Examining the Relationship Between Counselors-in-Trainings’ Self-Efficacy, Social Justice Attitudes, and Perceived Adoption Competency

Master of Science Clinical Mental Health Counseling

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Abstract

The lack of adoption competency training in graduate school fails to adequately prepare counselors-in-training (CITs) to effectively address the unique needs of adoption triad members. The present thesis aimed to (a) explore how well CIT self-efficacy (as measured by the Counselor Self-Efficacy Scale) and social justice alignments (as measured by the Social Justice Scale) predict perceived adoption competence (as measured by the demographic questionnaire); and (b) explore existing differences for demographic factors (i.e., race/ethnicity, gender, adoption status) for CIT self-efficacy, social justice alignments, and perceived adoption competence. Participants consisted of 77 CITs who were currently enrolled in CACREP graduate counseling programs in the U.S. A standard multiple regression was utilized to analyze the predictive ability of self-efficacy and social justice alignments for adoption competency, and a two-way factorial MANOVA assessed demographic differences among CIT self-efficacy, social justice alignments, perceived adoption competency. Findings from the current study are as follows: (a) CITs’ self-efficacy was a significant predictor for CITs’ perceived adoption competence; (b) female CITs reported significantly higher social justice alignment compared to males; (c) participants identifying as a racial/ethnic minority scored lower on the CSES, SJS, and APC; and (d) no significant differences occurred between adoption triad members and non-adoption triad members for the CSES, SJS, or APC. A discussion of the results, limitations of the study, implications for the counseling field, and suggestions for future research are provided.

Dedication

This thesis is dedicated to my mom, Shellie Gerrell, for being so transparent about her personal and professional experience as an adoptee, adoptive parent, biological parent, and licensed professional counselor. Without your example of what it means to be a clinical social justice advocate, working in adoption, I would be at a loss. Thank you for spending countless hours listening to me read this thesis aloud and validating the significance of my unique role in the adoption constellation. It is my hope this thesis serves as a steppingstone to recognizing clinical adoption competence as a necessary part of counselor development

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# Chapter I

**Introduction**

Up until the mid 1800s, adoption was an informal process often seen as a means to obtain cheap labor because it lacked judicial oversight. Without regulations to define legal adoption, the wellbeing of the child was put at risk. Recognizing this concern, in 1851, the Massachusetts Adoption of Children Act was passed (Herman, 2012). This was the first law in the United States to acknowledge adoption as a social and legal process. Further, the establishment of this adoption law marked the beginning of the child welfare movement (Herman, 2012).

Due to mass immigration to the U.S. from European countries, eastern U.S. cities quickly became poverty stricken. These circumstances led to overcrowding of orphanages and asylums housing neglected children. With this in mind, in 1853, the well-known evangelical minister, Charles Loring Brace, founded the Children’s Aid Society (CAS) in New York City. In his book, *The Best Method of Disposing of Our Pauper and Vagrant Children* (1859),he proposed the use of “orphan trains” as a way to relocate the overflow of homeless youth living in eastern port cities. Between 1854 and 1930, “orphan trains” transported a total of 200,000 children to be adopted by primarily midwestern protestant farming families. Brace believed these families would be able to instill “wholesome” values. However, there was still a lack of adoption legislation defining what constituted a “fit and proper” placement of children. Therefore, orphan trains began receiving criticism for the limited assessment of “quality of parenting” post-placement. These concerns for safeguards triggered the implementation of new “minimum standards” and focused on the state’s responsibility to protect child welfare by providing clear guidelines for the quality of placement. Overall, the “Orphan Train Movement” was considered to be the precursor to modern day foster-care and aided in defining the role of mental health professionals within the adoption process.

**First American Adoption Professional**

Senden van Theis is considered to be the first American adoption professional. She is most well known for her landmark adoption outcome study, *How Foster Children Turn Out* (1924), which followed 910 children who were placed in New York foster homes (Herman, 2012). Her study examined school success, self-support, and observance of law as factors indicating whether children were characterized as “capable,” “harmless,” or “incapable.” Although Theis’ findings reinforced the popular belief that foster children most likely came from “bad” backgrounds, her results indicated “bad” backgrounds were not always a predictor of bad outcomes. This challenged the eugenics position that foster children were a risk due to hereditary factors. Further, this study contradicted the belief that older children were less of a risk since more was known about their development and background. Moreover, in 1921, Theis and her colleague, Constance Goodrich, published the first training manual for professionals responsible for child placement. This manual provided step-by-step instructions for selection of children, homes, placement, supervision, replacement, rejecting applications, and placement of siblings. By highlighting the importance of psychological diagnosis, personality, and adjustment, Theis called attention to the need for adoption modernization, empirical research, and specialized training necessary to achieve preliminary adoption competence for the placement process (Herman, 2012).

**Empirical Adoption Research**

Since Theis’ outcome studies, empirical adoption research topics have expanded to include different types and classifications of adoption such as: domestic (i.e., children born in and adopted by U.S. citizens; Jones & Schulte, 2012; Zamostny et al., 2003), international (i.e., adoption from other countries by U.S. citizens; Jones & Schulte, 2012; Zamostny et al., 2003), transracial (i.e., child adopted by parents of a different race or ethnicity; Jones & Schulte, 2012; Zamostny et al., 2003), special needs (i.e., children older than five years of age, member of a minority group, part of a sibling group, or physical/emotional developmental delays; Zamostny et al., 2003), and levels of openness (i.e., defining pre and post placement contact between birth and adoptive families including accessibility and exchange of information directly or through a mediator; Zamostny et al., 2003).

Throughout the 20th century, research findings have continued to shape societal perception of adoption, therapeutic practices, and legislative policy (Palacios & Brodzinsky, 2010). Today, post adoption individual and family counseling has been recognized as one of the most effective support needs (Brooks et al., 2002; Houston & Kramer, 2008). However, a large portion of the available research guiding the development of therapeutic interventions and training curriculum is based on theoretical work primarily outside of the counseling discipline. Despite an increased interest within the fields of psychology and social work (e.g., application to public child welfare), there is still a call from the adoption research field for more adoption competent counselors (Baden & Wiley, 2007; Brodzinsky, 2011; Garber & Grotevant, 2015).

**The Need for Adoption Competent Counselors**

Previous literature has found adopted individuals are two to five times more likely to seek out mental health services than the general population (Brodzinsky et al.,1984; Brodzinsky & Weir, 2013; Grotevant, 1997; Pearson et al., 2007). In addition, it has been suggested that adopted children are referred for mental health treatment more often than their non-adopted peers (Casey Family Services, 2003; Keyes, Sharma, Elkins, Iacono, & McGue, 2008; Miller, Fan, Christensen, Grotevant, & van Dulment, 2000). Several studies have indicated adoptees (i.e., adopted individuals), birth/first parents (i.e., biological parents of relinquished child), and adoptive parents (i.e., legal parents of the adopted child) consider adoption competent counselors to be at the top of their list of pre and post adoption support needs (Brodzinsky, 2013; Casey Family Services, 2003; Smith, 2010).

As defined by Atkinson et al., (2013) an “adoption-competent practitioner” is an educated, licensed mental health professional with the knowledge, skills, and experience to work in adoption. In order to determine appropriate interventions, acquiring a general understanding of the adoption experience is necessary (Brodzinsky, 2013). Furthermore, counselors should recognize adoption as a lifelong process and understand developmental challenges associated while also acknowledging variability in the adoptive experience (Grotevant et al., 2017). However, finding adoption competent counselors with the knowledge, awareness, and skills to address the intricacies of adoption is difficult (Brodzinsky, 2013).

As evidence of this, a Massachusetts study found some adoptive families sought out services from up to 10 mental health professionals before finding one with an in-depth understanding of adoption circumstances (Frey, 1986). Furthermore, adoptive families have described instances where negative counseling experiences have caused harm to their families (Casey Family Services, 2003; Festinger, 2006; Linville & Lyness, 2007; Massachusetts Department of Mental Health, 1994; NACAC, 2002; Nelson, 1985; Smith & Howard, 1999; Tarren-Sweeney, 2010). In many cases, adoptive families and individuals have reported feeling as though they had to teach or educate mental health professionals about the basics of adoption such as attachment, trauma, loss, and use of appropriate language (Brodzinsky, 2013; Reyka, 2019). Previous literature attributes these insensitivities and lack of knowledge to the failure of counseling graduate training programs to prepare counselors with adoption specific coursework and the experience necessary for developing adoption competence (Brodzinsky, 2013).

**Lack of Clinical Adoption Competent Training in Graduate School**

Although clinical graduate training is the first step to building the foundation of adoption competence, graduate training alone is insufficient (Brodzinsky, 2016). According to Weir, Fife, Whiting, and Blazewick (2008), there is a severe lack of adoption training for counselors-in-training (i.e., CITs; students enrolled in counseling graduate programs), even though 14-26% of counseling graduates report working in adoption settings (e.g., adoption agencies, Child Protective Services). In a study comparing coursework across marriage and family therapy, social work, and counseling graduate programs, only about 5-16% of students reported they were offered access to adoption specific materials (Brodzinsky, 2013). In related fields, a sample of psychology professors reported they spent only about eight minutes per semester focusing on adoption specific content (Post, 2000; Sass & Henderson, 2000). In comparison, subjects impacting a smaller percentage of the population, such as autism, were discussed approximately 10 times more often (Brodzinsky, 2013; Post, 2000; Sass & Henderson, 2000). Historically, adoption has been considered to primarily be a function of the child welfare system (e.g., social work focused). Therefore, counselors working outside of the child welfare system (e.g., private practice and/or counselor education and supervision), do not consider adoption to be relevant to their work with clients (Hartman, 1991). Sass and Henderson (2007) found CITs do not have the same kind of access to adoption competency training programs such as the Center of Adoption Support and Education (CASE; Brodzinsky, 2013). The lack of emphasis put on adoption specific training in counseling graduate programs sends the message that achieving adoption competence is not important, despite previous literature highlighting the need for increased accessibility to training and services provided by adoption competent counselors (Brodzinsky, 2013; Casey Family Services, 2003; Fisher, 2003). Therefore, acquiring the education needed to achieve adoption competency falls to the CIT to seek out adoption competent supervisors, workshops, and experiences after graduation.

**CIT Self-Efficacy and Seeking Adoption Competent Training**

Previous research has linked self-efficacy to motivation, behaviors, making decisions, and quality of performance of a specific task (Bandura, 1986; Graham & Weiner, 1996). Self-efficacy can be defined as “belief of strength” regarding a specific issue (Bandura, 1997, 2001). Larson and Daniels (1998) claimed counselor self-efficacy is related to counselor performance and resilience. Therefore, a counselor with high self-efficacy would most likely fair better when met with a challenging clinical situation. Further, an individual will begin to develop expectations about their performance ability and if these expectations are not met, the individual may begin to develop avoidance behaviors related to that task (Betz, 2004). As applied to adoption counselor competency, these avoidance behaviors may explain the number of studies suggesting mental health professionals fail to address adoption specific issues in counseling, even when they are informed of its importance to therapy and development (Rosenberg, 1993). These findings lead one to assume CITs with high self-efficacy levels might be more willing to seek out and consistently apply future adoption competent training.

**CIT Social Justice Attitudes and Seeking Adoption Competent Training**

Authors have summarized the definition of social justice as “a value or belief, encompassing the idea that people should have equitable access to resources and protection of human rights…and that society should work toward empowerment with people from disadvantaged or disempowered groups” (Fietzer & Ponterotto, 2015, p.78). Torres-Harding et al. (2012) developed a measure that operationalized Ajzen’s (1991) social cognitive model that hypothesized how attitudes translate into behaviors. According to this theory, behaviors are directly predicted by (1) an individual’s attitude toward the behavior, (2) the subjective norms of society around that action, and (3) and an individual’s perceived behavioral control of the action. For the measure, Torres-Harding et. al (2012) defined social justice attitudes as “an individual’s acceptance of the social justice ideals and related values, such as the belief that one should act for social justice, or that it is right or fair to promote equality of opportunity for everyone, regardless of background” (p.79). Examining CITs’ social justice attitudes, which will be referred to in the study as social justice alignments, could provide insight on their openness and intentions for seeking out future training. In other words, this study is asking if CITs’ social justice alignments could be used as a way to predict willingness to seek adoption competence training after graduation. Currently, many professional in the field do not recognize adoption as in need of socio-political reform. By gaining an understanding of CIT’s social justice alignments, this could provide a framework of how to best infuse adoption competency into graduate training.

**Purpose of the Study**

The purpose of this study is to explore how well CIT self-efficacy and social justice alignments predict perceived adoption competence. Another purpose of this study is to examine what differences exist among demographic variables (i.e., racial/ethnicity, gender, adoption triad member status) across the three constructs. A goal of this study is to expand on social justice and multicultural counseling competencies through highlighting the need for specialized graduate training for working with adoption triad clients. One potential implication of this study is the further operationalization of the social justice competencies by using the adoption triad as an example of a population which could benefit from counselors embracing their role as a social justice advocate. In other words, this study is asking if CITs’ social justice alignments and self-efficacy could be used as a way to predict CITs’ willingness to seek adoption competence training after graduation.

**Significance of the Study**

Examining how well CIT self-efficacy and social justice alignments predict perceived adoption competence serves as a building block for future research exploring adoption competency training in CACREP graduate programs. These findings could potentially lead to establishing adoption counseling as a specialized area in clinical practice and furthering the standardization of training. Currently, adoption is not widely recognized as an area in need of or shaped by socio-political reform. By gaining an understanding of CITs’ social justice alignment, this could provide a framework of how to best infuse adoption competency into graduate training as a way to make it personally meaningful to students. Findings from this study may help to raise awareness in the mental health field in order to correct misperceptions of the adoptive experience and alleviate adoptive stigma within clinical settings. Through education, counselors can increase their understanding of the lifelong adoptive experience and the impact it has on adoptees, birth/first parents, and adoptive parents at each stage of life. Additionally, raising awareness has the potential to lessen the urge to pathologize externalized behaviors presented by adoption triad members. Becoming aware of the oppression faced by adoption triad members is the first step toward achieving adoption competent mental health services.

**Theoretical Framework**

**Feminist Theory**

The first framework utilized for the conceptualization of the current study was feminist theory. Feminist theory suggests that individual problems are largely influenced by the socio-political context in which they originate (Brown, 1994; Goodman et al, 2004). Feminist theory also highlights how marginalization and oppression contribute to mental health issues experienced by individuals (Brown, 1994; Goodman et al., 2004). Moreover, feminist theory recognizes symptomology as responses to oppression and marginalization rather than pathologizing individuals and families (Brown, 1994; Goodman et al., 2004). This is particularly important when working with adoption triad members, as they are often overrepresented in both in-patient and outpatient clinical settings, despite research showing many adopted children function at a normative range (Brodzinsky, 1991). These findings suggest non-adoption competent counselors may play a role in adoption triad members being overrepresented due to being inadequately trained to address their unique needs.

**Social Cognitive Theory**

According to Bandura’s (1986) reciprocal interactions model, behavioral (e.g., actions), environmental, and personal (e.g., thoughts) factors influence human functioning. These influences interact with each other in a reciprocal manner. This interaction is referred to as triadic reciprocity (Bandura, 1986). This framework demonstrates that high self-efficacy and an individual’s capability to develop agency and self-regulation is necessary to attain goals. In other words, how an individual feels about their capabilities in performing a task will determine how they decide to go about it in order to obtain a positive outcome. For example, a CIT who feels competent in their counseling performance with a specific population (e.g., marginalized groups) are more likely to persist, expend effort toward, and place themselves in environments that will help them learn (Schunk & Usher, 2019). Further, the interaction between personal (e.g., self-efficacy) and environmental factors (e.g., professor or supervisor makes a positive comment about counseling performance), leads to motivation. Bandura’s (1997) framework explains how individuals develop a sense of agency through intentional thoughts and actions aimed at achieving their goal. Aspects of SCT, such as reciprocal interactions (Bandura, 1986), influence motivation, which is fueled by self-regulation and self-efficacy. According to this theory, high levels of self-efficacy led to more engagement in cognitive and behavioral activities. For example, CITs with high levels of counselor self-efficacy are more likely to be motivated to get involved with additional training if they believe it to be relevant to their overall counseling goal.

Further, Bandura (1977) posits attitude is positively correlated with self-efficacy beliefs. As applied to the current study, respondents may indicate high levels of counselor self-efficacy and perceived adoption competence despite never taking an adoption competent training course. Since self-efficacy has been proven to be predictive of perceived performance, CITs’ self- efficacy regarding ability to provide adoption competent services may be a reflection of their confidence rather than the quality of services provided (Bandura, 1977, 1986).

**Research Questions & Hypotheses**

This study explored the relationships among CIT self-efficacy, perceived adoption competence, and social justice alignments for graduate students enrolled in CACREP programs. As such, the following research questions were examined.

**Research Question 1**

How well do CITs’ self-efficacy and social justice alignments predict CITs’ perceived adoption competence?

**Hypothesis 1a.** Higher scores for self-efficacy and social justice alignments will predict higher perceived adoption competence for CITs.

**Research Question 2**

What differences exist among demographic variables (i.e., race/ethnicity, gender, adoption status) for CITs’ self-efficacy, social justice alignments, and perceived adoption competence?

**Hypothesis 2a.** Participants who identify as a racial/ethnic minority will have higher scores for social justice alignments, self-efficacy, and perceived adoption competence compared to White participants.

**Hypothesis 2b.** Participants who identify as female will have higher scores for social justice alignments, self-efficacy, and perceived adoption competence compared to males.

**Hypothesis 2c.** Participants identifying as an adoption triad member will have higher self-efficacy, perceived adoption competence, and social justice alignments compared to non-adoption triad members.

**Potential Limitations**

There were several potential limitations in the current study. Adoption research reached its peak number of publications during the 1990s. Since then, adoption practices have changed in drastic ways (e.g., closed versus open adoption). This calls into question how generalizable the more dated adoption research is compared to the modern adoptive experience. The biggest limitation is the fact adoption counseling is not established as a specialty area in this discipline. This severely limits to availability and establishment of reliable and valid measures of adoption competence. As Atkinson et al., (2013) pointed out, this makes defining “adoption competence” difficult and does not allow for uniformity of training. Each state has varying adoption legislature in place which should be taken into consideration because legislation (e.g. open adoption records) could contribute to the degree of systemic oppression felt by adoption triad members in each state. Additionally, this study was restricted to only passive recruitment and online administrative procedures due to the outbreak of the Coronavirus. Moreover, this study did not evaluate whether “perceived adoption competence” was a true measure of adoption competence. Utilizing self-report surveys also poses the risk of inaccurate self-evaluation of competence and performance. An experimental research design would be needed to evaluate the cause and effect of adoption training administered to CITs and the impact adoption competent performance and seeking future training. Future research will be needed to expand on the findings of this study.

**Summary**

Throughout the 20th century, research findings have continued to shape societal perception of adoption, therapeutic practices, and legislative policies in the U.S. (Palacios & Brodzinsky, 2010). However, there is still more progress to be made within the counseling discipline, especially regarding the access to pre and post adoption mental health services to adoption triad members. Since previous literature points to the need for counselors to develop adoption competence, examining how well CITs’ self-efficacy and social justice alignments predict perceived adoption competency levels could provide a steppingstone toward ways to infuse more social justice and adoption competency training into graduate programs (Sass & Henderson, 2000). In order to standardize these training guidelines, a consensus is needed on how to define adoption competence and social justice within counseling (Atkinson, et al., 2013).

**Definition of Terms**  
**Self-Efficacy**. Self-efficacy is the perceived belief of strength an individual has regarding their ability to perform a particular activity (Bandura, 1997).

**Adoption Triad.** Adoptee, biological parents, and adoptive parents.

**Adoptee.** Individual who has been relinquished by biological parents.

**Birth/First Parent.** Individuals who have placed a child for adoption and relinquished rights.

**Adoptive Parent.** Individuals who are the relinquished child’s parents by law

**Counselor in Training**. Master’s level graduate student currently enrolled in CACREP clinical mental health counseling courses.

**Adoption Competence.** Although no widely accepted definition exists, the present study defines clinical adoption competence as: a range of knowledge skills and experiences related to the assessment and treatment of members of the adoptive kinship system.This competence starts with graduate level training in an area related to mental health and child/family/welfare (psychology, psychiatry, social work, marriage and family therapy, and clinical mental health counseling) (Atkinson, et al.,2013; Brodzinsky, 2013; Casey Family Services, 2003; Center for Adoption Support and Education, 2012; Janus 1997; National Child Welfare Resource Center for Adoption, 2007; Tarren-Sweeney, 2010; Tarren-Sweeney & Vetere, 2013).

**Adoption Competent Counselor.** Counselor with knowledge, skills, and awareness related to adoption. Often, competence requires specialized training in assessment, diagnosis, and use of appropriate interventions.

**Mental Health Professional**. Any professional working within the mental health field (psychologist, psychiatrist, counselor, family and marriage counselor, and social worker)

**Social justice alignments.** For the purpose of this study, social justice alignments refer to the overall score on the Social Justice Scale measure (Torres-Harding, Siers, & Olson, 2012).

**Adoptive Experience** The lived experience of adoption triad members.

**Chapter II**

**Review of the Literature**

**Adoption Triad Members and Clinical Adoption Competence**

It is estimated that 2% of children and adolescents living in the U.S. are adopted (Kreider & Lofquist, 2014). Considering the small percentage, it would be easy to assume the systemic impact of adoption would be limited. However, The Dave Thomas Foundation of Adoption estimated nearly two thirds of Americans are impacted by adoption through immediate family, close friends who are adoptees, birth parents, or adoptive parents (Baden, 2016; Harris Interactive for the Adoption Institute and Dave Thomas Foundation for Adoption, 2002). In other words, one adoption affects approximately 33 individuals (Henderson, 1994; Sass & Henderson, 2007). The people most directly affected by adoption are the adoptee (i.e., adopted persons), birth/first parents (i.e., biological parents of the adoptee), and the adoptive parents (i.e., legal parents of the adoptee). Collectively, these individuals are most commonly referred to as the adoption triad.

Due to the complex and diverse nature of adoption, adoptive families and adopted individuals might be more inclined to seek out mental health services to address adoption specific issues such as young adoptees’ experiencing cognitive delays (Loman,Wiik, Frenn, Pollak, & Gunnar, 2009), behavioral challenges, (Hawk & McCall, 2010), early attachment disturbances (Groza & Muntean, 2016) and various other social-behavioral difficulties that could be adding stress to the adoptive family system (Lawler et al, 2014). Previous literature reports adoptive families are two to five times more likely to utilize outpatient mental health services than non-adoptive families (Howard et al., 2004; Keyes et al., 2008; McRoy et al., 1988). Furthermore, adoptive families are four to seven times more likely to place their children into residential treatment centers (Elmund et al., 2007; Landers et al., 1996; McRoy et al., 1988). Therefore, counselors must be aware of the potential set of circumstances (e.g., early life adversity, rehoming, neglect, abuse) impacting the adoptee rather than pathologizing the behaviors as a whole. For instance, an adopted child’s symptomology could simply be a reaction to the experience of adoption itself rather than from within the individual (Brodzinsky, 2016). Moreover, adoption competent counselors should be knowledgeable of the unique feelings, perspectives, and experiences of each individual triad member and the impact on adoptive family dynamics. Acknowledging the contextual factors impacting adoption such as multiple family and extended family systems, legal system, child welfare system, special education system, medical system, stigmatization, and experience as a member of a marginalized group is essential for exercising adoption competence in clinical settings.

Utilizing a bio-ecological approach strengthens the effectiveness of services being provided (Brodzinsky, 2013). Additional training in assessment, diagnosis, and evaluation is necessary to select appropriate treatment and therapeutic interventions. When considering diagnosis, an adoption competent counselor is up to date on the current diagnostic limitations incapable of providing a true representation of adoption specific challenges since many adopted children are diagnosed with attachment disorders, Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD), and Major Depressive Disorder (MDD) (Brodzinsky, 2013). If counselors are unaware, this could lead to unnecessary pathologizing of adoptees and further reinforce stigmatizations of the adoption triad (Brodzinsky, 2013). Given the societal misperceptions and microaggressions experienced by adoption triad members, counselors have an ethical responsibility to develop adoption competency to include all levels of society such as policy, social activism, and social change to guide treatment planning. (Brodzinsky, 2016; Garber & Grotevant, 2015).

**Lack of Adoption Research in the Counseling Discipline**

As adoption has become more commonplace in the U.S., it has received scholarly interest across disciplines (e.g. social work, psychology, law, counseling). Despite the rise in prevalence, between the years of 1988-2017, only 24 empirical articles on adoption were published in counseling journals. Compared to the scarce amount of empirical counseling adoption articles, between 1990 and 2001, more than 102 multicultural counseling competency articles were published in the *Journal of Counseling and Development*. Considering adoption has a long history of stigmatization, systemic oppression, racial discrimination, patholotization, inequitable access to resources, and microaggressions that have been shown to have an adoption triad member have and still endure, continuously this population has been excluded from the empirical literature and socio-political conversation. Since empirical findings aid in shaping policy, perception, and practices, more emphasis should be placed on revisiting adoption literature and guiding what adoption competence looks like within clinical settings.

**First Wave of Adoption Research**

Since the late 1950s, adoption research questions and methodological procedures have evolved drastically. For example, the first wave of adoption research focused on presentation of psychological symptoms, academic performance, and level of developmental risk presented by adopted children compared to non-adopted children (Palancios & Brodzinsky, 2010). These research studies closely resembled the earlier landmark adoption outcome study conducted by Sophie van Senden Theis. These comparison studies were unguided by formal theory and samples were an underrepresentation of diversity within adoption (e.g. sample included primarily domestically born infant adoptions, same race adoptive parents, and confidential arrangements). There was little research focused on older adoption, intercountry, and open adoption. Despite the limitations, the focus on psychological risk present during this period defined a new field of inquiry in developmental and family research. However, there was little attention paid to the reasons underlying adopted children’s adjustment difficulties and the factors that contribute to overcoming early life adversities (Palacios & Brodzinsky, 2010).

**The Second Wave of Adoption Research**

The second wave of adoption research introduced international adoption and incorporated longitudinal studies examining the long-term effects of providing stable environments to combat early life adversity experienced by many adopted children (Palacios & Brodzinsky, 2010). During this time, intercountry adoption was on the rise due to the social climate in Romania in 1989. These children had experienced severe trauma, neglect, and malnourishment while in the orphanages. With this in mind, clinicians became increasingly interested in how institutionalization (i.e., early life adversity) impacted adopted children and their ability to overcome developmental delays due to early life trauma. This shed light on the importance of adoptive families to provide a stimulating, loving, protective environment to encourage developmental delay recovery. This research also contributed to understanding adjustment difficulties as a reaction to trauma rather than purely genetic disposition.

**Third Wave of Adoption**

Modern adoption research is referred to as the third wave. This wave acknowledges adoption as a lifelong process for all members of the adoption triad. Although largely ignored at the time of publication, Kirk’s (1964) book *Shared Fate*, has been a huge influence on how adoption is being discussed in relation to family dynamics. In his book, Kirk looked at adoptive parents’ level of openness in communication with adopted children and its impact on the child-parent relationship. He found, some parents used a “rejection of different strategy,” as a way to deny their feelings of doubt post adoption. Essentially, this was the equivalent of applying a “color-blind” approach to the adoptive parent-child relationship. However other parents readily admitted there was a difference in parenting biologically versus adopted children. These parents exercised the “acknowledgment of different strategy.” Kirk (1964) found parents who operated from acknowledgment of different strategy had close relationships with their adopted child and exercised open communication about adoption compared to parents who did not acknowledge differences. This close relationship and open communication led the development of stable home environment (Kirk, 1964).

Further, researchers in this wave are beginning to take into account the variability of the adoptive experience and how it can impact development without pathologizing behavior. For instance, in earlier years, an adoptee searching for their birth parents was considered to be maladaptive by counselors (Sass & Henderson, 2000). With the rise of open adoptions, counselors must emphasize how to encourage open communication between all triad members and educate adoptive parents of the importance of being supportive if the adopted child expresses a desire to search (Palacios & Brodzinsky, 2010).

**Defining Adoption Competence**

Since adoption competence is not yet clearly defined in the counseling discipline, the development of adoption competencies has been hindered (Atkinson et al., 2013; Casey Family Services, 2003). For this study, adoption competence can be defined as a range of knowledge, skills, and experiences related to the assessment and treatment of members of the adoption triad. The first step to achieving adoption competence begins with enrolling into graduate level training in a mental health related field (e.g., psychiatry, psychology, social work, counseling). These graduate level training programs only provide a foundation in regard to developing an understanding of clinical theory. According to Brodzinsky (2013), graduate training alone is insufficient to achieve adoption competency. Unfortunately, access to adoption competent training, materials, and resources is scarce. As outlined by Atkinson et al., (2014) key areas of adoption competence training include but are not limited to: (a) historical and contemporary perspectives on adoption practice; (b) the impact of adoption law on families and stability; (c) understanding the child welfare system and impact of family life; (d) adoption throughout lifelong development for all adoption triad members; (e) adoptive parent preparation (e.g. setting realistic expectations, processing personal loss such as infertility and impact on adoptive parenting, adoptive family dynamics, and support needs); (f) variance of experience and needs across different types of adoptions (e.g. domestic private versus international); (g) impact of neglect, abuse and trauma on neurological and behavioral development; (h) adoption related loss, grief, attachment difficulties, racial and cultural identity development; (I) support needs of the birth/first parents (e.g. child loss, stigmatization, search and reunion, etc.); (j) open adoption and navigating communication; (k) issues in adoption by sexual minority individuals and couples; (l) ethical issues in adoption practice and counseling (Atkinson et al., 2014; Brodzinsky, 2013). Attaining adoption competence does not stop at completing a training course. It is recommended counselors seek out more experienced adoption competent supervisors to assess and give feedback on the newly trained counselors’ application of knowledge, values, skills, and techniques acquired through adoption competent training (Brodzinsky, 2013). Supervision is a key component in advancement of adoption competent counseling skills. Unfortunately, to date, the only program widely known to require supervision following completion is Training for Adoption Competence Model (TAC) which is offered through C.A.S.E. Supervision consists of meeting in person, audio, or video group once a month for six months (Brodzinsky, 2013). As pinpointed by Fisher (2003) the absence of discussion and access to adoption competent training sends the message adoption is unimportant and/or irrelevant to counselors.

**Lack of Adoption Competent Training in Graduate School**

A study examining interactions between adoptive families and mental health professionals including social workers and counselors, indicated over 81% (n= 485, 84% adoptive parents, and 77% adopted persons) reported they have seen one or more mental health professionals (Atkinson et al., 2013). Findings indicated less than 25% believed the mental health professional to be adoption competent and 50% indicated some mental health professionals were adoption competent, but others were not. Additionally, 26% said none of the mental health professionals were adoption competent. For this study, adoptees reported only 14% of the mental health professionals to be adoption competent compared to adoptive parents who reported 26% were competent. Overall, these findings suggest adoptees had more of a negative experience than adoptive parents when it comes to interactions with mental health professionals. These findings also suggest adoptees and adoptive parents have different therapeutic needs and expectations within clinical settings. According to the study, counselors were viewed as being especially insensitive and lacking knowledge in the areas of attachment, trauma, loss, and use of appropriate language (Atkinson et al., 2013). In some instances, respondents claimed therapists did more damage to their families by applying inappropriate interventions or invalidated their experience. Examples of insensitive comments made by incompetent counselors were as follows: suggesting cancellation of pending adoption, inquiring if adoptive parents “had any children of their own,” falsely advertising as an adoption expert and then making a comment about how they did not think “open adoption was done anymore.” Another common invalidation experienced was discounting adoption related developmental impacts for adoptions finalized at infancy. The most damaging experience reported was a therapist misinterpretation of confidentiality and adamant refusal to provide therapy to the family as a whole. Fisher (2003) pointed out the lack of training sends the message adoption is unimportant and irrelevant to counselor training. A counselor who is unaware of core adoption issues may try to adapt conventional approaches into therapy with adoption triad members. However, this lack of awareness could actually do more harm. An example of this would be if a counselor utilized a behavioral approach when working with parents and their adopted child, but the counselor failed to recognize the potential for the adoptee to experience “cognitive distortions” (Weir, 2011a; 2011b). This emphasizes the importance of understanding the impact of relational issues, personalizing the consequence, and trust from an adoption and trauma informed perspective. This lack of preparation leaves many counselors confused about how to address adoption related issues in session. For example, McDaniel and Jennings (1997) presented licensed family therapists with a simulated case study of an adoptive family where the presenting problems were explicitly about adoption issues and only 16% of the therapists tailored their interventions to address adoption.

  In other surveys with adoptive parents who reported negative experiences with non-adoption competent mental health professionals, their complaints included: failing to validate or believe their experiences, blaming parents for their children’s problems, pathologizing adoption and the family, questioning parents’ motives for adoption, advising parents not to talk about adoption with children because it will “stir things up,” telling parents to give children back to the state, seeing children with attachment problems without parental presence or input, and failing to gather appropriate information about children’s histories of previous maltreatment or the impact (Casey Family Services, 2003; Festinger, 2006; Linville & Lyness, 2007; Massachusetts Department of Mental Health, 1994; NACAC, 2002; Nelson, 1985; Smith & Howard, 1999; Tarren-Sweeney, 2010). Considering these statistics, it is evident adoption triad members require counselors with specialized training in adoption for their unique needs to be met appropriately.

**Self-Efficacy and Adoption Competence Training**

It is important to clarify self-efficacy does not refer to confidence, but rather to an individual’s “belief of strength” in performing a certain task (Bandura 1997, 2001). Self-efficacy plays a role in motivation, behavior performance, and decision making (Bandura, 1986; Graham & Weiner, 1996). Self-efficacy is developed through performance accomplishment, and vicarious experience (Bandura, 1977), emotional arousal, and verbal persuasion (Bandura, 1977). Previous research indicates training is highly correlated with development of self-efficacy (Kozina et al., 2010). This sheds light on the importance of the content introduced during graduate training. For instance, Milsom (2002) found school counselors who were exposed to special education content during graduate school felt more comfortable working with students with disabilities. With this in mind, the same could be said if counselor educators assigned adoption related readings as coursework. Another way to develop self-efficacy is through experience. Counselors gain experiences in certain situations which will develop their self-efficacy for similar scenarios in the future (Barbee et al., 2003). Strike et al., (2004) found counseling graduate students who experienced working with persons with disabilities had higher competencies with that population. As applied to the current study, exposure to adoption, child welfare services, adoption legislation, transracial adoption, and working with members of the adoption triad during practicum and internship could contribute to the development of self-efficacy and adoption competency (Glenn, 1998).

Bandura’s reciprocal interactions model (1986) demonstrates that high self-efficacy working alongside an individual’s capability to develop agency and self-regulation behaviors can lead to attaining goals due to intentionally gearing thoughts and actions conducive to a perceive positive outcome.

In relation to the current study, if a CIT has a high level of counselor self-efficacy, then when met with a difficult scenario (e.g., addressing adoption specific issues with little training), they would be more likely to retain quality of services even when challenges or new experiences arise. However, if CITs have low self-efficacy, there is a chance avoidance behavior will develop, and core adoption issues will not be broached. Self-efficacy is developed through performance accomplishment, and vicarious experience (Bandura, 1977), emotional arousal, and verbal persuasion (Bandura, 1977). Previous research indicates training is highly correlated with development of self-efficacy (Kozina et al., 2010). This sheds light on the importance of the content introduced during graduate training. For instance, Milsom (2002) found school counselors who were exposed to special education content during graduate school felt more comfortable working with students with disabilities. With this in mind, the same could be said if counselor educators assigned adoption related readings as coursework. Another way to develop self-efficacy is through experience. Counselors gain experiences in certain situations which will develop their self-efficacy for similar scenarios in the future (Barbee et al., 2003). Strike et al., (2004) found counseling graduate students who experienced working with persons with disabilities had higher competencies with that population. As applied to the current study, exposure to adoption, child welfare services, adoption legislation, transracial adoption, and working with members of the adoption triad during practicum and internship could contribute to the development of self-efficacy and adoption competency (Glenn, 1998).

**Unique Therapeutic Needs of Adoption Triad Members**

Some examples of the unique therapeutic needs experienced by triad members include: trauma, adjustment, academic and psychological difficulties, identity development, stigmas enforced by society, grief (e.g. disenfranchised), loss (e.g. ambiguous and secondary), anger, infertility, exploring pregnancy options, helping with the decision making process, self-esteem, attachment, and managing transactions between extended family members gained through adoption (Brodzinsky, 2013). Additionally, research shows both prospective and adoptive parents have indicated there is a need for pre/post support in the decision-making process, making peace with decision post relinquishment, pregnancy options, and more education on how to prepare for the decision to adopt (Brodzinsky, 2013).

These therapeutic needs are considered unique to the adoptive triad members because they are experienced primarily within the context of and as a result of adoption. Due to the various modalities in which adoption can be achieved (e.g., foster care, private agency, intercountry etc.), mental health professionals should be mindful of the variability of experience among adoption triad members. There is no one size fits all solution when working with this population.

Friedlander (2003) pointed out counselors have a tendency to overgeneralize or overemphasize the significance of adoption on an individual’s life. Although there are common themes addressed in counseling with adoption triad members, these are influenced by a combination of pre/post adoption experiences, family structure, and the dynamic of the adoption itself (e.g., private agency, international, transracial, loss identity, variability of experience, acknowledgment of differences, stigmatization) (Brodzinsky, 2013). Essentially, adoption competent counselors need to be aware of the policy, practice, and have an in-depth understanding of the psychological impact adoption has on each triad member.

**Adoptee’s Unique Therapeutic Needs**

Previous literature has identified several areas of discussion that are unique to adoptees’ therapeutic needs. These topics include but are not limited to: cognitive delays (Loman et al., 2009), behavioral challenges (Hawk & McCall, 2010), early attachment disturbances (Groza & Muntean,2016), pre adoption adversity experiences (Balenzano et al., 2018), internalizing and externalizing behavioral issues (Hawk & McCall, 2010), struggles navigating racial and ethnic identity (Vonk, 2001), racial oppression (Leslie et. al, 2013), maladaptive adjustment due to multiple placements (van Londen et al., 2007), academic and language delays (van IJzendoorn & Juffer, 2005), and higher risk of received diagnosis for attention deficit hyperactivity disorder (ADHD), chemical dependency, depression, and anxiety (Brodzinsky, 2013; Casey Family Services 2003).

Grief is a common reaction to loss, but it is difficult for the adoptee to grieve because their loss often goes unacknowledged by society (Brodzinsky, 2013). This is called disenfranchised grief. Unacknowledged grief can manifest as feelings of anger, depression, anxiety, or fear (Verrier, 1993). These feelings can be triggered in childhood, adolescence, or during any life transition. Adoptees may also feel a loss of control over their lives (Groza & Rosenberg, 1998) and powerlessness (Hartman & Laird, 1990). Adoption competent counselors should also be aware of how these feelings can impact the adoptee’s identity development. Furthermore, understanding the adoptee’s history can provide insight into attachment patterns and traumas (Brodzinsky, 2013; Porch, 2007).

**Birth/First Parent’s Unique Therapeutic Needs**

Adoption was at its peak in the 1970s (Coleman & Garratt, 2016). During this time, agencies frequently encouraged unmarried young women to relinquish their parental rights and return back to their “pre-pregnancy life” (Silverman et al., 1988). Agency workers would try to convince birth parents that it would be in the best interest of the child because the adoptive parents would be better qualified to raise a child (Silverman et al., 1988). At this time, it was common practice to have confidential adoptions which meant all records would be sealed and there would be no contact between triad members. It was relayed that many birth mothers were pushed into relinquishment even though they preferred to keep their child (Silverman et al., 1988). Several birth mothers reported psychologists would tell triad members to “forget about the experience” and “move on with their lives” (Kirschner, 1990). Silverman et al. (1998) found birth parents who were encouraged to relinquish were more likely to search later in life than those who willingly relinquish their parental rights. The same authors also found 79% of birth parents search for their children and 74% participated in an adoption reform group. However, research has shown that never addressing birth parents’ loss, grief, and stigmas has had negative impacts on their self-esteem, future relationships, coping mechanisms and moving forward with their lives (Silverman et al., 1988). In some cases, birth parents find themselves unable to grieve and are faced with extreme guilt and shame (Brodzinsky, 2013; Porch, 2007). Additionally, the impact of relinquishing a child may be lifelong (Wiley & Baden, 2005). Birth mothers report a sense of loss and isolation post relinquishment, and they also struggle with moving past their decision which can impact their self-esteem. (Brodzinsky, 1990; Wiley & Baden, 2005). As mentioned in previous sections, when grief goes unacknowledged, this can lead to the development of disenfranchised grief (Brodzinsky, 1990). This grief can also manifest as symptoms of depression, anxiety, and post-traumatic stress disorder (Wiley & Baden, 2005). Because of the complexity of the nature of adoption, an adoption competent counselor should have an in-depth understanding of how relinquishment has shaped the lives of birth parents without judgment (Brodzinsky, 2016).

There is very limited research on birth fathers (Freundlich, 2002). Free ark et al. (2005) suggest marginalization of birth fathers within the adoption practices exacerbates feelings of powerlessness and disenfranchisement. For a non-adoption competent counselor, it would be easy to misinterpret this lack of research as suggesting birth fathers are not impacted by relinquishment (Porch, 2007). However, this could actually be a reflection of birth mothers’ tendency to be more influenced by the maternal grandmothers’ input which sometimes leads to the exclusion of birth fathers in the decision-making process (Coleman & Garratt, 2016).

Today, there is a wider acceptance of the child-and-family-centered approach to adoption practice. This means, birth and adoptive family members maintain contact at different degrees. Typically, this practice is usually just referred to as an open adoption. With this shift from confidential/closed adoption practices to open, birth parents are able to have more control in the placement process, and this promotes social and emotional well-being for all.

**Adoptive Parents’ Unique Therapeutic Needs**

In recent years, adoptions from the child welfare system have remained consistent despite an overall reduction in the rate of international and domestic adoptions in the U.S. This suggests many parents are adopting from the foster care system where there is an increased likelihood the child has experienced early life adversities (e.g., prenatal substance exposure, multiple foster placements, abuse and neglect). Considering this likelihood, it is imperative adoptive parents have been adequately prepared and trained to complete the unique parenting tasks often accompanying adoptive parenting such as managing medical problems, emotional problems, learning difficulties, behavioral problems, and developmental delays (Brodzinsky, 2008; Hardwood et al., 2013; Smith, 2010). However, many adoptive parents have indicated they felt ill prepared which resulted in setting unrealistic expectations about adoptive parenting and the adopted child (Brodzinsky, 2013). Often when these unrealistic expectations go unmet, it leads adoptive parents to seek out mental health services. An adoption component counselor with the skills, awareness, and knowledge necessary to address adoptive parents’ needs would aim to help adoptive parents accept and recognize there are differences between adoptive and biological parenting without invalidating the importance of each (Brodzinsky, 2013, 2016; Kirk, 1964). Acknowledging difference is key to creating a home environment that encourages open communication to process feelings of loss, struggles surrounding identity formation, disenfranchised grief (Doka, 1989, 2002), birth and adoptive family relationships, stigmatization experienced by the individuals in the adoption triad and the parent-child relationship. However, maintaining an open and honest environment to nurture a close parent-child relationship is difficult if adoptive parents do not process their own therapeutic needs.

Studies show many adoptive parents choose adoption to build their families after struggling with infertility (Brodzinsky, 2013; Pavao, 1998). Often, these difficulties lead to adoptive parents feeling defeated and powerless (Pavao, 1998). Counselors should be aware that adoptive parents’ struggles with infertility may resurface throughout the life cycle (Groza & Rosenberg, 1998; Pavao, 1998). These struggles with infertility can manifest as generalized anxiety, depression, decreased self-image, difficulties in marital communications or other forms (Brodzinsky, 1987). Adoptive parents may also feel a loss of support and acceptance from family and friends (e.g. throwing a baby shower may not happen due to the uncertainty of the adoption) (Brodzinsky, 1987; Kirk, 1964).

**Societal Perceptions of Adoption**

Historically, the societal perception of adoption has been guided by certain stereotypes for each adoption triad member. Typically, birth/first parents are associated with the narrative of “the single, morally impoverished birth mother who had an illegitimate child out of wedlock” (Wegar, 1997). Further, adoptive parents are seen as families who were incapable of forming a family due to “perceived deficiencies” such as infertility (Kressierer & Bryant, 1996; Miall, 1987; Wegar, 2000). In addition, society expects the adopted child to suffer from academic, behavioral, and emotional problems (Brodzinsky, 1993; Brodzinsky, Smith, & Brodzinsky, 1998; Kressierer & Bryant, 1996; Wegar, 2000; Zamostny et al., 2003). These narratives about adoption largely stem from and are reinforced by practices and policies that promote secrecy under the guise of protection (Henney et al, 2003). Originally, practices such as phenotypical matching were used to prevent adoptive families from being shamed or blackmailed by those who were resistant to accept the notion of adoption (Zamostny et al, 2003). However, the emphasis on limiting access to court proceedings set the tone for secrecy and confidentiality to be foundational components guiding adoption policy. Examples of this include the decision of the court to close off adoption records to protect the identities of the adoption triad members (Carp, 1998).

Today, despite two-thirds of the population having some kind of connection to adoption (Henderson, 2000), many do not see adoption as a practice in need of reform (Sass & Henderson, 2000). This is reinforced through the media’s portrayal of adoption which tends to focus on the “warm and fuzzy” aspects of search and reunion but rarely addresses the grief experienced by adoptees, birth parents, and adoptive parents. Motivating these inaccurate portrayals, are the six assumptions about adoption identified throughout the literature (Reyka, 2019). These assumptions include: (a) Adoption is a joyous experience; (b) Adoption parallels genetic birth experience and a biological family life (Grotevant, 1997; Zamostny et al., 2003); (c) Once adopted, all of the child’s problems disappear and there will be no additional challenges (Grotevant, 1997); (d) Creating a family through adoption is “false,” only biological families are “real,” (Petta & Steed, 2005) (e) The adoptive life is better than the biological life the child had or would have had (Grotevant, 1997; van Ijzendoorn et al., 2005) (f) and closed adoptions are in the best interest of the child (Jago et al., 1997; Reyka, 2019; von Korff & Grotevant, 2011). Due to these assumptions, many adopted individuals and families feel marginalized in their experience. Society holds positive and negative beliefs regarding adoption and expresses these messages to adoption triad members through the use of microaggressions. Microaggressions (Sue et al., 2007) refers to “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative. . . slights and insults towards [the marginalized group]” (p.271). Garber and Grotevant (2015) applied a microaggression framework (Sue et al., 2007) to identify the types of microaggressions experienced by adopted individuals in same race domestic infant adoptions. This was done to emphasize microaggressions also occur to those with “invisible” identities similar to the experience of members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community (Nadal et al., 2010). The long-term experience of microaggressions has been shown to have psychological, emotional, and physical impacts such as feelings of discomfort, higher levels of anger, depression, decreased self-esteem, and feelings of threat (Sue, 2010b; Swim et al., 2001; Swim et al., 2003). These findings suggest adoption triad members may seek mental health services as a result of stigmatization and marginalization.

**The Fifth Force of the Counseling Profession**

**Counselors as Advocates**

Recently, therehas been a push to infuse social justice concepts into graduate training programs (Goodman, 2004; Vasquez, 2012). Additionally, more researchers are starting to attend to how social justice interests are developed and the types of training programs that foster them (Beer et al., 2012; Linnemeyer et al., 2018; Singh et al., 2010). To analyze the current state of social justice content exposure in graduate school, a study examining American Psychological Association (APA)-accredited and Council for Accreditation of Counseling and Related Educational Programs (CACREP) multicultural counseling course syllabi (N = 54), found less than half of the syllabi included social justice concepts (Pieterse et al., 2009). Of the social justice content provided, much of the focus was on the nature and types of oppression rather than the role of counselors as advocates (Pierterse et al., 2009). Taking the aforementioned into account, the preamble to the ACA Code of Ethics provides more insight about the ethical guidelines of advocacy work. The preamble includes professional values and ethical principles. The professional values are listed as follows in the 2014 ACA Code of Ethics: (a) enhancing human development throughout the lifespan; (b) Honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts; (c) Promoting social justice; (d) Safeguarding the integrity of the counselor-client relationship; and (e) Practicing in a competent and ethical manner (ACA Code of Ethics, 2014). An example of identifying when to put these professional values into practice would be acknowledging when laws, regulations, and policies are impacting a client so much that it bars a counselor from providing quality mental health services. Since previous literature has linked values as a factor in motivating behavior, counselors who develop these ethical values, would be more inclined to recognize when they are working outside of their competencies and prompted to seek additional training (Bandura, 1977, 1986, 1997). This example also brings to attention the importance of counselors acquiring appropriate knowledge and awareness to be able to recognize when counseling interventions need to go beyond the individual level. A demonstration of these ethical values, as it applies to adoption related advocacy, would be a counselor participating in legislative efforts to establish Right-To-Know laws (i.e., legislation that oversees and protects adult adoptees’ access to original birth certificates; OBCs) in their state (Park-Taylor & Wing, 2020). When it comes to counseling graduate training, empirical studies have shown that faculty members are likely to have a large influence on students’ development of social justice engagements (i.e., advocacy efforts). Therefore, faculty and training programs infusing more social justice content and modeling opportunities to engage in action (i.e., lobbying) could increase CIT advocacy intentions and behaviors (Beer et al., 2012; Caldwell & Vera, 2010; Singh et al., 2010).

**Theoretical Framework**

**Feminist Theory**

Feminist theory asserts that the social, political, and patriarchal systems and policies are all forces that have an impact on the mental health of individuals. Feminist theory incorporates the belief that “the political is personal” because it asserts that the social, political, and patriarchal systems and policies are all forces that have an impact on the mental health of individuals. With this in mind, feminist theory rejects the medical model of counseling and replaces with the wellness model to promote a reduction in pathologizing clients for their symptomology (Brown, 1994; Goodman et al, 2004; Jodry & Trotman, 2008). Additionally, a counselor operating from a feminist theory perspective applies a “difference of knowing” lens and honors each client’s subjective experience which is crucial to acknowledging the variation of adoptive experience An adoption competent counselor utilizing a feminist approach would recognize the common behaviors externalized by adopted children especially if they have experienced early life adversity. Understanding how these behaviors present might help counselors steer clear of relying on labels/diagnosis and potentially damaging the client/family self-esteem. Additionally, feminist theory incorporates on-going self-evaluation (Jodry & Trotman, 2008). As a counselor, one must be aware of their own biases toward adoption and working with adoption triad members as to not practice outside their competencies (Atkinson et al., 2013; Brodzinsky, 2013; Brown, 1994; Goodman et al, 2004; Jodry & Trotman, 2008). Biases possessed by counselors that are relevant to adoption include, acceptance toward adoption openness practices and how beliefs impact deciding what is in the best interest of the adopted child. For instance, when advising for the termination of parental rights (e.g., child welfare) one must evaluate their own biases toward each triad member because so much stigma surrounds adoption and the reasons for relinquishment. Additionally, the feminist approach emphasizes advocacy work in practice. In regard to adoption, counselors should advocate for changes in adoption law in their states and a just society (Jodry & Trotman, 2008). An example of how a feminist collaborative therapeutic relationship could help empower an adopted client is participating in raising awareness about the need for adoption reform on a community level (e.g., lobbying). Often, adoption triad members feel isolated in their experience and have difficulty finding support (Brodzinsky, 2013). A feminist adoption competent counselor would work to build adoption triad support groups in the area or connect these individuals to helpful resources and psychoeducation. Moreover, a feminist approaching to family counseling would be beneficial when working with adoption triad members through normalizing the experience of adoptive parenthood by emphasizing strengths and setting realistic expectations of others and selves. Taking a feminist approach to counseling is beneficial for clients and families who are not considered to be “traditional” because it lessens the fear of judgment and influence of stereotypes.

**Social Cognitive Theory (SCT)**

Social cognitive theory is a psychological perspective that posits human functioning is influenced by personal, behavioral, and environmental factors. The model of triadic reciprocity was developed as a framework to explain how these factors interact with one another (Bandura, 1986). Key motivational processes identified in the model are self-efficacy and self-regulation. These are all part of personal influences which also include cognitions, beliefs, perceptions, and emotions (Bandura, 1986; Schunk & Usher, 2019). Essentially, this framework suggests feelings of competency performing a certain task (e.g. self-efficacy), further learning, exposure, persistence (behaviors). Further, environmental factors such as external validation through positive remarks can raise self-efficacy even more which increases motivation. Therefore, the three factors are cyclical in their relationship and influence each other. As applied to the current study, respondents may indicate high levels of counselor self-efficacy and perceived adoption competence despite never taking an adoption competent training course. Since self-efficacy has been proven to be predictive of perceived performance, CITs’ self- efficacy regarding ability to provide adoption competent services may be a reflection of their confidence rather than the quality of services provided (Bandura, 1977, 1986). Considering self-efficacy plays a critical role in motivational processes, examining the current levels of CITs’ counseling self-efficacy could provide insight into understanding how to develop motivation to seek additional adoption competence training.

**Summary**

Adoption has been largely influenced by historical, socio-political and cultural factors. Additionally, adoption is now acknowledged as a lifelong process with developmental impacts on all members of the triad. Previous studies support there is a desire for adoption competent services; however, the lack of adoption competency training in graduate school fails to adequately prepare CITs to effectively address the unique needs of adoption triad members. Although the practice of adoption has become more commonplace, the counseling field has made little effort to make empirical contributions. With the implementation of multicultural competencies and social justice competencies, counselors should embrace their role as an advocate and seek to understand the impact of oppression and marginalization on adoption triad members. Currently, most adoption competency training programs are offered post-graduate. Prior studies have shown self-efficacy improves through exposure to content and experiences while in graduate training. Additionally, self-efficacy has been tied to advocacy behavior and better performance when individuals are presented with a challenge. As such, this study aims to examine how well CITs’ self-efficacy and social justice alignments predict perceived adoption competence and to assess demographic differences (i.e., racial/ethnic minority, gender, adoptive status) across the three constructs (CIT self-efficacy, social justice alignments, perceived adoption competence).

**Chapter III**

**Methodology**

This first wave of adoption research was characteristically descriptive, unguided by theory, with psychoanalysis being the only exception, and flawed with methodological errors (Palacios & Brodzinsky, 2010). For three decades, adoption research investigated the overrepresentation of adopted youth in clinical settings, increased psychological and academic risk and psychological/clinical problems using comparative analysis between adopted and non-adopted youth (Palacios & Brodzinsky, 2010).

The second wave of adoption research introduced an interest in intercountry adoption, and the factors influencing developmental recovery from early life trauma through longitudinal studies (Palacios & Brodzinsky, 2010). Currently, the third wave of research emphasizes the influence of familial structure, attachment, parenting, and clarifying the individual factors contributing to the adjustment difficulties within the adoption kin- ship. Adoption research also points out the key to successful adoption transition is the utilization of mental health services in the preparation, education, and support pre/post adoption placement (Brodzinsky, 2016) However, CACREP graduate programs offer few courses specific to adoption related issues and many practicing clinicians indicate they need more training in adoption issues (Sass & Henderson, 2000). At the moment, adoption counseling is not established as a specialty area, which makes the standardization of adoption competent training difficult to implement. Therefore, seeking out additional adoption training/experiences depends solely on the individual post-graduation.

 Previous literature has linked self-efficacy and social justice attitudes to providing better quality services when presented with challenges, and social justice attitudes have been found to predict future social action (Melchert, et al., 1996; Torres-Harding et a., 2012). Previous research has not yet bridged the gap between these three constructs as a way to explore the possible factors influencing (a) whether or not CITs perceive themselves to be adoption competent, (b) their current self-efficacy, and (c) their social justice alignments. Thus, this study aims to examine how well CIT’s self-efficacy and social justice alignments predict perceived adoption competence and what differences exist among demographic variables (i.e., gender, racial/ethnic minority, and adoptive status) across the three constructs (i.e., CIT self-efficacy, social justice alignment, perceived adoption competence).

**Research Questions & Hypotheses**

This study explored the relationships among CIT self-efficacy, perceived adoption competence, and social justice alignments for graduate students enrolled in CACREP programs in the U.S. As such, the following research questions were examined.

**Research Question 1**

How well do CIT’s self-efficacy and social justice alignments predict CIT’s perceived adoption competence?

**Hypothesis 1a.** Higher scores for self-efficacy and social justice alignments will predict higher perceived adoption competence for CITs.

**Research Question 2**

What differences exist among demographic variables (i.e., race/ethnicity, gender, adoption status) for CITs’ self-efficacy, social justice alignments, and perceived adoption competence?

**Hypothesis 2a.** Participants who identify as a racial/ethnic minority will have higher scores for social justice alignments, self-efficacy, and perceived adoption competence compared to White participants.

**Hypothesis 2b.** Participants who identify as female will have higher scores for social justice alignments, self-efficacy, and perceived adoption competence compared to males.

**Hypothesis 2c.** Participants identifying as an adoption triad member will have higher self-efficacy, perceived adoption competence, and social justice alignments compared to non-adoption triad members.

**Participants**

Participants in this study consisted of graduate level counselors-in-training enrolled in universities in the U.S. An *a priori* power analysis was conducted to determine the sample size (G\*Power 3.0; Faul et al., 2008). Applying an alpha level of .05, a moderate effect size of .06, and a recommended power of .80 (Cohen, 1992), the analysis revealed a minimum sample size of 115. In order to be eligible for this study, participants had to be currently enrolled in a CACREP-accredited counseling graduate program and be at least 21 years of age. Participant selection was purposeful sampling which is a type of nonprobability sampling. I engaged passive (e.g., email, word of mouth) recruitment strategies. Upon IRB approval, I reached out to course instructors at the University of North Georgia and other participating U.S. universities via email to ask if they would be willing to distribute my online survey to students enrolled in their university’s counseling programs.

**Measures**

The following instruments were completed by participants: (a) researcher-developed perceived adoption competency and demographics survey; (b) Counselor Self- Efficacy Scale (CSES; Melchert et al., 1996); and (c) Social Justice Scale (SJS; Torres-Harding et al., 2012).

**Perceived Adoption Competency and Demographic Survey**

The research-generated demographic survey contained nine items and was utilized to collect general demographic information, as well as to assess CIT perceived adoption competency. For the present study, “perceived adoption competence” was defined as the level of knowledge and awareness of adoption-related clinical issues and the CITs’ perceived comfort in utilizing clinical skills with this population. Perceived adoption competence was measured by two 5-point Likert type items that were included as part of the demographics survey. Response options for the two items ranged from1 (*no perceived adoption competence ability*) to 5 (*high perceived adoption competence ability*). The items were summed to produce a total score, with possible scores ranging from 2 to 10. The remaining seven items on the demographics questionnaire collected basic demographic information from study participants. The form included questions about gender, age, years of education, year in school (e.g., first year, 2nd year, practicum, internship), race/ethnicity, adoptive status (e.g., are you a member of the adoption triad?). See Appendix A for a sample of the demographics survey.

**Counselor Self- Efficacy Scale (CSES)**

The Counselor Self-Efficacy Scale (CSES; Melchert, et al., 1996) is a 20-item self-report 5-point Likert scale indicating the individual’s level of confidence in his or her counseling ability ranging from values of 1-5 (agree strongly, agree moderately, neutral/uncertain, disagree moderately, and disagree strongly). Negatively worded questions were reverse coded to maintain high scores indicated high self-efficacy. All items are summed to produce a total score, with possible total scores ranging from 20 to100, with 10 items being reverse coded. Some sample items include: (a) I am not able to accurately identify client affect; (b) I can effectively facilitate appropriate goal development with clients; and (c) I can function effectively as a group leader/facilitator. Lower scores represent higher levels of self-efficacy. The CSES has demonstrated both content validity (Melchert et al., 1996) and convergent construct validity (*r* = .83) with the Self-Efficacy Inventory (SEI; Friedlander & Synder, 1983) Additionally, the CSES has demonstrated test-retest reliability of .85, and at least acceptable reliability (.77 - .93) across multiple studies (Constantine, 2001; Melchert et al., 1996; Pasquariello, 2013). .85. Mullen and Uwamahoro (2015) utilized the CSES to assess the development of self-efficacy in master’s level graduate students from a single CACREP entry-level counselor education program at a southeastern university in the United States. This study found during students’ preparation and training, the CSES internal consistency reliability was strong, with Cronbach alpha of .96 (Sink & Stroh, 2006; Streiner, 2003). The CSES was initially normed with counseling psychology students and licensed professional psychologists (Melchert et al., 1996) See Appendix B for a sample of the CSES.

**Social Justice Scale (SJS)**

The Social Justice Scale (SJS; Torres-Harding et al., 2012) has 24 items and four subscales, which are identified as (a) social justice attitudes (SJA), (b) perceived behavioral control (SJPBC), (c) subjective norms (SJSN), and (d) behavioral intentions (SJBI). The SJA subscale has 11 items. The SJPBC subscale has 5 items. The SJSN and the SJBI subscales both have 4 items. The SJS is a 7-point Likert-type scale ranging from values of 1 (*disagree strongly*) to 7 (*strongly agree*). Using Cronbach’s alpha, each subscale indicated good internal consistency (attitudes = .95; subjective norms = .82; perceived behavioral control = .84; and intentions = .88; Torres-Harding et al., 2012). All of the SJS subscales negatively correlate with symbolic racism (Henry & Sears, 2002), neosexism (Tougas et al., 1995), and a global belief in a just world (Lipkus, 1991). Therefore, higher scores on the SJS suggest respondents are less likely the deny minority populations (i.e., African Americans and women) are treated unfairly. Additionally, higher SJS scores suggest respondents as less likely to blame, become resentful of minorities, and were less likely to believe the world is just (Torres-Harding, 2012). The primary goal of the SJS is to better understand how attitudes in social justice lead to social action (Fietzer & Ponterotto, 2015).  The SJS has previously been normed on 178 doctoral-level students enrolled in American Psychological Association (APA) accredited counseling psychology programs (Keum & Miller, 2019). Keum and Miller (2019) reported a Cronbach’s alpha values for the SJS for SJA and BI were .96, and .92. For their study, they adapted the four-item social justice subjective norms (SNS) subscale in two versions directing participants to answer with respect to students in the program (SNS- Student; “Students in my program aware of issues of social injustices and power inequalities in our society.”), and faculty (SNS-Faculty; “Faculty members in my program are aware of issues of social injustices and power inequalities in our society.”) In regard to the two adapted versions, the Cronbach alpha values were .94 and .94 which indicated high internal consistency. See Appendix C for a sample of the SJS. However, the original 24 item version of the SJS (Torres-Harding et al., 2012) was used for this study.

**Procedures**

Prior to collecting data, I received approval from the University of North Georgia’s Institutional Review Board (IRB). Once I received IRB approval, I began recruiting eligible participants and collecting data from graduate level counselors-in-training currently enrolled at universities in the U.S. who were at least 21 years old. After consent was obtained, the participants completed (a) a researcher-developed perceived adoption competence and demographics questionnaire; (b) Counselor Self- Efficacy Scale(Melchert et al., 1996); and (c) Social Justice Scale (SJS; Torres-Harding et al., 2012). Contact was made through online survey distribution (i.e., Survey Monkey) to current CITs enrolled at nearby CACREP programs. Before participation in the study, participants were prompted to review the informed consent. Participation in this study was voluntary and participants were informed they could choose to discontinue their participation at any time without penalty. If participants chose to continue, they completed the researcher made perceived adoption competence and demographic questionnaire, CSES, and SJS.

**Data Analysis**

I conducted a preliminary analysis to identify outliers, missing data, and violations of the assumptions of normality, multicollinearity, and singularity. I entered all data into SPSS (version 27), a computer software program used to analyze statistical data. Using SPSS, I conducted a standard multiple regression analysis to assess the predictability value of CITs’ self-efficacy and social justice alignments on perceived adoption competence. Following, I utilized a two-way factorial MANOVA to examine the differences between demographic variables (e.g., race/ethnic minority, gender, adoptive status) for CIT self-efficacy, perceived adoption competence, and social justice alignments.

**Summary**

The present thesis intended to (a) explore how well CIT self-efficacy and social justice alignments predict perceived adoption competence; and (b) explore existing differences for race/ethnicity, gender, and adoption status for CIT self-efficacy, social justice alignments, and perceived adoption competence. A series of assessments were administered to 112 participants. For this study, I utilized a two-way factorial MANOVA and a standard multiple regression analysis to analyze the data collected from participants. For research question one, the independent variables included CIT self-efficacy and social justice alignments and perceived adoption competence was the dependent variable. For research question two, the independent variables were race/ethnicity, gender, and adoption status., and the dependent variables were CIT self-efficacy, social justice alignments, and perceived adoption competence. Results of the present study can be found in Chapter 4.

**Chapter IV**

**Results**

The current study examined the relationship between CITs’ self-efficacy, social justice alignments and perceived adoption competence. By investigating the relationship and predictive ability of CITs’ self-efficacy and social justice alignments on perceived adoption competence, more information can be gained to better understand potential factors influencing the development of CITs’ perceived adoption competence. Moreover, identifying the relationship among CITs’ self-efficacy, social justice alignments, and perceived adoption competence, across various demographic groups, can contribute to the empirical body of research specific to the counseling discipline. Data analyses were conducted utilizing the Statistical Package for the Social Sciences (SPSS) Version 27.

**Sampling and Data Collection Procedures**

The target population for this study was currently enrolled master’s level graduate students (i.e., CITs) attending CACREP counseling programs in the U.S. In order to be eligible to participate, students had to be at least 21 years of age. Nonrandomized sampling was utilized to obtain participants in this study because it allowed the researcher to recruit participants by a method that is not random (e.g., selecting surrounding CACREP programs to distribute to select groups of students).

In order to obtain participants, I contacted, via email, two professors from nearby universities to acquire permission and assistance collecting data from students enrolled in their program. The email distributed to students included the purpose of the study, eligibility, my contact information, proof of IRB approval, and a Survey Monkey link which led them to participate in the online survey. Prior to filling out the survey, participants were presented with an electronic version of informed consent. In order to proceed with the survey, participants had to give electronic consent by selecting “I agree and understand.” Further, four of my professors, at the University of North Georgia, assisted me in the data collection process by connecting me to eligible counseling programs. For this study, passive recruitment was the only strategy used to obtain participants. Participants were not required to provide any identifying information such as names or emails, and IP address tracking was disabled on the Survey Monkey collection settings to protect anonymity.

**Descriptive Data Results**

**Response Rate**

In total, 112 individuals participated in the study. However, only 77 completed the full online survey. This yielded a response rate of 69%. Of the completed surveys, all participants met the desired age range (21+) and education requirements for participation eligibility. Originally, the study was going to utilize both passive and active recruitment methods to obtain participants. However, the data collection process took place during the Coronavirus pandemic, which limited in person administration (i.e., active recruitment) of the pencil and paper version of the survey. The true response rate cannot be reported because the survey link only tracked how many students clicked on the survey link. Therefore, it is unclear how many students received the call for participants email in total.

**Participant Demographics**

Following are descriptive statistics for the 77 participants who participated and completed the study. The majority of participants identified as female (*n* = 65, 84.4%) compared to those who identified as male (*n* = 11, 14.3%), and to those identifying as other (*n =* 1, 1.3%). Of the participating females, 56 (86.1%) identified their ethnicity as White/Caucasian, while nine (13.8%) identified as a racial/ethnic minority. Of the participating males, 10 (90.9%) identified their ethnicity as White/Caucasian, while one male (9.1%) identified as a racial/ethnic minority.

Moreover, only 1.3% (*n* =1, Birth/First Parent) of the sample identified as a member of the adoption triad. See Table 4.1 for additional demographics related to ethnicity and gender.

**Table 4.1**

*Frequencies of Participants by Gender and Racial/Ethnic Minority Group*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Frequency | Percent by Gender | Percent (*n=*77) |
| White female  White male  White other  Minority female  Minority male | 56  10  1  9  1 | 86.1  90.9  100  13.8  9.1 | 72.7  13  1.3  11.7  1.3 |

*Note.* Minority female = racial/ethnic minority, Minority male = racial/ethnic minority

Participants ranged in age from 21 to 68, with a mean age of 28.4 (*SD =* 8.8). Participants were asked to indicate the course and/or year they were currently enrolled in their program. The participants consisted of 1st years in their program (*n = 23,* 29.9%), 2nd years (*n =* 21, 27.3%), 3rd years (*n =* 3, 3.9%), students enrolled in practicum (*n =* 14, 18.2%), internship I (*n =* 5, 6.4%), and internship II (*n* = 11, 14.3%). Participants were also asked to indicate if they identified as an adoption triad member (i.e., adoptee, birth/first parent, and/or adoptive parent). Of the 77 participants, only one (1.3%) identified as an adoption triad member. Further, this participant identified as a White/Caucasian female, birth parent, in the first year of their counseling program. Moreover, participants were asked to indicate if they were close with someone who is a member of the adoption triad. See Table 4.2 for more demographic information regarding adoption triad proximity.

**Table 4.2**

*Frequencies of Participants by Proximity to a Member of the Adoption Triad*

|  |  |  |
| --- | --- | --- |
|  | *n* | Percent |
| Yes  No | 37  40 | 48  52 |

At the end of the survey, participants were asked to indicate whether they were interested in future adoption competency training. See Table 4.3 for information regarding participant future interest.

**Table 4.3**

*Frequencies of Participant by Interest in Future Adoption Competent Training.*

|  |  |  |
| --- | --- | --- |
|  | *n* | Percent |
| No  Yes  Unsure | 2  60  15 | 2.6  77.9  19.5 |

**Counselor Self-Efficacy**

The Counselor Self-Efficacy Scale (CSES; Melchert et al., 1996) is a 20-item scale that measured CITs’ competency regarding key counseling tasks for group/individual counseling. Each item contains a 5-point Likert scale based on the individual’s level of confidence in their counseling ability ranging from *strongly disagree* (1)to *strongly agree* (5). All negatively worded items are reverse scored. For the current study, the Cronbach value reported for the CSES was .93. As suggested by Pallant (2013), this indicates the CSES demonstrated strong internal consistency in this study. This means all of the items on the CSES were likely measuring the same construct (e.g., CIT self-efficacy). Participant total scores for the CSES ranged from 37 to 99 (*M =* 75.3, *SD* = 12.4).

**Social Justice Alignments**

The Social Justice Scale (SJS; Torres-Harding et al., 2012) is a 24-item, 7-point Likert scale ranging from *disagree strongly* (1) to *strongly agree* (7) that measured how attitudes in social justice lead to social action (Fietzer & Ponterotto, 2015). The SJS contains four subscales: (a) social justice attitudes, (b) perceived behavioral control, (c) subjective norms, and (d) behavioral intentions. Participant scores for the total SJS ranged from 124 to 168 (*M* = 154.7, *SD* = 8.5). Cronbach’s assessing internal consistency of the SJS was .86, indicating a strong internal consistency of the scale (Pallant, 2013). Additionally, all four subscales demonstrated at least acceptable internal consistency. See Table 4.4 to view descriptive statistics and Cronbach’s for each SJS subscale.

**Table 4.4**

*SJS Cronbach’s*  *by SJS Subscales*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Cronbach’s | *M* | *SD* | *Mdn* | Minimum | Maximum | *#* of items |  |
| SJA  SJPBC  SJSN  SJBI  Total SJS | .74  .79  .84  .84  .86 | 73.9  30.9  23.5  26.2  154.7 | 3.3  2.9  3.1  2  8.5 | 75  31  24  27  157 | 63  17  14  18  124 | 77  35  28  28  168 | 11  5  4  4  24 |  |

*Note.* SJA= social justice attitudes, SJPBC= social justice perceived behavioral control, SJSN=social justice social norms, SJBI= social justice behavioral intentions, Total SJS= Social Justice Scale total score

**Perceived Adoption Competency**

The two items on the demographics questionnaire that aimed to measure CITs’ perceived adoption competency level were created by the researcher. A 5-point Likert scale was used to rank CITs’ level of familiarity/confidence ranging from *strongly disagree* (1) to *strongly agree* (5) for utilizing specific adoption topics in clinical counseling settings on two items. The Cronbach’s value was a .61, which did not meet Pallant’s (2013) suggested minimum value of .7 to indicate acceptable internal consistency. See Table 4.5 for more information about the individual descriptive statistics for the adoption competence questions.

**Table 4.5**

*Descriptive Statistics for Individual Adoption Competence Questions*

|  |  |  |
| --- | --- | --- |
| Questions | *M* | *SD* |
| 1. I am knowledgeable about the seven core issues of adoption (e.g. loss, rejection, guilt and shame, grief, identity, intimacy, mastery/control (Silverstein & Kaplan, 1982) 2. I am comfortable using adoption specific clinical skills when working with adoption triad members (e.g. using appropriate language/terminology, making referrals to adoption competent resources, working alongside Child Protective Services). | 2.4  2.2 | .97  .96 |

**Data Analysis**

The *Statistical Package for the Social Sciences* (SPSS, version 27) was utilized to analysis the two research questions and their accompanying hypotheses. In order to ensure less than 5% of the relationship between constructs was due to chance, an value of .05 was set. (Fink, 2013).

**Statistical Assumptions**

Prior to beginning the standard multiple regression and two-way factorial MANOVA, a preliminary analysis was conducted to test for missing data. No assumptions were violated.

**Results of Data Analysis**

**Research Question 1**

How well do CITs’ self-efficacy and social justice alignments predict CITs’ perceived adoption competence? In other words, the research question asks if CITs’ score on the adoption competence can be predicted by CITs’ performance on the CSES (Melchert et al., 1996) and SJS (Torres-Harding et al., 2012). Further, if results show CSES and/or SJS to be predictor variables of adoption competence, how strong is the predictive ability of each variable?

To address research question one, a standard multiple regression analysis was utilized. Two predictor variables were included in the study (a) TotalCSES (i.e., total scores from the CSES) and (b) TotalSJS (i.e., total scores from the SJS). The dependent variable was identified as TotalAPC (i.e., total score of perceived adoption competence). Results for research question one and the associated hypothesis are presented below.

**Hypothesis 1A.** The hypothesis proposed that higher scores for self-efficacy and social justice alignments would predict higher perceived adoption competence for CITs. Table 4.6 demonstrates the predictive ability of each independent variable.

**Table 4.6**

*Predicting Relationship between CITs’ Self-Efficacy, Social Justice Alignments and Perceived Adoption Competency*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | *B* | *SE B* | *t* | *p* |
| Constant  TotalSJS  TotalCSES | 1.7  -.009  .057 | -.047  .430 | .539  -.44  4.07 | .59  .66  .00\* |

*Note*. \* denotes significance at .05

Only one predictor variable, Counselor Self-Efficacy (TotalCSES), was a significant predictor of CITs’ perceived adoption competency (TotalAPC) scores at the .05 level (*p*<.001). Therefore, the hypothesis 1A was partially supported. According to the *r*2 value,18.3% of the variance in perceived adoption competence can be explained by the given model. This relationship is considered to have some practical significance since the effect size was greater than .10 (Pallant, 2013). See Table 4.7 for the Model Summary. Referencing the values in the ANOVA table (4.8), I could determine how well the independent variables predicted the dependent variable. The model was significant, *F* (2, 74) = 8.29, *p <.*001. It was determined that CITs’ CSES scores were a unique, significant predictor of CITs’ perceived adoption competence. Therefore, higher CSES scores are more likely than SJS to predict higher scores for perceived adoption competence. When scores for CSES are predicted to increase by one, scores on perceived adoption competence would increase by .43.

**Table 4.7**

*Model Summary*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Model | R | R2 | Adjusted R2 | Std Error of the Estimate |  |
| 1 | .428 | .183 | .161 | 1.51 |  |

**Table 4.8**

*ANOVA Table*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Model | Sum of Squares | Df | Mean Square | *F* | Sig |
| Regression  Residual  Total | 38.00  169.52  207.53 | 2  74  76 | 19.00  2.2 | 8.29 | .001 |

**Research Question Two**

The second research question asks: What differences exist among demographic variables (i.e., ethnic/racial, gender, and adoption triad member status) across the three constructs (CIT self-efficacy, social justice alignments, and adoption competence), as measured by the CSES (Melchert et al., 1996), SJS (Torres-Harding et al., 2012), and perceived adoption competence scale?

For this question, the three dependent variables identified were (a) TotalCSES, (b) TotalSJS, and (c) TotalAPC. The independent variables identified were gender (i.e., male, female, other), race/ethnicity (i.e., identifying as an ethnic/racial minority), and adoption triad member status (i.e., identifying as a triad member: adoptee, birth parent, and/or adoptive parent).

Following preliminary assumption testing, a two-way factorial multivariate analysis of variance (MANOVA) was conducted to address research question two. For this study, I utilized the Wilks’ Lambda with an level set to .05.

**Hypothesis 2A.** The first hypothesis proposed participants who identify as a racial/ethnic minority will have higher CSES, SJS, and APC scores compared to White/Caucasian participants. Results indicated a main effect for identifying as a racial/ethnic minority and the combined dependent variables, *F* (3, 69) = 4.85, *p =.*004; Wilks’ Lambda = .82; partial eta squared = .17. The only dependent variable to reach statistical significance (*p* < .05), was social justice alignments, *F* (5, 71) = 1.71, *p* = .000, partial eta squared= .17. A review of the SJS mean scores for participants identifying as a racial/ethnic minority indicated significantly lower mean SJS scores (*M =* 152.5, *n* = 10, SD= 11.1) compared to participants identifying as White/Caucasian (*M* = 155, *n* = 67, SD= 8.1). Therefore, hypothesis 2A was not supported by the results. Table 4.9 illustrates the between subjects’ statistics for racial/ethnic minority status.

**Table 4.9**

*Between Subjects for Racial/Ethnic Minority Status*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | *Df* | *F* | *P* | *N Squared* |
| Total APC  Total SJS  Total CSES | 1  1  1 | *.*11  14.5  .76 | *.*73  .00  .38 | *.*002  .17  .01 |

*Note*. \* denotes significance at .05

**Hypothesis 2B.** The second hypothesis proposed that participants who identify as female will have higher CSES, SJS, and APC scores compared to male participants. Results indicated a main effect for gender and the combined dependent variables, *F* (6, 138) = 3.25, *p = .*005; Wilks’ Lambda = .76; partial eta squared = .12. However, the only dependent variable to reach statistical significance (*p* < .05), was social justice alignments, *F* (5,71) = 1.71, *p* = .001, partial eta squared = .18. When reviewing the SJS mean scores, females reported a higher mean score for SJS (*M =* 155.1, *n* = 65, SD = 7.6) compared to males (*M* = 153, *n* = 11, SD= 12.8). Further, females (*M =* 4.7, SD=. 1.6) reported higher scores on perceived adoption competence compared to males (*M =* 4.2, SD= 1.4), but this did not reach statistical significance. Therefore, the hypothesis 2B was only partially supported by the data. Table 4.10 illustrates the between subjects’ statistics for gender.

**Table 4.10**

*Between Subjects Statistics for Gender and the Dependent Variables*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | *df* | *F* | *p* | *N2* |
| Total APC  Total SJS  Total CSES | 2  2  2 | 2.17  7.87  .14 | *.*12  .001\*  .867 | *.*05  .18  .00 |

*Note*. \* denotes significance at .05

**Hypothesis 2C.** The third hypothesis proposed that participants identifying as an adoption triad member will have higher CSES, SJS, and APC scores compared to non-adoption triad members. Results indicated a main effect for adoption triad member status and the combined dependent variables, *F* (3, 69) = 3.75, *p = .*015; Wilks’ Lambda = .86; partial eta squared = .14. The only dependent variable difference to reach statistical significance (*p* < .05), was social justice alignments, *F* (5, 71) = 1.71, *p* = .004, partial eta squared = .11. Analyzing the SJS mean scores for participants identifying as an adoption triad member indicated members of the adoption triad reported lower mean scores for SJS (*M =* 133, *n* = 1) compared to non-adoption triad members (*M* = 147.6, *n* = 76, SD = 8.5). Even though it did not reach statistical significance, adoption triad members reported a higher score on APC (*M =* 5, *n* = 1) than non-adoption triad members (*M =* 4.6, *n*= 76, SD = 1.6). Further, participants identifying as a member of the adoption triad (*n* = 1), reported lower CSES scores (*M* = 57, *n*=1) compared to non-adoption triad members (*M*= 75.5, *n*=76, SD = 12.4). Therefore, hypothesis 2C was not supported by the data. Table 4.11 displays the between subjects’ statistics for adoption triad members.

**Table 4.11**

*Between the Subjects for Adoption Triad Members*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | *Df* | *F* | *P* | *N2* |
| Total APC  Total SJS  Total CSES | 1  1  1 | .03  8.8  2.3 | .84  .004  .130 | .00  .11  .03 |

**Summary**

The purpose of conducting the current study was to explore how well CITs’ self-efficacy and social justice alignments predict perceived adoption competence. Further, the study aimed to identify what demographic differences (i.e., gender, racial/ethnic minority status, adoption triad member status) existed among the three constructs (CITs’ CSES, SJS, and APC). In all, two research questions and four hypotheses were utilized to understand the relationship between the independent/dependent variables across the three constructs (i.e., CSES, SJS, and APC). Survey data was collected from 112 participants and completed by 77. Eligible participants were currently enrolled as master’s level graduate students in CACREP counseling programs. In order to take part in the study, participants had to be at least 21 years of age. Of the four hypotheses, only two were partially supported. Hypothesis 1A was only partially supported by the standard multiple regression results by identifying CITs’ self-efficacy (CSES) as a significant predictor of CITs’ perceived adoption competence (APC). The results from the two-way factorial MANOVA, utilized to analyze research question two, revealed a significant main effect on gender, racial/ethnic minority status, and adoption triad member status and one of three dependent variables.

**Chapter V**

**Discussion**

The current study aimed to answer two research questions and four hypotheses related to CITs’ self-efficacy, social justice alignments and perceived adoption competence. Research question one asked: How well do CITs’ self-efficacy and social justice alignments predict CITs’ perceived adoption competence? The second research question asked: What differences exist among demographic variables, such as racial/ethnic minorities, gender, and adoption triad member status across the three constructs (CSES, SJS, and APC).

**Overview of Findings**

**CITs’ CSES and SJS as Predictors of Perceived Adoption Competence**

For research question one, it was hypothesized that CITs’ self-efficacy and social justice alignments would predict CITs’ perceived adoption competence levels. The data obtained from the standard multiple regression analysis identified CITs’ self-efficacy as the only predictor variable to reach statistical significance. In other words, CITs with high self-efficacy scores were more likely to report higher levels of perceived adoption competence. Therefore, the first hypothesis was partially supported.

Relevant to the current study, identifying CITs’ self-efficacy as a predictor of CITs’ perceived adoption competence serves as a starting place to develop a more reliable way to measure true adoption competence. Additionally, this provides insight into ways to encourage the development of CITs’ self-efficacy during graduate training. These findings are consistent with previous research indicating counselor self-efficacy shows a significant amount of development prior to the initial clinical interaction (Mullens et al., 2015).Therefore, an importance is placed on the information and learning experience CITs are exposed to in their graduate coursework (Mullens et al., 2015; Tang et al., 2004). Similar to the findings of the current study, Canella (2015) identifies self-efficacy as a significant predictor of disability competency and is highly correlated with the development of multicultural competence (Holcomb-McCoy et al, 2008). More of a consensus on what constitutes adoption competence is needed to clearly evaluate the effectiveness of adoption competent mental health services being provided to adoption triad members. A major contribution of the current study is that identifying CITs’ CSES as a predictor of perceived adoption competence offers insight into how best to introduce the issue into the CACREP curriculum. When reviewing CIT course/year in the counseling program, it was found 3rd years and students enrolled in Internship II reported the highest scores for CSES. This is reflective of prior literature demonstrating counselor self-efficacy increases through coursework, experience, and training (Mullens et al, 2015). Moreover, CSES scores remained true to studies showing self-efficacy increases the most from when a CIT begin the program to just before the initial clinical interaction (Barbee et al., 2003; Cashwell & Dooley, 2001; Kozina et al., 2010; Melchert et al., 1996; Tang et al., 2004).

It should be taken into consideration that the instrument used to measure APC was researcher made and did not meet Pallant’s (2013) minimum suggested level to indicate acceptable internal consistency. This low alpha score could indicate that the APC scale was not a true measure of perceived adoption competence. Unfortunately, there is not yet an established reliable and valid measure of perceived adoption competence.

Results did not find CITs’ social justice alignments to be a significant predictor of CITs’ perceived adoption competence. However, future research utilizing a valid and reliable measure of perceived adoption competence could yield different results. Based on Ajzen’s (1991) social cognitive model, behavioral performance (e.g., social justice actions) is best predicted by one’s stated intention to act (e.g., CIT indicating future interest in adoption training). With this in mind, 77% of CITs in this study reported they were interested in obtaining adoption competent training in the future. This might indicate that CITs’ future interest in obtaining adoption training could potentially be a better predictor of future advocacy behavior rather than perceived adoption competence. Future research is needed to explore if findings would be consistent with Ajzen’s (1991) social cognitive model. When reviewing CIT course/year in the counseling program, it was found, in this study, 3rd years and students enrolled in Internship II reported the highest scores for CSES. This is reflective of prior literature demonstrating counselor self-efficacy increases through coursework, experience, and training (Mullens et al, 2015). Moreover, CSES scores remained true to studies showing self-efficacy increases the most from the time a CIT begins the program to just before the initial clinical interaction (Barbee et al., 2003; Cashwell & Dooley, 2001; Kozina et al., 2010; Melchert et al., 1996; Tang et al., 2004). Overall, CITs reported high SJS scores in the current study, which is line with previous literature indicating those with higher SJS scores are likely to work in public service because it aligns with social justice values and ideals (e.g. counseling; Torres-Harding et al., 2012).

**Demographic Differences across Constructs**

Research question two examined what demographic differences existed across the three constructs. It was hypothesized that CITs identifying as a racial/ethnic minority would score higher on all three constructs (CSES, SJS, APC) compared to White/Caucasian CITs. Results indicated that participants who identified as a racial/ethnic minority reported lower scores on SJS, CSES, and APC compared to White/Caucasian participants. Therefore, the hypothesis was not supported. However, the only dependent variable to reach statistical significance for difference was SJS. In contrast, Torres-Harding et al., (2012) found no statistically significant differences across racial/minority demographics comparing SJS scores. One potential explanation for the current study’s results could be the small sample size, which did not meet G\*Power minimums. Further, the SJS instrument is still developing and has not been widely used for assessing this specific population (i.e., CITs). This is important to mention because it highlights that most CACREP counseling programs are composed of mostly Caucasian/White students and faculty. Therefore, using CITs in the current study as the sample size could have been impacted by these demographic statistics (CACREP Vital Statistics, 2014).

The next hypothesis proposed CITs identifying as female would have higher scores on all three constructs compared to males. Again, SJS was the only dependent variable to reach statistical significance for difference. Therefore, this hypothesis was partially supported by the data. Since the SJS subscales were found to be negatively correlated with symbolic racism, neosexism, and a global belief in a just world, respondents with higher SJS scores are less likely to deny minority populations (i.e. African Americans and women) are treated unfairly, blame, develop resentfulness, and less likely to believe in a just world (Torres-Harding et al., 2012). In regard to the practical significance of the current study, the results indicate female CITs are more likely than male CITs to have high levels of SJS. This finding is important to the field of counseling because social justice competency requires one to become aware of inequalities, and unjust conditions resulting from systematic oppression (Torres-Harding et al., 2012). Consistent with the findings of CACREP Vital Statistics (2014), the majority of CITs identify as female. Understanding that statistical significance is directly tied to sample size, male scores across the three constructs could have potentially been skewed since male CITs make up a much smaller part of the sample. Future studies should focus on how to further develop social justice alignments among female CITs. Overall, females reported higher scores on APC, but statistical significance was not reached. This could potentially be explained by female CITs reporting higher levels of SJS and possibility acknowledging adoption competence as an extension of social justice counseling competencies. As for the practical application of these findings, female CITs may be more likely to acknowledge the societal factors contributing to the systematic oppression experiences by adoption triad members. Therefore, they may be more likely to address adoption specific issues in the clinical setting if provided appropriate training and content in graduate school. Future research is needed to establish a valid and reliable measure of adoption competency and its relationship to the development of multicultural and social justice counseling competencies.

The third hypothesis for research question two proposed CITs’ identifying as a member of the adoption triad would report higher scores on all three measures (CSES, APC, and SJS). Again, SJS was the only dependent variable to reach statistical significance of difference. Therefore, the hypothesis was not supported. There are many explanations that could have contributed to these findings. First, there was only one participant who identified as an adoption triad member. Additionally, this participant identified as a female, white/Caucasian, birth/first parent in their first year of their counseling program. Considering these demographics, data obtained from this participant was not generalizable to the adoption triad as a whole. One of the main components of understanding adoption is acknowledging the variability in experience of all triad members (Brodzinsky, 2013). Therefore, the scores reported by one participant in the study cannot be representative of the experience of a CIT who identifies as an adoptive parent or adopted individual. Further, the small sample size does not allow for comparison of scores among birth parents, adoptive parents, and adoptees. When reviewing the CITs’ scores on CSES and SJS, they were much lower than those reported by non-adoption triad members. A contributing factor to these results could be that the participant was in their first year of the program, which could be impacting their counseling self-efficacy development since self-efficacy has shown to increase the most right before practicum but it at the highest point during internship (Mullens et al., 2015).

**Limitations**

Due to unforeseeable circumstances, there were several limitations throughout the study. Originally, participant recruitment was going to rely heavily on paper and pencil distribution. However, the outbreak of the Coronavirus pandemic limited survey distribution and participant recruitment was restricted. This was most likely the biggest contribution to why the sample size did not meet the G\*Power participant requirement and impacted the response rate. Further, more diversity (e.g., racial/ethnic, gender, and adoptive status) in the sample would have provided a better representation of the target population. Moreover, only one participant identified as an adoption triad member. Therefore, hypothesis 2c was purely based on one participant’s scores across instruments. Since the participant identified as a birth parent, information relevant to adopted individuals and adoptive parents, as CITs, was significantly limited and potentially under representative of the unique impact adoption status has on each triad member. Additionally, access to training criteria and materials used in currently established adoption training courses in other states was restricted. For this study, perceived adoption competency was measured using a researcher-made instrument which calls into question the reliability and validity of the APC value. Future adoption research utilizing a reliable and valid measure of perceived adoption competency would hopefully yield more significant results. Unfortunately, the lack of uniformity in defining adoption competence and curriculum contributes to the limited established instruments currently available to assess for true adoption competence and/or effectiveness in providing adoption services. Another limitation of the study was not requiring participants to indicate which counseling track and university they were enrolled. This information could have potentially been beneficial to future research regarding differences across program preparation and geographic factors influencing exposure to adoption specific exposure (i.e., adoption laws established in each state, states that have access to in person adoption training, and counselor licensure requirements).

**Implications**

Although the counseling field has focused more on the development of multicultural and social justice competencies, there is still a lack of research, education, training, supervision, and discussion about working with members of the adoption triad. Of the research that has been done, the vast majority focuses on psychology and social work graduate training programs (Boyle, 2017; Hill & Moore, 2015; Lawler, Koss, & Gunnar, 2017; van IJzendoorn & Juffer, 2005; Sass & Henderson, 2000). Therefore, a strength of the present study is its relevance to counselors and counselors-in-training. In regard to counselor education and supervision, this study highlights there is a need for professors and supervisors to prioritize adoption specific training, resources, and advocacy efforts because CITs’ counseling self- efficacy can be largely influenced by vicarious experiences and modeling behaviors (Bandura, 1977). Applying a social cognitive framework reinforces the idea that adoption-specific content should be infused into the counseling graduate training curriculum to introduce the issue, educate, and motivate future advocacy efforts and enhancing the development of counselor self-efficacy (Bandura, 1977, 1986). As pointed out in the literature, many counselors fail to address adoption in counseling, even when it has been identified as a core stressor. By developing stronger counseling self-efficacy related to working with adoption triad members, avoidance behaviors could be reduced (Bandura, 1977). Encouraging the utilization of feminist theory to working with adoption triad members emphasizes the responsibility of counselors to become aware of potential biases that could be reducing their quality of care. For example, media portrayal of adoption could lead a counselor who is not adoption competent to assume closed adoption is in the best interest of the child, when studies have shown open communication involving all members of the adoption triad has yielded better adjustment outcomes for the adopted child, adoptive parents and birth/first parents (Grotevant et a., 2013; von Korff et al., 2006). Moreover, a counselor using feminist theory is less likely to pathologize externalized behaviors that could be a result of attachment, early life adversities, trauma, and the potential complexities that come along with navigating relationships between adoptive and birth families. For this study, feminist and social cognitive theories came together to conceptualize the importance of CITs to develop the necessary skills, awareness, and knowledge to effectively work with members of a marginalized population such as the adoption triad.

**Conclusion**

Findings from the current study are as follows: (a) CITs’ self-efficacy is a significant predictor for CITs’ perceived adoption competence; (b) female CITs reported significantly higher SJS scores compared to males; (c) participants identifying as a racial/ethnic minority scored lower on CSES, SJS, and APC; (d) participants identifying as a member of the adoption triad scored lower on CSES and SJS but slightly higher than average on APC. However, this did not reach statistical significance. Further, this study found 77% of the participants indicated they were interested in obtaining future adoption training. Overall, linking perceived adoption competence to more widely researched constructs such as self-efficacy and social justice attitudes, introduces perceived adoption competence as a construct in need of further exploration in the counseling field.

**Appendix A**

**Perceived Adoption Competency Measure and Demographics**

*Instructions: Please rate on a scale of 1-5 ( strongly disagree, disagree, undecided, agree, and strongly agree) the following adoption-related clinical issues and comfort in utilizing clinical skills with members of the adoption triad (adoptees, birth parents, and adoptive parents).*

1. I am knowledgeable about the seven core issues of adoption (e.g. loss, rejection, guilt and shame, grief, identity, intimacy, mastery/control (Silverstein and Kaplan 1982).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 |
| Strongly Disagree | Disagree | Undecided | Agree | Strongly  Agree |

1. I am comfortable using adoption specific clinical skills when working with adoption triad members (e.g. using appropriate adoption language/terminology, making referrals to adoption competent resources in the area, working alongside Child Protective Services, and facilitating communication between adoptive and biological family members in open adoption arrangements).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 |
| Strongly Disagree | Disagree | Undecided | Agree | Strongly  Agree |

Age: \_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a member of the adoption triad (check all that apply)

\_\_\_\_adoptee \_\_\_\_birth parent \_\_\_\_adoptive parent \_\_\_\_N/A

Is there someone close to you who is a member of the adoption triad?

\_\_\_\_yes \_\_\_\_\_no

Education: *check which course you are currently enrolled and/or year in your program*

\_\_\_practicum \_\_\_internship I \_\_\_internship

\_\_\_\_ 1st year \_\_\_2nd year \_\_\_3rd year

Are you interested in obtaining adoption competent training in the future?

\_\_\_\_yes \_\_\_\_\_no \_\_\_\_\_unsure

**Appendix B**

The Counselor Self-Efficacy Scale Items (Melchert, Hays, Wilianen, & Kolocek, 1996)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. My knowledge of personality development is adequate for counseling effectively.
2. My knowledge of ethical issues related to counseling is ad- equate for me to perform professionally.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. My knowledge of behavior change principles is not adequate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am not able to perform psychological assessment to professional standards.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am able to recognize the major psychiatric conditions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. My knowledge regarding crisis intervention is not adequate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am able to effectively develop therapeutic relationships with clients.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I can effectively facilitate client self-exploration.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am not able to accurately identify client affect.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I cannot discriminate between meaningful and irrelevant client data.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am not able to accurately identify my own emotional reactions to clients.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am not able to conceptualize client cases to form clinical hypotheses.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I can effectively facilitate appropriate goal development with clients.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am not able to apply behavior change skills effectively.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am able to keep my personal issues from negatively affecting my counseling.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am familiar with the advantages and disadvantages of group counseling as a form of intervention.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. My knowledge of the principles of group dynamics is not adequate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am able to recognize the facilitative and debilitative behaviors of group members.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I am not familiar with the ethical and professional issues specific to group work.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

1. I can function effectively as a group leader/facilitator.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Agree  Strongly | 2  Agree Moderately | 3  Neutral/Uncertain | 4  Disagree Moderately | 5  Disagree  Strongly |

Scoring Note:Response options range from 1 to 5 (*agree strongly, agree moderately, neutral/uncertain, disagree moderately, disagree strongly*). All negatively worded items are recoded so that high scores indicate high self-efficacy.

**Appendix C**

**Social Justice Scale (Torres-Harding, Siers, & Olson, 2012)**

1. I believe that it is important to make sure that all individuals and groups have a choice to speak and be heard, especially those from traditionally ignored or marginalized groups.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to allow individuals and groups to define and describe their problems, experiences, and goals in their own terms

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to talk to others about societal systems of power, privilege, and oppression.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to try to change larger social conditions that cause individual suffering and impede well-being

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to help individuals and groups to pursue their chosen goals in life

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to promote the physical and emotional well-being of individuals and groups

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to respect and appreciate people’s diverse social identities

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to allow others to have meaningful input into decisions affecting their lives

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to support community organizations and institutions that help individuals and groups achieve their aims

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to promote fair and equitable allocation of bargaining powers, obligations, and resources in our society

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I believe that it is important to act for social justice

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I am confident that I can have a positive impact on others’ lives

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I am certain that I possess and ability to work with individuals and groups in ways that are empowering

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. If I choose to do so, I am capable of influencing others to promote fairness and equality

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I feel confident in my ability to talk to others about social injustices in the impact of social conditions on health and well-being.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. I am certain that if I try, I can have a positive impact on my community.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. Other people around me are engaged in activities that address social injustices

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. Other people around me feel that it is important to engage in dialogue around social injustices

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. Other people around me are supportive of efforts that promote social justice

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. Other people around me are aware of issues of social injustices in power and inequalities in our society.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. In the future, I will do my best to ensure that all individuals and groups have a chance to speak and be heard.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. In the future, I intend to talk with others about social power inequalities, social injustices, and the impact of social forces on health and well-being.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. In the future, I intend to engage in activities that will promote social justice

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

1. In the future, I intend to work collaboratively with others so that they can define their own problems and build their own capacity to solve problems

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  Disagree Strongly | 2  Disagree  Moderately | 3  Disagree | 4  Neutral | 5  Agree | 6  Agree  Moderately | 7  Agree  Strongly |

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