PARENT SATISFACTION WITH SCHOOL SERVICES FOR THEIR INTERNATIONALLY ADOPTED CHILD

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by
Kaitlyn Cariss
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Examining Committee Members:

Dr. Catherine Fiorello, Advisory Chair, School Psychology
Dr. Joseph DuCette, Educational Psychology
Dr. Frank Farley, School Psychology
Dr. Amy Lynch, Health and Rehabilitation Sciences
Dr. Janice Laurence, Outside Examiner, Policy, Organizational, and Leadership Studies

ABSTRACT

International adoption continues to be a popular method of growing a family in the United States. The effects of institutionalization prior to adoption can be seen across developmental areas including cognitively, socially, emotionally, and physically. Although much research has been conducted on the effects of institutionalization, abandonment, and neglect on a child's development, less time has been given to the quality of services a family can receive after the adoption has been finalized and the family begins their new life together. One significant resource for these families is the school system. The purpose of this study was to explore the variety of services a family receives through their child's educational setting as well as parent's satisfaction with these services. It was hypothesized parents of internationally adopted children are not completely satisfied with the services received in their child's educational settings due to non-expertise regarding adoption-specific issues. It was also hypothesized that there are significant differences in services offered between school settings, with the most services offered in public schools but the highest satisfaction of services found in private schools. This study surveyed 67 parents from 28 states regarding their internationally adopted child and the experiences they have had with their school. The analysis found that there was not a significant difference in services offered or satisfaction with those services among types of school, with the exception of behavioral services.

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CHAPTER 1

INTRODUCTION TO THE STUDY

Many people desire to be parents, whether married or single. With growing medical advancements, there are more opportunities for a person to grow their family. International adoption continues to be another popular means of growing a family in the United States. Over the past 10 years, 88,500 foreign children were adopted into families in the United States, with 4,714 adoptions in 2017. Adoptions were finalized in every state in the United States, including U.S. territories of Puerto Rico and the Virgin Islands (U.S. Bureau of Consular Affairs, 2017).

As is the case with many global welfare concerns, it is difficult to put a precise number on the orphan problem. This is true when attempting to calculate the precise number of children who are currently orphaned worldwide. Many sources, including the University of Southern California School of Social Work (2012), predict the number is around 145 million children. According to the University of Southern California School of Social Work (2012), 87,600,000 of these orphans are living in Asia, 43,400,000 in Sub-Saharan Africa, 12,400,000 in Latin American and the Caribbean, and 1,600,000 in North America, Europe, and northern Africa. UNICEF defines an orphan as a person who has lost one or both parents to death and is under 18 years old. With this definition, there were approximately 140 million orphans in 2015. When the definition is narrowed to a child who has lost both parents to death, the number is 15.1 million (UNICEF, 2017).

The reasons so many children are living without their families can be due to

universal circumstances around the globe but can also vary by country. Poverty, war, and death are factors that affect humanity worldwide and cause children to be left without a caregiver. More specific examples of catalysts to the orphan problem are the one-child policy in China and the AIDS epidemic in Africa. The one child policy came into effect in 1979 and exact numbers of children abandoned due to this policy are hard to determine because many pregnancies and births are not officially recorded due to laws against sex selective abortions and infanticide (Hesketh, Lu, & Xing, 2005). By 2003, HIV/AIDS had caused 14 million children to lose one or both parents (UNICEF, 2003). While the reasons for such high numbers of orphans vary, many of the outcomes can often be generalized.

In the recent past, much has been discovered regarding the conditions of orphanages. Popular press outlets have covered deplorable conditions in Romania and other Eastern European countries. ABC's show 20/20 first unveiled the plight of children in Romanian orphanages in October of 1990. Since then, many documentaries and news outlets have covered the topic. Many commonalities are present in orphanages around the globe. These include a low ratio of caregivers to children, most of the caregivers being female, and a lack of personal interaction and direct communication, resulting in neglect. Sexual and physical abuse are also common. Many children are not given proper medical care or the basic necessities of food and water that are needed to live (Ahern, 2013).

With many parents choosing adoption as an option for their families, medical and mental health professionals are beginning to see internationally adopted children in their practices. This is also true for school personnel. Much research has been conducted on the developmental trajectory of adopted children and the importance of specific services

to remediate risk factors and delays. However, there is a gap in research considering the both perceived quality of services that these families receive for their children post-adoption as well as the family's satisfaction with those services, specifically those services received in schools.

Because nearly 90% of internationally adopted children have been in institutionalized care (Lofy & Dole, 2004), differences in development in comparison with their non-institutionalized peers are expected. The potential neglect and abuse is manifested cognitively, behaviorally, socially, and physically and the severity is often correlated with the length of time spent in orphanages. Structural differences are seen in the brains of children who spent time in an institution, even after being in a safe, loving home for years (Hodel et al., 2016). It has been reported, overall, there is a one month developmental lag for every five months spent in an orphanage (Evan B. Donaldson Adoption Institute, 2006).

Despite these conditions, there is hope. Not all children adopted internationally will show long- term harm. Studies have shown that by the time they are teens and young adults, institutionalized children who have been adopted show no significant behavioral differences when compared with their non-adopted peers (Brand & Brinich, 1999). This finding is significant to combat unfounded low expectations and support early assessment and intervention. Although the child may display serious delays or problem behaviors early in their schooling, proper and thorough interventions allow many of these developmental lags to be reversed.

Despite the research detailing how beneficial early intervention can be for internationally adopted children, the treatment and services provided to this population

are fraught with complications, both in school and clinical settings. First, internationally adopted children are often misdiagnosed. Attention Deficit Hyperactivity Disorder is a very common diagnosis in adopted children. Although this is sometimes an accurate diagnosis, reactive attachment disorder, post-traumatic stress disorder, learning disabilities, sensory dysfunction (Chan, Miller, & Tirella, 2006), and "institutional autism" (Lofy & Doly, 2004) among other things, may actually be to blame for the symptomology mimicking ADHD.

Along with misdiagnosis of ADHD, learning disabilities are often hard to identify in adopted students within a typical school psychology model. Standardized intelligence and achievement tests cannot be used in the typical way, particularly soon after arrival to the United States. They may be used as benchmarks to show progress, but culture and language loading in these tests would invalidate them as standard measures (Gindis, 2003).

Children who are adopted have significant gaps in their personal history, typically an important part of an assessment. Typical assessments include consideration of historical factors which can impact performance, such as prenatal care, conditions at birth, and early development and illness. This information is largely unknown for an adopted child (Lofy & Doly, 2004). Additionally, adopted children often present with different symptomology than their non-adopted peers, with many professionals ~~are~~ not fully equipped to handle these cases effectively. Because of this, many families choose to see specialists in adoption when first having their children evaluated. Having reports from international adoption specialists can be a large help to their primary care physicians and other service professionals (Gunnar, Bruce, & Grotevant, 2000).

However, because not every family has access to specialists (Kalb & Tucker, 2018), and these services may not be geographically available (Hartinger-Saunders, Jones, & Rittner, 2019), it is important that professionals across all service domains are aware that the needs of adopted children may be different than other populations.

School personnel may also not have the training or knowledge needed to address the unique concerns of internationally adopted children. Specifically, the role of the school psychologist continues to expand and now includes the necessity to provide effective services to the whole family system. This moves past just educational services and encompasses much wider ranging mental health concerns. School personnel are looking to the school psychologist for consultation and guidance in more areas across all types of student needs and therefore school psychology training programs must continue to evolve to meet this need.

While no prior studies exist exploring parent satisfaction with school services for internationally adopted children, limited studies explore parental satisfaction with community based post-adoption services for the child adopted through the public child welfare system. Gibbs, Barth, and Lenerz (2000) found that parents describe community providers as lacking in skills and understanding to address the family's specific issues. Additionally, availability, access, cost, and matching family needs to provider services have been cited as barriers for these families (Fine, 2000). In these cases, public school becomes the primary forum for intervention.

Fortunately, public schools are required to provide special education and related services to students who are eligible and who require special education to make academic progress (IDEA, 2004). This is safeguarded through Federal Law and elaborated upon in

state law. Although the needs of an adopted child can be unique, the child is entitled to the same services as a non-adopted child to ensure a free and appropriate public education. This safeguard protects families who may not have access to or means to pay for specialized services and allows them to access services through their public school system.

Adopted children are eligible for a variety of services through IDEA (2004) and in public schools. Special education, speech and language therapy, occupational therapy, counseling services, behavioral services, and nursing services may all be considered when determining how to meet the needs of students in school. These services may be provided through an Individualized Education Program (IEP), a 504 plan, English as a Second Language programs, or an Individualized Health Plan (IHP), among other avenues. Each of these related services involves different school personnel coming together in an interdisciplinary team to provide services which meet the identified needs of the individual child.

Measuring the efficacy of services and ensuring competency and knowledge of service providers is a responsibility of schools. The No Child Left Behind Act (2001) placed a large emphasis on and began a nationwide discussion on accountability for educational outcomes. A lesser discussed and researched indirect indicator of positive educational outcomes is parent satisfaction. Higher parent satisfaction can lead to decreases in conflict between home and school, which in turn decreases funds spent on due process. Parent involvement can be tied to parent satisfaction, and both are linked to better educational outcomes for students (Laws & Millward, 2001). Additionally, both

legally and ethically, school providers need to ensure that parents, an important member of the IEP team, feel heard and understood.

Purpose of This Study

While much research has been conducted on the effects of institutionalization, abandonment, and neglect on a child's development, less time has been given to the quality of services a family can receive after the adoption has been finalized and the family is settling into their new life together. This study will explore the variety of services a family receives through their child's educational setting as well as parents' satisfaction with these services. The questions being asked are:

1. What services do children who have been adopted internationally receive through their educational placement?
2. How satisfied are parents with the services rendered by their child's school service providers?
3. Are there significant differences in services offered and satisfaction with those services between reported types of school settings?

Hypotheses to be tested include:

1. Children who have been adopted internationally receive a variety of related services through their school placements including counseling, physical therapy, occupational therapy, speech therapy, and special education.
2. Parents of internationally adopted children are not completely satisfied with the services received in their child's educational settings due to non-expertise regarding adoption-specific issues.

3. There are significant differences in services offered between school settings, with the most services offered in public schools but the highest satisfaction of services found in private schools.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Introduction

This chapter will discuss international adoption in the United States. It begins with an overview of adoption statistics as related to the country as a whole. Then, the profiles of adoptive families and their children, including cognitive, social-emotional, and physical implications of international adoption will be discussed. Pre- and post-adoption services available to families will also be covered and the current literature on parent satisfaction with these services will be reviewed. Finally, the importance of parent satisfaction for the school setting will be addressed.

International Adoption in the United States

The United States Bureau of Consular Affairs releases an annual report on intercountry adoption. The most recent available report covers the fiscal year 2017. In 2017, 4,714 children were adopted into the United States. Adoption numbers increased from 42 countries but decreased from China and the Democratic Republic of Congo (DRC) due to changes in policies which both directly and indirectly impacted adoption from these countries. However, the total number of adoptions from China was still 1,905 children in 2017, making Chinese adoptions the most numerous by far. The country with the second most finalized adoptions in 2017 was Ethiopia at 313 then South Korea at 276 adoptions (U.S. Bureau of Consular Affairs, 2017).

Every state, including the District of Columbia, Puerto Rico, and the Virgin Islands, had at least one finalized adoption in 2017. The state with the most finalized

adoptions was Texas with 406, followed by California with 334 (U.S. Bureau of Consular Affairs, 2017).

Profiles of Adoptive Families

Although each family has its own set of circumstances regarding their choice to expand their family through international adoption, there are some commonly shared features. The U.S. Department of Health and Human Services (2007) conducted a survey of adoptive families and found that 82% of families who adopt internationally have two married parents, which is significantly higher than families who adopt domestically through private agencies. This may be due to varying requirements by country of origin. Ninety-five percent of parents who adopt internationally have an education beyond high school and 58% of families have incomes that are more than four times the poverty threshold (U.S. Department of Health and Human Services, 2007). This availability of resources may contribute to self-selection of families in international adoption, as the median adoption fees range from $2,300 to $33,000 (U.S. Bureau of Consular Affairs, 2017). Internationally adoptive parents are also generally shown to be actively involved in their children's schooling and highly motivated to do what is right for their children (Gindis, 2003).

The reasons for choosing international adoption vary by family. The desire to provide a home for a child in need was reported as a reason for adoption by 90% of surveyed families. Expanding their family was a reason reported by 92% of families, infertility was reported by 72%, and desiring to provide a sibling for a child was reported by 36% of families (US Department of Health and Human Services, 2007).

Additionally, the parents of internationally adopted children may also share similar concerns post-adoption. With the stress that bringing another child into your family causes, there are additional pressures on the parents of adopted children. The more needs their children have, the higher the risk for depression and anxiety in parents (Judge, 2003). Using semi-structured interviews of adoptive parents, it was found that unmet or unrealistic expectations often lead to postadoption depression, although many parents are reluctant to admit that they have these struggles (Foli, 2010). Additionally, mothers and fathers often have different reactions post adoption, with fathers most likely to be angered by the lack of supports they received and mothers more likely to experience fatigue and an absence of bonding (Foli, 2010).

Parental stress can be divided into two components. The first component is child-related which entails the child's temperament and behavioral attributes and the parents' adaptation to those attributes (Judge, 2003). The second type of parent stress comes from the parents themselves: how they are reacting to the new role and emotionally coping with the change (Judge, 2003). Different types of situations may cause these different stressors. For example, many parents of children with disabilities have child-related stress while parents who are also going through a difficult time in their marriage are more likely to rate highly on parent-related stress (Judge, 2003). Knowledgeable and empathetic school personnel can assist in mitigating family stress.

Profiles of Internationally Adopted Children

Many children who have experienced institutionalization will have similar risk factors. These affect a variety of developmental areas including cognitive, social-emotional, behavioral, and physical. Because each child is a unique individual and has

had unique experiences, these risk factors will play out differently for different children. Some children display obvious delays at the time of adoption but it can be years after the initial placement that problems manifest (Reilly & Platz, 2003).

Cognitive. The deprivation and neglect often experienced by young children in institutions can lead to delays in cognitive development. Wilson, Weaver, Cradock, and Kuebli (2008) explored the initial developmental change rate in 26 recently adopted children for cognitive and motor skills measures. The researchers administered the Bayley Scales of Infant Development and the parents filled out the Ages and Stages Questionnaire at two times for each participant, six months apart. The institutionalized children scored mostly in the mild to significant delay range during the first administration but made significant improvements over the six months with the mean scores falling in the expected range at the second administration for developmental growth (Wilson et al., 2008). Those who were in an international foster care setting before adoption tended to have scores in the normal range at both time periods (Wilson et al., 2008). The authors concluded that many institutionalized adopted children make large gains in development directly after coming home (Wilson et al., 2008).

Van IJzendoorn, Juffer, and Poelhuis (2005) ran a meta-analysis of 62 studies comparing adopted children's IQ and school performance to those who were still in institutions and children who were non-adopted environmental peers. The results showed that there was not a difference in IQ between those adopted and the non-adopted environmental peers, although there was a significant difference in language abilities and school performance (Van IJzendoorn et al., 2005). Additionally, adopted children performed better in school and in IQ when compared to those children who stayed behind

(Van IJzendoorn et al., 2005). The authors concluded that there is a positive impact on a child's cognitive development when adopted, yet gaps in school performance still exist between adopted children and their non-adopted environmental peers and should be a target of specific interventions (Van IJzendoorn et al., 2005).

Van Londen, Juffer, and Van IJzendoorn (2007) studied attachment, cognitive, and motor development in 70 internationally adopted children soon after adoption. An interview was conducted with the parents to gain initial information. Two weeks after the interview, attachment, motor development, and mental development were assessed using the Ainsworth's Strange Situation Procedure and the Bayley Scales of Infant Development. It was found that the earlier the child was adopted, the less likely there were to be mental developmental delays (Van Londen et al., 2007). The average mental development of the sample was comparable to the national standard (Van Londen et al., 2007). Securely attached children also had higher cognitive development than insecurely attached children (Van Londen et al., 2007). The authors concluded that developmental progress and attachment are interdependent and further research on developmental implications of unattached children may be of clinical importance for future research (Van Londen et al., 2007).

Language deficits are widely seen in adoptive children. It has been reported that 59% have speech and language delays (Gindis, 2003). Additionally, internationally adopted children cannot be treated the same as other English Language Learners (ELL), English as a Second Language (ESL), or bilingual students. Stark differences exist between the two populations, which make it hard to generalize across these groups. Internationally adopted children are often weak in their native language, which can

inhibit the learning of their second language (Gindis, 2003). Further, once adopted, their new language strengthens while their native language fades away. Because of this process, most adopted children are never fully bilingual. Language development delays are often displayed in these children and short-term bilingual education supports and ESL classes prove beneficial upon arrival to the United States (Gindis, 2003).

Executive functioning. Executive functioning (EF) deficiencies are also largely reported in the international adoptee population. Merz and McCall (2011) studied EF in preschool and school-aged children adopted from institutions in Russia where there was adequate physical care but deprivation of psychosocial care. Children adopted at 18 months and older had more EF difficulties than those who were adopted when they were younger than 18 months old (Merz & McCall, 2011). Significant results were not found for the correlation between birth circumstance (birth weight or prematurity) and EF deficits (Merz & McCall, 2011). There was also a greater spike in EF difficulties at puberty for those who were adopted after 18 months. Children aged two to five years old who had been adopted did not exhibit significant differences in EF compared to a control sample and those adopted after 27 months showed no greater difficulties than those adopted from 18 to 26 months (Merz & McCall, 2011). The authors concluded that psychosocial deprivation in early childhood may increase EF deficits in children who were in such environments for a prolonged time and they may have an increased need for support services (Merz & McCall, 2011).

Abrines, Barcons, Marre, Brun, Fornieles, and Fumado (2012) also studied EF by specifically addressing ADHD symptoms in internationally adopted children as a function of country of origin and attachment patterns. Children from Eastern European

countries showed significantly more patterns of hyperactivity and attention problems than those from China (Abrines et al., 2012). Additionally, children with better attachment patterns showed fewer attention problems. The authors concluded that different factors are related to internationally adopted children's display of ADHD compared to the general population, like health history of mother and time in institutions, among other things (Abrines et al., 2012).

Tan's (2009) study addressed the behavioral, academic, and social longitudinal outcomes for 177 school-aged adopted girls originally from China. Additionally, the relationship between outcomes and pre-adoption adversity were determined. The main results of this study showed that attentional difficulties mediate the effect that developmental delay at time of adoption has on later academic performance (Tan, 2009). Additionally, there was a significant relationship between age at adoption and academic performance, with children adopted at a younger age performing better academically (Tan, 2009).

Social-Emotional. The social-emotional effects of not having a primary caregiver have been long documented. Spitz (1945) wrote extensively about the effects of maternal deprivation on infants and Anna Freud, John Bowlby, and Mary Ainsworth all contributed with work on the importance of attachment to a primary caregiver.

Fifty-three percent of internationally adopted children experience social and emotional delays (Chan, Miller, & Tirella, 2006). Studies have found that adoptees are less likely to have intimate relationships, to live with a partner, and to be married when compared to non-adoptees (Barcons et al., 2012). For children adopted over 20 years

ago, research found there are also disproportionally larger referral rates for adopted children into mental health facilities (Smith & Brodzinsky, 1994).

According to the U.S. Department of Health and Human Services (2007), 8% of surveyed families reported diagnoses of attachment disorder in their internationally adopted children. In the Van Londen, Juffer, and Van IJzendoorn study (2007) previously cited, the authors found that the earlier the child was adopted the less disorganized attachment was seen. Barcons, Abrines, Brun, Sartini, Fumado, and Marre (2012) studied 168 internationally adopted children's attachment patterns using a semi-structured interview. Results showed that 58.9% of children had a secure attachment with 41.1% demonstrating an insecure attachment. Interestingly, the researchers found that country of origin was the only significant predictor of having an insecure attachment pattern, with children coming from Eastern Europe being at more than twice the risk than those coming from other continents (Barcons et al., 2012). Although there are varied levels of care within countries, studies have shown that overall conditions vary significantly between countries, with Romania and Russia often being found to have the most limited stimulation and level of care (Pomerleau, Malcuit, Chicoine, Seguin, Belhumeur, Germain, Amyot, & Jeliu, 2005).

Stams, Juffer, and van IJzendoorn (2002) conducted a longitudinal study of 146 internationally adopted children that spanned from infancy to seven years of age and studied many variables during infancy that could predict adjustment in middle childhood like attachment, temperament, gender, and maternal sensitivity. The study found that many of the predictor variables were significantly correlated with outcome variables (Stams et al., 2002). The authors' main conclusion was that the early relationship

between mother and adopted child predicts cognitive and socio-emotional development through middle childhood better than SES, gender, or the infant's temperament (Stams et al., 2002).

Smith and Brodzinsky (1994) studied 85 adoptees' evaluation of adoption stress and coping. All participants had been adopted before their 2nd birthday. The adopted children appraised adoption as more positive than negative, although many did have varying levels of neutral or negative obtrusive thoughts regarding adoption, determined to be an indicator of stress (Smith & Brodzinsky, 1994). As children grew older, negative or ambivalent feelings about adoption increased. The authors concluded that an understanding of the implications of adoption increase with cognitive maturity. However, this change was accompanied by a decrease in intrusive thoughts about adoption. The authors concluded that although most infant-placed adopted children view adoption in a more positive than negative light, they still do experience stress regarding their own adoption (Smith & Brodzinsky, 1994).

Tan (2009) also found that internalizing symptoms increased with age in his study of 177 school-aged girls adopted from China. Tan concluded that early deprivation can have a long-term effect on behavioral adjustment, and that a focus on early intervention and prevention is vital.

Jacobs, Miller, and Tirella (2010) explored the predictive power of pre-adoption risk factors, measures of development directly after adoption, and risk factors in the post-adoptive environment on school readiness and outcomes of behavioral measures on a group of international adoptees. Surprisingly, results indicated language scores that were one standard deviation higher than those of the typical non-adopted population in the

United States, showing that for adopted children with no reported language disability, language performance is at or above typical levels (Jacobs et al., 2010). Age at arrival in the US was a statistically significant predictor of many of the other outcomes measured, with presence of problems correlated with older age at adoption. Although found in previous studies, growth measures were not found to be significant predictors. The researchers determined the predictive value of each of the arrival assessment scores to those at follow up and found that there were many that had high predictive value. High prevalence of oppositional and inattentive traits were found in the preschoolers (23-42%) and sensory-seeking behaviors were found in 48% of the population (Jacobs et al., 2010).

Juffer and van IJzendoorn (2007) conducted a series of meta-analyses to investigate differences in levels of self-esteem between 10,977 adoptees and 33,862 nonadoptees. No significant differences were found. This held true when comparing international and domestic adoptions, including transracial adoptions. The authors conclude that the resiliency shown by adoptees through adversity in their early years leading to typical levels of self-esteem.

McCall and Groark (2015) report that the type of institution and the level of care received play a large role in the outcomes of children living there. Stable caregivers within institutions is important for development. Moving children out of institutionalized settings and into family environments, such as foster homes, lead to better outcomes for children. Social-emotional concerns are well documented for children adopted internationally and may require post-adoption services.

Physical. Medical evaluations are an important first step in returning home with an adopted child. Serious medical problems have been found in 20% of children evaluated

in the United States and therefore it is imperative for families to seek medical care to start diagnosis and treatment early. Additionally, research done on children born in the Soviet Union in the 1990's discovered more than 50% of those children adopted had an undiagnosed medical condition (Judge, 2003). Commonly found complications are malnutrition and poor growth. There is also a higher frequency of infectious disease and exposure to chronic diseases. Many children have received poor or little medical care which puts them at higher risk for arriving in the United States with an undiagnosed disease or serious condition (Welsh, Viana, Petrill, & Matthias, 2007).

Additionally, physical and occupational therapy are important services for a family to obtain for their child, as gross motor delays have been found in 70% of adopted children and fine motor delays in 82% (Gindis, 2003). Wilson, Weaver, Cradock, and Kuebli (2008) explored the initial developmental change rate in recently adopted children for motor skills measures. The institutionalized children scored mostly in the mild to significant delay during the first administration but made significant improvements over the six months with the mean scores falling in the expected range at the second administration for developmental growth. Those who were in an international foster care setting before adoption tended to have scores in the normal range at both time periods. The authors concluded that many institutionalized adopted children make large gains in development directly after coming home. Additionally, having a baseline measure is important for internationally adopted children so that relative growth of skills can be monitored and decisions can be made regarding services and intervention needed. Comparing these children to age based US norms is not beneficial (Wilson et al., 2008).

Van Londen, Juffer, and Van IJzendoorn (2007) studied motor development in 70 internationally adopted children soon after adoption. It was found that the earlier the child was placed, the less likely there were to be motor and mental developmental delays. The average mental and psychomotor development of the sample was comparable to the national standard.

Hodel et al. (2015) studied 110 children adopted internationally through Magnetic Resonance Imaging (MRI) and found that structural differences were apparent in their brains, despite being in a support and nurturing environment for many years. These differences were compared to a control group of 62 peers who grew up with their biological parents. The biggest changes were seen in the prefrontal cortex, where cortical volume was lowered. The volume of the hippocampus was also shown to be directly related to time spent institutionalized; children who spent longer time in an institution had lower volumes than non-adopted peers in a comparison group. Hodel et al.'s (2015) findings provide a summation of all possible effects of early neglect and deprivation on child development. The global reduction in grey matter and the specific reductions of the hippocampus and prefrontal cortex may impact many areas of development. Acute medical issues and physical delays are another area of concern and often necessitate post-adoption treatment.

Services Available to Adoptive Families

Post-adoption programs and services began to emerge in the 1960's following an increase in federal funding for foster care (Gibbs, Siebenaler, & Barth, 2002) which also affected services for internationally adopted children. It is generally accepted that these services for adopted children and families increase the success of the adoption and allow

for better outcomes for the child and family as a whole (Barth & Miller, 2000). Additionally, there has been an increasing trend in adoptions of children with special needs which will likely lead to an increased need for pre- and post-adoption services (Gibbs et al., 2005).

Pre-adoption services. Parents may choose to seek consultation and guidance before they are united with their child. These services often take the form of parent trainings, social support, and having medical and mental health professionals review a prospective child's files. Meeting with other adoptive parents and their families can be a great support network. Additionally, having contact with experts in the field allows them to gain knowledge and experience. This also can help reduce post-adoption depression and connect families that are going through similar experiences (Foli, 2010).

Reviewing a child's health and birth history allows parents to have more realistic expectations for when their child comes home. However, Reilly and Platz (2003) conducted a survey of 249 families who domestically adopted special needs children who were also receiving adoption subsidies and they reported that 58% of families surveyed felt they did not receive enough information on their child prior to adoption and that the problems displayed by the child were more serious than reported by the agency in 37% of cases.

Post-adoption services: what is known to be available. Generally, the adoption agency and/or facilitators provide their services up until the finalization of an adoption. This includes services such as assessment training and matching the family to their child. Once a child is in the home, many of these agencies are no longer tied to the family (Kalb & Tucker, 2019). After the newly formed family arrives back in the United States and

begins adjusting to their new family structure, a variety of services may exist for these families to receive support through post-adoption agencies and community providers. These supports range from continued training of parents, to clinical services for the child and family, to material supports including respite and legal assistance (Dhami, Mandel, & Sothmann, 2007). On the clinical side of services, specific evidence-based therapies exist for children who have a history of trauma or attachment difficulties. These include Parent-Child Interaction Therapy (Eyberg et al., 2001) and trauma-focused cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2006).

In the Reilly and Platz' study conducted in 2004, they looked at families who had adopted children with special needs and assessed their service needs. Two hundred and forty- nine parents were surveyed. They found the most needed services included: financial, medical, dental, and financial subsidies. In- home respite and counseling services were highlighted as the most unmet needs. A higher satisfaction with parenting was significantly related to the amount of services the parents received (Reilly & Platz, 2004).

A current area needing to be addressed includes inviting the voices of adoptees to help shape post-adoption services. This has not been a huge priority in this field but Kalb and Tucker (2019) believe it is essential to continue to make progress regarding services offered. For many reasons, the voices of adoptees have not been sought. Adoptive families are physically spread across the country and therefore, development of a group identity within local regions can be slow. Adoptees are also careful, at times, to protect their adoptive parents and do not want honest discourse regarding the weaknesses of the post-adoption environment to, in turn, reflect poorly on their parents. Despite these

barriers, in order to continue developing further programming and services to meet the needs of adoptees and their families, voices of those who have lived it should be prioritized (Kalb & Tucker, 2019).

The use of mobile technology is also innovating the social service field. Hartinger-Saunders et al. (2019) propose that this service delivery model may improve the access to adoption services that are trauma informed. Although specifically addressing the needs of foster parents and children in the child welfare system, the principles can be extrapolated to any families parenting children who have experienced adverse childhood experiences (ACES). Access to service professionals who are knowledgeable on the effects of trauma on development can be difficult for some families due to resources or geographic location. Mobile applications to address the needs of families may be the answer to overcoming these barriers to services (Hartinger-Saunders et al., 2019).

Post-adoption services in the home. Gibbs, Bart, and Houts (2005) conducted a study representing 332 families who were receiving post-adoption services through a popular provider found in five states throughout New England. Data were collected via various measures at case opening. Among other things, they found that the majority of families of adopted children, both internationally and domestically, sought post-adoption services with the primary concern of behavioral issues.

Dhami, Mandel, and Sothmann (2007) conducted a survey of 43 adoptive families in Canada who adopted domestically and internationally regarding post-adoption services offered by the Adoption Support Program (ASP) in British Columbia, Canada. They found that 45% of parents reported needing services soon after their adoption. However,

many do not know what services are available to them in their area. The authors conclude that service providers need to better advertise their services. They also found that services are not necessarily needed throughout all of development, but at specific points in the child's life and the adoption process, such as when the child started school and when the child became a teenager. Parents sought support from many areas; 10% turned to professionals, 43% turned to personal resources, like friends, in addition to professionals, and 33% used professionals, personal connections, and the internet for support (Dhami et al., 2007).

Post-adoption services in the school. The school setting also has a large number of services available for all students. Laws such as the Americans with Disabilities Act (1990), Section 504 (Rehabilitation Act, 1973), and the Individuals with Disabilities Education Improvement Act (2004) protect students with disabilities and ensure appropriate programming and services are rendered. These services encompass many areas including: special education, counseling, occupational therapy, speech therapy, health services, transportation, and assistive technology, among others.

Special education. The Individuals with Disabilities Education Improvement Act (2004) ensures that students receive a free, appropriate public education in the least restrictive environment. The law ensures parents a legitimate role in their child's educational process by granting shared decision making with parents and school personnel. It also gives parents rights through procedural due process if parents are unhappy with an outcome. Parents also have legally protected roles in the areas of evaluation, IEP development, and eligibility decisions (IDEIA, 2004).

Through IDEA (2004) and state law, special education is available for students who meet eligibility criteria. There are thirteen areas of possible disability represented through IDEA: Other health impaired, autism, emotional disturbance, speech or language impairment, deafness, deaf-blindness, hearing impairment, intellectual, disability, multiple disabilities, orthopedic impairment, specific learning disability, traumatic brain injury, and visual impairment.

For students who are eligible, there is then a continuum of programs offered through special education with varying levels of intensity. In order from least restrictive to most restrictive, schools often offer placement in the general education, inclusion or in-class support, and pull- out replacement. The program for each student in special education is described in a student's Individualized Education Plan (IEP) and is based on the needs of the student. The IEP team must meet every year, at minimum, to determine the appropriate level of services needed for the student and to develop goals to address specific needs.

English as a second language. There are also a variety of laws that protect the rights of students whose first language is not English. Title VI of the Civil Rights Act (1964) ensures that people cannot be discriminated against based on their country of origin or race. Bilingual Education Act (1968) gave federal money for schools to set up ESL programs. Lau vs. Nichols (494 U.S. Reports, 563-72 Oct. term, 1974) mandated that schools must provide services to support students whose first language is not English. These services should allow the students to benefit meaningfully from the curriculum. Although students who have been adopted internationally do not fit the

typical ESL profile as English is substituting their original language, not acting as a second language, many are provided services through this avenue.

Counseling. Counseling in the school setting is provided both to students who receive special education and those who do not. According to IDEA (2004), school counseling services can be delivered by social workers, psychologists, school counselors, or other qualified personnel. However, most schools do not provide intensive therapy, instead focusing on skill building activities through counseling services. Savage (2007) states that school counselors are an important part of the IEP process.

Speech and language therapy. Speech and language therapy includes addressing issues with both communication and swallowing. Within the realm of communication, language, articulation, fluency, and voice can be addressed. Speech pathologists deliver services by collaboration, education, prevention, screening, assessment, treatment, and by introducing technology (American Speech-Language-Hearing Association, 2016). Speech and language services are typically accessed through an IEP, although not necessarily just for students who have a speech and language impairment. The collaborative IEP team makes a determination if speech and language assessment and services are necessary in a case-by-case basis.

Applied behavior analysis. When students present with challenging behavior in school, behavioral services may be provided. Applied Behavior Analysis (ABA) is the practice of identifying functions of behavior and implementing behavior plans to address the specific need. A Behavior Intervention Plan (BIP) may be included in a student's IEP to address specific needs.

Zirkel (2017) found that case law tends to be pro-district in cases involving Functional Behavior Assessments (FBAs) and BIPs. Decision-making on when FBAs and BIPs are necessary continues to be vague. There are only specific instances that require a district to complete an FBA prior to writing a BIP, such as when the behavior is determined to be a manifestation of a child's disability (Horner & Yell, 2017).

Physical and occupational therapy. Physical therapy (PT) and Occupational Therapy (OT) may be provided through a student's IEP to address motor concerns. PT is a related service that is included in the IDEA for students whose gross motor needs may hinder their education. While this service is provided through an IEP, the decision making process in determining the need for PT for a particular student is not always clearly outlined (Vialu & Doyle, 2017). OT is a related service that may be necessary if a student's fine motor skills are inhibiting educational goals. There are three delivery models in schools, including direct service, monitoring, and consultation (Dunn, 1988).

Nursing services. At times, those with more significant medical needs may require nursing services in school. Collaboration between a child's doctor, school nurse, and IEP team is necessary to determine the appropriate levels of support for students. The school nurse is an important member of the team when determining if health related factors are impacting learning and how to reduce these barriers. School nurses should be included when a child has health, hearing, or vision difficulties, and may be asked to provide an evaluation in these areas that determines the need for health-focused related services such as individual nursing services (Yonkaitis & Shannon, 2017).

These services should then be documented in the IEP as well as the student's individualized healthcare plan (IHP). The nursing services listed in an IEP only relate

directly to services that require a nursing license (Shannon & Yonkaitis, 2007), including things such as tube feedings and monitoring blood sugar testing. In addition to IEP's, students may receive nursing students through a 504 plan or IHP. Nurses can be a vital member of the team and contribute to interprofessional collaboration. As Flemming and Willgerodt (2017) state, "As health providers increasingly work with community entities whose primary focus is not health, but whose outcomes are dependent on the health of the populations they serve, the need for IPE [interprofession education] for health and non-health professionals grows stronger (p.9)."

Because 11% of internationally adopted children are school aged at the time of the adoption (Gindis, 2003), these services become vital. Delays may still be present when children enter school even if they were adopted at a younger age. It is best when effective intervention plans are put in place early and monitored closely. Because of this, appropriate services need to be sought in the school immediately and children need to be evaluated in a valid and thorough manner (Gindis, 2003).

Assessment procedures. Alternative assessment procedures must also often be used. For example, Daunhauer, Coster, Tickle-Degnen, and Cermak (2010) studied play behaviors and cognitive functioning in young children in institutions. Children with higher mental development scores also scored higher in more advanced play behaviors. This is consistent with research findings of play based assessment of children who live in traditional homes (Daunhauer et al., 2010; Farmer-Dougan, 1999; O'Grady & Dusing, 2015). The authors concluded that play assessments can be used in place of standardized testing to learn a child's general developmental level for newly adopted children (Daunhauer et al., 2010).

Additionally, Wilson et al. (2008) concluded that having a baseline measure is important for internationally adopted children so that relative growth of skills can be monitored and decisions can be made regarding services and intervention needed. This provides better information than standardized testing because comparing these children to age based US norms is not beneficial.

Training and Preparation for Service Providers

The intricacies and complexities of evaluation and treatment planning when working with children or adolescents who have been adopted are easy to see. Combining this with the expanding role of the school psychologist across the country creates an interesting situation. School psychologists are now expected to consult on and work with students coming from a wide variety of developmental backgrounds, with various diagnoses, and coming from an array of family systems and environments. How does one prepare for such demands? What is a reasonable expectation for school administration and families to have for the school psychologist? What areas are training programs for school psychologists spending the most time on?

The National Association of School Psychologists (NASP) has a practice model which guides training programs on how to tailor their instruction of new school psychologists (National Association of School Psychologists, 2010). According to NASP, supporting social and life skills is just as important as supporting academic skills in the job of a school psychologist. On a systems level, family and school collaboration falls under a service to be provided by the school psychologist. These services, among others, are innate to the psychologists' role. Each of these areas is imperative to the

success and functioning of students with diverse needs, including those who have been adopted internationally.

In the past, school psychologists were often pigeon-holed to strictly conducting assessment and being the gatekeepers of special education (Hosp & Reschly, 2002), though many desired to perform beyond this role and be involved in school based mental health (Curtis, Hunley, Walker, & Baker, 1999). With continuing advocacy across the state and national level, school psychologists are now tasked, at times, with case management, evaluation, counseling, behavior services, and consultation. While many in the field are happy with this progress, needs of students are becoming more diverse while more responsibility falls to the school psychologist.

School psychology training programs have needed to develop professionals with high levels of understanding in multi-cultural and diversity issues. Although great strides have been taken in this area in recent years, research is still limited on how this training is impacting practices of school psychologists and therefore outcomes for students (Newell et al., 2010).

Additionally, training programs cannot realistically cover all possible student needs and instead need to be teaching psychologists how to research and learn as they go. Continuing education throughout one's career, especially based on specific areas of need within specific caseloads, is imperative. Splett et al. (2013) stress the importance of high quality professional development available to school staff through school districts. Diversity in Development and Learning is named as one of the foundations that all school psychologists participate in, according to the practice model set out by NASP (NASP,

2010). This includes being culturally competent and working with others to learn how to best support all learners, including those from diverse backgrounds.

Introducing areas of specialization in school psychology could also assist in providing high levels of expertise to cases without imposing impossible expectations on all psychologists. Utilizing a team approach, which recognizes the strengths and limitations of each person's knowledge base and experience, allows for higher quality services to be provided to students and families (Splett, Fowler, Weist, & McDaniel, 2013).

Parent Satisfaction with Services

McDonald, Propp, and Murphy (2001) found that while many parents were positive about the adoption process and their child, they were far less positive regarding services. The two services regarded as needed but unavailable were social support groups and respite services. Notably, these are services that are not mandated to be provided educationally or medically.

Additionally, a lack of resources, both informal and formal, for adoptive parents of special needs children can cause enough stress to drastically impact the success of such adoptions (Reilly & Platz, 2003). However, it appears that there is not enough awareness of available services for families. It was found that less than 30% of adoptive families took advantage of most adoption services (Brooks, Allen, & Barth, 2002). This could be related to the inconsistency in the services that are available (Barth & Miller, 2000; Brooks, 2002; McDonald, 2001).

With all of the services and interventions that adoptive parents have available both pre- and post–adoption, stress over indecision on which to choose for their child and

family can occur. As stated by Gunnar et al., "the adoptive parents' search for the appropriate treatment for their children may result in tremendous stress and frustration that may greatly impact the parents' mental and physical well being (p. 688, 2000)." This search for evidence-based practices can be taxing when parents do not have help.

Although there have not been many studies on internationally adopted children, there have been studies done with families of children adopted domestically. Wind, Brooks, and Barth (2008) surveyed 560 families who had adopted domestically over an 8-year period. Researchers were interested in the effects that pre-adoption preparation and pre-adoptive risk history had on the use of post-adoption services. They found that families who were adopting a child with a known risk history were more likely to seek services. Use of services also increased with time. Parents who underwent better pre-adoption preparation were also more likely to utilize services post-adoption.

Reilly and Platz (2003) found that parents who adopted children domestically with special needs reported problems obtaining appropriate services for their child. The authors found that not knowing where to find services and not being able to find service providers who understood their family's problems as the two biggest barriers to obtaining services for their family.

Dhami et al. (2007) found that adoptive parents found that services helped improve their knowledge of adoption related issues but did not provide substantial improvement to their child's behavior, relationships, or performance at school. They also found that parents were least satisfied with child and teen groups. Results showed parents who adopted their child after infancy had more concerns with their own parenting ability

and were more concerned with post-adoption support compared with parents whose adopted child joined their family as an infant.

McDonald, Propp, and Murphy (2001) conducted a survey of 159 parents shortly after they adopted domestically. They found that while access to medical services was not reported as a problem for most adoptive families, a minority of families encountered problems with services not being covered or doctors who refused medical cards. While these studies were not done specifically with families who adopted internationally, it is clear that this is an area that deserves attention in the adoption community as a whole.

Specifically in the education realm, parents are an important part of the team that makes educational decisions for their child. The Individuals with Disabilities Education Improvement Act grants parents the right to attend and participate in meeting as a member of the IEP team (IDEIA, 2004). Although there are no studies on parent satisfaction with school services for those who have adopted, some research has been done on parent satisfaction with schools using a wider population.

One study sought to find the factors that could predict parent satisfaction with schools using questionnaires sent to parents as part of school improvement projects by Harris Interactive, Inc., a market research firm. Respondents represented 27 school districts across the United States. Researchers found that communication and involvement, school resources, quality of leadership, and budget adequacy were the three factors that meaningfully predicted parent satisfaction (Friedman, Bobrowski, & Markow, 2007).

Reiman et al (2010) found that parents reported feeling confused and lost during IEP meetings for their children. Although they are supposed to be an integral part of the

IEP team, teachers and school professionals often speak in jargon and quickly move through sections without allowing parents to fully process each step.

Parent satisfaction can be associated with factors that lead to more positive educational outcomes, such as more involvement in school activities. Laws and Millward (2001) distributed parent questionnaires to parents of children with Down Syndrome. Results indicated parent perceptions of parent involvement is related to parent satisfaction with the school. Climate of school and perceived self-efficacy were also directly related to satisfaction. Other secondary themes relating to satisfaction which were uncovered included dissatisfaction with the amount of time support staff was spending with students as well as the training of support staff. Additionally, a trend was found that satisfaction with school services is higher in parents of younger children compared to parents of older children. Lower levels of satisfaction also were seen with higher levels of education of the parent (Summers et al., 2005).

Parent satisfaction with school services, despite whether these services produce positive effects, is important when finding the origins of conflict between parents and schools. Researchers (Lake & Billingsley, 2000) used telephone interviews to look at the factors that escalate and de-escalate conflicts between parents of students with disabilities and schools. They identified eight factors: discrepant views of a child's needs, knowledge, service delivery, constraints, valuation, reciprocal power, communication, and trust. Understanding the basis for parent-school conflict in special education can lead to more sensitive and informed school professionals and ultimately better conflict resolution and agreeable outcomes for all parties.

Conflict resolution is a particularly motivating factor for schools. Satisfaction for their parents can negate costs from possible due-process proceedings. According to a 2013 survey of 200 randomly selected superintendents from districts across the country, an average due-process hearing can cost a district $10,512.50. When districts had to compensate attorney fees for parents, it costs an average of $19,241.38. An average settlement cost was $23,827.34 (Pudelski, 2013).

When specifically looking at the international adoptive parent, they tend to be more highly educated and have greater financial resources than the general population (U.S. Department of Health and Human Services, 2007). They may be more willing to advocate for services for their children. This may be due to many factors, including self-selection in the international adoption process or because of the rigorous background checks and home visits required through most adoption agencies.

The effects of institutionalization on development, and therefore later school success, are widely documented. Much is known regarding the profile of both a child adopted internationally and the family that adopts that child. However, the research is lacking when the perspective switches to post-adoption life for both the family and the child. Schools, whether public or private, are uniquely positioned to provide services to these students. Parent satisfaction with the services provided through the school may be the first marker in determining how effective they are at alleviating not only developmental concerns but also stress on the family system as a whole. School psychologists, specifically, are charged with fostering the academic, social, developmental, and mental health of individual children and also being a bridge between

the school and the home. Understanding a parent's perspective on their children's needs and how they view school providers can help accomplish this goal.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

Objective

The purpose of this study was to explore the services being received by families and children post-adoption in the child's educational placement as well as the parents' satisfaction with those services. Because there is little research on this topic pertaining to parents of internationally adopted children, this study is exploratory in nature and will begin to extend current research to this population.

Population and Sample

Participants were identified and recruited through various parenting support and advocacy groups specific to adoption nationwide. An email was sent to groups' facilitators requesting the survey be sent to their members through the groups' online communication system and social media sites explaining the nature and extent of the study as well as a link to an online survey. Five $50 Amazon gift cards were randomly drawn as incentives to participate. Participants include parents of at least one internationally adopted child who is 21 years old or younger. The responses from parents who did not meet this parameter were removed from the data.

Data Collection and Instrumentation

A survey was developed. Questions on the survey included demographic and familial information. Specifically, questions asked marital status of the parent and the state in which the family lives. Additional demographic questions included current ages of adopted children, age at time of adoption, and country of origin. Questions on school

information included whether the child is currently in school and then the type of school the child currently attends or will attend in the future. It also included questions regarding the school history of the child. The parent was asked to list services received and their satisfaction with each service provider's knowledge of adoption related issues as well as satisfaction with the service rendered. Open-ended questions allowed the parent to describe the strengths and weaknesses of the school professionals and school programs.

Various professionals reviewed the drafted survey for clarity and completeness. These included school psychologists in public and non-public settings, related service providers, and an expert in international adoption and post-adoption services. Upon completing development of the survey, it was disseminated through SuveryMonkey through parent advocacy and support groups nationwide to be completed online with an option to complete it over the phone with the researcher. A complete copy of the survey can be found in Appendix A.

Coding and Data Analysis

Responses to questions regarding level of services were coded before data were analyzed. These codes are presented in Table 3.1. Questions regarding satisfaction with services were presented using a Likert scale. For questions involving specific school service provider knowledge of adoption related issues and services rendered, a forced choice four-point Likert scale was given. For questions regarding overall satisfaction, a five-point scale was given. For data analysis purposes, the responses were given numerical codes. These codes are presented in Table 3.2

Table 3.1

Codes for Level of Service

Survey Question	*Code*
What services is your child receiving in school?	1= None 2= Consult 3= Push In 4= Pull Out

Table 3.2

Likert Scale Coding

Survey Question	*Code*
How satisfied are you with the knowledge of each of the following school professionals regarding adoption related issues?	1=Extremely Satisfied 2=Satisfied 3=Not Satisfied 4=Extremely Unsatisfied
How satisfied are you with the services rendered by each of the following school professionals regarding adoption related issues?	1=Extremely Satisfied 2=Satisfied 3=Not Satisfied 4=Extremely Unsatisfied
Overall, how satisfied are you with the amount of services received by the school?	1=Extremely Satisfied 2=Very Satisfied 3=Satisfied 4=Not Satisfied 5=Extremely Unsatisfied
Overall, how satisfied are you with the quality of services received by the school?	1=Extremely Satisfied 2=Very Satisfied 3=Satisfied 4=Not Satisfied 5=Extremely Unsatisfied

State of residence was also coded by region. Northeastern states were coded as a 1, Southern states were coded as a 2, and Midwestern states were coded as a 3. These regions were based on those used by the US Census.

Two types of data analysis were used in this study. First, information on demographics on the family, the child, and school were described. Information presented on families included how many children are in the family, how many children were adopted, relationship status, and state in which the family resides. Information on the child included gender, age at adoption, country of origin, and whether they were identified as having a special need before or after adoption. School information included the type of school the child attends, grade they are in, whether the child has been retained, and the school's awareness of the child's adoption history. This information is described using percentage frequency and means.

The first two research questions asked what types of services children who have been adopted internationally receive through their educational placement and how satisfied their parents are with the knowledge of adoption related issues of their child's school service providers. Percentage frequencies were used to answer these questions. The second question also included a one-way ANOVA used to determine whether overall levels of satisfaction differed among geographic regions.

The third research question asked if there are significant differences in services offered and satisfaction with those services between reported types of school settings. Overall satisfaction was explored as well as satisfaction with specific service providers. A non-parametric test, Kruskal-Wallis H Test, was used due to uneven, and sometimes very low, numbers in groups (Laerd Statistics, 2015).

CHAPTER 4

RESULTS

The sample included parents of internationally adopted children whose child was 21 years of age or younger. The survey was disseminated through parent support groups and adoption agencies. An email was sent to the leaders of groups around the country asking for them to forward to their members or post on their website or social media accounts. A total of 72 people started the survey but the sample size for specific questions analyzed here ranged from 52 to 65 due to skipped items. Five people agreed to start the study but did not have a child who was adopted internationally and were therefore removed from the sample.

Descriptive Statistics

Parent and Family Make-Up

Sixty-seven people responded to the survey and met stated parameters. Sixty-three disclosed their state of residence. Respondents represented 28 states, as shown in Table 4.1.

Table 4.1

Participant State of Residence

	Frequency	Percent of Sample
State of Residence		
Alabama	2	3.17
Alaska	1	1.59
California	3	4.76
Connecticut	1	1.59
Florida	2	3.17
Illinois	1	1.59
Indiana	2	3.17
Iowa	1	1.59
Kansas	4	6.35
Kentucky	2	3.17
Louisiana	1	1.59
Maine	1	1.59
Massachusetts	3	4.76
Michigan	1	1.59
Minnesota	5	7.94
Missouri	3	4.76
Nebraska	1	1.59
New Jersey	7	11.11
New York	2	3.17
North Carolina	4	6.35
Ohio	3	4.76
Oklahoma	2	3.17
Pennsylvania	4	6.35
South Carolina	1	1.59
Tennessee	1	1.59
Texas	1	1.59
Virginia	2	3.17
Wisconsin	1	1.59

Table 4.2 displays marital status, showing 77.6% of the sample is married, while 8.95% are divorced, and 10.44% are single and never married. Two respondents, or 2.98%, did not answer this question.

Table 4.2

Participant Marital Status

	Frequency	Percent of Sample
Marital status		
Married	52	77.6
Divorced	6	8.95
Single, Never Married	7	10.44
Missing	2	2.98

Table 4.3 shows that of the families surveyed, 43.28% had adopted one child internationally and 40.29% had adopted two children. (M=1.77, SD=1.065). Three parents (4.47%) did not answer this question.

Table 4.3

Total Number of Internationally Adopted Children per Family

	Frequency	Percent of Sample
1	29	43.28
2	27	40.29
3	6	8.95
4 -7	1	1.49
8+	1	1.49
Missing	3	4.47

Table 4.4 shows the total number of children per family. The majority of families surveyed had three total children or fewer (M=2.83, SD=1.719). Three respondents did not answer this question.

Table 4.4

Total Number of Children per Family

	Frequency	Percent of Sample
1	11	16.42
2	23	34.33
3	17	25.37
4 -7	12	17.91
8+	2	2.99
Missing	3	4.48

Child History

Respondents provided information on the child that was adopted first, or their oldest adopted child who was still under the age of 21. The average current age of this child was 13.52 (SD=4.423). Of respondents, 49.2% had male children, 49.2% had females, and 1.2% had a child who identified as transgender male. Grades for students spanned Pre-School through Post-Secondary.

Countries of origin for children of parents who completed the survey include: Belarus (1/64, 1.56%), Bulgaria (2/64, 3.13%), China (8/64, 12.5%), Colombia (1/64, 1.56%), Ethiopia (5/64, 7.81%), Guatemala (4/64, 6.25%), Haiti (1/64, 1.56%), India (5/64, 7.81%), Kazakhstan (2/64, 3.13%), Latvia (1/64, 1.56%), Lesotho (1/64, 1.56%), Mexico (1/64, 1.56%), Phillippines (1/64, 1.56%), Poland (1/64, 1.56%), Russia (21/64,

32.81%), Taiwan (1/64, 1.56%), Uganda (3/64, 4.69%), Ukraine (2/64, 3.13%), and Vietnam (3/64, 4.69%).

Educational Information

Of the total respondents, 27.69% had a child who was retained while 72.31% did not. Only 31.34% of children from the sample were adopted with an identified special need but since being home, 65.67% of respondents children were identified with a special need. Table 4.5 and 4.6 display these results.

Table 4.5

Children in Sample Identified with a Special Need Before Adoption

	Frequency	Percent of Sample
Yes	21	31.34
No	44	65.67
Missing	2	2.99

Table 4.6

Children in Sample Identified with a Special Need After Adoption

	Frequency	Percent of Sample
Yes	44	65.67
No	20	29.85
Missing	3	4.48

Percent frequencies of each type of school are presented in Table 4.7. The majority of the parents in the sample send their adopted child to public school (67.16%) with no parents choosing a private college preparatory school. The second smallest percentage sends their child to a private school for students with special needs (2.99%).

Table 4.7

Type of School Attended by Children in Sample

	Frequency	Percent of Sample
Type of School (n=65)		
Public School	45	67.16
Private School – College Prep	0	0.00
Private School – Religious Affiliation	7	10.45
Private School for Children with Special Needs	2	2.99
Charter School	3	4.48
Home School	4	5.97
Other	4	5.97
Missing	2	2.99

Respondents were asked how much their current school knew regarding their child's adoption history. Of the sample, 23.88% said that their school knew their child was adopted but did not know the child's pre-adoption history while 53.73% said the school knew both adoption status and pre-adoption history. Only 4.48% did not disclose any of this information to their child's school. These results can be found in Table 4.8.

Table 4.8

School Knowledge of Adoption Status and Pre-Adoption History

	Frequency	Percent of Sample
School Knowledge of Adoption Status		
Yes, but only adoption status	16	23.88
Yes, adoption status and pre-adoption history	36	53.73
No	3	4.48
Other	10	14.93
Missing	2	2.99

Research Question 1

The first research question explored the types of services children who have been adopted internationally receive through their educational placement. The percentage frequency for each service was calculated. Results are presented in Table 4.9 through Table 4.18.

Table 4.9 displays the percent frequency of school services across all levels of intensities. Special education services are the most received service, with 59.57% of respondents reporting their child received special education. The next most frequently received service is speech and language therapy (35.71%), then counseling (33.33%), occupational therapy (28.95%), behavior therapy (16.22%), physical therapy (17.5%), English as a Second Language (ESL)/English Language Learner (ELL) services (11.9%), wraparound (7.69%), and nursing (5.41%).

Table 4.9

School Services Received Across All Levels of Service

Services Received	Frequency	Percent of Sample
Special Education/IEP	28/47	59.57%
English as a Second Language/ English Language Learner	5/42	11.9%
Counseling	14/42	33.33%
Speech Therapy	15/42	35.71%
Behavioral Therapy/ABA	6/37	16.22%
Physical Therapy	7/40	17.5%
Occupational Therapy	11/38	28.95%
Wraparound Services	3/39	7.69%
Nursing Services	2/37	5.41%

Table 4.10 displays the percent of the sample receiving special education services by level of intensity. Of the sample who responded to this question, the highest frequency was no special education at 36.17%. Of those receiving the service, most were receiving special education in a pull-out setting at 27.66%.

Table 4.10

Special Education Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	13	27.66
Push-In	11	23.40
Consult	4	8.51
None	17	36.17
Don't Know	2	4.26
Missing	20	

Table 4.11 displays the percent of the sample receiving English as a Second Language or English Language Learner services by level of intensity. Of the respondents, the highest frequency was no ESL services at 88.10%. Of those receiving the service, the majority were receiving ESL services in a pull-out setting at 9.52%.

Table 4.11

English as a Second Language/English Language Learner Service Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	4	9.52
Push-In	1	2.38
Consult	0	0.00
None	37	88.10
Don't Know	0	0.00
Missing	25	

Table 4.12 displays the percent of the sample receiving counseling services by level of intensity. Of the respondents, the highest frequency was no counseling services at 64.29%. Of those receiving the service, the majority was receiving counseling services in a pull-out setting at 23.81%.

Table 4.12

Counseling Service Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	10	23.81
Push-In	0	0.00
Consult	4	9.52
None	27	64.29
Don't Know	1	2.38
Missing	25	

Table 4.13 displays the percent of the sample receiving speech therapy services by level of intensity. Of the respondents, the highest frequency was no speech therapy services at 64.29%. Of those receiving the service, the majority was receiving speech therapy services in a pull-out setting at 30.95%.

Table 4.13

Speech Therapy Service Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	13	30.95
Push-In	2	4.76
Consult	0	0.00
None	27	64.29
Don't Know	0	0.00
Missing	25	

Table 4.14 displays the percent of the sample receiving behavioral therapy or Applied Behavior Analysis (ABA) services by level of intensity. Of the respondents, the highest frequency was no behavior services at 83.78%. Of those receiving the service, there was an equal split between pull-out, push-in, and consult, with each service intensity falling at 5.41%

Table 4.14

Behavioral Therapy/ABA Service Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	2	5.41
Push-In	2	5.41
Consult	2	5.41
None	31	83.78
Don't Know	0	0.00
Missing	30	

Table 4.15 displays the percent of the sample receiving physical therapy by level of intensity. Of the respondents, the highest frequency was no physical therapy services at 82.5%. Of those receiving the service, the majority was receiving physical therapy services in a pull-out setting at 17.5%.

Table 4.15

Physical Therapy Service Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	7	17.50
Push-In	0	0.00
Consult	0	0.00
None	33	82.50
Don't Know	0	0.00
Missing	27	

Table 4.16 displays the percent of the sample receiving occupational therapy services by level of intensity. Of the respondents, the highest frequency was no occupational therapy services at 71.05%. Of those receiving the service, the majority were receiving occupational therapy services in a pull-out setting at 18.42%.

Table 4.16

Occupational Therapy Service Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	7	18.42
Push-In	0	0.00
Consult	4	10.53
None	27	71.05
Don't Know	0	0.00
Missing	29	

Table 4.17 displays the percent of the sample receiving wraparound services by level of intensity. Of the respondents, the highest frequency was no wraparound services at 87.18%. Of those receiving the service, the majority were receiving wraparound services in a push-in setting at 5.13%.

Table 4.17

Wraparound Service Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	0	0.00
Push-In	2	5.13
Consult	1	2.56
None	34	87.18
Don't Know	2	5.13
Missing	28	

Table 4.18 displays the percent of the sample receiving nursing services by level of intensity. Of the respondents, the highest frequency was no nursing services at 91.89%. Of those receiving the service, one child received it as a push-out service (2.7%) and one as a consult (2.7%).

Table 4.18

Nursing Service Received by Level of Intensity

	Frequency	Percent of Sample
Pull-Out	1	2.70
Push-In	0	0.00
Consult	1	2.70
None	34	91.89
Don't Know	1	2.70
Missing	30	

Many parents also reported receiving services outside of school. Open-ended responses included medical services, therapy with outside providers, occupational therapy, speech therapy, physical therapy, tutoring, psychiatric inpatient treatment, gender clinics, attachment therapy, and addiction related services. Of the 48 people who responded to the question, 36 have received some type of outside service.

Research Question 2

The main investigation of this paper is to determine parent satisfaction with services for their internationally adopted child. The second research question asked: How satisfied are parents with the services rendered by their child's school service providers? The percentage and frequency for each service and level of satisfaction can be found in Tables 4.19 through 4.24. The highest percentage of responses that reported being highly unsatisfied was for the school psychologist (38.46%). The highest percentage of parents that reported they are extremely satisfied with services was for the school speech therapist, falling at 21.05%.

Satisfaction with services received by the school psychologist is found in Table 4.19. Of the sample, 38.46% were extremely unsatisfied by services received from the

school psychologist. Only 3.85% were extremely satisfied and 19.23% were satisfied. The mean level of satisfaction was 3.12 (sd=.864).

Table 4.19

Satisfaction with School Services Received by School Psychologist

	Frequency	Percent
Extremely Satisfied	1	3.85
Satisfied	5	19.23
Not Satisfied	10	38.46
Extremely Unsatisfied	10	38.46
Not Applicable	28	
Missing	13	
Mean (n=26)	3.12	

Satisfaction with services received by the school speech pathologist is found in Table 4.20. Of the sample, 10.53% were extremely unsatisfied by services received from the school speech pathologist. Percent extremely satisfied was 21.05% and 52.63% were satisfied. The mean was 2.16 (sd=.898).

Table 4.20

Satisfaction with School Services Received by School Speech Pathologist

	Frequency	Percent
Extremely Satisfied	4	21.05
Satisfied	10	52.63
Not Satisfied	3	15.79
Extremely Unsatisfied	2	10.53
Not Applicable	32	
Missing	16	
Mean (n=19)	2.16	

Satisfaction with services received by the school physical therapist is found in Table 4.21. Of the sample, 14.29% were extremely unsatisfied by services received from the school physical therapist. Only 14.29% were extremely satisfied and 42.86% were satisfied. The mean was 2.43 (sd=1.282).

Table 4.21

Satisfaction with School Services Received by School Physical Therapist

	Frequency	Percent
Extremely Satisfied	1	14.29
Satisfied	3	42.86
Not Satisfied	2	28.57
Extremely Unsatisfied	1	14.29
Not Applicable	41	
Missing	19	
Mean (n=7)	2.43	

Satisfaction with services received by the school occupational therapist is found in Table 4.22. Of the sample, 13.33% were extremely unsatisfied by services received from the school occupational therapist. Percent extremely satisfied was 13.33% and 40.00% were satisfied. The mean was 2.47 (sd=1.088).

Table 4.22

Satisfaction with School Services Received by School Occupational Therapist

	Frequency	Percent
Extremely Satisfied	2	13.33
Satisfied	6	40.00
Not Satisfied	5	33.33
Extremely Unsatisfied	2	13.33
Not Applicable	35	
Missing	17	
Mean (n=15)	2.47	

Satisfaction with services received by the special education teachers is found in Table 4.23. Of the sample, 21.43% were extremely unsatisfied by services received from the special education teachers. Only 10.71% were extremely satisfied and 28.57% were satisfied. The mean was 2.71 (sd=.937).

Table 4.23

Satisfaction with School Services Received by Special Education Teachers

	Frequency	Percent
Extremely Satisfied	3	10.71
Satisfied	8	28.57
Not Satisfied	11	39.29
Extremely Unsatisfied	6	21.43
Not Applicable	24	
Missing	15	
Mean (n=28)	2.71	

Satisfaction with services received by the school counselor is found in Table 4.24. Of the sample, 27.59% were extremely unsatisfied by services received from the school counselor. Only 3.45% were extremely satisfied and 31.03% were satisfied. The mean was 2.97 (sd=.928).

Table 4.24

Satisfaction with School Services Received by School Counselor

	Frequency	Percent
Extremely Satisfied	1	3.45
Satisfied	9	31.03
Not Satisfied	11	37.93
Extremely Unsatisfied	8	27.59
Not Applicable	24	
Missing	14	
Mean (n=29)	2.90	

Responses for satisfaction with overall quality of services received can be found in Table 4.25. The highest percentage of the sample reported that they are satisfied with overall services received by their school (38.64%) while the second highest percentage of the sample reported they are not satisfied (27.27%).

Table 4.25

Satisfaction with Overall Quality of School Services

	Frequency	Percent Sample
Extremely satisfied	1	2.27
Very satisfied	7	15.91
Satisfied	17	38.64
Not Satisfied	12	27.27
Extremely unsatisfied	7	15.91
Not Applicable	8	
Missing	15	
Mean (n=44)	3.39	

Many parents chose to further elaborate on their responses by including more details in two open-ended questions. One question asked, "In what areas does your school need to improve regarding your adopted children?" Of the 49 respondents to this question, 24 parents expressed displeasure with the knowledge the staff had on trauma, fetal alcohol syndrome, and reactive attachment disorder on child development.

While most parents mention schools being more open to adoption and understanding the effects of it, one parent reported, "The current [school] is not aware of [my] son's social and emotional needs. It turns out to be the best experience so far because the microscope he was put under at previous schools made his life worse."

A one-way ANOVA was used to determine if there were differences in satisfaction among different regions in the United States. The satisfaction with overall quality of services received through the school was not statistically different for the northeast, south, and midwest geographic regions in the United States, $F(2,35)=1.527$, p=.231.

Research Question 3

The third research question investigated whether there are significant differences in services offered and satisfaction with those services between reported types of school settings. Krusal-Wallis H tests were used to investigate differences in overall satisfaction with amount of services and quality of services. Kruskal-Wallis H tests were also used to determine differences among school settings and the services received by respondents. The Kruskal-Wallis test was used due to uneven, and sometimes very low, numbers in groups.

The first Kruskal-Wallis H test was used to determine differences in overall satisfaction with the amount of services across school settings: public school (n=35), college preparatory private school (n=0), private school with a religious affiliation (n=4), private school for children with special needs (n=2), progressive school (n=0), or charter school (n=2). As assessed by a visual inspection of a boxplot, shown in Figure 4.1, distributions were not similar across all groups. The mean rank of overall satisfaction with amount of school services was not statistically significantly different between groups $\chi 2(4) = 2.078$, p = .556.

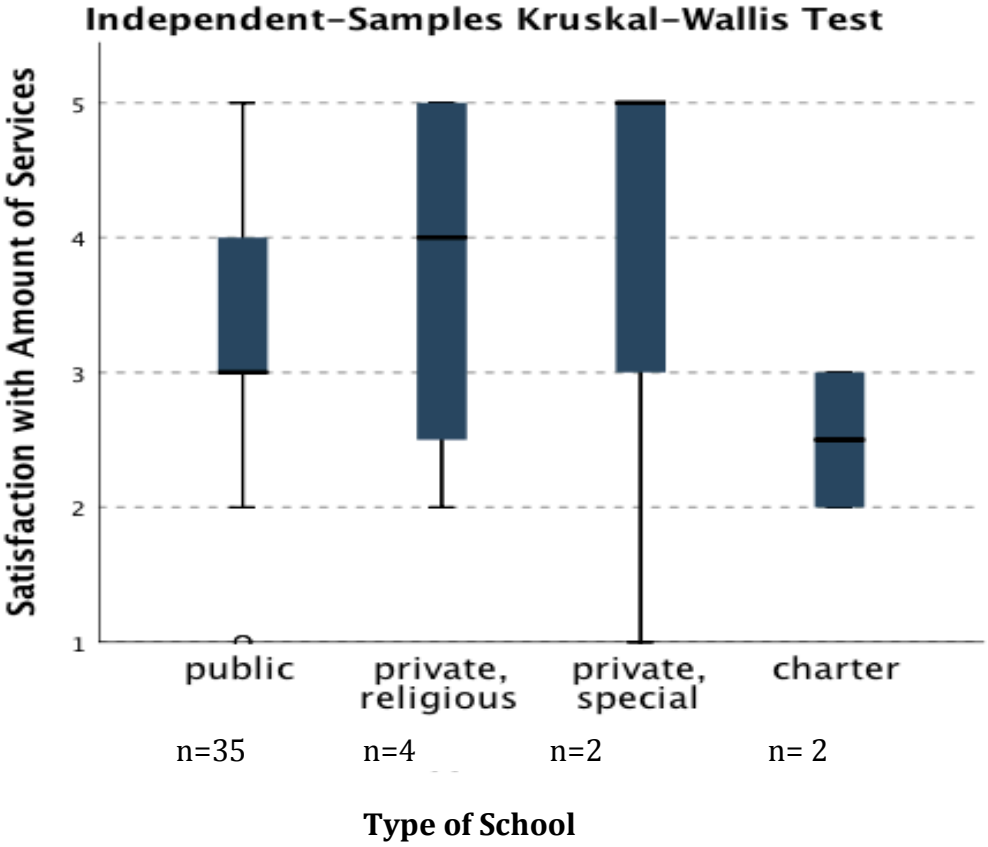

Figure 4.1: Boxplot of Kruskal-Wallis H Test showing differences in overall satisfaction with amount of services by type of school attended.

The second Kruskal-Wallis H test was used to determine differences in overall satisfaction with the quality of services received between school settings. As assessed by a visual inspection of a boxplot, distributions were not similar across all groups. Boxplot is shown in Figure 4.2. The mean rank of overall satisfaction with quality of school services was not statistically significantly different between groups $\chi 2(4) = .896$, $p = .826$.

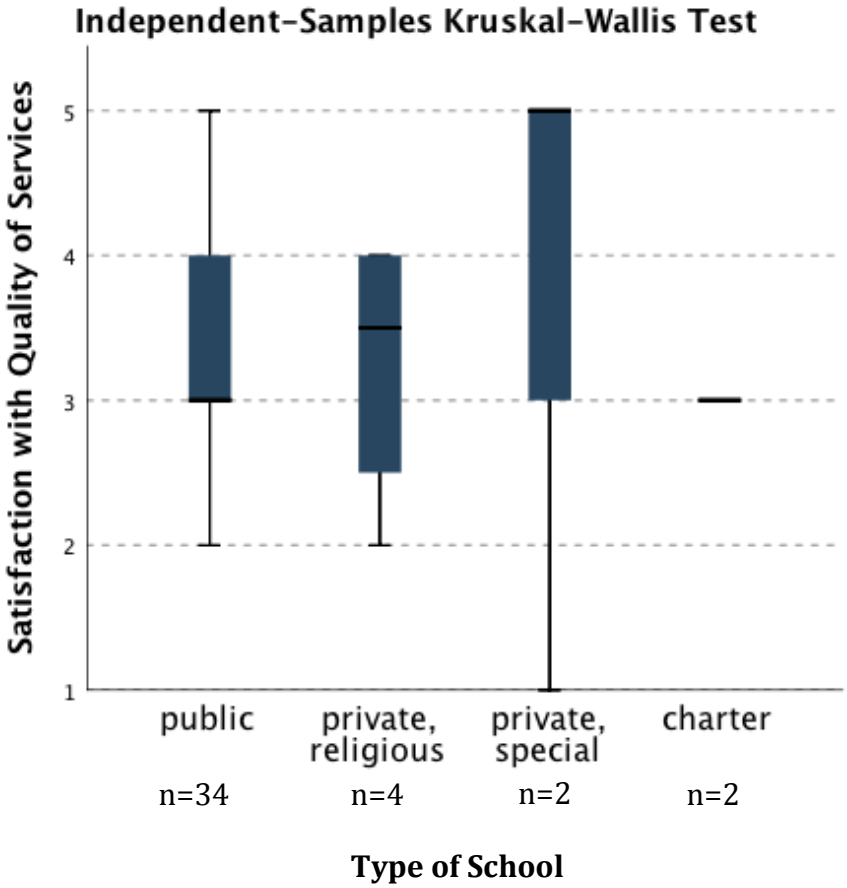

Figure 4.2: Boxplot of Kruskal-Wallis H Test showing differences in overall satisfaction with quality of services by type of school attended.

A Kruskal-Wallis H test was also used to determine if there was a differences in services received across different schools. Test were run for each included service: special education, English as a Second Language/English Language Learner, counseling, speech and language therapy, behavior therapy or Applied Behavior Analysis (ABA) services, physical therapy, occupational therapy, wraparound services, and nursing services. Results of these analyses are presented in Table 4.26. The mean rank of types

of services students are receiving was not statistically significant between groups. The exception, as seen in the table below, is for behavior therapy/ABA services.

Table 4.26

Kruskal-Wallis H Test Results by Service

Services Received	Significance Level
Special Education/IEP	.076
English as a Second Language/ English Language Learner	.736
Counseling	.128
Speech Therapy	.560
Behavioral Therapy/ABA	.011
Physical Therapy	.658
Occupational Therapy	.207
Wraparound Services	.315
Nursing Services	.812

Due to the uneven distributions among groups, median ranks were not used and therefore data did not meet assumptions for a post-hoc test to determine which type of school showed a difference in behavior services. However, median scores are reported below in Table 4.27, to assist in understanding where differences may exist.

Table 4.27

Median Score for Types of Service Received Across School Types

Services Received	Public School	Private School-Religious	Private School – Special Education	Charter	Homeschool
Special Education/IEP	3.00	1.00	3.00	3.5	1.00
English as a Second Language/ English Language Learner	1.00	1.0	1.0	1.0	1.0
Counseling	1.00	1.00	4.00	1.5	1.0
Speech Therapy	1.00	1.00	2.50	2.50	1.00
Behavioral Therapy/ABA	1.00	1.00	4.00	2.00	1.00
Physical Therapy	1.00	1.00	1.00	1.00	1.00
Occupational Therapy	1.00	1.00	1.00	4.00	1.00
Wraparound Services	1.00	1.00	1.00	2.00	1.00
Nursing Services	1.00	1.00	1.00	1.00	1.00

Despite no significant differences being seen in parent satisfaction across school settings, comments provided by respondents indicate parents changed their child's school placements, at times, because their current placement was not providing an appropriate program for their child. Of the 47 respondents who answered this question, 22 had children who changed schools in order to find a more appropriate placement. One parent reported it has taken seven years to find the right fit for their child and described the process as "long, arduous, and gut wrenching." Another parent reported up to twelve

Individualized Education Plan meetings in one year in order to attempt a successful placement in one school before moving to another. Parents report moving schools for the various reasons. One parent reported, “We have never found a good placement. We’ve changed schools four times. Public, private, mainstream, and special schools for deaf kids. None of them worked.” Another stated, “We thought we’d found a good fit for a school. We were very disappointed after starting school. We do not plan to re-enroll him in public school again. We will be looking at private options in the future.” “We are in the process of finding a more sympathetic school.”

When describing what attributes are important to her in a school, one parent reported, “I look for schools with good representation of diversity and speak with families that mirror mine to pick the best fit. Test scores, etc, are not my priority.”

CHAPTER 5

DISCUSSION

Children who have been adopted internationally provide an interesting challenge for school systems. Some of these students have extensive and pervasive needs while others will make quick and significant progress and not require special services. Parents of internationally adopted children play a vital role in educating school staff members about their child and their pre-adoption history. Often, these parents are great advocates for their students but can find it challenging to work collaboratively with school personnel. This study sought to collect more information on services children who have been adopted internationally receive through their educational placement and parent satisfaction with these school services.

The following discussion will include the findings of the current study and the relation to the existing literature, including services offered, parent satisfaction with those services, and knowledge of nuances of international adoption by service providers. Applications to today's school psychologists and other professionals working in school systems will be outlined. The limitations of the current study and areas for future research will also be discussed.

Summary of results and findings

The sample for this research included parents of an internationally adopted child who was currently 21 years of age or younger when the survey was administered. Twenty-seven states were represented in the sample. Of all respondents, 77.6% were married at the time of the survey. This was a similar finding to the survey conducted by

the U.S. Department of Health and Human Services, which found that 82% of families who adopt internationally have two married parents (2007) at the time of adoption. The children who were adopted originated from nineteen different countries. Russia was the most popular country of origin in the sample at 32.81%. This may be due to the adoption support groups that were targeted in the study or because Russia was in the top three countries for international adoption during the years most children in the study were adopted (U.S. Department of State, Bureau of Consular Affairs, 2017). Information was collected on the family demographics, the child's history, and information on the child's schooling.

In this sample, 31.34% of children were identified with a special need before the adoption. However, 65.67% were identified with a special need after adoption. The relationship between these findings and the findings from Reilly and Platz (2003) could be further researched. These researchers found that 58% of families surveyed felt they did not receive enough information on their child prior to adopting and that 37% of children displayed more serious delays than reported by the adoption agency. The relationship between parent expectations pre and post adoption and satisfaction were not addressed in this survey but could be investigated. Children with special needs require a different degree of support in the home and school. The needs of these children strain both the family and school system.

Services Received The first question of this study asked: what services do children who have been adopted internationally receive through their educational placement? The hypothesis stated children who have been adopted internationally receive a variety of related services through their school placements including counseling, physical therapy,

occupational therapy, speech therapy, and special education. Responses confirmed the hypothesis. Of the sample, 59.57% received special education services and 35.71% received speech and language services. A pull-out model was the most common service intensity. It is unknown if this is because the needs of the students necessitate the higher level of intervention or if a consult or push-in model is not available in the district or state in which the child is educated. Further research should be conducted to investigate this.

The highest percentage of the sample received special education and speech and language therapy. This seems to support the conclusion made by Van IJzendoorn, Juffer, and Poelhuis (2005) who found that there was little difference in IQ between adopted and non-adopted peers but that there was a significant difference in language abilities and school performance. Similarly, Gindis (2003) reported that up to 59% of adopted children have speech and language delays.

Many families also received a variety of services outside of the school setting. As noted in many of the parent responses, families looking to receive additional supports for their children often utilize community mental health facilities and medical facilities. Services ranged from physical and developmental therapies including speech, occupational therapy, and physical therapy to more intensive levels of support including inpatient hospitalization, gender clinics, attachment therapies, and addiction treatment.

Satisfaction with School Services The second question of this study asked: How satisfied are parents with the services rendered by their child's school service providers? The hypothesis stated parents of internationally adopted children are not completely satisfied with the services received in their child's educational settings due to non-expertise regarding adoption-specific issues. Overall, the highest percentage frequency of

respondents said they were satisfied with the quality of services provided to their child in school (38.64%); however many displayed varying degrees of dissatisfaction across different service providers. Only 19.23% of the sample was satisfied with school services received by the school psychologist, while 38.46% were not satisfied.

A one-way ANOVA was used to explore possible differences in satisfaction with services between regions of the United States. A significant difference was not found between regions. Further research may explore differences in satisfaction with services between rural, suburban, and urban populations.

Parent comments on the following open-ended questions shed more light on satisfaction. The survey asked, "In what areas does your school need to improve regarding your adopted child(ren)?" and, "In what areas does your school excel regarding your adopted child(ren)?" An ongoing theme related to the staff knowledge of trauma and its impact on development. While some parents experienced teachers and staff doing their best to educate themselves, others mentioned good intentions but a lack of experience and expertise.

One parent described the complexities of providing adequate services to internationally adopted children:

> Understanding the unique needs of internationally adopted children with regards to language in particular would be at the top of my list [for things to improve]. However, for adopted children domestically and internationally, I would say all schools need more information, training, and development on trauma informed practices…Progress is being made, but currently many children are being identified as having disabilities when it is likely trauma related. That being said, it can often be impossible to render support services to a child who has not been identified with a disability, so it is sometimes necessary to identify a child as having a disability in order to provide the services they need. This is a policy issue which also needs to be addressed in schools and

> other settings. Nevertheless, it is still possible and important to provide trauma informed care for children who have been adopted."

Parents were also asked, "How comfortable do you feel advocating for your child's needs in the school setting?" Many parents felt very comfortable in this area, which supports the findings from Gindis (2003) which found that adoptive parents are very involved in their child's schooling.

Differences between Groups. The third question of this study asked: Are there significant differences in services offered and satisfaction with those services between reported types of school settings? The hypothesis stated there are significant differences in services offered between school settings, with the most services offered in public schools but the highest satisfaction of services found in private schools. This study found that there are not significant differences in services offered between school settings or parent satisfaction with those services. The only exception was with behavior or ABA services. However, due to limitations in the data, a post-hoc test could not be run to determine where these differences lie. However, inspection of median scores suggests private, special education schools provide a higher intensity of behavioral services. Additional research should be done to explore these differences in how the school type affects behavior services.

The results of this question should be investigated further with larger sample sizes. A large majority of children represented by the sample attended public school, with some types of schooling only having a sample size of one or two. Therefore, this result should be interpreted with caution.

General implications of findings

The implications of this study for public school systems are important. Students who are internationally adopted make up a significant and growing population in schools. These students often have developmental delays that require early intervention services. Fortunately, resilience and remediation are the norm. While this is certainly good news, it provides a challenge to public schools to play a role in providing the type of services these children need to overcome possible delays.

That challenge leads to another interesting debate: the delivery of FAPE and the legal and ethical implications for schools when providing services to children who have been adopted internationally. School districts have a responsibility to provide free and appropriate education to all students (IDEA, 2004). It is often mutually beneficial when a student can be educated and receives supplementary services in the public schools, rather than a private specialized school, because it ensures the student an education in the least restrictive environment as well as minimizes costs of out of district placements.

Additionally, specialized services and knowledge are often required for best outcomes and are sometimes hard to find. When public school systems have quality services and can meet the needs of the student and families without extra cost and burden to the family, all students receive appropriate services, regardless of economic status or availability of specialists.

With the expanding role of the school psychologist comes expanding responsibility and expectation. Training programs need to teach and advocate for continuing professional development throughout one's career as well as knowing your areas of expertise and deferring to others when needed (Splett et al., 2013). Trauma

informed care should be covered in training programs. Although service providers may not have many, or any, students who have been adopted on their caseload, they are bound to work with students who have experienced trauma. One parent's comment on this topic suggests the need for specific training or resources for school personnel on adoption and/or trauma related needs: "Administration and teachers have been very receptive to learning and want to help. They're just not sure how to help." Another parent said, "We did have a school-based counselor who tried very hard to help, but he was not knowledgeable about trauma." The topic of trauma informed care was a particular area of concern for many parents.

Parent satisfaction is an important indicator for schools and leads to a variety of implications in practice. Parents who adopted internationally are shown to be more actively involved in their children's schooling and development (Gindis, 2003). This could mean that buy-in from adoptive parents may be more difficult but ultimately have a high pay off for schools, even compared to the general population. One aspect of the NASP practice model is collaboration between family and school (NASP, 2010). In order to be effective in this role, a school psychologist must build and maintain a healthy rapport with families. In turn, parent satisfaction can increase and better outcomes can be achieved both systemically and for an individual child.

A common thread through parent comments included satisfaction directly related to school climate and the willingness of school staff to invest in building rapport with their children, as is recommended in trauma informed care. Some of the most beneficial experiences were reported to be the relationships developed between service providers and teachers with the parents and student. One parent said the most beneficial experience

in their child's schooling as "teachers who made an effort to connect with her in early years."

Another emerging theme from the responses was how a good relationship with a service provider at a school can make parents feel more comfortable with the school's recommendations and provide for a more collaborative team. It is important that parents and the schools maintain a cooperative relationship, as it will ensure better outcomes for the student as well as minimize possible costly litigation for the district (Pudelski, 2013).

While many school psychologists and other service providers in schools are competent in performing their jobs and experts in their field, children who have been institutionalized have unique needs that do not always fit within typical eligibility models. Differential diagnosis is complicated when attempting to rule out post-traumatic stress disorder, reactive attachment disorder, sensory dysfunction (Chan, Miller, & Tirella, 2006) and institutional autism (Lofy & Doly, 2004) from attention deficit disorder. Additionally, typical standardized tests will not produce valid results soon after adoption due to high culture and language loading (Gindis, 2003). According to comments from many parents in this sample, knowledge of these very specific adoption related issues is a concern when dealing with their school personnel. Providing opportunity for professional development as well as evidence-based resources for teachers and service providers working with students who have been adopted internationally, or who have experienced trauma, is imperative.

Although writing about school mental health more globally, Splett, Fowler, Weist, and McDaniel (2013) proposed a series of recommendations regarding school psychologists as mental health professionals in schools. They recommend that training

programs do a better job of preparing school psychologists to be confident and effective in delivering mental health services by engaging in more mental health field experiences during graduate school. Training programs should evaluate their course offerings to ensure it aligns with the NASP practice model and that students are being exposed to experts from a variety of specialties in psychology. They also propose introducing and encouraging areas of specialization within school psychology. This ensures that student and family needs are met without putting an impossible expectation on each psychologist to be experienced and confident providing services for all unique cases.

Limitations

Results from this study should be interpreted with caution, due to a number of limitations. While it describes characteristics of families and general views on school related services, further study is needed to determine relationships between types of schools and satisfaction with services.

The sample was not representative of all regions in the United States or family constellations and therefore cannot be generalized with certainty across cultural and geographic regions. Participants in this study were self-selected. Recruitment for the study utilized contact lists from parent support groups. Those parents that participate in such groups may have greatly different experiences than those that choose not to. Despite attempts to attract a wide, diverse sample, the response rate was modest. Additionally, the measurement tool used in this study was not exhaustive and many confounding variables could be impacting results.

Due to the nature of the data, only descriptive statistics were appropriate for two questions in this study. Nonparametric statistics were used due to the uneven and

sometimes very low numbers in some groups. The results of the Kruskal-Wallis H Tests must be interpreted with caution as visual examination of the boxplots showed that distributions were not similar across groups. Because medians were not used, the data did not meet assumptions for a post-hoc test, and therefore findings were limited.

Additionally, the respondents represented 28 different states and the services offered and structure of special education and related services can be vastly different across states. Educational terminology and available services can differ and therefore may not be applicable across respondents. For example, the structure of a push-in program or service in one state might look different than another. Additionally, decisions regarding the intensity of service are made differently across states. Therefore, using level of intensity of service may not be a valid indicator or correlate with actual student need.

Future Directions

The results from this study were exploratory in nature and therefore only touch the surface of the issue of parent satisfaction with school services. Future research areas include student centered, family centered, and school professionals centered. When related to specific student need, studies should explore how students adopted internationally are gaining access to special education and related services in varying states, including exploring the specific eligibility categories used. The differences between urban, suburban, and rural areas, can be looked into to determine whether there is a relationship between location and services students are receiving. Additional questions can also be asked of the data collected. For instance, the relationship between the age of adoption and amount of services received could be explored, as researchers

have found that the earlier the child was adopted, the less likely developmental delays would be seen (Van Londen et al., 2007). The relationship between country of origin and services received could also be explored.

Parent involvement in meetings and data on due process proceedings for these cases should also be considered. Although few comments and quotes from the open-ended questions on the survey were included, these answers can be coded to find out more details regarding parent satisfaction and opinion on services for their child. Summers et al. (2005) found the older the parent was and the higher education they had, the lower their overall levels of satisfaction with the relationships they had with the professionals working with their children. They also found that the older their child was, the lower satisfaction was rated. These findings' generalization could also be explored within the adoptive community. Additionally, comparing parent satisfaction with school services within the international adoption community to parent satisfaction with special education in general may provide more insight into this topic.

An investigation into the expanding role of the school psychologist and how that impacts both the training of new psychologists and the quality of work produced by current psychologists should be explored. In addition, looking at how current psychologists participate in professional development to keep up with a changing and growing caseload could shed light on the gap between the good intentions of school professionals and actual school outcomes utilizing trauma informed care.

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APPENDIX A

SURVEY FORM

1. Do you have a child who was adopted internationally?
    a. Yes – question 2
    b. No – end survey
2. How many children have you adopted internationally?
    a. Drop down box
3. How many children do you have in total?
    a. Drop down box
4. State in which you live:
    a. State Drop Down box
5. Current Marital Status
    a. Married
    b. Widowed
    c. Divorced
    d. Separated
    e. In a domestic partnership or civil union
    f. Single, but cohabitating with a significant other
    g. Single, never married

Please answer for your internationally adopted child. If you have adopted more than one child, please answer for the child you adopted first, or the child who is 21 years of age or younger.

6. How old is your child?
    a. Drop down box
7. What is your child's gender?
8. Is your child currently in school?
9. What grade is your child in?
    a. Grade Drop Down
10. Has your child been retained?
    a. Yes
        i. If yes, what grade?
    b. No
11. How old was your child at time of adoption?
    a. Drop Down Box
12. Where is your child's country of origin?
    a. Country Drop Down
13. Did your child come home with an identified special need?
    a. Yes – Please specify: _____
    b. No
14. Since being home, has your child been identified as having a special need?
    a. Yes – Please specify: _____
    b. No
15. Please choose the type of school your child attends or will attend:
    a. Public School

b. Private School – College Preparatory

c. Private School – Religious Affiliation

d. Private School for Children with Special Needs

e. Progressive School

f. Charter School

g. Homeschool

h. Other – please specify _____

16. Is your child's school aware of their adoption status and pre-adoption history?

a. Yes, but only adoption status

b. Yes, adoption status and pre-adoption history

c. No

d. Other (please specify)

17. What services is your child receiving **in school**? Check all that apply:

Special Education	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know
English as a Second Language/English Language Learner	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know
Counseling	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know
Speech Therapy	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know
Behavioral Therapy/ABA	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know
Physical Therapy	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know
Occupational Therapy	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know
Wraparound Services	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know

Nursing Services	a. None	b. Consult	c. Push In	d. Pull Out	e. Don't know
Other (please specify):					

18. How satisfied are you with the **knowledge** of each of the following school professionals regarding adoption related issues?

School Psychologist	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
School Speech Pathologist	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
School Physical Therapist	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
School Occupational Therapist	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
Special Education Teachers	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
School Counselor	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable

19. How satisfied are you with the **services rendered** by each of the following school professionals?

School Psychologist	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
School Speech Pathologist	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
School Physical Therapist	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
School Occupational Therapist	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
Special Education Teachers	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable
School Counselor	a. Extremely Satisfied	b. Satisfied	c. Not Satisfied	d. Extremely Unsatisfied	e. Not Applicable

20. Overall, how satisfied are you with the amount of services received?

a. Extremely satisfied

b. Very satisfied

c. Satisfied

d. Not Satisfied

e. Extremely unsatisfied

f. N/A

Comment Box

21. Overall, how satisfied are you with the quality of services received?

a. Extremely satisfied

b. Very satisfied

c. Satisfied

d. Not Satisfied

e. Extremely unsatisfied

f. N/A

Comment Box

22. What school experiences have been most beneficial for your adopted child(ren)?

(open ended)

23. In what areas does your school need to improve regarding your adopted child(ren)?

(open ended)

24. In what areas does your school excel regarding your adopted child(ren)? (open ended)

25. How comfortable do you feel advocating for your child's needs in the school setting?

(open ended)

26. Has your child changed schools (other than as expected due to changing grades)? If so, please describe your process in finding the right fit for the school placement of your child. (open-ended)
27. Briefly describe any services your child receives that are outside of the school system. (open-ended)