopted male clients (including both same-race and transracially adopted male clients) in a more negative way compared with adopted female clients, as measured by the outcome variables." The trends in responses were the same as those in Hypothesis 3. Overall, the diagnoses of major depression, attachment-related disorder, adjustment-related disorder and dependent personality disorder were rated as more relevant for female adopted clients than male adopted clients. However, none of these effects were statistically significant.

Hypothesis 5

The fifth hypothesis was that "the relationships identified in Hypotheses 1–4 would vary based on counselor trainees' adoption-related knowledge, attitudes and skills." It was predicted that counselor trainees with lower adoption-related knowledge, attitudes and skills would perceive adopted clients in a more negative way compared with nonadopted clients, as measured by the outcome variables. Counselor trainees' adoption-related knowledge, attitudes and skills did not significantly interact with adoption status or client gender on any of the outcome variables. Thus, trainees with lower adoption-related knowledge, attitudes or skills did not perceive clients (based on either adoption status or sex) any differently than trainees with higher knowledge, attitudes, and skills.

However, there were several main effects of trainee knowledge, attitudes and skills. There was a significant relationship between trainee attitudes and trainee ratings of clients' level of functioning. Trainees with more positive attitudes towards adoption gave higher level-of-functioning scores overall: $F(1, 403) = 3.61$, $p = .06$, $\eta^2 = .009$. Less positive attitudes of adoption held by trainees were related to longer estimates of the needed treatment plan, $F(1, 394) = 8.153$, $p = .005$, $\eta^2 = .02$, regardless of adoption status. And finally, trainees with more positive attitudes towards adoption found the diagnosis of attachment-related disorder to be less relevant overall: $F(1, 405) = 6.65$, $p = .010$, $\eta^2 = .016$.

Exploratory Hypothesis 6

The sixth hypothesis was that "the relationships identified in Hypotheses 1–4 will vary based on counselor trainees' sex." It was hypothesized that male counselor trainees would perceive adopted clients in a more negative way, compared with nonadopted clients, than female counselor trainees. There were no main or interaction effects found, except that female participants ($M = 16.09$) tended to give longer treatment estimates than male participants ($M = 13.23$), $F(1,394) = 5.496$, $p = .02$, $\eta^2 = .014$, regardless of adoption status.

Exploratory Hypothesis 7

The seventh hypothesis was that "the relationships identified in Hypotheses 1–4 will vary based on counselor trainees' level of clinical training and professional experience." It was hypothesized that counselor trainees with less clinical training and less professional experience would perceive adopted clients in a more negative way compared with nonadopted clients. (Trainee experience was defined as the number of clients that a trainee had seen in supervised sessions and the total years of counselor experience.) There were no significant interaction effects on any of the outcome variables. However, there was a trend for participants who had seen more clients to check more favorable adjectives, $F(1, 402) = 3.38$, $p = .067$, $\eta^2 = .008$, regardless of adoption status. In addition, the more clients a trainee had seen, the longer the estimates of the needed treatment plan: $F(1,394) = 6.862$, $p = .009$, $\eta^2 = .017$.

Trainees who were more experienced also rated the several diagnoses as relevant as compared with trainees who were less experienced. Regardless of adoption status, experienced trainees rated the diagnoses of depression NOS, $F(1, 405) = 8.54$, $p = .004$, $\eta^2 = .021$, attachment-related disorder, $F(1, 405) = 4.15$, $p = .042$, $\eta^2 = .01$, and adjustment-related disorder, $F(1, 405) = 3.91$, $p = .05$, $\eta^2 = .01$, to be more relevant overall.

Finally, trainees also reported the total number of same-race and transracially adopted clients that they had treated. However, only 20% ($n = 89$) and 13% ($n = 59$) had seen clients that identified as same-race or transracial adoptees, respectively. There

were no significant effects using these more specific experience variables in the GLMs. Because the lack of effects may be due to small sample size, these results are not reported in further detail.

Summary of Findings

In conclusion, counselor trainees perceive adopted clients (both same-race and transracially adopted clients) differently from nonadopted clients on several variables. As predicted in Hypothesis 1, findings demonstrated that counselor trainees assigned significantly higher ratings of concern to adopted clients than nonadopted clients, and rated adopted clients' problems as significantly more severe than nonadopted clients. Counselor trainees also rated the diagnosis of attachment disorder as significantly more relevant for adopted clients than nonadopted ones. As predicted in Hypothesis 2, counselor trainees rated same-race adopted clients as significantly lower on overall functioning than both nonadopted clients and transracially adopted clients.

Several additional differences between groups emerged when trainees were asked to rate the relevance of different diagnoses. First, trainees rated the diagnoses of major depression and dependent personality disorder as significantly more relevant for same-race adopted clients than transracially adopted clients. As stated in Hypothesis 2, I had predicted that counselor trainees would significantly assign these diagnoses more to transracially adopted clients than to same-race adopted clients, so study findings actually support the opposite of my original hypothesis. Second, trainees rated several

diagnoses significantly more relevant for female clients (overall and adopted) versus male clients (overall and adopted), including major depression, attachment-related disorder, adjustment-related disorder, and dependent personality disorder. Although I originally predicted a difference between female and male clients, as well as adopted female and adopted male clients, I predicted that male clients, particularly male adopted clients, would be assigned significantly more diagnoses than female clients. Results were the opposite of what I had predicted in Exploratory Hypothesis 6.

Contrary to hypotheses, there were no differences reported in the areas of treatment planning and prognosis or the assignment of favorable or unfavorable adjectives across the independent variables: (a) adopted client versus nonadopted client, (b) same-race adopted versus nonadopted, (c) male versus female client, and (d) male adopted versus female adopted client. Results will be discussed in greater detail in the next chapter.

CHAPTER IV

DISCUSSION

In this study I explored counselor trainees' perceptions of adopted clients, and how these perceptions might vary according to counselor trainees' adoption-related knowledge, attitudes, and clinical experience. The overall findings of this study support the hypothesis that trainees view adopted clients differently and generally more negatively based on their adoption status. Counselor trainees rated adopted clients' problems as significantly more severe, and indicate same-race adopted clients are significantly lower functioning than nonadopted clients. Contrary to hypotheses, there were no interactions between the trainees' adoption-related knowledge, attitudes and skills and trainee perceptions of clients. With a large sample size and corresponding statistical power in this study, small effect sizes could be adequately detected, so the lack of main or interaction effects is likely not due to error.

Differences in Perception Based on Adoption Status

Several differences emerged in counselor trainees' perception of clients based on adoption status. The first study hypothesis was that counselor trainees would perceive adopted clients (including both same-race and transracially adopted clients) in more negative ways compared to nonadopted clients. The second study hypothesis was that

trainees would perceive transracially adopted clients in more negative ways compared to same-race adopted clients. As hypothesized, counselor trainees perceived adopted clients differently from nonadopted clients in ratings of concern and severity of problems, and ratings of diagnosis for attachment disorder. Trainees indicated having significantly greater levels of concern for adopted clients, and rated them as having significantly more severe problems than nonadopted clients. These findings are consistent with previous research showing that adopted children are seen as being different (Friedman-Kessler, 1987, as cited in Evan B. Donaldson, n.d.-b), that adopted children are perceived less favorably than biological children in general (Bonds-Raacke, 2009), and that mental health professionals perceived adopted clients as having a greater problem severity (Kojis, 1990).

In this study, counselor trainees rated attachment disorder as significantly more relevant for adopted clients than nonadopted clients. This is consistent with previous research and the clinical literature that indicates adoptees experience higher rates of attachment-related issues or disorders when compared to nonadoptees (Borders et al., 2000; Feeney, Passmore, & Peterson, 2007). Adoption researchers and practitioners state that attachment issues can become salient for adopted clients in adolescence and adulthood in particular, a period when learning to negotiate interpersonal relationships is a normative developmental task regardless of adoption status (Pavao, 2007). The hypothetical client case scenario used in this study in fact, featured a 20-year old college student. When participants rated attachment disorder as being more relevant for

adopted clients, it is possible they did so because they were familiar with adoption and attachment-related literature. However, 92% of counselor trainees in this study had read "three or fewer" empirical articles about adoption, 54% had read "none," 67% had never attended a lecture or presentation about adoption issues, and 73% had no previous experience working clinically with adopted clients. With this lack of exposure to adoption-related research, training, and experience, the high rates of diagnosis assigned by participants are likely not attributable to their knowledge about adoption issues. The results of this study suggest that bias is a significant contributor to counselor trainees' perceptions. Moreover, the results also suggest that the previous body of research on adopted clients showing that they experience a greater frequency of attachment-related disorders may not be decoupled from this potential bias.

The second study hypothesis was that counselor trainees would perceive transracially adopted clients in a more negative way compared to same-race adopted clients. Differences in the perception of same-race versus transracial adoptees have not previously been empirically examined, except for one small study from South Africa (Moos & Mwaba, 2007). The authors reported that in their sample of 72 undergraduate college students, most had positive attitudes towards and supported transracial adoption. Although the authors expressed optimism that these attitudes among young adults were an indication of a new generation committed to positive racial relations, it is difficult to generalize results of this study to other contexts because of both their small sample of convenience, and because the complex contextual/historical factors in South Africa are

unique. As such, this study is the first to examine perceptions of same-race versus transracial adoption in the U.S. and among mental health professionals. Results indicated that counselor trainees perceive differences between same-race adopted clients and transracially adopted clients by the ratings they provided on the relevance of several diagnoses. But findings were not in the direction anticipated. Counselor trainees rated major depressive disorder and dependent personality disorder as significantly more relevant for same-race adopted clients than transracially adopted clients. Trainees also rated major depression as significantly more relevant for nonadopted clients *and* same-race clients than transracially adopted clients. It is interesting that both nonadoptees and same-race adoptees fared worse (i.e., were assigned major depression as being more relevant) than transracial adoptees. Because there has been no research on the differences in counselor trainees' or mental health professionals' perceptions of transracially adopted clients in comparison with same-race or nonadopted clients, it is difficult to conceptualize why these findings might have emerged. The limited but emerging literature on transracial adoption reveals a longstanding debate on the perceived benefits versus risks associated with transracial adoption. Perhaps the perceived benefits of transracial adoption contributed to participants' overall perception and response patterns.

Some of the perceived benefits attributed to the practice of transracial adoption could be related to altruistic intentions communicated either implicitly or explicitly as there are "needy children" who need "good homes." Due to complex and extenuating

social, economic and political factors from adoptees' countries of origin, these well-intentioned sentiments could tend to be directed towards transracial adoptees in particular. Although transracial adoptions occur domestically in the U.S., the majority of transracial adoptions are international adoptions (National Data Analysis System, 2007). According to the latest published records of immigration visas issued to orphans in 2002, the top 10 countries of origin of U.S. international adoptees are, in rank order, China, Russia, Guatemala, South Korea, Ukraine, Kazakhstan, Ethiopia, India, Columbia and the Philippines (U.S. Department of State, 2006). Children are available for adoption internationally as a result of various complex sociopolitical and economic situations, including poverty, social stigma (i.e., towards biracial children), deaths of caregivers, mandated population controls, incidents of war and natural disasters (Baden, 2007; Fisher 2003). On the one hand, a common perspective in adoption literature is that overall, adoption is a very positive and effective solution in problematic situations when children need care (Brodzinsky, 1993; Zamostny, O'Brien, et al., 2003). Children born in these environments of poverty, for example, whose biological parents cannot or will not provide for them need permanent "good" homes—the perception perhaps being that transracial adoptees are "better off" postadoption, and particularly better off postadoption in the U.S. as compared to their countries of origin. On the other hand, critics argue that the U.S. should be focusing on solutions to the problems leading to the availability of large numbers of international adoptees, rather than adopting them (Quiroz, 2007). Other critics of the practice have conceptualized international adoption

as a type of colonialism or cultural genocide (Tizard, 1991) and "the ultimate expression of American Imperialism" (Ryan, 1983, p. 51). Regardless of differing perspectives within the field of adoption research, practice and policy, it is still difficult to conceptualize why the findings in this study regarding trainee perceptions of transracially adopted clients emerged in the direction it did. It is a provocative idea that the responses of counselor trainees were influenced by certain perceived benefits to transracial adoption that they do not associate with same-race adoption.

Outcome studies investigating the adjustment of transracial adoptees reveal mixed results, but overall speak to the complexity that exists when a child is adopted by parents of a different race or ethnicity. On the one hand, empirical evidence suggests that transracial adoptees struggle with increased behavioral and psychiatric problems (Brooks & Barth, 1999; Cederblad, Hook, Irhammar, & Mercke, 1999); lower self-esteem (Hollingsworth, 1997); discomfort with their racial or ethnic appearance (Brooks & Barth, 1999; Feigelman, 2000); racial and ethnic identity development (Baden, 2002; Hollingsworth, 1997; Lee, 2003); and experiences of discrimination (Feigelman, 2000). On the other hand, other studies could find no significant differences in adjustment when transracial adoptees are compared with nonadoptees (Simon & Altstein, 2004; Tizard, 1991). Overall, adoption researchers and practitioners who specialize in transracial adoption issues emphasize that when transracial adoption is a factor in an adoptee's experience, there are additional layers of complexity involved with adjustment and identity development that have yet to be fully understood in research or

practice (Baden, 2002; Baden & Wiley, 2007; Lee, 2003). This multilayering of complex adoption-related issues has been labeled "cumulative adoption trauma" (Lifton, 1994). It has been suggested that these additional layers of complexity involving the negotiation of ethnic identity and layers of differences magnify already existing and normative adoption-related issues such as loss, grief, and a lifelong process of identity development (Baden & Wiley, 2007; Grotevant, 1997; Zamostny, Wiley, et al., 2003). Results of this study suggest that counselors and mental health professionals must be aware of the unique issues faced by adoptees in general and transracial adoptees in particular.

Another significant finding that emerged in this study was that trainees viewed same-race adoptees as lower functioning than nonadoptees, as indicated by scores on the Global Assessment of Functioning Scale (American Psychiatric Association, 2000). Even though a small effect size was detected, the result is noteworthy. There is a longstanding debate in the adoption literature revolving around whether or not adoption is a risk factor for increased rates of pathology and maladjustment (see Appendix A). On the one hand, some adoption researchers conclude that adopted individuals are at significantly higher risk for negative psychological and behavioral adjustment when compared to nonadopted individuals (Cederblad et al., 1999; Collishaw, Maughan, & Pickles, 1998; Cubito & Brandon, 2000; Moore & Fombonne, 1999; Wierzbicki, 1993). On the other hand, other researchers report no significant differences between adopted and nonadopted individuals, and conclude that adoptees are at no greater risk for

maladjustment based on adoption status alone (Borders, Black, & Pasley, 1998; Brodzinsky & Brodzinsky, 1992; Burrow, Tubman, & Finley, 2004; Kelly, Towner-Thyrum, Rigby, & Martin, 1998). Regardless of whether or not the experience of adoption or identity as an adoptee puts individuals at greater risk, it appears that counselor trainees participating in this study believe that it does.

Another possible explanation for why counselor trainees rate same-race adopted clients as lower functioning than nonadopted clients could be connected to the claim made by adoption researchers that adoption has been stigmatized historically in our society (Zamostny, O'Brien, et al., 2003) and that trainees experience bias against adopted clients. Although adoption researchers and practitioners clearly state that while the practice of adoption seems to be increasingly accepted by the American public, bias and skepticism continue to exist (Freundlich, 2002, 2007). Half the participants in a 1997 national study ($N = 1,554$), for example, reported believing that adoption is inferior to having a biological child, and 25% felt it would be more difficult to love an adopted child (Evan B. Donaldson Institute, 1997). Similarly, Bonds-Raacke (2009) documented that college students have a more favorable attitude towards biological children than adopted children.

Negative attitudes towards adopted clients on the part of mental health professionals were demonstrated in Kojis' 1990 study. Kojis reported that mental health professionals perceived adopted clients differently than nonadopted clients in ratings of seriousness of treatment plans and prognosis, and in the assignment of

favorable versus unfavorable adjectives. This study did not parallel Kojis' (1990) findings, although questions in this study designed to assess counselor trainees' seriousness of treatment plans and prognosis were modeled closely after Kojis', and the same subscale of the Adjective Checklist was utilized to assess positive or negative adjectives. The difference in findings from this study in comparison to Kojis' may be due to (a) differences in the samples and (b) changes in attitudes and biases that are reflected in the contemporary population. In Kojis' study, all participants were practicing psychiatrists (37%), psychologists (38.8%) or social workers (34.2%). Perhaps differences in theoretical orientation or emphases in clinical training programs from an earlier generation (e.g., greater emphasis on diagnosis or pathology) could account for the different results based on samples. And although Kojis' unpublished dissertation study was completed in 1990, the sample was identified as providing data in 1982. More than 25 years, or a generation, has passed since the Kojis study, and contemporary attitudes and understanding may simply reflect different values and worldviews. For example, in 2002, 64% of Americans (N = 1,416 sampled) had a "very favorable" opinion about adoption (Evan B. Donaldson Adoption Institute, 2002), and the survey's authors concluded that there is overwhelming support for adoption nationally. While the current study findings diverged from Kojis' findings, and this difference could be a reflection of more positive attitudes towards adoption in general, there is still evidence that adoption is devalued, remains a source of stigma, and is seen as an option that most Americans try to avoid (Bonds-Raacke, 2009; Fisher, 2003;

Freundlich, 1998) or consider only if they are unable have a biological child (Whatley, Jahangardi, Ross, & Knox, 2003).

Differences in Perception Based on Client Sex

Regarding sex differences, the third study hypothesis was that counselor trainees would perceive male clients in a more negative way compared with female clients, and the fourth study hypothesis was that counselor trainees would perceive adopted male clients (including both same-race and transracially adopted male clients) in a more negative way compared with adopted female clients. There were significant differences in how trainees perceived clients based on sex of the client. Counselor trainees rated several diagnoses as being more relevant for female clients (regardless of adoption status) and for female adopted clients when compared to male clients. Counselor trainees rated virtually every diagnoses as more relevant for female than male clients, including major depression, attachment-related disorder, adjustment-related disorder and dependent personality disorder despite an identical case scenario that varied only according to sex and adoption status. Many researchers have expressed concern that sex bias exists in diagnosis, and cited evidence that women are diagnosed with mental illness at higher rates than men, and across significantly more disorders (Eriksen & Kress, 2008; Hartung & Widiger, 1998). In 1983, researchers such as Kass, Spitzer, and Williams acknowledged that sex bias might exist at the referral stage, when women might be more likely to be referred for treatment than men. But they argued that sex

bias does not exist once individuals are diagnosed in treatment facilities where diagnostic criteria are applied. Regardless of their argument, statistics clearly indicate that prevalence rates among specific disorders differ by sex. Women are significantly overrepresented in all forms of mood and anxiety disorders (Hartung & Widiger, 1998; Horsfall, 2001) and dependent personality disorder (Nehls, 1998), while men predominate within substance abuse and sexually related disorders. Findings from this study support an overall bias in the willingness of counselor trainees to apply more significant and substantial diagnoses to women over men.

In regards to the fourth hypothesis, even though adoption researchers remain divided on whether or not adoption itself is a risk factor for maladjustment, several studies report that male adoptees are at particular risk for behavior problems and delinquent behaviors (Brodzinsky, Hitt, & Smith, 1993) as well as increased rates of alcohol use and lower attainment of social support (Collishaw et al., 1998) when compared to adopted females, and nonadopted males and females. Using the literature as a basis, I predicted that counselor trainees would report greater concern and severity of problems, more serious treatment plans, more negative adjectives and lower scores on level of functioning for male clients overall, and for adopted male clients in particular, in comparison with nonadopted males and females. No differences, however, were found in any of these areas. One hypothesis for this finding may be that bias in diagnosis related to sex is stronger or more powerful than bias in diagnosis related to adoption status. Eriksen and Kress (2008) argue that gender stereotyping and bias in

diagnosis continues to exist in the mental health professions. In the current study, it appears that sex bias in diagnosis had a greater influence on participants than that of adoption status alone, and adoption status and sex combined. Eriksen and Kress (2008) caution counselors to be more aware of and sensitive to the role of stigma and socialization when prescribing diagnoses, and recommend that counselor training programs include topics on gender and diagnosis as part of their preexisting multicultural training.

Effect of Adoption Knowledge, Attitudes and Skills

The fifth study hypothesis was that all of the relationships identified in Hypotheses 1-4 would change based on the counselor trainees' adoption-related knowledge, attitudes and skills. Specifically, it was hypothesized that counselor trainees with lower adoption-related knowledge, attitudes and skills (as measured by KASAS scores) would perceive adopted clients in a more negative way compared with nonadopted clients. Surprisingly, no main or interaction effects were found, indicating that adoption knowledge, attitudes and skills as measured by the KASAS in this study may not be related to trainees' perceptions of clients.

As discussed in Chapter II, the KASAS was developed explicitly for this study and modeled closely after the Multicultural Awareness, Knowledge and Skills Survey—Counselor Edition (MAKSS-CE; Kim et al., 2003). The MAKSS-CE was one of the first instruments created to assess the three domains of multicultural competence based

on the model of cross-cultural counseling developed by Sue et al. (1982). The three dimensions are beliefs or attitudes, knowledge, and skills. Sue et al. (1982) stated that culturally skilled and multiculturally competent counselors will have an awareness of how their beliefs and attitudes can affect minority clients, and will possess specific knowledge about, and skills for, working clinically with their clients' ethnic group or identity. The MAKSS-CE has undergone several revisions and validation studies. Overall, it has been well received by counseling and multicultural communities. As reported in its 2003 revision publication, the MAKSS-CE had been requested for administration in over 650 locations, including universities, in six different countries since its original publication in 1991 (Kim et al., 2003). Despite its popularity, it has received some criticism for needing more rigorous examination, including additional factor analyses to test the three-factor structure, and to provide stronger evidence for the construct and criterion-related validity of the scores. Like the MAKSS-CE, additional psychometric support for the validity of the KASAS is certainly needed. Even though I processed the KASAS through a rigorous reliability process and determined a cohesive and clear factorial structure that I used in study analyses, the KASAS may be somewhat limited in capturing nuances of bias as they relate to clinical work with adopted clients.

Another explanation for this lack of finding in this study may be related to measurement method. I relied solely on self-report data, and instruments that rely solely on self-report data will always be something of a limitation in data collection. Cartwright, Daniels, and Zhang (2008) state that this limitation can be even more

pronounced when attempting to assess for multicultural competencies. In their 2008 study, they examined the predictive validity of counselor trainees' self-reported multicultural counseling competence—using scores from the MAKSS-CE—in comparison to scores generated by independent observers who rated videotaped role-play interactions. They found significant discrepancies between counselor trainees' self-reported competencies and independent observers' ratings. Across all three subscales of the MAKSS-CE, the self-report scores were significantly higher than those of the independent observers: Awareness (self-report, $M = 55.87$, $SD = 7.97$, versus observer, $M = 32.56$, $SD = 10.26$); Knowledge ($M = 49.63$, $SD = 5.71$ versus $M = 29.22$, $SD = 6.57$); and Skills ($M = 43.80$, $SD = 7.56$ versus $M = 33.22$, $SD = 8.79$). Their results challenge the accuracy of using self-report data to measure the three domains of multicultural counseling competence: awareness, knowledge and skills. While this clearly supports the use of multimethod measurement approaches in general, more specifically for this study, the use of self-report data may only partly explain why I was unable to find a significant relationship associated with the KASAS. Consequently, caution must be used in interpreting the lack of significant findings here.

Researchers state that additional research is needed to examine existing multicultural assessment tools (Hays, 2008) and develop new measures that can assess for implicit biases of clients from diverse backgrounds (Boysen & Vogel, 2008). Traditional explicit measures of bias are self-report instruments, which require the use of conscious awareness, but implicit measures can assess attitudes, actions or judgments

(a) that can emerge without having to ask for the information directly, (b) that the participant may not have conscious awareness of or control over, or (c) that predict some forms of subtle biases better than explicit measures (Boysen & Vogel, 2008; Greenwald, McGhee, & Schwartz, 1998; Nosek, Banaji, & Greenwald, 2002). In a study examining multicultural competency and bias among counselor trainees towards African Americans and lesbian and gay men, Boysen and Vogel (2008) found that implicit bias toward diverse groups was present despite high self-report multicultural competency scores. The self-report measure of multicultural competency used was the Cross-Cultural Counseling Inventory—Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), which, like the MAKSS-CE, also assesses for the three domains of multicultural awareness, knowledge and skills. Boysen and Vogel (2008) concluded that implicit biases among counselor trainees can coexist with strong self-reported beliefs of personal and professional multicultural competencies. Abreu (2001) states that understanding the complex interaction between multicultural competency and counselors' implicit and explicit beliefs and attitudes is a difficult but crucial component in counselor training and multicultural education. No studies could be located on the relationship between implicit bias and adoption issues. The field of adoption research would benefit from a further exploration of counselor trainees' levels of implicit biases towards adoption.

Limitations of the Study

Study limitations should be considered when interpreting the present findings. First, the sampling procedure used resulted in two potential limitations to the generalizability of results. A large percentage of respondents were in their first or second years of training (69.2%) and had very little or no clinical experience. Thirty-four percent had not seen any clients at the time of the survey, and almost 20% had seen only 1-10 clients. Self-selection could be a limitation if participants in their first few years of graduate study with less clinical experience were more likely to respond to the request for participation in this study. It was my goal to gather data from a broadly representative sample of trainees with a wide range of clinical experience, and to do so during several different years of their training. However, more advanced students did not participate at the same rates as earlier trainees.

Second, measurement may have been another limitation of this study. The KASAS was both developed and used in this one study. Further development of the KASAS is needed. Additional factor analyses will be necessary to be sure results are generalizable to populations of interest. Also, it is possible that while the KASAS is clearly assessing for the constructs of knowledge, attitudes, and skills, perhaps it is actually the existence of bias that has a stronger impact on perceptions of clients. Therefore, the findings from this study with respect to the lack of interaction effects of adoption-related knowledge, attitudes, and skills on perceptions of clients should be interpreted with caution.

Implications for Future Research

Future research should consider study limitations, as well as the findings and contributions of this study, by focusing on several different aspects of measurement development to enhance exploration of not only potential counselor bias, but also how bias may affect clinical work with adopted clients.

First, since many counselor trainees and mental health professionals may be unaware of their own subtle biases towards adoptees and adoptive families, researchers must pay particular attention to construction methodologies and instruments that can successfully detect such subtle and perhaps often unconscious or implicit biases. An important variable for future adoption research is the role of bias in mental health professionals' perceptions of clients, and why increased knowledge, attitudes, and skills do not necessarily have an effect on bias. In light of these issues, the KASAS should undergo continued examination to provide stronger and additional evidence for the criterion and construct validity of the subscale scores, as well as additional factor analyses to test the three-factor structure. Furthermore, the measure should be validated among different professional populations, including practicing psychologists and other mental health professionals with more practical experience than the trainees examined in the present study.

Second, future adoption research would benefit from the recommendations made by Boysen and Vogel (2008) and Cartwright et al. (2008) regarding the role of implicit

bias in multicultural competency development and counselor training. Specifically, the next study to examine adoption competence among mental health professionals should include the KASAS and an additional measure designed to assess professionals' implicit biases (Boysen & Vogel, 2008) towards adoption issues. Further investigation is warranted to explicate the relationships between (a) adoption-related implicit bias; (b) adoption-related knowledge, attitudes and skills; and (c) counselor perceptions of clients based on adoption status.

Finally, future research should also utilize multimethod approaches to measurement, and not rely solely on self-report data, which is particularly salient when assessing for multicultural competencies among counselor trainees (Cartwright et al., 2008). Following the recommendations of Cartwright et al. (2008), independent observer ratings from actual videotaped interactions with adopted clients (or in response to a hypothetical case vignette) should be included in the study design to assess the predictive validity of the adoption-related competence (KASAS) and implicit bias measures.

Implications for Practice

The results from this study also provide direction for future counselor training efforts. In addition to the biases that emerged, counselor trainees in the present study overwhelmingly report a desire for additional training in adoption issues. A majority (64%) feel either "not very prepared," or have "no knowledge" about dealing with

adoption issues in therapy. Only 30% feel "somewhat prepared," and 89% want additional training about adoption issues. This is consistent with results reported by Sass and Henderson (2000), who documented that 90% of practicing psychologists in their survey ($n = 210$) believe they need more education about adoption.

As Baden and Wiley (2007) posit, mental health professionals must have an understanding and a certain level of competence about adoption-related issues in order to effectively engage in clinical practice with adopted clients and members of the adoption triad. They advocate for professionals to have increased clinical training opportunities with members of the adoption triad, and that adoption issues should receive increased attention in counselor training programs' coursework, research seminars and practicum training. As findings of this study support, counselor training must specifically address adoption-related issues and require trainees to engage in active self-exploration of their own subtle assumptions or biases about adoption, in order to adequately prepare them to work with clients who are members of the adoption triad. Experts in the field of adoption research and practice emphasize that counselors working with adoptees and their families must be able to recognize their "overall resilience, strength, and positive coping abilities" (Porch, 2007, p. 303). Baden and Wiley (2007) offer a comprehensive set of suggestions and guidelines for clinical practice that should be included as a component in counselor training programs, particularly in practicum training and internship seminars. Based on the findings from

the present study, counselor trainees need to be provided with more information about adoption issues.

One of the suggestions made by Baden and Wiley (2007) for adoption-sensitive practice is that counselors must be able to acknowledge the uniqueness and complexity within each individual adoption experience, and avoid overpathologizing, or overgeneralizing to such a diverse population. Counselors should also be aware of their own attitudes and biases about adoption and adopted persons. Baden and Wiley (2007) also suggest that counselors must have knowledge about the multiple social, cultural and historical influences impacting members of the adoption triad, as well as the resources available to adopted clients. Practicing counselors and other mental health professionals should seek to become more adoption-sensitive. The Knowledge, Attitudes and Skills of Adoption Survey (KASAS) developed for this study can be used as a self-assessment tool for both trainees and professionals. Subscale scores from the KASAS and endorsements on individual items could offer either a starting point for engaging in critical self-examination of one's personal and professional competence with adoption issues, or a chance to reflect on the work one has already done and identify any areas or directions for ongoing improvement or professional development.

Also, the KASAS could be used to assess the efficacy of adoption-related counselor training when administered as a pre- and posttest instrument. The KASAS could be administered to assess the effectiveness of graduate training courses or lectures that are designed to enhance counselor trainees' competence in working therapeutically

with members of the adoption triad. It could also be administered before and after a course or lecture on adoption issues to explore potential changes in the trainees' level of adoption counseling competence as a result of participating in an adoption-training program.

Conclusion

The findings of this study provide a unique and valuable contribution to the existing literature base. Previous to this study there had been no research attempting to empirically examine mental health professionals' adoption-related knowledge, attitudes or skills, nor were there studies directed toward understanding how these constructs might relate to perceptions of clients based on adoption status. There has also been no prior study to assess for counselor trainee differences in the perception of same-race and transracially adopted clients. Furthermore, the present study represents an effort to develop a reliable and accurate measure of adoption competence for counselor trainees. Future research and practice would benefit from increased efforts directed towards measurement development and towards understanding counselor perceptions. Finally, adoption-related issues should be incorporated into existing counselor training and education programs so that mental health professionals can better serve adopted clients and all members of the adoption triad.

APPENDIX A

EXTENDED LITERATURE REVIEW

Introduction

Adoption is a personal, legal and social act steeped in emotion, cultural values, and at times, controversy. In the majority of cases, adoption involves three sets of people, commonly referred to as the "adoption triad": the adoptee, the adoptive family, and the birthmother or biological family. Also, adoption is no longer viewed as a single act, but a lifelong process for all members of the adoption triad (Brodzinsky et al., 1998).

Historically, adoption has a complex history in the United States, dating back to sociocultural events associated with orphaned children needing homes. Legal and informal adoptions took place throughout the industrial revolution and when the "orphan trains" brought dependent children to the West in the 1800s. Later, declining birth rates domestically and a rise in the number of international orphans associated with World Wars I and II influenced the rise in international adoption and unregulated domestic adoptions (Zamostny, O'Brien, et al., 2003). More recently, contemporary adoption practice has been influenced by the Civil Rights and Women's Movements of the 1960s and '70s, the advent of contraception and legalization of abortion, and a documented rise in infertility (Zamostny, O'Brien, et al., 2003).

To some extent, controversy has always existed in the practice of adoption. The debate over whether or not parents are suitable to adopt, or whether a particular placement for a particular child is appropriate or not, has existed throughout the long and rich worldwide history of adoption (Zamostny, O'Brien, et al., 2003). The focus of

the debate, however, has shifted over time: from determining the best interests of the parents to acting in the best interests of the child (Wilson, 2004; Zamostny, O'Brien, et al., 2003). Another longstanding debate revolves around whether or not the practice of adoption is itself a risk factor. Although historically and culturally, adoption has often been viewed as a positive and effective solution to certain social issues and problems (Zamostny, O'Brien, et al., 2003), the debate surges in the literature as to whether or not adoption puts adoptive children at risk for increased rates of psychopathology, maladjustment, and behavior problems. Consensus regarding the potential negative or harmful results of adoption remains inconclusive, and even posing this question may reflect a particular political agenda or bias itself. What is clear is that adoption research is widely criticized for its generally poor methodology and for allowing stigma associated with adoption practice to influence sampling and design issues (O'Brien & Zamostny, 2003; Zamostny, O'Brien, et al., 2003).

Underlying these debates is that the issues faced by members of the adoption triad are still misunderstood. It is estimated that 58% of all Americans have had some experience with adoption (Evan B. Donaldson Adoption Institute, 1997), and approximately 5-15% of all people who seek mental health services or counseling are adopted or involved in an adoption triad (Brodzinsky, 1993). Despite these numbers, multiple researchers and clinicians have documented that adoption issues as a clinical concern are virtually ignored or discounted in counselor training programs and that

there is a strong lack of knowledge of adoption issues among clinical practitioners (Porch, 2007; Sass & Henderson, 2000, 2007).

The purpose of this extended literature review is to review existing research on adoption and on clinical practice around adoption issues. Although all members of the adoption triad are important in research and practice, in this review I focus primarily on issues facing adoptees. I present prevalence rates and types of adoption, theoretical perspectives related to adoption research and practice, and I provide a critique of the extant literature on adoptee adjustment. I highlight the importance of conducting more in-depth research and increasing the rigor of counselor training related to adoption and adoption issues.

Adoption Prevalence and Types

Prevalence

The number of adoptions that occur each year in the U.S. have always been difficult to calculate. Statistics on adoption are generally considered incomplete and inconsistent because no single comprehensive data source exists for collecting adoption statistics in the United States (Zamostny, O'Brien, et al., 2003). For private adoptions in particular, there are no reporting requirements (National Data Analysis System, 2007). Existing estimates are generally made from a combination of state court records, numbers of international orphan visas issued, private nonprofit agencies' data collection, and national foster care records (Biafora & Esposito, 2007). Data suggest

that there are currently anywhere from 1 million (Stolley, 1993) to 5 million (Hollinger, 1998) adoptees in the U.S. The 2000 United States Census was the first census in history to collect data on adopted children, and it is reported that there are approximately 2.1 million adopted children in the U.S., with 1.6 million of these being less than 18 years old at the time of data collection (U.S. Census Bureau, 2003). This indicates that 2.5% of all children in the U.S. are adopted. In addition to recent census data, private, nonprofit organizations such as the Evan B. Donaldson Adoption Institute, has conducted large-scale data collection and analysis on U.S. adoptions. In their 1997 national survey, they found that 58% of Americans have had some personal experience with adoption. To have had experience with adoption, one had to be a member of the adoption triad—the adoptee, biological parent, or adoptive parent—or had to have a close family member or friend who is a member of this triad (Evan B. Donaldson, 1997).

Types

There are several different types of adoption, all of which have seen dramatic increases in the past decade. Domestic foster care adoptions have steadily increased from 28,000 in 1996 to 51,000 in 2001 (Porch, 2007). International adoptions have surged from approximately 7,000 in 1990 to 21,968 in 2005, based on federal records indicating the number of immigrant orphan visas issued (U.S. Department of State, 2006). A total of 234,358 children were adopted in the U.S. from countries other than

the U.S. between 1989 and 2005 (National Data Analysis System, 2007). In rank order, as of 2002, international adoptees from the following countries have received the highest number of immigrant orphan visas: China, Russia, Guatemala, South Korea and Ukraine (U.S. Department of State, 2006). Transracial adoption, generally understood as the adoption of children by parents of a different race or culture (Baden & Steward, 2007), by definition is assumed to occur in most all international adoptions and in approximately 15% of domestic foster care adoptions (data up to 1998; National Adoption Information Clearinghouse [NAIC], 2003). Special needs adoptions occur domestically within the foster care system and internationally, and refer to the adoption of children with physical, emotional or developmental conditions (Zamostny, O'Brien, et al., 2003).

In 1995, 500,000 women initiated adoption proceedings, and while the majority of adoptive parents are married, approximately 12-25% of adoptions that year were to single parents (Evan B. Donaldson Adoption Institute, n.d.-a). Researchers are documenting an increasing rate of lesbian or gay adoptive parents (Brooks & Goldberg, 2001). Adoptions can be "open" or "closed," referring to the varying levels of confidentiality and knowledge that is exchanged between the biological birth parents and the adoptive parents and child. Adoptions can occur between people who are not biologically related or are biologically related. In nonrelated adoptions, most two-parent families are likely to be European American, middle class, educated and dealing with infertility issues (Mosher & Bachrach, 1996). Relative adoptions most often occur

within the domestic foster care system, and adoptive parents are more likely to be African American with lower socioeconomic status and education than in nonrelative and international adoptions (Stolley, 1993).

Age at the time of adoption can vary widely. Approximately half of international adoptees are under the age of 1 year, and 90% are under the age of 5 (Evan B. Donaldson Adoption Institute, n.d.-a). It is generally assumed that older international adoptees have been in institutions or orphanages (Grotevant, 1997). Adoptees from foster care tend to be older and are likely to have experienced or been exposed to neglect or abuse (Porch, 2007).

Theoretical Perspectives of Adoptee Adjustment

A number of theoretical perspectives attempt to explain developmental patterns and adjustment problems unique to adoptees and their families. These include social role theory, attachment theory, family systems theory, and stress and coping theory. Each of these has been applied to adoptee and adoptive family adjustment. In this section, I review and critique each of these theoretical perspectives and applications. These perspectives, while helpful in some ways, also emerge out of a historical bias within psychology and related fields that tends to pathologize individuals and that locates problems as endogenous while ignoring or minimizing strengths or contextual, exogenous factors related to problem development (Zamostny, O'Brien, et al., 2003). These perspectives coalesce with a sociocultural bias against the "normality" of

adoptive families. Together, most of these theoretical perspectives are focused on an a priori conceptualization that there is vulnerability within any adopted child and family system. Moreover, these perspectives fail to thoroughly consider the whole ecology of issues and contexts in which adoption, with all its benefits and potential drawbacks, exists.

Social Role Theory

Kirk's (1964) social role theory is the first theory to attempt to explain adoption adjustment in terms of systemic patterns and family interactions. The theory assumes that relationships within adoptive families are built around issues related to loss and unique stressors resulting from social stigma for all members of the adoption triad (Brodzinsky et al., 1998; Zamostny, O'Brien, et al., 2003). To cope with feelings of loss and stress, Kirk (1964) suggested that parents either openly acknowledge the ways their family is different from biological families, or they reject their differences. The theory posits that the acknowledgement of differences and open communication within the family are crucial for healthy adjustment. If maladaptive behavior or adjustment occurs, social role theory posits it is primarily due to the inability of adoptive parents to negotiate social roles or "role handicaps" unique to adoptive families (Smith & Brodzinsky, 1994, p. 91).

Empirical support for this theory is limited and results are mixed, leading researchers to conclude that extreme patterns of either communication approach

(acknowledgment or rejection of differences) could be problematic (Brodzinsky et al., 1998; Zamostny, O'Brien, et al., 2003). Regardless, Kirk's (1964) theory is considered a foundational theory in adoption literature, and is praised for conceptualizing adoption adjustment within a broad ecological and social context (Zamostny, O'Brien, et al., 2003).

Attachment Theory

Bowlby's (1982) attachment theory posits attachment is a lifelong process that begins in infancy and continues throughout the lifespan. Infants' attachment experiences with primary caregivers are a primary survival function for their needs to get met, and these experiences impact the development of future relationships. Adoption researchers and clinicians favoring Bowlby's (1982) attachment theory tend to attribute later psychosocial problems to early separation and loss, particularly when the time of adoption occurs after the first year of life (Brodzinsky et al., 1998; Zamostny, O'Brien, et al., 2003). For example, Johnson and Fein (1991) have discussed how attachment theory conceptualizes the impact of adoption-related experiences such as bonding and loss on adoptees.

However, the limited amount of empirical research analyzing attachment with adoptees has produced conflicting results (McGinn, 2007). Some researchers have reported negative relationships between attachment problems with adoptees with histories of abuse or neglect in special needs adoptions (Groze & Rosenthal, 1993), and

prolonged exposure to institutional neglect and deprivation in international adoptees (O'Connor & Rutter, 2000). On the other hand, several researchers have reported no differences in attachment relationships between adoptees placed prior to age 6 months (Singer, Brodzinsky, Ramsay, Steir, & Waters, 1985) or international and transracial adoptees as compared to nonadoptees placed prior to the age of 6 months (Juffer & Rosenboom, 1997). Brodzinsky et al. (1998) state the need for additional research on adoptees and attachment to better understand adoptees' development of meaningful relationships throughout the lifespan.

Family Systems Theory

The family systems approach to adoption is based on the idea that the act of adoption unites all individuals involved in the adoption triad "in a lifelong kinship network" (Zamostny, O'Brien, et al., 2003, p. 668). Rooted in key ideas such as interdependence, subsystems, circularity, homeostasis, and morphogenesis, a family systems perspective focuses on the quality of emotional and behavioral interactions within adoptive families. Several authors have utilized family systems theory to conceptualize how adoption might influence traditional family structures and levels of functioning (Brodzinsky et al., 1998). Family systems theory has been valuable in that is has recognized that adoptive families' experiences and developmental stages can be unique throughout the lifespan when compared to those of biological families (Zamostny, O'Brien, et al., 2003). Although researchers acknowledge that this theory

has provided a useful conceptual framework for understanding adoptive families, it has not been empirically tested (Brodzinsky et al., 1998), and has been criticized for not providing a unified or broader contextual understanding of adoption (Zamostny, O'Brien, et al., 2003).

Stress and Coping Theory and Model

Brodzinsky's (1990, 1993) Stress and Coping Model of Children's Adoption Adjustment (Figure 1) is a model directly applied to the child's response to the adoption process based on stress and coping theory. The stress and coping model is an integrative and multidimensional perspective that emphasizes the impact of developmental, cognitive, and contextual factors on adoption adjustment. Brodzinsky's (1990, 1993) model is based on stress and coping theory described by Lazarus and Folkman (1984), who suggest that the perception of a life event as meaningful, and either stigmatizing, challenging, or involving loss, is likely to be experienced as stressful. This stress is commonly associated with patterns of negative emotions, including anger, sadness, confusion, shame, and anxiety. Once a situation or event is interpreted as stressful, various coping strategies may be utilized, ranging from positive coping strategies such as cognitive-behavioral problem solving or proactively seeking social or emotional support, to more negative strategies such as cognitive or behavioral avoidance of the stressful thoughts or stimuli. The theory posits that an overutilization of avoidance strategies will lead to psychological adjustment problems.

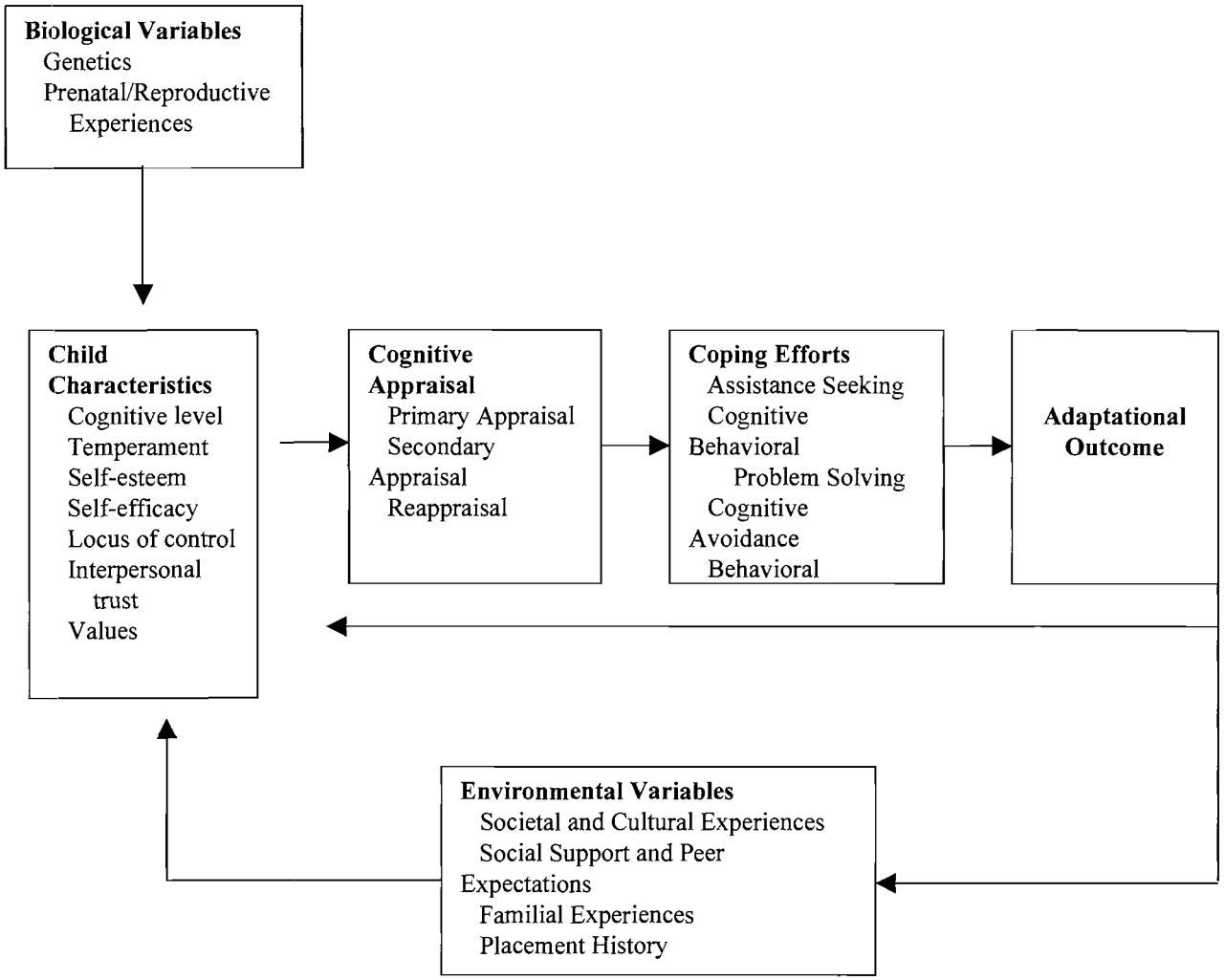

FIGURE 1. A Stress and Coping Model of Children's Adoption Adjustment (Brodzinsky, 1990).

Brodzinsky (1993) adapted this theory to articulate a stress and coping model of children's adoption adjustment in order to better conceptualize the unique developmental adjustment experiences of adoptees and their families. The primary assumption of this model is that children's adjustment to adoption is determined largely by how they perceive their adoption experience and the type of coping mechanisms they utilize to manage adoption-related stress (Brodzinsky, 1993). According to this model, even though adoptees may report overall positive feelings about their adoption experience, the processes of adoption inherently include feelings of loss (of a biological family of origin) and are associated with a social stigma that an adoptive family is somehow not as "real" or "normal" as nonadoptive families (Zamostny, et al., 2003, p. 648).

According to this model, adoptees will inevitably experience a pattern of negative emotions associated with stress when adoption is perceived as a source of loss or stigmatization. This is particularly relevant to the developmental period of middle childhood (approximately ages 5-7), when children's cognitive development advances enough for them to be able to more fully grasp the concept of adoption. Even though this may include increased feelings of being "special," loved, or "chosen" by their adoptive parents, they are also faced with the realization that in order to have been "chosen" (Brodzinsky, 1990, p. 7), they must first have been relinquished. This results in feelings of loss, and may also include the realization that they are different from their peers, contributing to a level of stress manifesting as anger, confusion, anxiety or

sadness. The key idea related to adjustment hinges upon which coping strategy the child chooses to use in order to relieve their feelings of distress. For example, when children experience such emotions, a positive coping strategy might include talking with and seeking support from their friends or parents, or cognitively reframing their experience in a new, less distressing way. A negative cognitive strategy might include ignoring their feelings or trying to avoid thinking about adoption. Brodzinsky (1993) states that an overreliance on ignoring or avoiding these feelings is more often associated with increased general and adoption-specific adjustment problems.

Most important, however, the stress and coping model acknowledges that the ways in which children interpret their adoption experience is tied to multiple, complex factors. These include, but are not limited to, biological variables (genetics, prenatal or birthing experiences), individual child characteristics (cognitive abilities, temperament, levels of self-esteem and self-efficacy, and trust), cognitive appraisal strategies, and environmental variables (social and cultural norms, social support networks, unique family experiences and placement history). Thus, children whose biological parents exhibit psychopathology or who experience a difficult or high-risk birth are at an increased risk for developing postadoption problems. This is also true for children who may have a difficult temperament or who require extra support for cognitive or medical special needs. The model also recognizes how a lack of social support for the adoptive family and increased exposure to adverse social and cultural attitudes can also lead to increased risk for maladjustment. It is this kind of multidimensional ecological

perspective that arguably makes this model the most comprehensive in the conceptualization of adoptee adjustment.

The stress and coping model has been examined empirically. Smith and Brodzinsky (1994), for instance, found that the majority of adoptees between the ages of 6 and 17 viewed adoption as a positive experience, but still experienced adoption-related stress, as defined by ambivalent feelings and "intrusive" thoughts about their adoption. They concluded that negative and ambivalent feelings about adoption were positively correlated with both cognitive and behavioral avoidant coping strategies, whereas intrusive thoughts were associated with increased coping behavior, assistance seeking, and problem solving (Smith & Brodzinsky, 1994).

The value of Brodzinsky's (1990, 1993) model has been debated rather extensively, most notably in a landmark special issue on adoption and counseling psychology in *The Counseling Psychologist* (2003). On the one hand, the model is applauded for its nonpathologizing, non-deficit-based framework, and its ability to include salient contextual variables to conceptualize individual differences in adoption adjustment (Zamostny, O'Brien, et al., 2003). On the other hand, even though it is considered one of the most ecological theoretical perspectives, there is room for improvement. Researchers attempting to empirically test and interpret data through this model have noted that the stress and coping model deemphasizes the more positive outcomes of adoption for adoptees. For example, Sharma, McGue, and Benson (1998) posit Brodzinsky's model cannot explain why adoptees in their study demonstrated

fewer social problems and less withdrawn behaviors than their nonadopted counterparts, and why adopted girls in particular have demonstrated more prosocial behaviors than their same-gender, nonadopted birth siblings.

What researchers appear to agree upon, however, is that Brodzinsky's (1990, 1993) model provides a solid foundation for improving adoption research even if it does not fully explain the complexity of the adoption process or triad experience (O'Brien & Zamostny, 2003). Consensus within the field of adoption appears to be that if a theoretical model could capture the truly encompassing, ecological nature of the adoption experience that includes both risk and benefits common to the experience in multiple domains and contexts, research design and methodology would follow. Researchers in counseling and counseling psychology in particular specialize in using more resiliency and strength-based theories and carry out subsequent empirical investigations grounded in these theories. Applying this specialization to explain some of the underlying correlates and mechanisms utilized by adoptive families within their environmental contexts to adjustment is an important next step in adoption research. In the spirit of identifying an integrative, multisystemic, and strength-based approach, O'Brien and Zamostny (2003) suggest that the ideal theoretical model of adoptive family functioning should be drawn from cross-cultural, attachment, ecological, developmental, and family systems theories.

Perspectives in Adoption Research

Historically, adoptee adjustment research and practice have been approached from two perspectives, both of which are supported by research. On the one hand, some adoption research findings indicate adopted individuals are at significantly higher risk for negative psychological and behavioral adjustment as compared to nonadopted individuals. Researchers suggest the core developmental tasks that occur during childhood and adolescence such as identity development, negotiating parent-child relationships and establishing autonomy, combined with a normative level of adoption-related stress (characterized by loss, stigma, adoption identity development and conceptualizing individual adoption experience), place adopted individuals, and adolescents in particular, at higher risk for psychological maladjustment and increased rates of pathology and problem behaviors (Brodzinsky et al., 1998).

The other perspective is that there are no significant differences between adopted and nonadopted individuals, and adoptees are at no greater risk for maladjustment. Supporters of this perspective cite empirical evidence documenting little or no statistically significant differences between adopted and nonadopted individuals across developmental, academic, and psychological adjustment indices (e.g., Kelly, et al., 1998). Proponents of this perspective argue that any challenges associated with adoption-related issues are surmountable (Freundlich, 2007), and that adoption is a positive option for children who, for whatever reason, cannot be raised by their biological parents (Wilson, 2004). To add depth to the controversy, a few studies even

suggest that adoptees function at a higher level of psychological and academic functioning as compared to nonadoptees (Marquis & Detweiler, 1985; Van IJzendoorn, Juffer, and Poelhuis, 2005).

To complicate the issue further, researchers are also divided on whether certain factors and experiences unique to transracial and special needs adoptions—e.g., additional stress accompanying racial identity development and the additional care and burden faced by special needs adoptive families—may act as significant mediators on adoptee adjustment (Baden & Steward, 2007).

Research on Adoptee Adjustment

In this section, I present a review of the extant literature on adoptee adjustment. In the first section, I will review studies reporting findings that indicate adoptees may be more at risk for adjustment problems. In the second section, I will review studies that report mixed results or no differences between adoptees and nonadoptees on a variety of measures.

Adoptees at Risk

In 1993, Wierzbicki conducted a meta-analysis of 66 studies comparing adoptees and nonadoptees on measures of psychological adjustment, and compared a clinical sample of adoptees to the general population. Inclusion criteria included published manuscripts written in English that reported sufficient data to calculate an

effect size for differences. The author calculated a mean within-study effect size of .72 and concluded that adoptees have significantly higher levels of psychological maladjustment than nonadoptees. Wierzbicki attributes these findings, in part, to data suggesting that adoptees are overrepresented in clinical populations (mean effect size of 1.38). The meta-analysis results also indicated that adoptees were significantly higher in comparisons of general severity (e.g., global ratings of adjustment, number of days hospitalized), externalizing disorders or symptoms, and academic problems. The meta-analysis found no statistical differences on comparisons of internalizing disorders, psychotic disorders, or neurological factors. This study also found no significant differences in adjustment and age at adoption, which contradicts other research findings and commonly stated beliefs that adoptions occurring later in childhood and adolescence put adoptees at risk for increased maladjustment (Wierzbicki, 1993).

In this study, the author acknowledges certain limitations in the methodology used, including an inability to determine the etiology of the elevated rates of psychological distress in adoptees. Wierzbicki (1993) hypothesizes that both genetic and environmental factors may influence adoption-related risk. The researcher cautions, however, that despite the results of the meta-analysis, the majority of adoptees do not experience problems.

In another study, Brodzinsky, Hitt, and Smith (1993) investigated adoptees' adjustment to the stressful life experience of adoptive parent divorce. They compared male and female child adoptees in response to parent divorce. After controlling for

levels of stress, the authors concluded that adopted girls showed no differences in adjustment, but that adoptive boys rated higher on aggression, lack of open communication, and delinquent behaviors. These findings were compared to both adopted girls and nonadopted boys and girls in divorced families.

Collishaw et al. (1998) also examined the psychosocial development of adult adoptees, utilizing a sample size of 2,872, which was drawn from a larger national study in Britain (the National Child Development Study). In this study, researchers compared adoptees to nonadoptees on variables that included relationship histories, parenting histories, psychological well-being, social support, and employment histories. No difference was found between adoptees and nonadoptees in relationship or parenting histories. However, male adoptees reported lower sources of social support and increased psychological distress (as reported by higher rates of alcohol use) than female adoptees and nonadoptees. In addition to lower social support, male adoptees also reported increased rates of unemployment and other employment-related problems.

In a Swedish study (Cederblad et al. 1999), researchers investigated the mental health of adolescent and young adult adoptees compared to nonadopted Swedish youth. They found little difference in scores on overall mental health and self-esteem and no significant differences on scores reported on the Child Behavior Checklist (CBCL) or the Family Relations Scale (FARS). While there were no differences on measures of depressive or anxious symptoms, adoptees did endorse significantly higher scores on the Obsessive-Compulsive diagnostic category of the Symptom Check List (SCL-90). This

study used a sample size of 211 adopted children in 147 families, all of whom were born outside of Sweden. Researchers discuss implications related to foreign-born and transracial adoptee adjustment, but no specific information is provided regarding the racial or ethnic composition of the adoptee sample population studied (Cederblad et al. 1999).

In another study, Moore and Fombonne (1999) examined the relationship between adoption status and disruptive disorders in a child and adolescent clinical population. Their large sample size ($N = 4,507$) was drawn from outpatient referrals to a London hospital over a period of 15 years. After controlling for age at time of adoption, adoptees were compared to a nonadopted clinical control group on socio-demographic, clinical, psychosocial and family-related variables. Participants completed a thorough demographic item sheet used routinely for intake at the hospital, and were sorted into diagnostic categories according to the ICD multiaxial classification systems (ICD-10, World Health Organization). According to score reports, adoptees and nonadoptees were grouped by diagnosis, including conduct disorder, internalizing emotional disorders, mixed disorders, attention-deficit/hyperactivity disorder, no diagnosis, and a residual category for "other" diagnoses. Moore and Fombonne (1999) concluded that both male and female adoptees were at greater risk of developing disruptive behavior, including conduct disorder and ADHD, than nonadoptive children and adolescents. But findings also indicated significantly higher scores on psychosocial

adversity for nonadoptees, and significantly higher rates of emotional disorders in nonadopted girls.

Cubito and Brandon (2000) conducted a study examining adult adoptees' psychological adjustment, specifically on measures of general distress, depression and anger. Utilizing a sample size of 716 adult adoptees (525 female, 191 male) recruited from adoption conferences, support meetings, adoption agencies, or adoption-related Internet sites, researchers assessed levels of general distress using the Brief Symptom Inventory (BSI); depression with the Zung Self-Rating Depression Scale (SDS); and anger, using the Anger Content Scale (ACS). Adult adoptee data was then compared to nonclinical, normative data reported on the measures used for assessment. In their analysis of adoptees versus nonclinical norms, adoptees reported higher levels of distress than the normative sample across all dependent variables, except for men's anger scores on the ACS, which were comparable to the normative sample. The authors acknowledged that despite their findings of elevated adoptee scores on psychological maladjustment, their dependent measure scores were consistently lower than outpatient norms, but the authors did not report this data. Several limitations of this study include lack of information about the sample population on which the measures were normed. It is unlikely that these measures assessed for adoption status. The authors acknowledge the limitations of generalizing their data, because the sample size of adoptees was selected primarily from adults involved in or seeking adoption-related support (from existing support groups or adoption-related support web pages).

Adoptees Not at Risk or Mixed Results

In contradiction to the above findings, several authors have reported findings indicating adoption status is not correlated with increased risk or differences in adjustment when compared to nonadoptees. In 1992, for example, Brodzinsky and Brodzinsky conducted a study to analyze the mediating effects of siblings and family structure on adoptee adjustment. They concluded that adoption order and the presence of nonadopted biological siblings had no significant influence on adjustment based on data collected from the Child Behavior Check List (CBCL), Adoption Adjustment Scale (AAS), teachers, and parent and child reports. Participants were recruited from a range of public and private agencies in a wide geographical region of the Eastern United States. Of the 130 adoptive children studied (65 boys and 65 girls), most were from middle-class families where the adopted child was adopted at birth and was of the same racial/ethnic background as the adoptive parents.

In their 1998 study, Kelly et al. determined that adoptee functioning on developmental tasks (i.e., educational involvement, career planning, life-style planning, life management and cultural participation as measured by the Student Developmental Task and Lifestyle Inventory) was indistinguishable from nonadopted young adults. The researchers utilized a sample size of 98 participants and compared 49 adopted college students (63% female and 37% male) with 49 nonadopted college students (76% female and 24% male). In addition, multivariate analysis of covariance (with covariates

age and gender) revealed that adoptees' social self-esteem self-reports on the Multidimensional Self-Esteem Inventory (MSEI) revealed no significant difference when compared to nonadoptees. However, utilizing MANOVA and regression analyses of scores on the Family Environment Scale (FES) and MSEI, they also reported that adoptees were more likely to be self-critical, as determined by scores on self-control and moral self-approval ratings, and family dynamics within adoptive families appeared less individuated than those of nonadoptive families. The authors concluded that there is no difference between adoptees and nonadoptees on levels of social self-esteem and achievement of developmental tasks.

Also in 1998, Borders et al. concluded there were no differences between adoptive families and nonadoptive families on measures of the children's overall well-being, problem behaviors, or prosocial behaviors. Data were analyzed from the National Survey of Families and Households with an original random sample of 13,017. For the purposes of this study, 72 adoptive and 72 nonadoptive families were identified and matched (with no differences on variables such as race, education, age, income, etc.) for comparison. Results indicated no differences between adoptees and nonadoptees in parental perceptions of their child's well-being, prosocial or problem behaviors and parental expectations of educational achievement. The researchers concluded that adopted children and families are at no greater risk than nonadoptees across all measured variables.

Consistent with these findings, a 2004 longitudinal study of 20,745 participants funded by the National Institute of Child Health and Human Development found little evidence of increased maladjustment among adopted and nonadopted adolescents (Burrow et al., 2004). The researchers also found few differences across adjustment measures in transracial versus same-race adopted adolescents. Participants ranged in age from 12 to 19 years old, with 6,002 males and 6,543 females. Data were collected in 1994 and 1995 via self-report questionnaires administered in the school and in-home interviews for the following variables: academic outcomes (using scales for grades, connectedness, learning problems and academic expectations); familial relationships (using scales assessing closeness to each parent); and physical health. Finally, psychological adjustment was assessed according to externalizing behaviors measured by number of delinquent behaviors, and internalizing behaviors as measured by self-reports of depression and self-worth.

On the other hand, Burrow et al. (2004) report mixed results in the same study. They found differences between adoptees when developmental stage was analyzed. On measures of academic performance, distant family relationships and psychological adjustment, adolescent adoptees scored lower than middle-childhood adoptees and nonadoptees. The authors conclude these results are consistent with some adoption literature suggesting that the normative developmental task of the search for autonomy is more complex during adolescence in the context of adoption (Burrow et al. 2004). These authors also found group differences by gender across indices. Male adoptees

reported more learning problems and lower grades than female adoptees. Females reported higher rates of depression, psychosomatic conditions, and lower self-worth. Researchers are careful to note that these results by gender are consistent with patterns of adjustment outcomes found in the entire sample, including nonadoptees.

Several researchers have published findings stating that adoptees perform better on certain measures of adjustment than nonadopted individuals and nonadopted siblings. Ternay, Wilborn, and Day (1985) were interested in studying the personal and social adjustment and quality of the parent-child relationship in families with both adopted and biological siblings ($n = 44$), families with only adopted children ($n = 45$), and families with only biological children ($n = 44$). Scores reported on the California Test of Personality (CTP) were used to measure adjustment. Researchers found that adoptees with nonadopted siblings had higher adjustment scores than children without nonadopted siblings. They also reported that a comparison of the same groups indicated no differences in parent-child relationship ratings, as measured by the Child-Parent Relationship Scale (CPRS).

In their 1994 study, Sobol, Delaney and Earn compared perceptions of family relationships among adopted ($n = 48$) and nonadopted ($n = 72$) college students. Using scores from the Functional Assessment Rating Scale (FARS), they concluded that adoptive family structures tended to be portrayed as more cohesive and adaptable than nonadoptive families. In particular, male adoptees rated their families as having higher cohesion and adaptability than male nonadoptees. Higher levels of adaptability in

adoptive families were correlated with open communication about adoption during different developmental stages throughout childhood and adolescence.

In a 2005 meta-analysis of 62 studies, Van IJzendoorn et al. examined cognitive development (IQ scores) and school performance in domestic and international adoptees, compared to their siblings remaining in institutional care and to nonadopted peers or unrelated siblings in their new environments. In six of the 62 studies that qualified, they found a large and significant effect size for adopted children who scored higher on IQ tests and performed better in school than their nonadopted siblings or peers who remained in institutional care. With a smaller effect size they also outperformed the same comparison group in school performance. Van IJzendoorn et al. (2005) also reported that age at time of adoption was a significant factor in school achievement results in the studies that compared adoptees with nonadopted classmates and peers. Adopted children did not perform as well as nonadopted classmates or peers from the general population, but for children adopted within the first year of their life, the difference was insignificant. However, the differences were significant for adoptions occurring during and later than the second year of life. Drawing from the same data, Van IJzendoorn and Juffer (2005) also concluded that adoption itself is an effective intervention and has a positive impact on IQ scores, cognitive competence, and chance of academic success for children adopted internationally from institutional care, as compared to their nonadopted siblings and peers who remained in international institutions.

Transracial Adoption Research

Research on transracial adoption (TRA) adjustment issues is a fairly recent area of study. The limited research available on TRA illustrates that this area of adoption research is limited by poor construct definition, measurement, and methodological limitations (Baden, 2002; Haugaard, Dorman, & Schustack, 1997; Vonk, 2001). Nevertheless, a brief overview of existing research on TRA appears to support that, by and large, adoptees experience few adjustment problems. Multiple studies indicate that transracial adoptees show no significant differences in school performance, behavioral problems, or familial relationships when compared with nonadopted peers (Tizard, 1991); with nonadopted siblings within the transracially adoptive family (Simon & Alstein, 2004); or within same-race adoptive families (Haugaard et al., 1997). In their 2004 landmark longitudinal study, for instance, Simon and Alstein analyze same-race and transracial adoptions over a 20-year period. They indicate that successful outcomes are prevalent and "the norm," with statistically insignificant differences between same-race and transracial adoptees. Transracial adoption researchers, however, are careful to acknowledge that positive adjustment and outcomes for transracial adoptees and families involve an additional complex set of factors that has yet to be empirically examined sufficiently. Although Hollingsworth (1997) reported that transracial adoptees had lower racial identity and self-esteem scores than nonadoptees, in a meta-analysis of six studies ($N = 157$ transracial adoptees), there are many factors that still

need to be explored. Lee (2003) for example, states the relationship between transracial adoptees' psychological adjustment and their racial and ethnic experiences has not yet received the attention it deserves.

Critiques of Adoption Literature

Many adoption researchers have critiqued the methodologies used in existing adoption research studies. In this section, I present a critique of the adoption literature with a focus on methodology and the existing stigma surrounding adoption issues in the research. I conclude by presenting recommendations for future adoption research.

Methodologies

A primary critique of existing adoption literature is that the majority of research has been conducted on white, middle- to upper-class SES families who adopt children at birth or early infancy from private agencies (Zamostny, O'Brien, et al., 2003). Consequently, the following types of adoptions are significantly underrepresented and understudied: transracial, international, special-needs, foster-care, extended family ("relative") adoptions, single-parent, LGBTQ-parent adoptions, and adoptions occurring in later-childhood or adolescence (Hollingsworth, 1998; Lee, 2003; Zamostny, O'Brien, et al., 2003).

Other limitations that have been identified include small sample sizes, sampling biases, insufficient comparison groups and inadequate measures of adjustment

(Brodzinsky, 1993; Burrow et al., 2004; Finley, 1999). The studies utilizing larger samples have also been criticized for significant self-selection bias (Miller et al., 2000), or an overreliance on parent or child self-reports rather than observational data (O'Brien & Zamostny, 2003). Burrow et al. (2004) also critique the commonly used design of grouping (adolescents in particular) into adoption status and comparing outcome data to mean levels of adjustment, with little consideration for developmental stages or processes. Burrow et al. (2004) state that researchers have not adequately established that grouping adolescents by adoption status provides any additional insight beyond those studies that group participants by developmental stage or sex.

Stigma and Bias

Researchers and practitioners have suggested that the methodological problems addressed above are rooted in epistemological biases and assumptions about adoption (Zamostny, O'Brien et al., 2003). Although there may be risk factors associated with adoption and adjustment, there are also protective and adaptive factors that are often ignored or overlooked in research. Historically, adoption has been stigmatized and adoptive families have been viewed as nontraditional or somehow abnormal. Researchers have documented that members of the adoption triad often experience social stigma, and that the stigma surrounding adoption is a significant influence on adjustment to adoption (Leon, 2002; Wegar, 2000).

Even though the practice of adoption seems to be increasingly accepted by the American public, bias and skepticism continues to exist (Freundlich, 2002, 2007). These sociocultural biases have influenced adoption researchers' choice of research questions, design and methodologies. Adoption research has been too pathologizing (Zamostny, O'Brien, et al., 2003), and simple comparison studies (adopted versus nonadopted participants) that originate from an existing implied deficit model are not capable of conceptualizing or understanding the uniqueness of the adoption experience (Grotevant, 2003).

Perhaps the controversy about whether or not adoption is a risk factor for maladjustment is less important than identifying and understanding what kind of key developmental or social and contextual variables contribute to adoptees' healthy growth and adjustment. Research that attempts to measure adoption outcomes by focusing primarily on a few select factors such as genetics, attachment issues, and internalized or externalized problems does not adequately capture the complexity of adoptee adjustment. As Brodzinsky et al. (1998) posit, adjustment to adoption involves a set of unique factors that are highly variable from one person's experience with adoption to another, and only a multidimensional perspective emphasizing developmental and contextual factors can truly capture the complexity of an individual's adjustment to adoption.

Recommendations for Future Research

Considering the strengths and weaknesses of existing theoretical models and research methodologies, I will review three primary recommendations proposed by O'Brien and Zamostny (2003). First, as mentioned earlier, adoption epistemologies, theory and research must become less pathology oriented and more strength-based. They state it is imperative to shift from deficit-based paradigms to strength-based models that conceptualize the strengths and risks of adoption. In addition, Sharma et al. (1998) posit the differences showing poorer adoptee adjustment in comparison to nonadoptees is often overstated in adoption literature, and that variables and factors contributing to healthy psychological functioning must be empirically examined further.

Second, O'Brien and Zamostny (2003) state that research and theoretical models must recognize the broad variability in adoption experiences. Interestingly, Brodzinsky et al. (1998) also acknowledge that this is an area for improvement within Brodzinsky's own stress and coping model of adoption adjustment, and in research in general. Adoption is clearly not a risk factor for all triad members across all situations. Instead of focusing primarily on risk factors for an entire population, researchers must become more interested in what particular factors and contexts are correlated with greater vulnerability in some individuals. Also, increased attention towards identifying what conditions or variables promote resiliency, coping, and healthy adjustment is needed.

A final and significant suggestion proposed by O'Brien and Zamostny (2003) challenges researchers and practitioners to consider the powerful influence of social

context and cultural factors on adoption. Race, ethnicity, socioeconomic status, culture and context are crucial variables in the practice of adoption, in terms of differences in individual experience and perceptions; exposure to bias, prejudice and discrimination; and also in terms of unfair treatment or misrepresentation in clinical services, research designs, and social policies.

Despite increased attempts by researchers and practitioners to conceptualize adoption through multiple theoretical models, few have been tested empirically or elaborated upon adequately (Zamostny, O'Brien, et al., 2003). Furthermore, research findings regarding adoption as a risk factor remain inconclusive, and positive outcomes are disproportionately ignored or understudied. Transracial, special needs, late-age adoptions, as well as single-parent, LGBTQ and extended family adoptions are all underrepresented in adoption literature and discourse. Overall, many questions remain unanswered, thereby limiting our understanding of key developmental, theoretical, and contextual factors unique to the adoption experience, as well as our capacity to provide appropriate mental health and community-based prevention and intervention services.

To illustrate these issues, in this section I discuss adoption in clinical practice and clinical training. I begin with an overview of clinical and developmental issues, and discuss adoptees in clinical settings, with particular attention to the role of stigmatization and adoptee experiences in therapy.

Overview of Clinical Issues

There are several clinical and developmental issues that are unique to working with adopted clients and their families. According to Smith and Howard (1999), all members of the adoption triad confront challenges and unique experiences that have the potential to complicate psychological adjustment, interpersonal relationships and developmental tasks. In 1988, Silverstein and Kaplan identified seven core issues related to adoption: loss, rejection, guilt and shame, grief, identity, intimacy, and mastery/control. In addition, even though adoption is considered to be a lifelong process, Silverstein and Kaplan suggest that adoptees revisit these issues as core tasks to be resolved at different developmental stages throughout their lifetime. First, I will address issues of identity and loss in greater detail, and then I will discuss several developmental issues that adoptees might experience during childhood, adolescence and adulthood.

Identity

Several researchers and clinicians believe identity formation for adoptees is unique and more complex than for nonadoptees (Brodzinsky et al., 1998; Grotevant, 1997). Grotevant states that a core task of identity development for adoptees is the successful integration of their adoption status into their overall sense of identity. Grotevant, Dunbar, Kohler, and Esau (2000) defined "adoptive identity" as an individual's sense of identity as an adopted person. Some adoptees may feel this

identity development task is inhibited by not having a biological or genetic link to another person. A general lack of information can also influence healthy identity development and integration, such as not knowing why the adoption or relinquishment occurred (Brodzinsky et al., 1998).

Grotevant (1997) believes this adoptive identity formation becomes increasingly challenging, as layers of "differentness" are added (p. 4). This is believed to be particularly salient for international and transracial adoptees whose identity formation includes multiple layers of "differentness." Transracial adoptees must experience looking different and being ethnically and racially different from their parents, as well as experiencing prejudice and discrimination. In her 2002 study, Baden found a wide range of variability in the ethnic and racial identity development of transracial adoptees. This variability of experience is also a crucial component in understanding clinical issues with adoptees and their families.

Loss

Brodzinsky, Schechter, and Henig (1993) posit one of the primary tasks for adoptees is to come to terms with the multiple losses that have occurred because of adoption, including a loss of genetic or biological identity, loss of an extended biological family, and a feeling of loss arising from feeling different from other children or families. Brodzinsky (1987) identifies a general feeling of loss of self. In the case of foster care adoptions, adoptees, depending on their age at the time of adoption, may

have experienced several different homes and may have become attached and removed from several different caregivers, exaggerating feelings of loss. International adoptees may experience a sense of loss from their birth culture or culture of origin.

Janus (1997) suggests that adoptees' feelings of loyalty to their adoptive parents can complicate their ability to talk about issues related to loss. Social norms inadvertently promote the idea that adoptees are "lucky" and should be "grateful" for being adopted. Janus (1997) states a true exploration of the core issues of adoption can be a significant challenge for adoptees who feel an intense sense of loyalty to their adoptive parents, and who believe they could be perceived as ungrateful.

Overview of Developmental Considerations

Clinical Issues for Children

Adoption experts and researchers emphasize that adoption is a lifelong process (Brodzinsky, Schechter, & Henig, 1993). Silverstein and Kaplan (1988) suggest that adoptees revisit issues such as loss and identity as core tasks to be resolved at different developmental stages throughout their lifetime. Brodzinsky and Brodzinsky (1992) state that children begin to understand the concept of adoption once they reach school age and are fully confronted with the knowledge that most other children are not adopted. Many young children might feel a sense of loss, confusion or trauma upon the realization they are not biologically related to or born from their adoptive mother (Lifton, 2007).

As cognitive development progresses, older children begin to consider the meaning of adoption, including thinking about the implications of having been relinquished by a birth parent. Researchers and clinicians suggest this is the time when children begin to recognize feelings of loss (Brodzinsky, Schechter, & Henig, 1993; Janus, 1997). School-age children also become exposed to others' attitudes about adoption, such as teachers, counselors and other families, which at times can be negative (Friedman-Kessler, 1987, as cited in Evan B. Donaldson Adoption Institute, n.d.-b). Children and adolescents also begin to fantasize about what their lives would be like and how they might be different as individuals had the adoption not occurred (Lifton, 2007).

Clinical Issues for Adolescents

Janus (1997) reports that most adolescent adoptees seek counseling for issues related to identity development. Although identity formation is a key developmental task for all adolescents, it can be particularly challenging for adoptees (Brodzinsky, Schechter, & Henig, 1993). When information about one's biological heritage is either missing or problematic, adoptive parents might struggle with how to help their adolescent develop a complete sense of self (Pavao, 2007). Adolescent adoptees' feelings of grief, sadness and loss may present as anger and resentment (Nydam, 2007).

Adoption researchers interested in attachment issues posit adopted adolescents' experience with separation and individuation from their adoptive family is further

complicated by a perceived need to separate from a biological family that may or may not be known (McGinn, 2007). Depending on the age at the time of adoption, attachment issues in adolescence and later in adulthood can become more salient. For older adopted children, there could be additional issues related to abuse, trauma, posttraumatic stress, and attachment disorders (Pavao, 2007). In school or medical settings, adoptees may be asked to discuss their genealogy or give medical family histories, which are often incomplete, and they are faced with how to integrate and communicate their unique experiences. Adolescence is also the developmental period when many adoptees may begin to consider searching for their biological parent.

Clinical Issues for Adults

Clinical issues for adults might be related to their decision to search for birthparents, ongoing identity development, or issues related to intimacy and interpersonal relationships (Janus, 1997). The average age that adoptees decide to search for birthparents is 29 (Brodzinsky, Schechter, & Henig, 1993), and it is not uncommon for them to seek counseling to explore their motivation for searching, and to be prepared for a variety of outcomes (Janus, 1997). Several clinicians and researchers posit identity development occurs throughout the lifespan, and this is true for adoptive identity as well (Brodzinsky, Schechter, & Henig, 1993). Adopted adults may revisit exploring their identity as adoptees with each major life transition such as marriage, pregnancy, adoption, death of a parent, and career transitions (Janus, 1997).

In their survey of 100 adopted middle-aged adults, Penny, Borders, and Portnoy (2007) investigated how adult adoptees attempted to find meaning in their adoptive identity and resolve any existing feelings of loss or grief. They found five patterns or phases that capture distinct developmental stages related to resolution or reconstruction of adoptive identity: no awareness/denying awareness, emerging awareness, drowning in awareness, reemerging from awareness, and finding peace. Participants were recruited through a local foster care and adoption agency via newsletter advertisements, and 75% of participants reported having received counseling at some point in their lives.

Conclusion

This review of research, theoretical perspectives about adoption adjustment, and implications for clinical training and practice has demonstrated the complexities involved with adoption research and practice. Adoption researchers continue to be divided on whether or not adoption status is correlated with increased risk for problems, and theoretical models must still be developed that can conceptualize the complexities, both vulnerabilities and strengths, associated with adjustment to adoption. Because many adoptive families seek therapeutic services and are reportedly dissatisfied with treatment, and many counselors report wanting more training on adoption issues, the intent of this extended literature review is to encourage an ecological and strength-based approach to future research, training, and discussion on the important and unique clinical issues related to adoption.

APPENDIX B

RESEARCH GROUP FEEDBACK FOR THE DEVELOPMENT OF THE KNOWLEDGE, ATTITUDES AND SKILLS OF ADOPTION SURVEY (KASAS)

Details

1. Friday August 17, 2007 (American Psychological Association, Society of Counseling Psychology, Division 17, Adoption Special Interest Group): six researchers, including three licensed counseling psychologists, two doctoral students in psychology and one representative from a nonprofit that provides education and support to families adopting transracially.

2. Saturday August 18, 2007 (APA, Continuing Education Workshop on Adoption): six researchers, all licensed psychologists in a variety of settings (one academic faculty and five in private practice or affiliated with community mental health agencies).

Experts' Recommendations

Likert Scale:

- Change Likert 4-point scale to 6- or 7-point scale.

Demographics questions:

- Ask for participants' identity as adoptee/adoptive parents/birthparents.

Attitudes Scale:

- Add a question asking if respondents have a preference for biological over adopted children.
- Keep the "real parents" question.
- Add a question asking if when a family has both a biological and an adopted child, if they believe it is possible to really love and treat them equally.

Transracial adoption questions:

- Ask if TRA are more concerned about cultural and racial issues.
- Ask if TRA can be raised in white communities with little impact on their identity.

Construct Validity:

- Overall impression from groups was that these questions appear to address the three constructs of interest (Knowledge, Attitudes and Skills).
- Need to do a factor analysis in pilot study to have empirical data that this is the case.

Additional Comments:

- Social desirability issue can be accounted for with included social desirability measure.
- Positive feedback included: "What an excellent instrument;" and "This is such a needed area of research – great work."

APPENDIX C

INFORMED CONSENT FORM

You may print a copy of this form for your records.

You are invited to participate in a research study conducted by Emilie E. Cate, a doctoral candidate in the counseling psychology program at the University of Oregon. The purpose of the study is to expand current knowledge and awareness about the needs of counselor education and training.

As a participant in this study, you will have the opportunity to participate in a confidential raffle in which you may enter to win one of five $50 gift certificates for Amazon.com. If you choose to participate in this raffle, you will be asked to provide your email address upon completion of the survey. Your identity and contact information will not be linked in any way to your answers on the survey. Upon completion of my participant recruitment process, I will randomly select five participants who will win a $50 Amazon.com gift certificate. The chance of winning is approximately 1 in 60.

This survey will take approximately 20-30 minutes to complete. Participation is completely voluntary, and you may discontinue participation at any time without penalty. Only the researcher will have access to survey materials.

You are eligible to participate in this study if you are:

- Currently a graduate student in psychology or counseling (or a related field)
- 18 years or older
- Able to write and speak English

By participating in the study, you are making a significant contribution to research that may enhance counselor training based on findings from this study. Further, responses will enable counselors and psychologists to develop and apply more effective strategies when addressing clinical practice and training. A potential benefit from participating in this study is increased awareness about counselor training issues.

If you have any questions or concerns about the survey or your participation, please feel free to contact the primary researcher or her research advisor:

Emilie E. Cate, MA	Benedict McWhirter, Ph.D.
Doctoral Candidate	Associate Professor, Counseling Psychology
University of Oregon	University of Oregon
541.517-5888	541.346.5501
ecate@uoregon.edu	benmcw@uoregon.edu

This study has been approved by the University of Oregons's Institutional Review Board. If you have questions regarding your rights as a research subject, contact the

Office for Protection of Human Subjects, University of Oregon, Eugene, OR 97403, (541) 346-2510. This Office oversees the review of the research to protect your rights and is not involved with this study.

Selecting the "Continue" box below indicates that you have read and understand the information provided above, and that you willingly agree to participate with the option to withdraw your consent at any time and discontinue participation without penalty. Thank you.

APPENDIX D

MEASURES—ORIGINAL VERSIONS

(Please see Appendix E for copy of survey as administered to participants.)

Presented in order of administration:

1. Case study vignettes
2. Case study questionnaire
3. Adjective Checklist (ACL)
4. Global Assessment of Functioning Scale (GAF)
5. Social Desirability Scale
6. Knowledge, Attitudes and Skills of Adoption Survey (KASAS)
7. Demographics Questionnaire

Case Study Vignettes

Note: Each participant received only **one** of the following six scenarios.

	Adoption Status		
Gender	Nonadopted	Same-Race Adoptee	Transracial Adoptee
Female	*Condition #1*	*#3*	*#5*
Male	*#2*	*#4*	*#6*

Directions: Please read the following brief scenario and answer the questions below.

Condition #1: Female nonadopted

A 20-year-old middle-class, heterosexual, able-bodied female client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client has a history of depression in her biological family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my boyfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Condition #2: Male nonadopted

A 20-year-old middle-class, heterosexual, able-bodied male client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months,

but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client has a history of depression in his biological family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my girlfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Condition #3: Female same-race adoptee

A 20-year-old European American middle class, heterosexual, able-bodied female client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client is adopted. She has no information about her biological family or medical history, but reports a history of depression in her adoptive family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my boyfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I don't know why they adopted me in the first place. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Condition #4: Male same-race adoptee

A 20-year-old European American middle class, heterosexual, able-bodied male client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client is adopted. He has no information about his biological family or medical history, but reports a history of depression in his adoptive family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my girlfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I don't know why they adopted me in the first place. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Condition #5) Female transracial adoptee

A 20-year old Asian American, middle-class, heterosexual, able-bodied female client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client is a transracial adoptee, adopted by European-American parents. She has no information about her biological family or medical history, but reports a history of depression in her adoptive family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my boyfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I don't know why they adopted me in the first place, and I certainly don't know why they didn't adopt a white baby that looks like them. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

#6) Male transracial adoptee

A 20-year-old Asian American middle-class, heterosexual, able-bodied male client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client is a transracial adoptee, adopted by European-American parents. He has no information about his biological family or medical history, but reports a history of depression in his adoptive family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my girlfriend

doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I don't know why they adopted me in the first place, and I certainly don't know why they didn't adopt a white baby that looks like them. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Case Study Questionnaire

Directions: Please answer the following questions based on the case study you have just read, given time or cost of treatment were not an issue. The amount of information provided might seem somewhat limited, but please use your best initial impressions based on the vignette only.

1. Please rate your overall level of concern for this client.

1	2	3	4	5
No concern				Very concerned

2. Please rate how severe you judge this client's problems to be.

1	2	3	4	5
Not at all severe				Very severe

3. Please rate how you judge this client's strengths.

1	2	3	4	5
No strengths				Multiple strengths

Please indicate how likely you would be to recommend the following treatment:

4. Inpatient treatment

1	2	3	4	5
Not at all likely				Definitely

5. Outpatient individual therapy every other week

1	2	3	4	5
Not at all likely				Definitely

6. Outpatient individual therapy every week

1	2	3	4	5
Not at all likely				Definitely

7. Outpatient individual therapy more than once a week

1	2	3	4	5
Not at all likely				Definitely

8. Family therapy

1	2	3	4	5
Not at all likely				Definitely

9. Family therapy with individual therapy

1	2	3	4	5
Not at all likely				Definitely

10. Community support groups (no therapist)

1	2	3	4	5
Not at all likely				Definitely

11. Support groups (with therapist)

1	2	3	4	5
Not at all likely				Definitely

12. No treatment recommended at this time.

1	2	3	4	5
Not at all likely				Definitely

13. Would you rate your treatment plan as:

1	2	3	4	5
Limited				Detailed

14. Would your prognosis (i.e. your prediction for the course and outcome of treatment) for this client be:

1	2	3	4	5
Excellent				Poor

15. If time and cost were not an issue, how many individual counseling sessions would you need (approximately) to assist this individual? _____

16. Please list the primary presenting issues you think are present in the client scenario:

_____

_____

Directions: While it might be difficult to say given the limited amount of information provided, please use your best initial impressions and hypothesis here. Review the following list of treatment themes, and identify those you think might be "very important," "potentially important" or "likely unimportant."

	Very Important	Potentially Important	Likely Unimportant
17. Academic advising	( )	( )	( )
18. Anger	( )	( )	( )
19. Anxiety	( )	( )	( )
20. Belongingness	( )	( )	( )
21. Career development	( )	( )	( )
22. Delusions	( )	( )	( )
23. Dependency issues	( )	( )	( )
24. Depression	( )	( )	( )
25. Discrimination	( )	( )	( )
26. Alcohol or other drug use	( )	( )	( )
27. Racism	( )	( )	( )
28. Communication skills	( )	( )	( )
29. Identity development	( )	( )	( )
30. Self-esteem	( )	( )	( )
31. Loneliness	( )	( )	( )
32. Discrimination	( )	( )	( )
33. Loss	( )	( )	( )
34. Relationship issues	( )	( )	( )
35. Sexuality	( )	( )	( )
36. Grief	( )	( )	( )
37. Financial concerns	( )	( )	( )
38. Guilt	( )	( )	( )
39. Body Image	( )	( )	( )
40. Abandonment	( )	( )	( )

Directions: While it might be difficult given the limited amount of information provided, please do your best to answer these next questions. Read the following list of diagnosis, and indicate whether you think they could be "Very relevant," "Potentially relevant," or "Not relevant."

	Very Relevant	Potentially Relevant	Not Relevant
41. Major depressive	( )	( )	( )
42. Dysthymic	( )	( )	( )
43. Depressive NOS	( )	( )	( )
44. Attachment-related disorder	( )	( )	( )
45. Panic attack	( )	( )	( )
46. Social phobia	( )	( )	( )
47. Generalized anxiety	( )	( )	( )
48. Other anxiety-related disorder	( )	( )	( )
49. Dependent personality	( )	( )	( )
50. Adjustment-related disorder	( )	( )	( )
51. Alcohol dependence	( )	( )	( )
52. Alcohol abuse	( )	( )	( )
53. Other substance-related disorder	( )	( )	( )
54. Anorexia nervosa	( )	( )	( )
55. Other eating-related disorder	( )	( )	( )
56. Antisocial personality disorder	( )	( )	( )
57. Other personality-related disorder	( )	( )	( )
58. Bipolar disorder	( )	( )	( )
59. Other mood-related disorder	( )	( )	( )

60. Is there anything else you would like to say about this client, or how you might conceptualize and intervene? _____

_____

Adjective Checklist (ACL)

(Reduced version mandated by copyright restrictions.)

Directions: Based on the brief scenario provided earlier, click on as many words as you believe may apply to this client:

(Favorable adjectives: five sample items)

Insightful
Warm
Adaptable
Friendly
Kind

(Unfavorable adjectives: five sample items)

Dependent
Rigid
Moody
Cold
Unkind

Global Assessment of Functioning (GAF) Scale

Directions: Based on the brief scenario provided earlier, please give your assessment of this client's level of functioning using the scale below. Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Pick a number 1-100: _____

Code	**Note: Use Intermediate codes when appropriate, (e.g., 45, 68, 72)**
91 – 100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, has many positive qualities. No symptoms.
81 – 90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, socially effective, generally satisfied with life, no more than everyday problems or concerns.
71 – 80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning.
61 – 70	Some mild symptoms (e.g., depressed mood; mild insomnia) OR some difficulty in social or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
51 – 60	Moderate symptoms (e.g., flat affect) OR moderate difficulty in social or school functioning (e.g., few friends, conflicts with peers or co-workers).
41 – 50	Serious symptoms (e.g., suicidal ideation) OR any serious impairment in social, or school functioning (e.g., no friends, unable to keep a job).
31 – 40	Some impairment in reality testing or communication (e.g., illogical speech) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed and avoids friends, neglects family).
21 – 30	Serious impairment in communication or judgment (e.g., sometimes incoherent, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

11 – 20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement.

0 – 10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR serious suicidal act with clear expectation of death.

Modified from the American Psychiatric Association (2000), Global Assessment of Functioning Scale (GAF)

Marlowe-Crowne 2(10) Social Desirability Scale

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

	True	False
1. I never hesitate to go out of my way to help someone in trouble.	( )	( )
2. I have never intensely disliked anyone.	( )	( )
3. There would have been times when I was quite jealous of the good fortune of others.	( )	( )
4. I would never think of letting someone else be punished for my wrongdoings.	( )	( )
5. I sometimes feel resentful when I don't get my way.	( )	( )
6. There have been times when I felt like rebelling against people in authority even though I knew they were right.	( )	( )
7. I am always courteous, even to people who are disagreeable.	( )	( )
8. When I don't know something I don't at all mind admitting it.	( )	( )
9. I can remember "playing sick" to get out of something.	( )	( )
10. I am sometimes irritated by people who ask favors of me.	( )	( )

Knowledge, Attitudes and Skills of Adoption Survey (KASAS)

Directions: Please read each of the following statements carefully and click on the answer that best reflects your agreement with the statement.

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
strongly disagree	*moderately disagree*	*disagree*	*agree*	*moderately agree*	*strongly agree*

1. In general, if an adopted person comes to counseling, it is likely that their presenting issue is related to being adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

2. Promoting an adopted client's sense of gratitude for having been adopted by a good family is usually a safe goal to strive for in most counseling situations.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

3. When counseling international adoptees, it is generally safe to assume they have experienced early trauma or neglect in orphanages or institutions.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

4. When counseling transracial adoptees, it is generally safe to assume their racial and ethnic identity development is similar to other members of the same racial or ethnic group who were not adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

5. When counseling an adopted adult, it is generally safe to assume relationship issues such as challenges with intimacy or attachment might be connected to being adopted as a child.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

6. In counseling, it is important to find a balance between exaggerating the influence of adoption, and minimizing its relevance.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Directions: Please indicate how you would react to the following statements:

7. In families with a biological child and an adopted child, it might be challenging to love and treat them equally.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

8. Adoptees are at higher risk for psychological and behavioral problems than people who are not adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

9. In particular, transracial adoptees are at higher risk for psychological and behavioral problems than biological children and adoptees who are the same race as their adoptive parents.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

10. Adoption is a diversity or multicultural issue.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

11. Adoptees and adoptive families do not experience additional stigma or bias because they are not biologically related.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

12. Transracial adoptees can be raised in Caucasian families and predomonently Caucasian communities with little impact on their identity development.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

13. When talking about adoption in the past, I might have said "real parents" when referring to the biological or birth parents.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Directions: At the present time, how would you rate your understanding of the following terms and concepts:

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
very limited	*moderately limited*	*limited*	*good*	*moderately good*	*very good*

14. "Adoption triad"
(1) (2) (3) (4) (5) (6)

15. "Transracial adoption"
(1) (2) (3) (4) (5) (6)

16. "Adoptee identity development"
(1) (2) (3) (4) (5) (6)

17. The "seven core issues of adoption"
(1) (2) (3) (4) (5) (6)

18. Ethnic identity development for transracial adoptees
(1) (2) (3) (4) (5) (6)

19. Adoption-sensitive counseling
(1) (2) (3) (4) (5) (6)

20. Developmental issues related to adoption
(1) (2) (3) (4) (5) (6)

21. Adjustment issues related to adoption
(1) (2) (3) (4) (5) (6)

22. Adoption-sensitive language
(1) (2) (3) (4) (5) (6)

Directions: Please indicate how you would react to the following statements:

23. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of an adopted client or member of the adoption triad?

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
very limited	*moderately limited*	*limited*	*good*	*moderately good*	*very good*

24. At the present time, how would you rate your confidence in being able to provide "adoption sensitive" counseling?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

25. At the present time, how would you rate your ability to recognize resilience and positive coping skills within adoptive families?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

26. How well would you rate your ability to accurately assess the mental health needs of all members of the adoption triad?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

27. How well would you rate your ability to accurately assess the mental health needs of transracial adoptees?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

28. At this time in your life, how would you rate yourself in terms of understanding how your cultural background influences the way you think and act?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

29. How would you rate your level of training for working with members of the adoption triad?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

30. How well would you rate your ability to effectively assess the influence adoption has had on your client's life, without overemphasizing or minimizing it in treatment?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Demographic Questionnaire

1. In therapy, do you routinely ask your clients if they are a part of the adoption triad?
   ( ) Yes
   ( ) No
   ( ) Sometimes
   ( ) Rarely
   ( ) Not applicable: I have not seen clients yet in my training

2. Do you identify as any of the following? Please check all that apply:
   ( ) Adoptee (same race/ethnicity as adoptive parents)
   ( ) Transracial adoptee
   ( ) Birth mother (you have made an adoption plan)
   ( ) Birth father (you have made an adoption plan)
   ( ) Adoptive parent
   ( ) Step-parent
   ( ) Parent to biological children
   ( ) None of the above

3. Approximately how many people do you know that identify as an adoptee who is of the same race/ethnicity as their adoptive parents? If none, please enter "0."
   ____

4. Approximately how many people do you know who identify as a transracial adoptee? If none, please enter "0." _____

5. Approximately how many clients have you treated who were part of the adoption triad (defined as either an adoptee, adoptive parent or birth parent)? If none, please enter "0" _____

Directions: If you have worked with clients who are a member of the adoption triad, please answer the following questions. If you have not, and entered "0" above, please skip these next four questions and press "Continue" at the bottom.

6. Of these clients, how many identified as an adoptee (same race as adoptive parents)? _____

7. Of these clients, how many identified as a transracial adoptee? _____

8. Of these clients, how many identified as a birth parent who made an adoption plan? _____

9. Of these clients, how many identified as an adoptive parent? _____

10. In your graduate training, have your practicum or clinical supervisors discussed adoption or adoption-related issues in terms of case conceptualization?

    ( ) Yes
    ( ) No
    ( ) Sometimes
    ( ) Rarely
    ( ) Not applicable: I have not seen clients yet in my training

11. At this time, how well prepared do you feel to deal with adoption issues in therapy:

    ( ) Very well prepared
    ( ) Well prepared
    ( ) Somewhat prepared
    ( ) Not very prepared
    ( ) No knowledge about adoption

12. How many UNDERGRADUATE courses have you taken that provided information about adoption issues, particularly any emotional or behavioral challenges that members of the adoption triad might encounter?

    ( ) None ( ) One ( ) Two ( ) Three ( ) Four or more

13. How many GRADUATE courses have you taken that provided information about adoption issues, particularly any emotional or behavioral challenges that members of the adoption triad might encounter?

    ( ) None ( ) One ( ) Two ( ) Three ( ) Four or more

14. How many lectures or presentations have you attended in which you received information about with adoption issues.

( ) None ( ) One ( ) Two ( ) Three ( ) Four ( ) Five ( ) Six or more

15. If you have attended lectures or presentations, where did they occur? Please select all that apply.
    _____Undergraduate coursework
    _____Required graduate coursework
    _____Elective graduate coursework
    _____Local conferences.
    _____Regional conferences
    _____National conferences
    _____Community-based trainings or workshops
    _____Presentations sponsored by an adoption agency
    _____Other. Please specify_____

16. Approximately how many empirical articles have you read in which you received information about adoption issues?
    ( ) None
    ( ) 1-3
    ( ) 4-6
    ( ) 6-10
    ( ) 11 or more

17. Approximately how many nonempirical articles or books have you read about adoption?
    ( ) None
    ( ) 1-3
    ( ) 4-6
    ( ) 6-10
    ( ) 11 or more

18. Have you learned about adoption from any other source(s)? Please describe them here:

    _____

    _____

19. Would you like additional training about adoption issues?
    ( ) Yes ( ) No

20. If you answered "yes," what kind of information or topics would you like to learn more about?

    _____

    _____

21. What is your age? _____

22. What is your sex?
    ( ) Female
    ( ) Male
    ( ) Transgender
    ( ) Other (please specify)_____

23. Your Race/Ethnicity: *please mark all that apply*
    ( ) Black or African-American
    ( ) White or European-American
    ( ) Hispanic
    ( ) Latino(a)
    ( ) Chicano(a)
    ( ) Asian or Asian-American
    ( ) Native American or Alaskan Native
    ( ) Pacific Islander
    ( ) Middle Eastern
    ( ) Multi-ethnic
    ( ) Other (please specify) _____

24. What is your highest level of education completed?
    ( ) Bachelors or undergraduate degree
    ( ) Masters
    ( ) Doctorate

25. What degree are you currently pursuing?
    ( ) Master of Arts (MA)
    ( ) Master of Science (MS)
    ( ) Master of Social Work (MSW)
    ( ) Master of Education (MEd)
    ( ) Doctor of Philosophy (PhD)
    ( ) Doctor of Psychology (PsyD)
    ( ) Other: Please specify_____

26. Area of Specialization/Area of Emphasis (select one):
    ( ) Clinical Psychology
    ( ) Counseling Psychology
    ( ) School Psychology
    ( ) School Counseling
    ( ) Marriage and Family Therapy (MFT) or Couples and family therapy (CFT)
    ( ) Rehabilitation Counseling

( ) Social Work
( ) Other: Please specify_____

27. Have you yourself been a client in therapy before?
( ) Yes ( ) No

28. For how long have you been a client in therapy? _____

29. Have you begun to see clients as part of your training or practicum experience?
( ) Yes ( ) No

30. What year are you in your current graduate program?
( ) 1st ( ) 2nd ( ) 3rd ( ) 4th ( ) 5th ( ) 6th or more

31. Are you currently in a practicum placement now? ( ) Yes ( ) No

32. Have you completed your required practicum training? ( ) Yes ( ) No

33. Are you currently employed as a counselor or providing therapy as part of a paid position? ( ) Yes ( ) No

34. If you are currently in practicum or have completed supervised practicum training, please indicate the number of months you have you seen clients in the following types of settings:
_____College or university counseling center
_____Veterans Administration (VA) hospital
_____Other hospital setting
_____Community mental health agency
_____Community college counseling center
_____High School
_____Middle School
_____Elementary School
_____Other (Please specify number of months and type of setting:)_____

35. As of today, approximately how many clients have you seen in practicum training?
    ( ) None
    ( ) 1-5
    ( ) 6-10
    ( ) 11-20
    ( ) 21-30
    ( ) 31-40
    ( ) more than 40 clients

36. What is your primary theoretical orientation? Please select one.
    ( ) Behavioral
    ( ) Cognitive Behavioral
    ( ) Interpersonal
    ( ) Humanistic/Existential
    ( ) Integrateive
    ( ) Eclectic
    ( ) Psychodynamic/Psychoanalytic
    ( ) Systems
    ( ) Other (Please specify): _____

37. Did you have experience providing counseling services prior to entering your current training program? ( ) yes ( ) no

38. How many total years of counseling experience do you have? Include all experience gained prior to your current program, practicums, externships, employment, internships, etc. _____

APPENDIX E

COPY OF SURVEY AS ADMINISTERED ONLINE TO PARTICIPANTS

Survey on Counselor Training Issues

Directions: Please read this brief scenario and answer the following questions.

(Note: Each participant only received **one** of the following six scenarios:)

Condition #1: Female nonadopted

A 20-year-old middle-class, heterosexual, able-bodied female client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client has a history of depression in her biological family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my boyfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Condition #2: Male nonadopted

A 20-year-old middle-class, heterosexual, able-bodied male client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client has a history of depression in his biological family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my girlfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Condition #3: Female same-race adoptee

A 20-year-old European American middle-class, heterosexual, able-bodied female client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client is adopted. She has no information about her biological family or medical history, but reports a history of depression in her adoptive family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my boyfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I don't know why they adopted me in the first place. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Condition #4: Male same-race adoptee

A 20-year-old European American middle-class, heterosexual, able-bodied male client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client is adopted. He has no information about his biological family or medical history, but reports a history of depression in his adoptive family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my girlfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I don't know why they adopted me in the first place. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Condition #5: Female transracial adoptee

A 20-year-old Asian American, middle-class, heterosexual, able-bodied female client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship

for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client is a transracial adoptee, adopted by European-American parents. She has no information about her biological family or medical history, but reports a history of depression in her adoptive family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my boyfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I don't know why they adopted me in the first place, and I certainly don't know why they didn't adopt a white baby that looks like them. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

#6: Male transracial adoptee

A 20-year-old Asian American middle-class, heterosexual, able-bodied male client presents with relationship problems and symptoms related to depression. During the initial interview you learn that your client has been in a monogamous relationship for several months, but reports feeling "disconnected" and lacking meaningful relationships with friends and family. In gathering family history information, you learn that your client is a transracial adoptee, adopted by European-American parents. He has no information about his biological family or medical history, but reports a history of depression in his adoptive family. Recently, your client reports having trouble getting to classes and work on time, and is sleeping more than usual.

Client: "What am I going to do? I'm practically failing my classes and sometimes wonder why I'm even at this school. I hardly have any real friends. Even my girlfriend doesn't understand me. I'm not sure anyone does. I feel like I don't know where I belong, or who I belong with. My parents never have understood me. I don't know why they adopted me in the first place, and I certainly don't know why they didn't adopt a white baby that looks like them. I'm sick of feeling different. I think I want to take some time off school until I can figure something out, but I can't tell my parents. They would be so disappointed in me. What am I going to do?"

Directions: Please answer the following questions based on the case study you have just read, given time or cost of treatment were not an issue. The amount of information provided might seem somewhat limited, but please use your best initial impressions based on the vignette only.

1. Please rate your overall level of concern for this client.

1	2	3	4	5
No concern				Very concerned

2. Please rate how severe you judge this client's problems to be.

1	2	3	4	5
Not at all severe				Very severe

3. Please rate how you judge this client's strengths.

1	2	3	4	5
No strengths				Multiple strengths

Directions: Please indicate how likely you would be to recommend the following treatment:

4. Inpatient treatment

1	2	3	4	5
Not at all likely				Definitely

5. Outpatient individual therapy every other week

1	2	3	4	5
Not at all likely				Definitely

6. Outpatient individual therapy every week

1	2	3	4	5
Not at all likely				Definitely

7. Outpatient individual therapy more than once a week

1	2	3	4	5
Not at all likely				Definitely

8. Family therapy

1	2	3	4	5
Not at all likely				Definitely

9. Family therapy with individual therapy

1	2	3	4	5
Not at all likely				Definitely

10. Community support groups (no therapist)

1	2	3	4	5
Not at all likely				Definitely

11. Support groups (with therapist)

1	2	3	4	5
Not at all likely				Definitely

12. No treatment recommended at this time.

1	2	3	4	5
Not at all likely				Definitely

13. Would you rate your treatment plan as:

1	2	3	4	5
Limited				Detailed

14. Would your prognosis (i.e. your prediction for the course and outcome of treatment) for this client be:

1	2	3	4	5
Excellent				Poor

15. If time and cost were not an issue, how many individual counseling sessions would you need (approximately) to assist this individual? _____

16. Please list the primary presenting issues you think are present in the client scenario:

_____

_____

Directions: While it might be difficult to say given the limited amount of information provided in the case vignette, please use your best initial impressions and hypothesis here. Read the following list of treatment themes, and indicate whether you think they might be "Very Important," "Potentially Important" or "Likely Unimportant."

	Very Important	Potentially Important	Likely Unimportant
17. Academic advising	( )	( )	( )
18. Anger	( )	( )	( )
19. Anxiety	( )	( )	( )
20. Belongingness	( )	( )	( )
21. Career development	( )	( )	( )
22. Delusions	( )	( )	( )
23. Dependency issues	( )	( )	( )
24. Depression	( )	( )	( )
25. Discrimination	( )	( )	( )
26. Alcohol or other drug use	( )	( )	( )
27. Racism	( )	( )	( )
28. Communication skills	( )	( )	( )
29. Identity development	( )	( )	( )
30. Self-esteem	( )	( )	( )
31. Loneliness	( )	( )	( )
32. Discrimination	( )	( )	( )
33. Loss	( )	( )	( )
34. Relationship issues	( )	( )	( )
35. Sexuality	( )	( )	( )
36. Grief	( )	( )	( )
37. Financial concerns	( )	( )	( )
38. Guilt	( )	( )	( )
39. Body Image	( )	( )	( )
40. Abandonment	( )	( )	( )

Directions: While it might be difficult given the limited amount of information provided, please do your best to answer these next questions. Read the following list of diagnosis, and indicate whether you think they could be "Very relevant," "Potentially relevant," or "Not relevant."

	Very Relevant	Potentially Relevant	Not Relevant
41. Major depressive	( )	( )	( )
42. Dysthymic	( )	( )	( )
43. Depressive NOS	( )	( )	( )
44. Attachment-related disorder	( )	( )	( )
45. Panic attack	( )	( )	( )
46. Social phobia	( )	( )	( )
47. Generalized anxiety	( )	( )	( )
48. Other anxiety-related disorder	( )	( )	( )
49. Dependent personality	( )	( )	( )
50. Adjustment-related disorder	( )	( )	( )
51. Alcohol dependence	( )	( )	( )
52. Alcohol abuse	( )	( )	( )
53. Other substance-related disorder	( )	( )	( )
54. Anorexia nervosa	( )	( )	( )
55. Other eating-related disorder	( )	( )	( )
56. Antisocial personality disorder	( )	( )	( )
57. Other personality-related disorder	( )	( )	( )
58. Bipolar disorder	( )	( )	( )
59. Other mood-related disorder	( )	( )	( )

60. Is there anything else you would like to say about this client, or how you might conceptualize and intervene? _____

Directions: The following page contains a list of 150 adjectives. Please read through them quickly and select each word you believe may apply to the client presented earlier. Work quickly and do not spend too much time on any one word. If you do not think the word could apply, please leave it blank.

(Please note this section of the survey can not be shared in full due to copyright restrictions from the Adjective Checklist. What follows listed as Questions #61 and #62 is a reduced version, not the full 150 adjectives listed on the online survey)

61. Please select as many words as you think MAY apply to the client presented earlier:

( ) Insightful
( ) Warm
( ) Dependent
( ) Rigid
( ) Adaptable

62. You are more than halfway through the list of adjectives. Please continue to select as many words you believe MAY apply until the end of this page:

( ) Cold
( ) Friendly
( ) Kind
( ) Moody
( ) Unkind

Directions: Based on the brief scenario provided earlier, please give your assessment of this client's level of functioning using the scale below. Consider psychological, social and occupational functioning on a hypothetical continuum of mental health – illness.

63. Pick a number between 1 and 100 using the scale below: _____

Code	**Note: Use Intermediate codes when appropriate, (e.g., 45, 68, 72)**
91 – 100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, has many positive qualities. No symptoms.
81 – 90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, socially effective, generally satisfied with life, no more than everyday problems or concerns.

71 – 80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning.
61 – 70	Some mild symptoms (e.g., depressed mood; mild insomnia) OR some difficulty in social or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
51 – 60	Moderate symptoms (e.g., flat affect) OR moderate difficulty in social or school functioning (e.g., few friends, conflicts with peers or co-workers).
41 – 50	Serious symptoms (e.g., suicidal ideation) OR any serious impairment in social, or school functioning (e.g., no friends, unable to keep a job).
31 – 40	Some impairment in reality testing or communication (e.g., illogical speech) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed and avoids friends, neglects family).
21 – 30	Serious impairment in communication or judgment (e.g., sometimes incoherent, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
11 – 20	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement.
0 – 10	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR serious suicidal act with clear expectation of death.

Modified from the American Psychiatric Association (2000), Global Assessment of Functioning Scale (GAF)

Directions: Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

	True	False
64. I never hesitate to go out of my way to help someone in trouble.	( )	( )
65. I have never intensely disliked anyone.	( )	( )
66. There would have been times when I was quite jealous of the good fortune of others.	( )	( )

67. I would never think of letting someone else be punished for my wrongdoings.	( )	( )
68. I sometimes feel resentful when I don't get my way.	( )	( )
69. There have been times when I felt like rebelling against people in authority even though I knew they were right.	( )	( )
70. I am always courteous, even to people who are disagreeable.	( )	( )
71. When I don't know something I don't at all mind admitting it.	( )	( )
72. I can remember "playing sick" to get out of something.	( )	( )
73. I am sometimes irritated by people who ask favors of me.	( )	( )

You are more than 50% finished with this survey. Your participation is sincerely appreciated. Please continue to the end. Thank you!

Now we would like to know more about your experiences and perceptions about adoption and adoption-related topics. There are no incorrect answers. Your honest responses might help us better understand the educational needs of counselor trainees. Please select the answer that is honestly true for you; not the answer you anticipate to be the "right" one. Thank you again for your participation.

Directions: Please read each of the following statements carefully and click on the answer that best reflects your agreement with the statement.

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
strongly disagree	*moderately disagree*	*disagree*	*agree*	*moderately agree*	*strongly agree*

74. In general, if an adopted person comes to counseling, it is likely that their presenting issue is related to being adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

75. Promoting an adopted client's sense of gratitude for having been adopted by a good family is usually a safe goal to strive for in most counseling situations.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

76. When counseling international adoptees, it is generally safe to assume they have experienced early trauma or neglect in orphanages or institutions.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

77. When counseling transracial adoptees, it is generally safe to assume their racial and ethnic identity development is similar to other members of the same racial or ethnic group who were not adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

78. When counseling an adopted adult, it is generally safe to assume relationship issues such as challenges with intimacy or attachment might be connected to being adopted as a child.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

79. In counseling, it is important to find a balance between exaggerating the influence of adoption, and minimizing its relevance.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Directions: Please indicate how you would react to the following statements:

80. In families with a biological child and an adopted child, it might be challenging to love and treat them equally.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

81. Adoptees are at higher risk for psychological and behavioral problems than people who are not adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

82. In particular, transracial adoptees are at higher risk for psychological and behavioral problems than biological children and adoptees who are the same race as their adoptive parents.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

83. Adoption is a diversity or multicultural issue.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

84. Adoptees and adoptive families do not experience additional stigma or bias because they are not biologically related.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

85. Transracial adoptees can be raised in Caucasian families and predomonently Caucasian communities with little impact on their identity development.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

86. When talking about adoption in the past, I might have said "real parents" when referring to the biological or birth parents.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Directions: At the present time, how would you rate your understanding of the following terms and concepts:

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
very limited	*moderately limited*	*limited*	*good*	*moderately good*	*very good*

87. "Adoption triad"
(1) (2) (3) (4) (5) (6)

88. "Transracial adoption"
(1) (2) (3) (4) (5) (6)

89. "Adoptee identity development"
(1) (2) (3) (4) (5) (6)

90. The "seven core issues of adoption"
(1) (2) (3) (4) (5) (6)

91. Ethnic identity development for transracial adoptees
(1) (2) (3) (4) (5) (6)

92. Adoption-sensitive counseling
(1) (2) (3) (4) (5) (6)

93. Developmental issues related to adoption
(1) (2) (3) (4) (5) (6)

94. Adjustment issues related to adoption
(1) (2) (3) (4) (5) (6)

95. Adoption-sensitive language
(1) (2) (3) (4) (5) (6)

Directions: Please indicate how you would react to the following statements:

96. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of an adopted client or member of the adoption triad?

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
very limited	*moderately limited*	*limited*	*good*	*moderately good*	*very good*

97. At the present time, how would you rate your confidence in being able to provide "adoption sensitive" counseling?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

98. At the present time, how would you rate your ability to recognize resilience and positive coping skills within adoptive families?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

99. How well would you rate your ability to accurately assess the mental health needs of all members of the adoption triad?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

100. How well would you rate your ability to accurately assess the mental health needs of transracial adoptees?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

101. At this time in your life, how would you rate yourself in terms of understanding how your cultural background influences the way you think and act?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

102. How would you rate your level of training for working with members of the adoption triad?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

103. How well would you rate your ability to effectively assess the influence adoption has had on your client's life, without overemphasizing or minimizing it in treatment?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

104. In therapy, do you routinely ask your clients if they are a part of the adoption triad?

( ) Yes
( ) No
( ) Sometimes
( ) Rarely
( ) Not applicable: I have not seen clients yet in my training

105. Do you identify as any of the following? Please check all that apply:

( ) Adoptee (same race/ethnicity as adoptive parents)
( ) Transracial adoptee
( ) Birth mother (you have made an adoption plan)
( ) Birth father (you have made an adoption plan)
( ) Adoptive parent
( ) Step-parent
( ) Parent to biological children
( ) None of the above

106. Approximately how many people do you know that identify as an adoptee who is of the same race/ethnicity as their adoptive parents? If none, please enter "0."

____

107. Approximately how many people do you know who identify as a transracial adoptee? If none, please enter "0." _____

108. Approximately how many clients have you treated who were part of the adoption triad (defined as either an adoptee, adoptive parent or birth parent)? If none, please enter "0" _____

Directions: If you have worked with clients who are a member of the adoption triad, please answer the following questions. If you have not, and entered "0" above, please skip these next four questions and press "Continue" at the bottom.

109. Of these clients, how many identified as an adoptee (same race as adoptive parents)? _____

110. Of these clients, how many identified as a transracial adoptee? _____

111. Of these clients, how many identified as a birth parent who made an adoption plan? _____

112. Of these clients, how many identified as an adoptive parent? _____

113. In your graduate training, have your practicum or clinical supervisors discussed adoption or adoption-related issues in terms of case conceptualization?

( ) Yes
( ) No
( ) Sometimes
( ) Rarely
( ) Not applicable: I have not seen clients yet in my training

114. At this time, how well prepared do you feel to deal with adoption issues in therapy:

( ) Very well prepared
( ) Well prepared
( ) Somewhat prepared
( ) Not very prepared
( ) No knowledge about adoption

115. How many UNDERGRADUATE courses have you taken that provided information about adoption issues, particularly any emotional or behavioral challenges that members of the adoption triad might encounter?

( ) None ( ) One ( ) Two ( ) Three ( ) Four or more

116. How many GRADUATE courses have you taken that provided information about adoption issues, particularly any emotional or behavioral challenges that members of the adoption triad might encounter?

( ) None ( ) One ( ) Two ( ) Three ( ) Four or more

117. How many lectures or presentations have you attended in which you received information about with adoption issues.

( ) None ( ) One ( ) Two ( ) Three ( ) Four ( ) Five ( ) Six or more

118. If you have attended lectures or presentations, where did they occur? Please select all that apply.

_____Undergraduate coursework
_____Required graduate coursework
_____Elective graduate coursework
_____Local conferences.
_____Regional conferences

_____National conferences
_____Community-based trainings or workshops
_____Presentations sponsored by an adoption agency
_____Other. Please specify_____

119. Approximately how many empirical articles have you read in which you received information about adoption issues?
( ) None
( ) 1-3
( ) 4-6
( ) 6-10
( ) 11 or more

120. Approximately how many nonempirical articles or books have you read about adoption?
( ) None
( ) 1-3
( ) 4-6
( ) 6-10
( ) 11 or more

121. Have you learned about adoption from any other source(s)? Please describe them here:
_____
_____

122. Would you like additional training about adoption issues?
( ) Yes ( ) No

123. If you answered "yes," what kind of information or topics would you like to learn more about?
_____
_____

124. What is your age? _____

125. What is your sex?
( ) Female
( ) Male
( ) Transgender
( ) Other (please specify)_____

126. Your Race/Ethnicity: *please mark all that apply*
( ) Black or African-American
( ) White or European-American
( ) Hispanic
( ) Latino(a)
( ) Chicano(a)
( ) Asian or Asian-American
( ) Native American or Alaskan Native
( ) Pacific Islander
( ) Middle Eastern
( ) Multi-ethnic
( ) Other (please specify) _____

127. What is your highest level of education completed?
( ) Bachelors or undergraduate degree
( ) Masters
( ) Doctorate

128. What degree are you currently pursuing?
( ) Master of Arts (MA)
( ) Master of Science (MS)
( ) Master of Social Work (MSW)
( ) Master of Education (MEd)
( ) Doctor of Philosophy (PhD)
( ) Doctor of Psychology (PsyD)
( ) Other: Please specify_____

129. Area of Specialization/Area of Emphasis (select one):
( ) Clinical Psychology
( ) Counseling Psychology
( ) School Psychology
( ) School Counseling
( ) Marriage and Family Therapy (MFT) or Couples and family therapy (CFT)
( ) Rehabilitation Counseling
( ) Social Work
( ) Other: Please specify_____

130. Have you yourself been a client in therapy before?
( ) Yes ( ) No

131. For how long have you been a client in therapy? _____

132. Have you begun to see clients as part of your training or practicum experience?
( ) Yes ( ) No

133. What year are you in your current graduate program?
( ) 1st ( ) 2nd ( ) 3rd ( ) 4th ( ) 5th ( ) 6th or more

134. Are you currently in a practicum placement now? ( ) Yes ( ) No

135. Have you completed your required practicum training? ( ) Yes ( ) No

136. Are you currently employed as a counselor or providing therapy as part of a paid position? ( ) Yes ( ) No

137. If you are currently in practicum or have completed supervised practicum training, please indicate the number of months you have you seen clients in the following types of settings:

_____College or university counseling center
_____Veterans Administration (VA) hospital
_____Other hospital setting
_____Community mental health agency
_____Community college counseling center
_____High School
_____Middle School
_____Elementary School
_____Other (Please specify number of months and type of setting:)_____

138. As of today, approximately how many clients have you seen in practicum training?

( ) None
( ) 1-5
( ) 6-10
( ) 11-20
( ) 21-30
( ) 31-40
( ) more than 40 clients

139. What is your primary theoretical orientation? Please select one.

( ) Behavioral
( ) Cognitive Behavioral
( ) Interpersonal
( ) Humanistic/Existential
( ) Integrateive

( ) Eclectic
( ) Psychodynamic/Psychoanalytic
( ) Systems
( ) Other (Please specify): _____

140. Did you have experience providing counseling services prior to entering your current training program? ( ) yes ( ) no

141. How many total years of counseling experience do you have? Include all experience gained prior to your current program, practicums, externships, employment, internships, etc. _____

Please click the "continue to next page" button below for raffle entry instructions.

THANK YOU!

APPENDIX F

KASAS ORIGINAL VERSION (30-ITEMS): KNOWLEDGE, ATTITUDES AND SKILLS OF ADOPTION SURVEY (KASAS)

Directions: Please read each of the following statements carefully and click on the answer that best reflects your agreement with the statement.

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
strongly disagree	*moderately disagree*	*disagree*	*agree*	*moderately agree*	*strongly agree*

1. In general, if an adopted person comes to counseling, it is likely that their presenting issue is related to being adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

2. Promoting an adopted client's sense of gratitude for having been adopted by a good family is usually a safe goal to strive for in most counseling situations.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

3. When counseling international adoptees, it is generally safe to assume they have experienced early trauma or neglect in orphanages or institutions.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

4. When counseling transracial adoptees, it is generally safe to assume their racial and ethnic identity development is similar to other members of the same racial or ethnic group who were not adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

5. When counseling an adopted adult, it is generally safe to assume relationship issues such as challenges with intimacy or attachment might be connected to being adopted as a child.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

6. In counseling, it is important to find a balance between exaggerating the influence of adoption, and minimizing its relevance.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Directions: Please indicate how you would react to the following statements:

7. In families with a biological child and an adopted child, it might be challenging to love and treat them equally.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

8. Adoptees are at higher risk for psychological and behavioral problems than people who are not adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

9. In particular, transracial adoptees are at higher risk for psychological and behavioral problems than biological children and adoptees who are the same race as their adoptive parents.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

10. Adoption is a diversity or multicultural issue.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

11. Adoptees and adoptive families do not experience additional stigma or bias because they are not biologically related.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

12. Transracial adoptees can be raised in Caucasian families and predomonently Caucasian communities with little impact on their identity development.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

13. When talking about adoption in the past, I might have said "real parents" when referring to the biological or birth parents.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Directions: At the present time, how would you rate your understanding of the following terms and concepts:

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
very limited	*moderately limited*	*limited*	*good*	*moderately good*	*very good*

14. "Adoption triad"
(1) (2) (3) (4) (5) (6)

15. "Transracial adoption"
(1) (2) (3) (4) (5) (6)

16. "Adoptee identity development"
(1) (2) (3) (4) (5) (6)

17. The "seven core issues of adoption"
(1) (2) (3) (4) (5) (6)

18. Ethnic identity development for transracial adoptees
(1) (2) (3) (4) (5) (6)

19. Adoption-sensitive counseling
(1) (2) (3) (4) (5) (6)

20. Developmental issues related to adoption
(1) (2) (3) (4) (5) (6)

21. Adjustment issues related to adoption
(1) (2) (3) (4) (5) (6)

22. Adoption-sensitive language
(1) (2) (3) (4) (5) (6)

Directions: Please indicate how you would react to the following statements:

23. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of an adopted client or member of the adoption triad?

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
very limited	*moderately limited*	*limited*	*good*	*moderately good*	*very good*

24. At the present time, how would you rate your confidence in being able to provide "adoption sensitive" counseling?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

25. At the present time, how would you rate your ability to recognize resilience and positive coping skills within adoptive families?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

26. How well would you rate your ability to accurately assess the mental health needs of all members of the adoption triad?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

27. How well would you rate your ability to accurately assess the mental health needs of transracial adoptees?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

28. At this time in your life, how would you rate yourself in terms of understanding how your cultural background influences the way you think and act?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

29. How would you rate your level of training for working with members of the adoption triad?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

30. How well would you rate your ability to effectively assess the influence adoption has had on your client's life, without overemphasizing or minimizing it in treatment?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

APPENDIX G

KASAS FINAL VERSION POSTFACTOR ANALYSIS (19-ITEMS):

KNOWLEDGE, ATTITUDES AND SKILLS

OF ADOPTION SURVEY (KASAS)

Directions: Please read each of the following statements carefully and click on the answer that best reflects your agreement with the statement.

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
strongly disagree	*moderately disagree*	*disagree*	*agree*	*moderately agree*	*strongly agree*

1. In general, if an adopted person comes to counseling, it is likely that their presenting issue is related to being adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

2. When counseling international adoptees, it is generally safe to assume they have experienced early trauma or neglect in orphanages or institutions.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

3. When counseling an adopted adult, it is generally safe to assume relationship issues such as challenges with intimacy or attachment might be connected to being adopted as a child.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Directions: Please indicate how you would react to the following statements:

4. In families with a biological child and an adopted child, it might be challenging to love and treat them equally.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

5. Adoptees are at higher risk for psychological and behavioral problems than people who are not adopted.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

6. In particular, transracial adoptees are at higher risk for psychological and behavioral problems than biological children and adoptees who are the same race as their adoptive parents.

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

Directions: At the present time, how would you rate your understanding of the following terms and concepts:

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
very limited	*moderately limited*	*limited*	*good*	*moderately good*	*very good*

7. "Adoption triad"
(1) (2) (3) (4) (5) (6)

8. "Transracial adoption"
(1) (2) (3) (4) (5) (6)

9. The "seven core issues of adoption"
(1) (2) (3) (4) (5) (6)

10. Adoption-sensitive counseling
(1) (2) (3) (4) (5) (6)

11. Developmental issues related to adoption
(1) (2) (3) (4) (5) (6)

12. Adjustment issues related to adoption
(1) (2) (3) (4) (5) (6)

13. Adoption-sensitive language
(1) (2) (3) (4) (5) (6)

Directions: Please indicate how you would react to the following statements:

14. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of an adopted client or member of the adoption triad?

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*
very limited	*moderately limited*	*limited*	*good*	*moderately good*	*very good*

15. At the present time, how would you rate your ability to recognize resilience and positive coping skills within adoptive families?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

16. How well would you rate your ability to accurately assess the mental health needs of all members of the adoption triad?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

17. How well would you rate your ability to accurately assess the mental health needs of transracial adoptees?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

18. At this time in your life, how would you rate yourself in terms of understanding how your cultural background influences the way you think and act?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

19. How well would you rate your ability to effectively assess the influence adoption has had on your client's life, without overemphasizing or minimizing it in treatment?

(1) *(2)* *(3)* *(4)* *(5)* *(6)*

APPENDIX H

COPYRIGHT PERMISSION LETTER FOR THE ADJECTIVE CHECKLIST

mind garden

855 Oak Grove Avenue, Suite 215 Menlo Park, CA 94025
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Date: July 21, 2008

To whom it may concern,

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Sincerely,

Vickie Jaimez
Mind Garden, Inc.
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