

HOPE CONNECTION 2.0: A THERAPEUTIC CAMP INTERVENTION  
TO IMPROVE ADOPTIVE FAMILY FUNCTIONING

by

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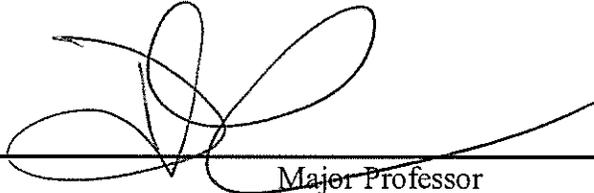
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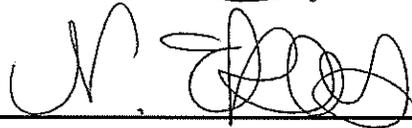
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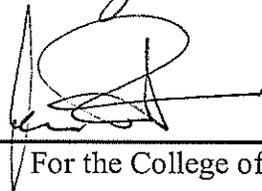
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## Hope Connection 2.0: A Therapeutic Camp Intervention to Improve Adoptive Family Functioning

Children who are adopted often experience early-life trauma, which can lead to deficits in attachment and sensory processing that are often manifested by dysregulation (Schore & Schore, 2008) and severe emotional (Merz, McCall, Groza, 2013) and behavioral (Juffer & Van Ijzendoorn, 2005; Merz & McCall, 2010; Miller, Chan, Tirella, Perrin, 2009) problems. In an effort to improve adopted children's trauma-related emotional and behavioral problems, the Karyn Purvis Institute of Child Development (KPICD) at Texas Christian University created Hope Connection<sup>®</sup> camp, a three-week summer camp intervention for adopted children that focused on addressing the impacts of trauma (attachment and sensory processing deficits). The Hope Connection camps consistently proved effective in improving trauma-related symptoms, such as anxiety, depression, anger, conduct problems, peer problems, and hyperactivity (Purvis, 2001; Purvis, 2003; Purvis & Cross, 2006; Purvis, McKenzie, Cross, & Razuri, 2013). However, there were two limitations to the original Hope Connection model. One limitation was a lack of intervention with each member of the adoptive family system. Family system theory suggests that all family members are influenced by the trauma-related needs of one member, which can lead to secondary traumatic symptoms in other family members (Bowen, 1978; Coulter & Mooney, 2017). A second limitation was the feasibility of an annual three-week summer camp due to the time commitment necessary of families. In order to address the trauma-related emotional and behavioral problems of adopted children and improve the relationships within the family system as well as address the feasibility of camp participation, the KPICD created Hope Connection 2.0, a two-weekend therapeutic family camp for adoptive families.

The aim of this proposed study is to examine the feasibility and effectiveness of Hope Connection 2.0 in improving the trauma-related emotional and behavioral problems of adopted children as well as the relationships within the adoptive family system.

### **Impact and Symptoms of Trauma in Adopted Children**

Adopted children often endure early-life adverse experiences that affect their development across the lifespan (Colvert et al., 2008). Whether these children are adopted at birth or later in life or through foster care or international adoption, adopted children experience early-life trauma in some form. This early-life trauma can negatively impact adopted children's development (Goldman & Ryan, 2011), causing deficits in attachment (van den Dries, Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2009) and sensory processing (Wilbarger, Gunnar, Schneider, & Pollak, 2010). These deficits are manifested by self-regulation difficulties, which lead to emotional problems, including anxiety, depression, and anger, as well as behavioral problems, including conduct problems, peer problems, and hyperactivity (Forslund, Brocki, Bohlin, Granqvist, & Eninger, 2016; Gourley, Wind, Henninger, & Chinitz, 2013; Juffer et al., 2001).

**Trauma and its impact on adopted children.** Adopted children often experience complex developmental trauma, which is the experience of numerous traumatic events (most often relational trauma) over a prolonged period of time (van der Kolk & Courtois, 2015). Lack of nurturing caregivers, institutionalization, multiple caregivers and placements, abuse, and neglect are just a few of the many traumatic experiences vulnerable children may face prior to adoption (Purvis, 2013). The prevalence of traumatic experiences in vulnerable children is so great that one study found that children in the foster care system experience trauma at more than twice the rate of combat war veterans (Pecora, White, Jackson, &

Wiggins, 2005). Often, adopted children experience these traumatic events early in life, which can lead to a profound impact on brain chemistry during the critical years of development (Bremner, 2003).

The lack of an attachment figure for many adopted children during the critical years of development can lead to a persistent delay in all aspects of development, including physical, cognitive, emotional, and social (Bowlby, 1988; Fagan, 2011). According to attachment theory, the presence of a responsive, consistent, and protective adult is necessary for healthy, secure attachment, and this secure attachment leads to subsequent healthy child development (Bowlby, 1969). For many adopted children, the presence of this responsive type of caregiver was missing prior to adoption (Van den Dries et al., 2009). The lack of responsive caregiving during early-life development can lead to insecure attachment (van den Dries, et al., 2009). Insecure attachment is connected to delayed overall development, which can persist across the lifespan, having a lasting impact on one's physical, cognitive, emotional, and social development (Bowlby, 1969; Sroufe, 2005).

Many adopted children experience deficits in sensory processing due to early-life institutional care and suffering abuse or neglect (van der Vegt, van der Ende, Ferdinand, Verhulst, & Tiemeier, 2009; Wilbarger et al., 2010). Children need healthy nurturing care from an attachment figure during the critical years of development in order to gain the skills necessary to process sensory information (Tirella & Miller, 2011). Institutional care or multiple changes in caregivers do not tend to provide the nurturing care necessary for healthy development as children often experience both sensory and social deprivation in these settings (Rutter, Kreppner, & O'Connor, 2001). The inconsistency of caregivers and the lack of nurturing care from a primary caregiver deprives children of the typical sensory

experience received from caregiver-child interactions (Wilbarger et al., 2010). When abuse or neglect is also experienced from adults in the role of caregivers this can lead to greater disruption of a child's ability to process sensory information, as children are not only lacking nurturing care but experiencing trauma during caregiver-child interactions (Lin, Cermak, Coster, & Miller, 2005). In addition to this early-life trauma, some adopted children experience prenatal drug exposure, which further alters their ability to process sensory information (Schneider, et al., 2008). Prenatal drug exposure is believed to contribute to child protective services involvement and is a consistent risk factor for children in the foster care system (Prindle, Hammond, & Putnam-Hornstein, 2018; Smith, Johnson, Pears, Fisher, & DeGarmo, 2007). Prenatal drug exposure alters brain development and disrupts the ability to process sensory information prior to birth (Fisher, Kim, Bruce, & Pears, 2011; Schneider, et al., 2008). This experience of early-life trauma and/or prenatal drug exposure can disrupt children's ability to modulate their responses to the environment, leading a child to either avoid or seek sensory input rather than process sensory experiences in a healthy way (Wilbarger et al., 2010).

**Symptoms of the impact of trauma.** Because adopted children often have experienced early-life trauma, including lack of attachment figures, institutionalization, multiple placements, abuse, and neglect, they often struggle with self-regulation (Tirella & Miller, 2011). Children who have experienced early-life trauma have learned to self-regulate in a manner adapted to survive their unhealthy environments (i.e. self-rocking, hyperarousal, and hoarding; Wilbarger et al., 2010). When they are placed into a safe, loving family, the adaptations that helped them to survive their previous environments no longer match their new environmental needs and become maladaptive instead. However, because their

maladaptive self-regulation behaviors often develop during the critical early years of life, they persist despite living in a healthy environment (Tirella & Miller, 2011). This struggle with healthy self-regulation is often exhibited in adopted children's emotions and behaviors; specifically, they struggle with anxiety, depression, anger, conduct problems, hyperactivity, and peer problems (Juffer, et al., 2011; Tirella & Miller, 2011).

Some adopted children have not only experienced these early-life traumatic experiences that shaped their learning of self-regulation, but they also experienced prenatal drug exposure that directly affected their ability to self-regulate (Fisher, et al. 2011). Prenatal drug exposure alters brain development, decreasing cortisol levels and disrupting the stress response. This disruption to the stress response alters one's ability to regulate behavior. When these children experience altered brain development due to prenatal drug exposure in addition to further early-life trauma, their brains continue to develop in a way that disrupts ability to regulate behavior (Fisher, et al. 2011; Prindle, et al., 2018; Smith, et al., 2007).

Due to the trauma adopted children often experience and the subsequent deficits they tend to have in attachment and sensory processing, adopted children exhibit greater dysregulation and emotional and behavioral problems than non-adopted children (Brown, Waters, & Shelton, 2017; Juffer, et al., 2011; Merz & McCall, 2010; Merz, McCall, Groza, 2013; Wiik, et al., 2011). Common and/or predictable symptoms of trauma among adopted children are anxiety, anger, depression, peer problems, attention problems, and aggressiveness (Brown, et al., 2017; Elovainio, Hakulinen, Pulkki-Raback, Raaska, Lapinleimu, 2018; Juffer & van Ijzendoorn, 2005; Juffer, et al., 2011; Merz & McCall, 2010;

Merz, et al., 2013; Wiik, et al., 2011; Wretham, & Woolgar, 2017). This is true for children adopted internationally as well as from foster care.

Across a range of studies, internationally adopted children, consistently presented with greater anxiety, depression, anger, conduct problems, hyperactivity, and peer problems than non-adopted children (Juffer & van Ijzendoorn, 2005). In addition, elementary-aged children adopted from foster care also demonstrated greater emotional problems, conduct problems, and hyperactivity than non-adopted children (Wretham, & Woolgar, 2017). Furthermore, these findings are consistent with several other studies comparing emotional and behavioral problems in adopted children and non-adopted children (Brown, et al., 2017; Juffer, et al., 2011; Merz & McCall, 2010; Merz, et al., 2013; Wiik, et al., 2011).

Unfortunately, these emotional and behavioral problems often persist after children are adopted into safe, loving families (Juffer & van Ijzendoorn, 2005; Tirella & Miller, 2011). Deficits in attachment and sensory processing often adversely affect adjustment into the adoptive family system and family life after the initial adjustment period (Tirella & Miller, 2011). Addressing these issues is necessary to improve the quality of life for both the adopted child and the adoptive family system (Miller, Jacobs, & Tirella, 2009).

### **Hope Connection®**

To assist adopted children in gaining healthier functioning, the KPICD created The Hope Connection®. The Hope Connection was founded by Drs. Karyn Purvis and David Cross to meet the attachment and sensory processing needs of adopted children who had experienced early-life trauma (Purvis, 2001; Purvis, 2003).

The Hope Connection began as a three-week summer camp for adopted children to address the impacts of trauma. Specifically, the camp was designed to address (a) attachment

problems by emphasizing connections between the child and their caregiver and “camp buddy” and (b) sensory processing problems by creating a sensory-rich environment and including sensory activities (e.g., “the Crash-n-Bump”; see [Purvis, 2003]). To facilitate improved attachment (i.e., connection), each child was assigned a “buddy,” an adult volunteer who was always with the child during camp activities. Connecting with the camp buddy was thought to naturally facilitate healthier attachment and social skills improvement. In addition, each day began with an attachment ritual in which parents gave permission to the camp buddy to care for their child for the day. Buddies asked, “May I be the boss of your child today while he is in camp?” and “If your child asks for a hug today, may I give him a hug?” This ritual was designed to/intended to remind the child that his parent was in charge of him and his safety (Purvis, 2001).

To provide developmentally appropriate sensory input, children participated in “Crash-n-Bump,” designed by occupational therapists to activate sensory processing through activities, such as climbing, trampoline jumping, and crawling through tunnels, to assist children in meeting their unique sensory needs. Because adopted children often overly avoid or seek sensory input, the “Crash-n-Bump” allowed them to meet their powerful sensory needs and consequently feel regulated. Three other groups occurred each camp day: nurture group, life skills group, and closure group. Nurture group focused on building trust and attachment through playful interaction in effort to increase attachment behavior and social skills. Life skills group involved teaching behavioral scripts and developing self-regulation skills in order to reduce emotional and behavioral problems. Finally, closure group at the end of each day was used to reflect on the day and prepare for the next camp day, which

created cohesion of the group and predictability of the schedule to ease dysregulation (Purvis, 2001).

Children attending the first camp showed significant improvements in trauma-related emotional and behavioral problems from pre- to post-camp (Purvis, 2001). Specifically, adopted children exhibited improvements in anxiety and depression, anger/aggression, attachment behavior, and attention problems via parent report (Purvis, 2001). Due to the promising results, The Hope Connection camps continued in following summers with variations in parental involvement and camp scheduling (Purvis, et al., 2008). Data collected from children attending each camp consistently demonstrated improvements in trauma symptoms such as reductions in emotional and behavioral problems (anxiety, depression, anger/aggression, conduct problems, peer problems, and hyperactivity), suggesting that camp was successfully addressing the developmental deficits associated with trauma (i.e., attachment and sensory processing; Purvis, 2003; Purvis & Cross, 2006; Purvis, McKenzie, Cross, & Razuri, 2013).

**Limitations.** Although evidence suggests The Hope Connection was successful at meeting the needs of adopted children, there were two limitations to the design. The first limitation was that the intervention targeted only the adopted child rather than the entire family system. Family system theory suggests that the family is a dynamic, connected unit and each member affects the other members (Bowen, 1972). In an adoptive family, the needs of the adopted child can adversely affect the other members of the family system (Tirella & Miller, 2011). The Hope Connection did not address the way in which the whole family system may be negatively impacted by the adopted child's early-life trauma. The second limitation was the feasibility of participating in a three-week summer camp for families. At

least one parent was required to attend each camp day for the three weeks; however, this schedule is not manageable for many working families who may benefit from a therapeutic intervention for their adopted children (Bureau of Labor Statistics, 2017).

***Family systems.*** With the increase in attachment and trauma work within adoptive families, it has become apparent that the emotional and behavioral needs of the adopted child influence the other members of the family system (Tirella & Miller, 2011). According to family system theory, members of the family system influence and are influenced by the other members. There is an emotional interdependence and complex connection between family members inherent in every family system (Erdem & Ommay, 2018). Each member's functioning affects, negatively or positively, the functioning of the other members (Bowen, 1972). When an adopted child has trauma-related emotional and behavioral problems, it is theorized that these problems affect the emotionality of the other family members.

Several key concepts of family systems theory align with what may be occurring within the adoptive family system, including the balance of two forces: individuality and togetherness. Members of a family operate in a balance of these two forces – the need to be autonomous and the need to be close and accepted (Bowen, 1972). Bowen theorized that in times of crisis, the force of togetherness is more salient and families “fuse” together in effort to promote survival (Kerr & Bowen, 1988). This balance of forces is very similar to what may occur in an adoptive family when the needs of the adopted child are severe: family members either join together, focused on a common goal of helping the child, or become autonomous. This balance of forces requires flexibility of the family system in times of stress, making flexibility an important characteristic of a healthy family system (Bowen, 1978).

Triangulation in family systems is another concept that may be relevant to the adoptive family system. According to family systems theory, a dyadic relationship is unstable and cannot handle much tension whereas a triangle can handle much more tension and anxiety (Bowen, 1978). Family relationships operate in a triangle due to its ability to handle this increased tension. However, in this triangle, there is always one who is on the outside of the close bond between the other two (Rothbaum, Rosen, Ujie, & Uchida, 2002). As one person becomes closer to another person, this dynamic automatically moves the third person to the outside (Bowen, 1972). In the adoptive family, parents may be triangulated with the adopted child, especially as attachment grows with the adopted child (Rothbaum et al., 2002). However, other triangles may also be at play, including the triangle of the sibling, the adopted child, and the parent. Due to triangulation, cohesion is another important measure of healthy family functioning. The degree to which a family functions cohesively can determine the healthy functioning of a family system (Olson, 2011).

The complex interactions of the family system create an environment of interdependence, reaction, and connection (Bowen, 1972). When a family chooses to adopt a child, this addition to the family system has the potential to bring tension as the family shifts to include its new member. When the adopted child also enters with trauma-related emotional and behavioral problems, this can lead to an unhealthy family system (Tirella & Miller, 2011). It is important to examine the cohesion and flexibility of the family system to determine if the adoptive family is functioning healthily or is negatively impacted by the trauma-related needs of the adopted child.

***Feasibility.*** The Hope Connection extensive camp schedule made it possible for only a select population of families to participate in the intervention. Many families could not

commit to being involved in a three-week camp, especially as later Hope Connection camps involved parent training and observation during most of the camp days (Purvis, et al., 2008). The three-week schedule may have prohibited families in which both parents worked full-time from participating. Only 76% of private industry workers and 60% of government employees had access to paid vacation in 2017 (Bureau of Labor Statistics, 2017). Of those that did receive paid vacation, the average number of vacation days that full-time employees received after five years of service was 15 days (Bureau of Labor Statistics, 2017), which is the exact number of days necessary for participation in the original Hope Connection summer camp. This means that participation may have been a financial constraint for families in which both parents worked full-time, did not receive paid vacation, and could not afford to take time off from work. It is important to make interventions accessible to families that may need them but are not able to commit to a lengthy amount of time for participation.

### **Hope Connection 2.0**

Hope Connection 2.0 was created to address the two limitations of The Hope Connection. First, in addition to addressing developmental deficits for adopted children who have experienced trauma, Hope Connection 2.0 also involves participation of the whole family system by including activities geared to meet the individual needs of all immediate family members to improve the cohesion and flexibility of the family system. Involving the whole family system is specifically expected to improve relationships that may be negatively impacted by the trauma-related needs of the adopted child. Second, in order to address feasibility, Hope Connection 2.0 is a two-weekend family camp. The first round of Hope Connection 2.0 occurs over two weekends (October 26-28, 2018 and November 9-11, 2018)

during the school semester rather than three weeks over the summer months. Everyone in the adoptive family system who lives in the home is required to attend camp activities from 6-8 PM Friday, 8:30 AM – 3:30 PM Saturday, and 8:30 AM – 2:30 PM Sunday during both weekends. This schedule change is expected to make it manageable for a variety of working families to potentially benefit from the intervention.

The therapeutic framework comprising Hope Connection 2.0 builds on the original Hope Connection’s framework by adding trauma-informed elements for the whole adoptive family. Thus, Hope Connection 2.0 activities are designed to address the same two trauma-related deficits in adopted children as The Hope Connection (attachment and sensory processing), as well as to improve cohesion and flexibility within the family system. The following sections summarize the therapeutic framework of Hope Connection 2.0, which involves all members of the family system.

**Adopted children.** Similar to The Hope Connection, each child is paired with a “buddy,” who is a TCU student in the child development major or minor. This buddy is partnered with the child for the duration of the camp activities each day and serves as a natural way of building connection and social skills. Similar to the original camp, each day begins with an attachment ritual in which the parent is acknowledged as the person in charge of the child and his safety in order to establish attachment (Purvis, 2001; Purvis, 2003). Then, children participate in a “crash-and-bump” course for thirty minutes, which is designed by an occupational therapist and involves multiple sensory activities in effort to meet the sensory needs of the child, as was the intent in The Hope Connection (Purvis, 2001; Purvis, 2003). Next, children participate in a nurture group, which intends to build connection and cohesion through playful interaction. On the first day, nurture group is just for children and

their buddies in effort to learn the format of nurture group and learn relational skills. On the second day, nurture group is conducted in the context of the family system with the aim of building connection among family members to improve relationships and address the limitation of The Hope Connection. Then, the children participate in a movement group to continue meeting the children's sensory needs and promote self-regulation. Next is a life skills group in which the children learn behavioral scripts (i.e., use your words) and self-regulation skill in a similar manner to The Hope Connection (Purvis, 2001; Purvis, 2003). In the afternoon, the children participate in three separate groups, including speech, art, and sensory groups, each aimed at improving sensory processing and self-regulation using the same interventions used in The Hope Connection (Purvis, 2001; Purvis, 2003). Throughout the camp day, children receive multiple breaks for nutrition and hydration and frequent opportunities for movement and physical activity to address sensory needs and self-regulation (Purvis, 2001; Purvis, 2003).

**Non-adopted children.** The non-adopted children in the family also participate in a similar camp schedule as the adopted children. This is a primary difference between The Hope Connection and Hope Connection 2.0, as non-adopted children did not participate in the original camp activities. Much of the intervention with non-adopted children is preliminary, as intervention has yet to be conducted with this population. These children also receive a buddy with whom they are partnered for all camp activities both weekends. The intended purpose of the buddy is to build connection and attend to the needs of the non-adopted child, who may not be receiving as much attention in the family system (Ward & Lewko, 1988; Phillips, 1999). They participate in the family nurture group alongside their adopted siblings, which intends to facilitate connection between family members in a playful

manner and improve family cohesion. Non-adopted children also participate in each of the sensory activities and the afternoon groups of speech, art, and sensory. The primary difference in schedule between adopted and non-adopted children is that non-adopted children participate in a separate life skills group from their adopted siblings. In this life skills group, non-adopted children discuss and process the experience of being adoptive siblings. They also learn ways of coping with the trauma and loss their family may have experienced associated with their adopted sibling's emotional and behavioral problems. After the life skills group, the non-adopted children have a one-on-one debrief time with their buddies during which they process the group and discuss the child's feelings further than what can be done in a group setting.

**Parents.** The adoptive parents have a separate schedule of events as part of their participation in Hope Connection 2.0. Prior to camp, parents have three weeks to complete online Trust-Based Relational Intervention® (TBRI®) pre-training, which is an attachment-based, trauma-informed intervention aimed at meeting the needs of adopted children. TBRI is an evidence-based practice for parent training according to the California Evidence-Based Clearinghouse for Child Welfare (CEBC, 2014). The specific pre-camp training involved in Hope Connection 2.0 includes watching three videos from the KPICD's *Healing Families* video series – *Attachment: Why it Matters*, *Children from Hard Places and the Brain*, and *Trust-Based Parenting*. Parents are required to answer questions about each video as part of the online training in effort to increase parents' understanding of their children's needs and begin developing skills to meet those needs. This is a new addition to Hope Connection 2.0 and is aimed at equipping parents with the skills necessary to care for their adopted children and their needs (Purvis et al., 2008).

During camp hours, parents receive additional training while their children are participating in camp activities. Additional parent training intends to teach parents how to use TBRI strategies to meet the unique needs of their adopted child and family system, which is an addition to the camp schedule from The Hope Connection (Purvis, 2001). Parents have multiple opportunities during their training to ask experts in the field questions about the specific needs of their children and families. Parents participate in family nurture group with their children on both Sundays of camp in effort to facilitate connection and cohesion between family members. Similar to The Hope Connection, parents observe the “crash-and-bump” course to learn ways of meeting the sensory needs of their children in the home (Purvis, 2001; Purvis, 2003). Parents are given two opportunities for respite during the camp hours for couples to spend time together, which may not often be possible for adoptive parents when their children’s needs are severe. Finally, parents are given TBRI resources (i.e. books, DVDs, and online training) to use at home and are expected to continue working with their respective TBRI Practitioners post-camp in effort to equip families to meet the long-term needs of their family system.

In summary, the pilot Hope Connection 2.0 therapeutic family camp occurred in fall 2018. This intervention intends to utilize trauma-informed, attachment-rich activities to meet the needs of each member of an adoptive family system. Particular attention will be paid to improving the trauma-related attachment and sensory processing deficits of the adopted children and improving the relationships within the family system.

### **Current Study**

The current study aims to examine the effectiveness and feasibility of the pilot Hope Connection 2.0 to improve emotional and behavioral problems in adopted children as well as

relationships within the family system. To evaluate improvements in emotional problems (i.e., anxiety, depression, and anger), behavioral problems (i.e., hyperactivity, conduct problems, and peer problems), and family relationships (i.e., cohesion and flexibility) data is collected for and compared across an intervention condition and a waitlist (i.e., comparison) condition.

The study aims to answer four research questions.

1. Compared to the waitlist condition, do adopted children who attend camp demonstrate a greater decrease in problem behavior (emotional problems, conduct problems, hyperactivity, and peer relationship problems) and clinical symptoms (anxiety, depression, and anger/aggression)? *Hypothesis 1: Adopted children in the intervention condition will exhibit greater improvements in anxiety, depression, anger, conduct problems, hyperactivity, and peer problems than adopted children in the waitlist condition.*
2. Compared to family members on the waitlist, do parents who attend camp demonstrate greater improvements in their relationships with the adopted child, and do siblings who attend camp demonstrate greater improvements in their relationships with the adopted child? *Hypothesis 2: Family members in the intervention condition will report greater improvements in relationship quality with the adopted child than family members in the waitlist condition.*
3. Compared to families on the waitlist, do families who attend camp demonstrate a greater improvement in family functioning? *Hypothesis 3: Families in the intervention condition will report greater improvements in family functioning than families in the waitlist condition.*

4. Is the Hope Connection 2.0 feasible for adoptive family participation? *Hypothesis 4: Families will report the schedule and expectations were feasible and easily manageable for their family to participate.*

## **Method**

### **Participants**

Study participants ( $n = 9$  families: 5 intervention, 4 waitlist) were recruited via TBRI Practitioners (child welfare professionals who have completed TBRI Practitioner training). The KPICD maintains a list of TBRI Practitioners and their respective cities and organizations where they practice. The KPICD sent an email and recruitment flyer, explaining the details of Hope Connection 2.0, and requested that willing practitioners forward the information to eligible clients. The sole medium for families to receive information about Hope Connection 2.0 was through a practitioner. Families must have been receiving services from a practitioner to be eligible to participate in Hope Connection 2.0. Preference was given to families who maintained involvement with their practitioner for a minimum of six months post-camp. This long-term involvement was encouraged to continue support for the family as they implemented new strategies in their home.

Inclusion criteria were: families had at least one adopted child who is between 6 and 9 years old by the first camp date; the adopted child would have lived in the home for at least one year prior to the first day of camp; all members of the family system living in the home agreed to participate in assessments and camp activities. Exclusion criteria were: families with children who had severe emotional/behavioral problems that may pose a threat to caregivers, self, or others; families who could not commit all members of the family living at home to attend both weekends of camp; and families that were unwilling to sign consents for

research participation and media releases for videography and photography during camp weekends.

In total eleven families completed their family application by the deadline: one family removed themselves due to beginning a new intensive intervention at the same time and another family was unwilling to sign the media release forms for camp participation. With the two who were removed, the sample included 9 families. These families received official notice of acceptance in September, one month prior to baseline. A final family was added to the waitlist condition in October so that 5 families were in the intervention condition and 5 families were in the waitlist condition, but due to missing the first data collection period, their data were not analyzed for the purposes of this study.

The final study sample included 9 families: 5 families in the intervention condition and 4 families in the waitlist condition. In both conditions, 1 family was a single-parent household and the other families were two-parent households. The mean age of parents was 41.6 years in the intervention condition and 42.0 years in the waitlist condition. The mean number of children in each family was 2.6 children (range: 1-4 children) in the intervention condition and 2.5 children (range: 1-3 children) in the waitlist condition.

There were a total of 13 children (7 biological, 6 adopted) in the intervention condition and 10 children (3 biological, 7 adopted) in the waitlist condition. The mean age of biological children was 12.6 years (range: 7-19 years) in the intervention condition and 12.0 years (range: 11-13 years) in the waitlist condition. The mean age of adopted children was 8.2 years (range: 7-11 years) in the intervention condition and 8.1 years (range: 2-17 years) in the waitlist condition. Of the adopted children in the intervention condition, all were adopted through foster care and none were adopted internationally. Of the adopted children

in the waitlist condition, 6 children were adopted through foster care and 1 child was adopted internationally. All children adopted from foster care in both conditions had either documented or suspected prenatal drug exposure. The adopted children had been officially adopted for a mean of 4.35 years (range: 13 months-8 years) in the intervention condition and 2.92 years (range: 1 year-5.5 years) in the waitlist condition. The adopted children came home at a mean age of 3.7 years (range: 6 weeks-7 years) in the intervention condition and 5.9 years (range: 8 months-15 years) in the waitlist condition.

### **Procedure**

Data collection included four waves or time points (T0, T1, T2, and T3) for both the intervention and waitlist conditions (see Appendix A for diagram). Data were collected via confidential online surveys, pencil and paper assessments, and follow-up interviews.

Families in both conditions completed data collection activities during the same periods of time. The following is a brief summary of data collection in chronological order. A more detailed description of procedures at each time point is subsequently provided.

Families who were interested in attending camp and participating in the study were invited to apply via an online survey (T0). Demographic data from families meeting the criteria to participate and consenting to participate in the study were retained for future analysis. At T1 and T3, participants in both conditions completed an assessment packet, which consisted of assessments measuring (a) the emotional and behavioral problems in adopted children, (b) the relationship quality between family members and the adopted child, and (c) the overall relationship within the family system. The intervention condition also completed an online survey at T2 and T3 to assess the use of specific TBRI strategies in the home as well as a follow-up phone interview at T3. Paper assessments were mailed to the

families' provided address with franked envelopes with the research team's mailing address pre-populated. Families were asked to use the included envelopes to return the completed assessments to the research team. The link to the online surveys was e-mailed to the primary contact within all families. Families had a two-week period to complete assessments during each data collection period; they received an email reminder one week prior to the deadline to complete and return the assessments.

**T0 (July 30-August 20).** The KPICD maintains a list of TBRI Practitioners and their respective cities and organizations where they practice clinically. For the purposes of this project, the KPICD created an abbreviated list of TBRI Practitioners within 120-mile radius of TCU's campus. The KPICD sent an email and recruitment flyer, explaining the details of Hope Connection 2.0, and requested that willing Practitioners forward the information to eligible clients.

Interested families completed the online application. The online application included demographic questions, questions about each family member and their history, and questions about the family's goals for camp participation. Inclusion and exclusion criteria were included in the application. Eligible families included those with an adopted child who was between the ages of 6 and 9 years by October 26, 2018, and had lived in the home for at least one year. All members of the family living at home were willing and able to participate in camp and research activities. Families were willing to be filmed and photographed during both camp weekends. Parents were willing to complete a criminal background check and online pre-training prior to camp attendance. The cost of participation was \$495 per family. The fee included all camp materials, meals and snacks during camp, online parent training, TBRI materials, and access to TBRI 101<sup>®</sup>, an online self-paced training, after the research

study. Scholarships were available for families who were unable to pay the fee. Exclusion criteria included families with children who had severe emotional and behavioral problems that posed a threat to caregivers, self, or others. Families who could not commit to all aspects of the research study or commit to attending both weekends of camp were not be eligible to participate.

After the application deadline, the KPICD reviewed the online applications and created a list of eligible families. These eligible families received an emailed link to consent forms for each member 18 years and older and online assent forms for each minor to be signed electronically. Then, phone interview screening of eligible families were completed. Phone interviews were approximately 20 minutes and consisted of clarifying questions about the family's online application answers. The interview also consisted of detailed explanation of the research protocol and expectations of participation in the research study. Families had the opportunity to choose whether they did not wish to participate.

When the phone screenings were completed and families were determined to meet the eligibility criteria, the KPICD selected 9 eligible families; five families to participate in the fall 2018 cohort (intervention condition) and four families to participate in the spring 2019 cohort (waitlist condition), based on the family's cohort preference listed on their application. Families were notified of their acceptance into the program and their respective cohort assignment on September 10, 2018.

**T1 (September 12-26).** Families in the intervention and waitlist condition completed the assessment packet and returned it to the KPICD. Parents completed measures about the emotional and behavioral problems of their adopted children and the relationship quality between them and their adopted child (i.e., SDQ, TSCYC, and PRQ). Non-adopted children

completed a measure about their relationship with their adopted sibling (i.e., SRQ). All members of the family system completed a measure about the overall family relationship (i.e., FACES IV). Families returned the completed assessments to the KPICD by mail using the pre-paid envelope provided. This data collection period served as the baseline for families pre-intervention.

**Online parent pre-training (September 28-October 22).** Parents in the intervention condition completed online parent TBRI pre-training. Pre-training involved watching three DVDs, *Children from Hard Places and the Brain* (KPICD, 2014), *Trust-Based Parenting* (KPICD, 2011), and *Attachment: Why it Matters* (KPICD, 2012). Parents completed study guide questions about the videos via an online survey. This pre-training was self-paced and took an average of 8-10 hours to complete. The waitlist condition did not participate in training at this time.

**Camp weekend 1 (October 26-28).** Families in the intervention condition arrived at TCU for the first weekend of Hope Connection 2.0. Participation included camp activities for a total of 15 hours (see Appendix B for Hope Connection 2.0 camp schedule). All children were paired with a “buddy,” who was an undergraduate student in TCU’s child development major or minor academic program. This buddy participated in all activities with their assigned child. Activities included sensory-rich, attachment-rich exercises designed to reduce trauma-related deficits in attachment, sensory processing, and self-regulation. Parents received a total of 9 hours of in-person parent training during camp activities. Parent training involved an overview of TBRI and specific strategies to assist each family with their identified stressors. Parents participated with children during some camp

activities and had one opportunity for respite during the remaining hours of the total 15 hours of camp. The waitlist condition did not participate in any camp activities at that time.

**T2 (October 29-November 5).** Parents in the intervention condition completed an online survey to determine the level of use of specific TBRI strategies in the home. The waitlist condition did not have activities to complete during this time.

**Camp weekend 2 (November 9-11).** Families in the intervention condition returned to TCU for the second weekend of Hope Connection 2.0. Participation included camp activities for a total of 15 hours with a similar schedule as the first camp weekend (see Appendix B). All children were paired with their same “buddy” from the first weekend. This buddy participated in all activities with their assigned child. Activities included sensory-rich, attachment-rich exercises designed to continue reducing trauma-related attachment, sensory processing, and self-regulation. Parents received a total of 8 hours of in-person parent training during camp activities. Parent training involved specific strategies to assist each family with their identified stressors. Parents participated with children during some camp activities and had one opportunity for respite during the remaining hours of the total 15 hours of camp. The waitlist condition did not participate in any camp activities.

**T3 (November 16-30).** Families in the intervention and waitlist condition completed the same assessment packet from T1. Parents completed measures about the emotional and behavioral problems of their adopted children and the relationship quality between them and their adopted child (i.e., SDQ, TSCYC, and PRQ). Non-adopted children completed a measure about their relationship with their adopted sibling (i.e., SRQ). All members of the family system completed a measure about the overall family relationship (i.e., FACES IV). Families returned the completed assessments to the KPICD by mail using the pre-paid

envelope provided. This data collection period provided the post-intervention data necessary to determine if there were short-term changes from pre- to post-intervention. Parents in the intervention condition also completed the online TBRI survey and a 10-20 minute follow-up phone interview. The parents were contacted during the data collection period and were asked to select a 30-minute window of time for a follow-up interview. The interview was conducted by a member of the research team who had no contact with the camp families prior to the interview.

## **Measures**

**Demographic questionnaire.** Background data is obtained from the online application families completed two months prior to camp. This questionnaire includes questions about family demographics (names, birthdates, ages, contact information, biological/adopted classification of children) and family goals, strengths, and challenges. Specific demographic questions about each child in the family are also included (trauma history, medical history, presenting emotional and behavioral problems, history of harm to self or others, and child's specific strengths, challenges, and goals for camp participation). The demographic information serves as descriptive data.

**Trauma Symptom Checklist for Young Children (TSCYC).** The TSCYC is a reliable measure of trauma symptoms in children (Briere et al., 2001). This measure is completed via parent report for each adopted child in the family system at T1 and T3. The TSCYC is a 90-item parent-report measure for children ages 3-12 years and includes eight clinical scales: anxiety, depression, anger/aggression, posttraumatic stress-intrusion, posttraumatic stress-avoidance, posttraumatic stress-arousal, dissociation, and sexual concerns. Parents indicate how often their adopted child has done each item on a 4-point

Likert scale ('1' *not at all*, '2' *sometimes*, '3' *often*, and '4' *very often*) (Briere et al., 2001). For the purposes of this study, the following subscales are of particular interest due to prevalence of these emotional problems among adopted children (Elovainio, et al., 2018).

The anxiety subscale ( $\alpha = .86$ ; Briere, 2005) assesses the level of observed fear and worry in the child. Example items include "being afraid to be alone" and "being easily scared." The depression subscale ( $\alpha = .84$ ; Briere, 2005) assesses the feelings, thoughts, and behaviors associated with depression. Example items include "crying for no obvious reason" and "acting sad or depressed." The anger subscale ( $\alpha = .91$ ; Briere, 2005) assesses the level of observed anger and aggression in the child. Example items include "temper tantrums" and "getting into physical fights."

**Strengths and Difficulties Questionnaire (SDQ).** The SDQ is a 25-item questionnaire about child behavior for children aged 3-16 years (Goodman, 1997). This measure is completed via parent report for each adopted child in the family system at T1 and T3. The SDQ includes five subscales (emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior) and a total difficulties score. Parents rate how often their child does each item on a 3-point Likert scale ('0' *not true*, '1' *somewhat true*, and '2' *certainly true*). For the purposes of this study, the following subscales are of particular interest due to prevalence of these emotional and behavioral problems among adopted children (Elovainio, et al., 2018).

The emotional symptoms subscale ( $\alpha = .70$ ; Muris, Meesters, & van der Berg, 2003) assesses the emotional attributes of anxiety, depression, and somatic symptoms of the child. Sample items include "many worries or often seems worried" and "nervous or clingy in new situations, easily loses confidence." The conduct problems subscale ( $\alpha = .55$ ; Muris et al.,

2003) assesses the behaviors, including lying, stealing, and fighting, of the child. Sample items include “often has temper tantrums or hot tempers” and “steals from home, school, or elsewhere.” The hyperactivity subscale ( $\alpha = .78$ ; Muris et al., 2003) examines the hyperactivity and impulsivity of the child. Example items include “restless, overactive, cannot stay still for long” and “easily distracted, concentration wanders.” The peer problems subscale ( $\alpha = .66$ ; Muris et al., 2003) examines the peer-related social skills of the child. Example items include “rather solitary, tends to play alone” and “has at least one good friend.”

**Parenting Relationship Questionnaire (PRQ).** The PRQ is a measure of the parent-child relationship to assess factors that influence the development of a healthy child (Kamphaus & Reynolds, 2006). Each parent completes this measure based on their relationship with their adopted child at T1 and T3. This 71-item measure is completed via parent report and is valid for parents with children aged 6-18 years. It includes scales of attachment, communication, discipline practices, involvement, parenting confidence, satisfaction with school, and relational frustration (alpha values for all scales are at or above .82; Kamphaus & Reynolds, 2006). Norms broken down by age are given for each of the subscales for both mother and father report. Scores below the norms are considered to be reflective of relationship problems and the necessity of family intervention. The PRQ has been found to be both a reliable and valid measure of parent-child relationship factors (Kamphaus & Reynolds, 2006). Parents indicate how often they do each item with their child on a 4-point Likert scale (‘0’ *never*, ‘1’ *sometimes*, ‘2’ *often*, and ‘3’ *almost always*). For the purposes of this research study in examining the relationships between the adopted

child's trauma-related emotional and behavioral problems and the parent-child relationship, the following subscales were examined.

The attachment subscale measures how well the parent can assess their child's thoughts and feelings and the parent's ability to comfort the child when distressed. Example items include "I can sense my child's moods" and "when my child is upset, I can calm him or her." The communication subscale assesses the amount and quality of communication between parent and child. Example items include "I listen to what my child has to say" and "my child tells me about the things that he or she is doing with friends." The parenting confidence subscale measures the parent's level of confidence and comfort in caring for their child. Example items include "I know how my child will react in most situations" and "It is easy for me to make decisions about what my child should do." The relational frustration subscale examines the amount of stress and frustration the parent experiences while parenting. Example items include "I remain calm when dealing with my child's misbehavior" and "My child and I get into heated arguments."

**Sibling Relationship Questionnaire (SRQ).** The SRQ is a measure of the quality of the sibling relationship (Furman & Buhrmester, 1985). Non-adopted children, aged 9 years and older, in the family complete this measure based on their relationship with the adopted child at T1 and T3. The SRQ is a 72-item measure with three subscales, including warmth/closeness, conflict, and relative status/power. Research on the SRQ has demonstrated its reliability and validity (Derkman, Scholte, Van der Veld, & Engels, 2010). Non-adopted children respond how often each item occurs based on a 5-point Likert scale, ranging from '1' (*hardly at all*) to '5' (*extremely much*). For the purposes of measuring how

the trauma-related emotional and behavioral problems of the adopted child affect the relationship with the non-adopted child, the following subscales were examined.

The warmth/closeness subscale ( $\alpha = .94$ ; Derkman et al., 2010) consists of seven underlying relationship qualities, including intimacy, prosocial behavior, companionship, affection, similarity, admiration of the sibling, and admiration by the sibling. An example item is “How much do you and your sibling do nice things for each other?” The conflict subscale ( $\alpha = .93$ ; Derkman et al., 2010) consists of three underlying relationship qualities, including quarreling, antagonism, and competition. An example of an item is “how much do you and this sibling disagree and quarrel with each other?”

**Family Adaptability and Cohesion Scale IV (FACES IV).** The FACES IV is a 62-item measure of family cohesion, adaptability, communication, and satisfaction (Olson, 2000). This measure is completed by each family member 12 years old and older at T1 and T3. The FACES IV is comprised of six subscales – cohesion, flexibility, disengaged, enmeshment, rigidity, chaos – that measure the dimensions of cohesion and flexibility and two additional scales of satisfaction and communication. Family members indicate their agreement with each statement on a 5-point Likert scale (‘1’ *strongly disagree*, ‘2’ *generally disagree*, ‘3’ *undecided*, ‘4’ *generally agree*, and ‘5’ *strongly agree*). The FACES IV is a reliable and valid measure of family functioning (Olson, 2011).

The cohesion scale ( $\alpha = .89$ ; Olson, 2011) examines the emotional bond between family members within a family system. Example items include “family members are involved in each other’s lives” and “family members feel very close to each other.” The flexibility scale ( $\alpha = .84$ ; Olson, 2011) assesses the quality and expression of leadership and organization within the family system as well as the role relationships and rules of the family

system. Example items include “when problems arise, we compromise” and “we have clear rules and roles in our family.” The satisfaction subscale ( $\alpha = .92$ ; Olson, 2010) examines the degree to which family members feel happy and fulfilled within the family system. Example items include satisfaction with “the degree of closeness between family members” and “the way problems are discussed.” The communication subscale ( $\alpha = .90$ ; Olson & Barnes, 2010) examines the quantity and quality of communication within the family system. Example items include “family members try to understand each other’s feelings” and “family members can calmly discuss problems with each other.”

**TBRI at Home Survey.** This measure is an online survey adapted for this project from TBRI strategy use measures used for previous KPICD research studies that measures how often parents utilize specific TBRI strategies with their children. Parents in the intervention condition complete the survey at T2 and T3. Each specific TBRI strategy (i.e. redos, IDEAL response, and life value terms) is listed and parents are asked to rate how often they currently use each strategy on a 5-point Likert scale: *never (1), some of the time (2), half of the time (3), most of the time (4), always (5)*.

**Follow-Up Interviews.** The follow-up interview consists of 13 questions about the family’s functioning two weeks post-camp and the feasibility of the camp format for each specific family. The interview was scheduled during T3 with the parents in the intervention condition. A member of the research team who had no previous experience with the participants completed the interviews. The interviews were audio-recorded and then transcribed. Transcriptions were analyzed for themes and patterns in participants’ responses in the intervention condition.

## Results

Pre- and post-camp data collection occurred for both the waitlist and intervention conditions to determine any changes in the adopted child behavior, the parent-adopted child relationship, the sibling-adopted child relationship, and the overall adoptive family functioning. General trends of each of the assessments pre- and post-camp for both the intervention and waitlist conditions are below. Assessment results are organized based on the research question the data address.

### Child Behavior

**Trauma Symptom Checklist for Young Children (TSCYC).** The TSCYC was used to assess changes in trauma-related emotional and behavioral problems in adopted children between 6-12 years via parent report. Adopted children ( $n = 6$ ) in the intervention condition demonstrated reduced anxiety with parents reporting a mean  $t$ -score of 62.8 pre-camp and 60.8 post-camp whereas adopted children in the waitlist condition ( $n = 5$ ) demonstrated increased anxiety from a mean  $t$ -score of 62.0 pre-camp and 65.4 post-camp (see Table 1). The intervention condition also reported reduced mean depression  $t$ -scores of 64.7 pre-camp to 59.1 post-camp whereas the waitlist condition reported a consistent mean depression  $t$ -score of 53.4 pre-camp and 53.2 post-camp. Anger/aggression mean  $t$ -scores were reduced for the intervention condition from 72.3 pre-camp to 65.8 post-camp whereas it decreased slightly for the waitlist condition, reporting 62.0 pre-camp and 60.0 post-camp.

Table 1

*General trends of trauma-related emotional and behavioral problems (i.e. anxiety, depression, and aggression) as measured by the TSCYC from pre-camp to post-camp for both the intervention (n = 6) and waitlist (n = 5) conditions.*

Subscale	Pre-Camp <i>M (SD)</i>	Post-Camp <i>M (SD)</i>	Pre-Waitlist <i>M (SD)</i>	Post-Waitlist <i>M (SD)</i>
Anxiety	62.8 (8.8)	60.8 (14.9)	62.0 (4.4)	65.4 (8.7)
Depression	64.7 (10.9)	59.1 (8.0)	53.4 (9.9)	53.2 (7.4)
Aggression	72.3 (22.1)	65.8 (15.4)	62.0 (8.3)	60.0 (9.4)

**Strengths and Difficulties Questionnaire (SDQ).** The SDQ was used to assess changes in emotional and behavioral problems for all adopted children between 6-17 years via parent report. There were no differences in mean SDQ scores from pre- to post-camp for adopted children in either the intervention ( $n = 6$ ) or waitlist conditions ( $n = 6$ )(see Table 2). Emotional problem mean scores remained the same for the intervention condition (4.0 pre-camp to 4.3 post-camp) and the waitlist condition (3.3 pre-camp to 3.2 post-camp). Conduct problem mean scores remained the same for the intervention condition (5.2 pre-camp to 5.2 post-camp) and for the waitlist condition (4.7 pre-camp to 4.7 post-camp). Hyperactivity mean scores increased slightly for the intervention condition (7.5 pre-camp to 8.2 post-camp) and remained constant for the waitlist condition (6.5 pre-camp to 6.3 post-camp). Peer problems mean scores decreased for the adopted children in the intervention condition (4.2 pre-camp to 3.0 post-camp) and remained constant for the waitlist condition (3.2 pre-camp to 3.3 post-camp).

Table 2

*General trends of in trauma-related emotional and behavioral problems (i.e. emotional problems, conduct problems, hyperactivity, and peer problems) as measured by the SDQ from pre-camp to post-camp for both the intervention (n = 6) and waitlist (n = 6) conditions.*

	Pre-Camp <i>M (SD)</i>	Post-Camp <i>M (SD)</i>	Pre-Waitlist <i>M (SD)</i>	Post-Waitlist <i>M (SD)</i>
Subscale				
Emotional Problems	4.0 (1.6)	4.3 (1.9)	3.3 (2.3)	3.2 (1.3)
Conduct Problems	5.2 (2.1)	5.2 (2.4)	4.7 (1.9)	4.7 (2.5)
Hyperactivity	7.5 (1.1)	8.2 (2.1)	6.5 (3.1)	6.3 (3.3)
Peer Problems	4.2 (1.4)	3.0 (1.8)	3.2 (1.6)	3.3 (2.4)

In their follow-up interviews after camp, each of the five families in the intervention condition were asked to discuss their progress on their goals listed on their family application. All five families had at least one goal of improving self-regulation behavior in their adopted children. Each of the families noted progress in meeting this goal, stating that their children are using calming strategies, de-escalating before meltdowns, trying to stay calmer, or learning self-control since attending camp.

### **Dyadic Relationships**

**Parenting Relationship Questionnaire (PRQ).** All parents in the intervention and waitlist conditions completed the PRQ for each of their adopted children to assess changes in the parent-adopted child relationship. Parents in the intervention condition ( $n = 11$ ) reported increased attachment from a mean  $t$ -score of 28.8 pre-camp to 34.5 post-camp, increased communication from 30.7 pre-camp to 33.1 post-camp, and increased parenting confidence from 30.4 pre-camp to 33.3 post-camp (see Table 3). Parents in the waitlist condition ( $n = 10$ ) reported slightly decreased attachment from a mean  $t$ -score of 34.8 pre-camp to 33.9

post-camp, decreased communication from 33.8 pre-camp to 31.2 post-camp, and consistent parenting confidence from 41.6 pre-camp to 41.2 post-camp. Parents in the intervention condition reported decreased relational frustration from a mean *t*-score of 71.4 pre-camp to 68.1 post-camp. Parents in the waitlist condition reported slightly increased relational frustration from a mean *t*-score of 62.0 pre-camp to 63.4 post-camp.

Table 3

*General trends of in the parent-adopted child relationship (i.e. attachment, communication, parenting confidence, and relational frustration) as measured by the PRQ from pre-camp to post-camp for both the intervention (n = 11) and waitlist (n = 10) conditions.*

Subscale	Pre-Camp <i>M (SD)</i>	Post-Camp <i>M (SD)</i>	Pre-Waitlist <i>M (SD)</i>	Post-Waitlist <i>M (SD)</i>
Attachment	28.8 (9.9)	34.5 (9.7)	34.8 (7.3)	33.9 (3.7)
Communication	30.7 (8.1)	33.1 (9.1)	33.8 (8.3)	31.2 (6.6)
Parenting Confidence	30.4 (8.6)	33.3 (9.1)	41.6 (4.2)	41.2 (6.3)
Relational Frustration	71.4 (9.6)	68.1 (8.9)	62.0 (8.2)	63.4 (7.8)

**Sibling Relationship Questionnaire (SRQ).** The SRQ was completed by all biological children in the family who were 9 years and older. There were no reported differences in biological children’s relationship with their adopted sibling (see Table 4). The intervention condition (*n* = 6) reported warmth/closeness mean scores of 3.3 pre-camp and 3.3 post-camp whereas the waitlist condition (*n* = 3) reported mean scores of 3.0 pre-camp and 3.2 post-camp. For the conflict subscale, the intervention condition reported conflict mean scores of 2.4 pre-camp and 2.7 post-camp whereas the waitlist condition reported 3.0 pre-camp and 2.1 post-camp. When looked at more closely, the decrease in conflict and

slight increase in warmth/closeness in the waitlist condition is a result of one child reporting significant changes in their relationship with their sibling.

Table 4

*General trends of in the sibling-adopted child relationship (i.e. warmth/closeness and conflict) as measured by the SRQ from pre-camp to post-camp for both the intervention (n = 6) and waitlist (n = 3) conditions.*

Subscale	Pre-Camp <i>M (SD)</i>	Post-Camp <i>M (SD)</i>	Pre-Waitlist <i>M (SD)</i>	Post-Waitlist <i>M (SD)</i>
Warmth/Closeness	3.3 (0.5)	3.3 (0.6)	3.0 (0.5)	3.2 (0.6)
Conflict	2.4 (0.9)	2.7 (1.0)	3.0 (1.0)	2.1 (0.5)

In the follow-up interviews after camp, when asked the question, “what has gone well in your family since participating in camp?”, three out of the five families stated that the parents have improved connection with their children since attending camp. Three of the families also noted that the parents feel “empowered” to use the TBRI strategies and feel more confident in parenting their children since attending camp. When asked what the biggest difference in the family is since participating in camp, two families mentioned improved communication, two families mentioned improved connection, and one family mentioned improved parenting confidence. For the sibling relationships, parents stated that the non-adopted children have learned more about their emotions, how they have been affected by adoption, and how to communicate their feelings since attending camp.

### **Overall Family Functioning**

**Family Adaptability and Cohesion Scale IV (FACES IV).** FACES IV was used to assess any changes in the overall family functioning pre and post-camp. All family members 11 years and older completed this assessment. Cohesion scores remained consistent for the

intervention condition ( $n = 14$ ) from mean percentile scores of 68.9% pre-camp to 68.8% post-camp whereas cohesion mean scores decreased for the waitlist condition ( $n = 9$ ) from 59.4% pre-camp to 56.1% post-camp (see Table 5). Flexibility mean percentile scores remained consistent for both the intervention condition (48.1% pre-camp to 48.5% post-camp) and the waitlist condition (48.1% pre-camp to 48.6% post-camp). The family communication mean percentile score increased for the intervention condition from 44.8% pre-camp to 53.1% post-camp and slightly for the waitlist condition from 40.9% pre-camp to 43.8% post-camp. The family satisfaction mean percentile score increased for the intervention condition from 35.9% pre-camp to 41.4% post-camp and decreased slightly for the waitlist condition from 22.8% pre-camp to 19.9% post-camp.

Table 5

*General trends of in the overall family functioning (i.e. cohesion, flexibility, communication, and satisfaction) as measured by the FACES IV from pre-camp to post-camp for both the intervention ( $n = 14$ ) and waitlist ( $n = 9$ ) conditions.*

Subscale	Pre-Camp <i>M (SD)</i>	Post-Camp <i>M (SD)</i>	Pre-Waitlist <i>M (SD)</i>	Post-Waitlist <i>M (SD)</i>
Cohesion	68.9 (13.5)	68.8 (14.0)	59.4 (16.5)	56.1 (19.4)
Flexibility	48.1 (12.5)	48.5 (12.3)	48.1 (17.0)	48.6 (15.8)
Communication	44.8 (29.4)	53.1 (27.5)	40.9 (22.5)	43.8 (21.9)
Satisfaction	35.9 (32.3)	41.4 (30.6)	22.8 (12.3)	19.9 (10.3)

**TBRI at Home Survey.** The TBRI at Home Survey assessed parents' use of TBRI strategies in the home. Parents in the intervention condition ( $n = 9$ ) reported increased use of the TBRI principles from between camp weekends to post-camp (see Table 6). From between camp to post-camp, parents reported an increased use of empowering principles (3.2

pre-camp to 3.7 post-camp), connecting principles (3.2 pre-camp to 3.8 post-camp), and correcting principles (2.9 pre-camp to 3.5 post-camp).

Table 6

*Changes in the use of TBRI principles (i.e. connecting, empowering, and correcting) as measured by the TBRI at Home Survey from pre-camp to post-camp for the intervention condition (n = 9).*

Symptom	Pre-Camp <i>M (SD)</i>	Post-Camp <i>M (SD)</i>
Empowering	3.2 (0.5)	3.7 (0.4)
Connecting	3.2 (0.4)	3.8 (0.4)
Correcting	2.9 (0.4)	3.5 (0.2)

The data from follow-up interviews revealed improved communication in four of the five families since attending camp, stating that they now have a common language. In discussing their goals that were made before camp, four of the five families had made goals to improve family connection and each of the families stated that their family connection has improved since attending camp.

**Feasibility.** Data from the follow-up interviews was transcribed and coded. Families were asked, “How feasible was the two-weekend schedule for you and your family?”, and each of the five families stated that the schedule was feasible for their family and it was not difficult to participate in camp during the weekends. Then families were asked, “Was it difficult to complete all the research?”, and three of the five families stated that it was difficult but it was due to personal circumstances (i.e., a death in the family and online graduate program), not the expectations. The other two families stated that it was not difficult to complete the research. In response to the question, “Was there anything that

made it difficult for your family to participate?”, all of the families stated that there was not anything that made it difficult for them to participate. The final question about feasibility was if there was anything that would have made it easier for their family to participate, and four of the five families stated that there was nothing that would have made it easier, as it was already easy for them to participate. One family noted that having a few more weeks for online parent pre-training prior to attending camp would have been helpful.

### **Discussion**

Children who are adopted often experience early-life trauma, including neglect, abuse, institutional care, multiple placements, and prenatal trauma (Tregeagle, Moggach, Trivedi, & Ward, 2019). These experiences can disrupt development and cause deficits in attachment (van den Dries, et al., 2009) and sensory processing (Wilbarger, et al., 2010), which manifest by self-regulation issues (Juffer et al., 2011). Issues with self-regulation can lead to trauma-related emotional and behavioral problems (Juffer et al., 2005), such as anxiety, anger, depression, peer problems, attention problems, and aggressiveness (Brown, et al., 2017). In order to combat some of these trauma-related emotional and behavioral problems in adopted children, the Hope Connection<sup>®</sup> camp was created to address the effects of early-life trauma. Results of Hope Connection demonstrated the intervention’s effectiveness in addressing these effects (Purvis, et al., 2008). However, this intervention only targeted the adopted child without addressing the effects of these trauma-related emotional and behavioral problems on the family system, and due to the intensity of the intervention, Hope Connection was not feasible for working families. To address these limitations, Hope Connection 2.0 was created as a therapeutic camp intervention for adoptive families.

The current study aimed to examine the effectiveness and feasibility of Hope Connection 2.0 in improving the trauma-related emotional and behavioral problems of adopted children as well as the relationships within the adoptive family system. There were four primary hypotheses in this study aimed at examining changes in adopted child trauma-related emotional and behavioral problems, changes in dyadic relationships with the adopted child, changes in the overall family functioning, and the feasibility of the intervention for family participation. The results of the study revealed reduction in some trauma-related emotional and behavioral problems in adopted children, improvements in the parent-adopted child relationships, improvements in overall family functioning, and feasibility of the camp structure for family participation.

The first hypothesis was that adopted children in the intervention condition would exhibit greater improvements in anxiety, depression, anger, conduct problems, hyperactivity, and peer problems than adopted children in the waitlist condition. The results revealed that trauma-related anxiety, depression, and anger/aggression improved for adopted children in the intervention condition but remained consistent or worsened for the waitlist condition. Parents reported a reduction in peer problems in adopted children in the intervention condition. Peer problems remained consistent for adopted children in the waitlist condition. However, there were no reported changes in emotional problems, conduct problems, or hyperactivity for adopted children in the intervention or waitlist condition. Additionally, during the follow-up interviews two weeks post-camp, each of the parents in the intervention condition reported improved behavior in their adopted children after attending camp. Specifically, there were reported improvements in self-regulation and self-control. The hypothesis that adopted children's trauma-related emotional and behavioral problems would

improve after attending camp was partially supported in that depression, anxiety, anger/aggression, and peer problems improved for adopted children in the intervention condition, but there were no reported changes in emotional problems, conduct problems, and hyperactivity.

The second hypothesis stated that family members in the intervention condition would report greater improvements in relationship quality with the adopted child than family members in the waitlist condition. To address this hypothesis, the current study examined changes in the parent-adopted child relationship and changes in the non-adopted child and adopted child sibling relationship. In the parent-adopted child relationships, the results revealed improvement in attachment, communication, parenting confidence, and relational frustration in families in the intervention condition whereas parents in the waitlist condition reported a decline in these variables. According to the follow-up interviews two weeks post-camp, families in the intervention condition reported improved connection with their adopted children, improved communication, and improved parenting confidence since attending camp. The hypothesis that Hope Connection 2.0 would report improvements in the relationship quality between the parent and the adopted child was supported.

The hypothesis that Hope Connection 2.0 would report improvements in the sibling relationship quality between the non-adopted child and the adopted child was not supported by the results of this study. There were no reported changes in warmth/closeness or conflict in the sibling-adopted child relationship for the intervention condition. There were slight improvements in conflict for the waitlist condition, but when examined more closely, these changes were reflected by one child's extreme differences in reporting from the first to the second data collection period. After further examination of the way in which the intervention

impacted the non-adopted children in the family system, these results are consistent with what was experienced at camp. Changes to the way in which the intervention's effectiveness for non-adopted children are addressed in the section on future directions of this research.

The third hypothesis was that families in the intervention condition would report greater improvements in family functioning than families in the waitlist condition. According to the results, family cohesion and flexibility remained consistent, but communication and satisfaction increased for families in the intervention condition. For the waitlist condition family cohesion decreased, flexibility remained consistent, communication increased slightly, and satisfaction decreased slightly. Of families who were in the intervention condition, four of the five families stated in their follow-up interviews that family communication and family connection have improved since attending camp. The hypothesis that family functioning would improve for families who attended Hope Connection 2.0 was partially supported, as some measures of family functioning did demonstrate improvements for the intervention condition while others did not show these same improvements.

The final hypothesis was that families would report the schedule and expectations were feasible and easily manageable for their family to participate. According to the follow-up interviews, parents in the intervention condition stated that the camp schedule was feasible, it was easy for their family to participate, and there were no suggestions for ways to improve the feasibility of camp for families. This hypothesis was supported by the results of the follow-up interviews two weeks after camp participation.

The results of Hope Connection 2.0 revealed the intervention's effectiveness in reducing some trauma-related emotional and behavioral problems, improving the parent-

adopted child, relationship, and improving communication and satisfaction in adoptive families. The intervention also was found to be a feasible intervention for adoptive family participation. However, there were some trauma-related emotional and behavioral problems and a few aspects of relationships within adoptive families that did not improve. There are two reasons that may explain why the findings of the current study only partially supported the hypotheses in this study. The first reason is that families already had experience with TBRI and were using it in their homes to parent their adopted children prior to participating in Hope Connection 2.0. All families were working with a counselor who is trained in TBRI, and most families had watched videos about TBRI or attended TBRI conferences. The second reason is that the schedule of Hope Connection 2.0 is much shorter than the original model, which means the primary emphasis shifted to equipping parents to implement TBRI at home rather than on creating those changes during camp activities. Both reasons are explained further in the following paragraphs.

Previous studies examining the effectiveness of TBRI were conducted with participants who did not have any experience with the intervention prior to participating in the study. Whether participants attended Hope Connection or caregiver training, they first learned about TBRI and experienced it during participation in the study. The newness of TBRI for these participants allowed for the true effectiveness of the intervention to be tracked from pre- to post-intervention. However, in the current study, participants were recruited through counselors trained in TBRI, meaning that participants were already receiving TBRI training from their counselors. Each of the families who participated in the intervention were already attempting to implement

TBRI in their homes with some reported success. The reason for this type of recruitment was so that participants could continue receiving support from a counselor trained in TBRI post-camp in effort to continue learning how to best implement it in their homes. Because participants were already familiar with TBRI and using it in their homes prior to participating in the current study, any reductions in trauma-related emotional and behavioral problems may not be as significant in the current study. Changes would most likely not be as drastic, as families were already exposed to and using TBRI previously.

Additionally, the focus of the original camp model was in the therapeutic work that was done with children during the two or three weeks that children participated in camp, which is different from the current model. Children received therapeutic intervention from buddies and staff during camp with the intention that the camp experience would lead to long-term improvements in the children's trauma-related issues. In this revised model, the primary emphasis is no longer on the therapeutic work done at camp but rather on parents becoming equipped to continue the use of TBRI® at home via parent training during the camp weekends. This change in emphasis is due to the difference in time commitments for the two versions of Hope Connection: the original model involved 2-3 weeks of intervention and the current model is a much shorter schedule that involves two weekends of intervention. This shift in emphasis may result in less immediate improvements in trauma-related emotional and behavioral problems. The results of the original Hope Connection examined the effects of two or three weeks of therapeutic intervention on the adopted child. However, because children are not receiving as extensive of an intervention during camp, examination of Hope Connection 2.0's effectiveness may be more primarily examining parents'

implementation of TBRI in their homes. This, understandably, may not result in as markedly improved outcomes just two weeks after camp, as was found in the original model, but instead, may result in greater improvements several months after camp.

This pilot study examined the effectiveness of a therapeutic camp intervention in a population who was already familiar with TBRI and it was done in a much more limited timeframe than what has been previously researched. Both reasons may be necessary to consider when comparing the results of the current study with previous literature.

While these results are preliminary, they are consistent with research on the original Hope Connection therapeutic camp that addressed the trauma-related emotional and behavioral problems in adopted children. Research results of Hope Connection have demonstrated significant changes in the trauma-related emotional and behavioral problems of the adopted children who participated in camp (Purvis, 2001; Purvis, et al., 2008; Purvis, et al., 2013). These reductions in trauma-related emotional and behavioral problems are similar to what was found in the current study. Further, the current study revealed improvements in attachment representations for adopted children, which is also consistent with findings from the original camp model (Purvis, 2001; Purvis, et al., 2008; Purvis, et al., 2013).

The results are also consistent with research on TBRI caregiver training, which is similar to the training parents in the intervention condition received during the camp weekends. Previous studies examined the effectiveness of TBRI caregiver training in reducing trauma-related emotional and behavioral problems in adopted children. According to this literature, some trauma-related emotional and behavioral problems,

including anxiety, depression, anger/aggression, emotional problems, conduct problems, and hyperactivity, decreased for adopted children of parents who participated in a web-based TBRI parent training (Razuri, et al., 2015) and a 4-day in-person training (Purvis, 2015). The findings of the current study demonstrated changes in some of these same trauma-related emotional and behavioral problems, including anger/aggression, depression, anxiety, but did not reveal any changes in emotional problems, conduct problems, or hyperactivity. This inconsistency may be a result of one of the two reasons stated above to explain the partially-supported hypotheses: the current study involved parents who already were trained in TBRI to varying degrees and were using it in their parenting. Thus, changes may not have been as significant in the current study because some trauma-related emotional and behavioral problems may have already improved in the adopted children prior to participating in the intervention.

The current study is also consistent with the results of a systematic review of interventions aimed at addressing the needs of adopted children and their parents (Chobhthaigh & Duffy, 2019). The results of the review demonstrated that interventions aimed at addressing parent behavior and knowledge of adopted children lead to improvements in both the trauma-related emotional and behavioral problems in adopted children as well as the parent-adopted child relationship (Chobhthaigh & Duffy, 2019). However, no previous research has been found that examines the use of an intervention to improve adoptive family functioning or adoptive sibling relationships. One previous study addressed the need for an intervention aimed at meeting the needs of the adoptive family, revealing that adoption from foster care is negatively associated with family functioning (Crea, Chan, & Barth, 2013). The results of this previous study showed the

importance of adoptive family functioning on the outcomes for adopted children, as the family environment was a significant mediator between foster care adoption and ADHD symptoms (Crea, et al., 2013). In our knowledge, the current study was one of the first to examine the effect of a therapeutic intervention on overall family functioning in order to best meet the needs of adoptive families.

### **Family Systems**

Family systems theory states that families are complexly connected, emotionally interdependent units: the emotional and behavioral needs of one family member influence the emotional state of the other members of the family (Bowen, 1972). Knowing this, the current study aimed to address the needs of each member of the adoptive family – adoptive parent, adopted child, and adoptive sibling – in effort to improve the overall functioning of the family unit. The current study results demonstrated preliminary success in meeting the needs of adoptive families and supported family systems theory. Through Hope Connection 2.0, the targeted needs of each member of the family were addressed. Parents received parent training and respite, adoptive siblings received group and individualized therapeutic intervention, and adopted children received therapeutic intervention. Improvements in individual members' emotional state were noted in each family's follow-up interviews and satisfaction, communication, and cohesion improved for families who participated in Hope Connection 2.0.

Applying the results of the current study to family systems theory provides several implications. According to the demographic questionnaires and the follow-up interviews of families in the intervention condition, the trauma-related emotional and

behavioral problems of adopted children affected the emotionality of the other family members. Even more so, parents noted that the emotional struggles of their non-adopted children had a direct effect on their family's overall level of healthy functioning. Each of the families in both the intervention and waitlist conditions noted low family satisfaction levels both before and after camp. In applying for camp, three of the five families in the intervention condition listed goals of improving family connection and finding way to have more peace in the home. The other two families listed goals of improving the siblings' emotional state in effort to build more connection in the home. Families were actively seeking an intervention in improving their family functioning, which provides support for applying family systems theory to adoptive families. Each family noted both trauma-related emotional and behavioral problems with their adopted children as well as a need for improvement in the overall functioning of the family unit. The current study provides preliminary evidence for using therapeutic intervention to meet the needs of each family member in effort to improve the overall functioning of the entire family unit.

### **Implications**

There are several practical implications of the current study. As stated above, evident from this study is the need to intervene at the level of each member of the adoptive family in effort to truly meet the needs of the whole adoptive family system. Only meeting the needs of the adopted children in the family does not take into consideration the feedback from the parents involved in this study or the interdependent nature of the family system – that the trauma-related emotional and behavioral problems of the adopted child have affected the emotional state of each member of the adoptive family. The intervention used in this study is

the first to begin intervening at the level of each individual in an adoptive family system who is impacted, whether directly or indirectly, by early-life trauma.

Further, the way in which the trauma-related emotional and behavioral needs of the adopted children affect the entire family system have been more accurately understood through this study. Both parents and non-adopted children discussed the way in which the trauma-related issues of the adopted children in their families have impacted both them as individuals and the family system as a whole. Having a better understanding of the influence of these trauma-related issues allows for the creation of better support for adoptive families. Many families are not prepared for the way in which each member is affected by adoption; understanding the how and why of this effect could potentially better prepare families and minimize the influence of trauma on the family system. Having better prepared families with a healthier family functioning has the potential to minimize some of the trauma-related emotional and behavioral needs of the adopted children (Crea, et al., 2013).

Another practical implication of the current study was the feasibility of participation in a therapeutic family camp. Each family in the intervention condition stated that participation was easy and there was nothing that made it difficult to participate. If families did not live close enough to commute from home for the intervention, they stayed in a hotel room during the camp weekends. Of the families who attended camp, four of the five families received financial support from their adoption organization to attend camp, which waived the camp fee for the families. None of the parents in the intervention condition took time off of work to participate in this therapeutic camp intervention. With the busyness of today's family, more work needs to be done to determine how to therapeutically intervene effectively in a family without a large time commitment that makes it impossible for many

families to participate. In the current study, with pre-training and two weekends at camp, families were able to experience positive changes both individually and in their overall functioning. This study provides preliminary evidence for the effectiveness of an intervention that requires much less of a time commitment than previous interventions.

### **Limitations**

There are several limitations to this pilot study. One of the most significant limitations of the current study is the small sample size, which limited the use of advanced statistical analyses. Due to the intensive nature of the therapeutic intervention, only a few families could participate in each camp, and due to the time constraints of this thesis project, only the results of one Hope Connection 2.0 could be examined in the current study. Additionally, because of the time constraints, follow-ups could not be a part of the current study although they are part of the ongoing research study of Hope Connection 2.0. Future research on Hope Connection 2.0 will pool multiple cohorts of data in order to use advanced statistics to examine the differences in adopted child behavior, dyadic relationships, and overall family functioning. This future research will also examine whether sustained changes occur by assessing families at three- and six-month follow-ups. Until this further research can be pooled together and follow-ups can occur, significant changes in each of these levels of the adoptive family cannot be determined.

Another limitation of the current study was that the assessments of trauma-related emotional and behavioral problems were done solely via parent report. This form of data collection may impact the results because parents were also receiving their own training in understanding and more clearly seeing their children's behavior and emotions in effort to meet the needs of their children. It is possible that parents may have become more aware of

their children's trauma-related emotional and behavioral problems than what they were prior to participating in camp. This new awareness may skew the reported trauma-related emotional and behavioral problems in their children from pre- to post-camp.

Further, in selecting families as participants for a therapeutic intervention, it is not possible to select five families who have the same demographics. Families have different structures, which means the families in the intervention condition and the waitlist condition have different numbers of adopted and biological children, diverse ages of children, and varied levels of trauma histories and years the adopted children have lived in the home. Thus, these families are not perfect groups to compare results. This also means that there is variance in the amount of challenges the family has prior to attending camp, which affects the overall mean scores for both the intervention and waitlist conditions. If families have less challenges initially, there may be less change noted over time simply because the family was already functioning in a healthy way. The diversity in families may affect the overall results, especially given the small sample sizes of the current study.

After experiencing the initial Hope Connection 2.0 camp weekends, one of the limitations in the current study that became apparent was the lack of examination of changes at the non-adopted child level. The non-adopted children experienced an intensive group therapy each day for 45 minutes that had a much more powerful effect on the whole of Hope Connection 2.0 than was originally realized. There was much emotional growth for the non-adopted children in the family reported by both the parents and the non-adopted children that occurred during these children's camp participation. Each family who had non-adopted children in the family noted in their follow-up interview this emotional change in their children who attended camp. However, there was no quantitative measure of these changes

in the non-adopted children. The focus of the current study was examining whether the sibling relationship improved; however, the effect of the intervention may have been more appropriately centered on the non-adopted children's emotional state.

### **Future Directions**

From this pilot study comes several future directions of research. Hope Connection 2.0 is anticipated to be conducted two-three times each year, which will allow for much more data to be collected on the effectiveness of this camp intervention. Future research of Hope Connection 2.0 will pool data from multiple cohorts of families in order to use more advanced statistical analyses. This future research will help to determine any significance in changes at the child behavior, dyadic relationships, and overall family functioning that cannot be done with the small sample sizes in the current study. Future research will also involve data collection at three and six months after participation in Hope Connection 2.0, which will permit examination of sustained changes at these three levels of the adoptive family system. Additionally, having multiple cohorts participate in camp will allow for the feasibility of the model to continue being examined with a larger sample of families with varying demographics.

After experiencing the pilot Hope Connection 2.0, future research should examine the individual changes that occur within the non-adopted children who participate in camp. As stated previously, changes in this population may not have been accurately measured. Only changes to the sibling relationship were examined whereas it seems that the most notable change was in the non-adopted children's overall well-being. Further research should capture whether these improvements in well-being are actually occurring for these individuals.

In addition to examining the effectiveness of Hope Connection 2.0, the current study intended to provide support for future studies that examine intervention at the family system level and not just the level of adopted child. This study provides evidence of the need to address the way in which the trauma-related emotional and behavioral problems of adopted children may affect the other members of the adoptive family. Future research should look at this relationship more closely to determine how this trauma affects other members of the family and, even further, how to best support adoptive families when they have been affected by secondary trauma.

In summary, the current study provides preliminary evidence for the effectiveness and feasibility of Hope Connection 2.0, a revised model of Hope Connection. The results of this pilot study revealed reductions in some trauma-related emotional and behavioral problems in adopted children, improvements in the quality of the parent-adopted child relationships, and improvements in the overall functioning of adoptive families after participating in this therapeutic family camp intervention.

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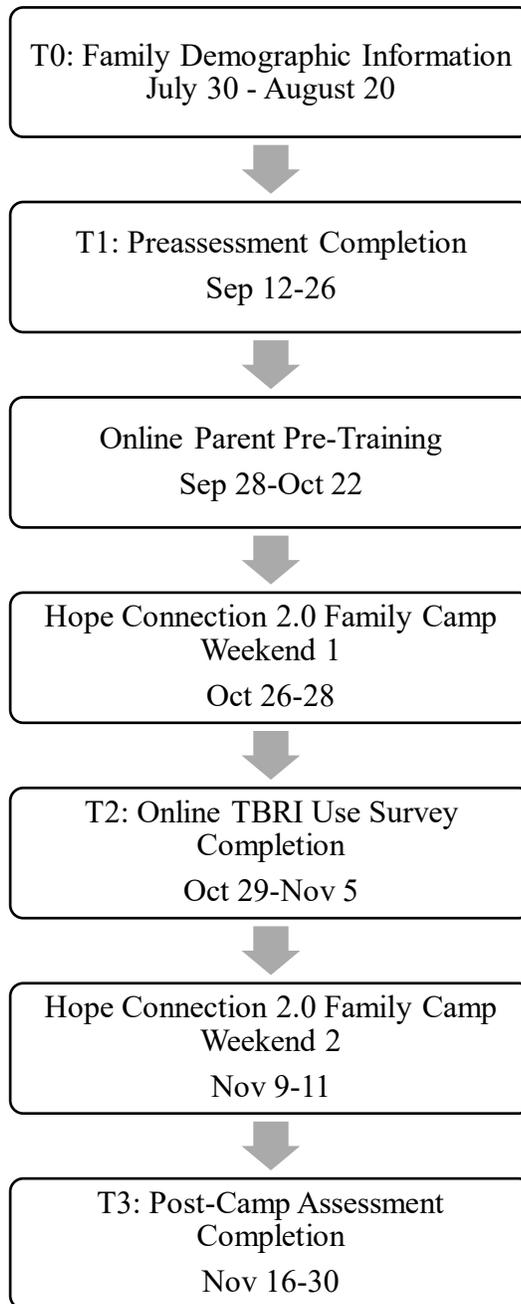
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## APPENDIX A

The Hope Connection 2.0 timeline of events.



**APPENDIX B**  
 Hope Connection 2.0  
 Camp Schedule Week 2

**Friday: Weekend 1**  
**October 26, 2018**

<b>Time</b>	<b>Children</b>	<b>Parents</b>
6:00-7:00	Meet & Greet and Dinner: Reveal buddies	
7:00-7:20	Friendship Bracelets with Buddies	Schedule of Events/Expectations
7:30-8:00	Memory Book Creation	

**Saturday: Weekend 1**  
**October 27, 2018**

<b>Time</b>	<b>Children</b>	<b>Parents</b>
8:30-9:00	Check-In	
9:00-9:30	Crash and Bump	Training 9-11 AM ( <i>empower, connect</i> )
9:35-10:15	Nurture Group: <i>use your words</i>	
10:15-10:30	Snack	
10:30-11:00	Movement Group: <i>pretend animals</i>	
11:00-11:30	Life Skills Group: <i>use your words</i> (adopted & bio separate)	Parent Respite 11:00-1:00
11:30-12:15	Lunch	
12:20-12:50	Outside Play: <i>parachute</i>	
1:00-2:00	Rotations (speech, sensory, art)	Training 1-2:20 PM ( <i>correct</i> )
2:00-2:15	Snack	
2:20-3:00	Memory Books	
3:00-3:30	Most Super Cool Awesome Group	

**Sunday: Weekend 1**  
**October 28, 2018**

<b>Time</b>	<b>Children</b>	<b>Parents</b>
8:30-9:00	Check-In	
9:00-9:30	Crash and Bump	
9:35-10:15	Nurture Group	
10:15-10:45	Movement Group: <i>rhythm sticks</i>	Training 10:15-12:00 ( <i>sensory &amp; sensory Q&amp;A with OT</i> )
10:45-11:00	Snack	
11:00-11:30	Life Skills Group: <i>show respect</i> (adopted & bio separate)	
11:30-12:00	Rotations (speech, sensory, art)	
12:00-12:30	Memory Books	
12:45-2:30	Cookout and Bounce House	

Hope Connection 2.0  
Camp Schedule Week 2

**Friday: Weekend 2**  
**November 9, 2018**

Time	Children	Parents
6:00-7:00	Dinner and Catch-Up	
7:00-8:00	Scavenger Hunt	

**Saturday: Weekend 2**  
**November 10, 2018**

Time	Children	Parents
8:30-9:00	Check-In	
9:00-9:30	Crash and Bump	
9:35-10:15	Nurture Group	
10:15-10:30	Snack	Training 10:15-11:45 (connect & empower Q&A)
10:30-11:00	Movement Group: <i>lean on me</i>	
11:00-11:30	Life Skills Group: <i>gentle and kind</i> (adopted & bio separate)	
11:30-12:15	Lunch	Lunch 11:45-1:00 <i>give gift cards</i>
12:20-12:50	Outside Play: <i>blob tag</i>	
1:00-2:00	Rotations (speech, sensory, art)	Training 1-2:20 PM (correct Q&A)
2:00-2:15	Snack	
2:20-3:00	Memory Books	
3:00-3:30	Most Super Cool Awesome Group	

**Sunday: Weekend 2**  
**November 11, 2018**

Time	Children	Parents
8:30-9:00	Check-In	
9:00-9:30	Crash and Bump	
9:35-10:15	Nurture Group	
10:15-10:45	Movement Group: <i>dance</i>	Wrap-Up & Final Q&A 10:15-12:00
10:45-11:00	Snack	
11:00-11:30	Life Skills Group: <i>listen and obey</i> (adopted & bio separate)	
11:30-12:00	Rotations (speech, sensory, art)	
12:00-12:30	Memory Books	
12:45-2:30	Picnic	

## VITA

Personal  
Background  
Jana Lynn Hunsley  
Born July 8, 1991, Wanatah, Indiana  
Daughter of Brian and Colleen Hunsley

Education  
Honors Diploma, Morgan Township High School,  
Valparaiso, Indiana, 2010  
Bachelor of Science, Psychology, Honors Scholar,  
Indiana Wesleyan University  
Marion, Indiana, 2013  
Master of Arts, Social Work, University of Chicago,  
Chicago, Illinois, 2015  
Master of Science, Experimental Psychology,  
Texas Christian University,  
Fort Worth, Texas, 2019

Experience  
Graduate Research Assistant, Karyn Purvis Institute of Child  
Development, Texas Christian University,  
Fort Worth, Texas, 2017-present  
Post-Adoption Therapist, Bethany Christian Services,  
Elkins Park, Pennsylvania, 2015-2017  
Mobile Therapist, Access Services, Inc.,  
Fort Washington, Pennsylvania, 2016-2017  
Clinical Services Intern, Family & Youth Services Bureau,  
Valparaiso, Indiana, 2014-2015  
School Social Work Intern, Beacon Therapeutic Day School,  
Chicago, Illinois, 2013-2014  
Child & Family Case Manager, Porter-Starke Services,  
Valparaiso, Indiana, 2013  
Teaching Assistant, Indiana Wesleyan University,  
Marion, Indiana, 2012-2013  
Research Assistant, Indiana Wesleyan University,  
Marion, Indiana, 2012-2013

Professional  
Memberships  
Licensed Social Worker (LSW)  
Psi Chi Honor Society  
Alpha Chi National Honor Society  
Lilly Scholar Network

## **ABSTRACT**

### **HOPE CONNECTION 2.0: A THERAPEUTIC CAMP INTERVENTION TO IMPROVE ADOPTIVE FAMILY FUNCTIONING**

By JANA L. HUNSLEY, MS, MA, 2019  
Department of Psychology  
Texas Christian University

Thesis Advisor: David R. Cross, Professor of Psychology  
Thesis Committee Members: Casey D. Call, Assistant Professor of Professional Practice  
Naomi V. Ekas, Associate Professor of Psychology

Children who are adopted often experience early-life trauma, which can lead to deficits in attachment, sensory processing, and self-regulation that are often manifested by severe emotional and behavioral problems. When these children are adopted, their trauma-related problems can affect the entire family system due to the emotional interdependence of families. The current study examined the effectiveness of a two-weekend therapeutic family camp intervention aimed at addressing the needs of each member of the adoptive family through using a two-group (waitlist vs. intervention) pre-post design. The results of the study indicated decreased trauma-related emotional and behavioral problems in adopted children, improved quality of the parent-adopted child relationship, and improvement in the overall functioning of the adoptive family for families who participated in the intervention as compared to families in the waitlist condition. These findings support the efficacy of a therapeutic family camp intervention to improve outcomes for adoptive families.