
Supporting Special-Needs Adoptive Couples: Assessing an Intervention to Enhance Forgiveness, Increase Marital Satisfaction, and Prevent Depression

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Abstract

An educational group intervention focusing on forgiveness and marriage education was implemented with adoptive parents. Couples qualified by having adopted at least one special-needs child. Data were examined for 112 adoptive parents: 54 from a treatment group that immediately received a 36–contact hour intervention and 58 from a waiting list comparison group that received the intervention after the treatment group was completed. Forgiveness, marital satisfaction, and depressive symptoms were measured in both groups. The treatment group showed statistically significant gains on all three dependent measures vis-à-vis the comparison group. The comparison group showed similar gains when they became the treatment group. All

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gains were maintained at a 3.5-month follow-up (one semester). Implications are discussed for the effectiveness and appropriateness of this intervention for special-needs adoptive families.

Keywords

special needs, adoption, forgiveness, marriage, intervention

Although more than 135,000 adoptions take place in the United States each year (Smith, 2006) and many more worldwide, the response to issues related to adoption by the mental health community has largely been one of silence (Zamostny, Wiley, O'Brien, Lee, & Baden, 2003). Furthermore, the attention that has been given to adoption in the areas of theory and research has been overly oriented toward pathology (Zamostny, O'Brien, Baden, & Wiley, 2003), which has meant that discussions of persons involved in the adoption triad (adoptive parents, adoptees, and birth parents) have been excessively connected to issues of illness rather than concerns regarding normative adjustment challenges. Adoptions in the United States currently represent 59% from the child welfare system, 26% from international adoptions, and 15% from voluntarily relinquished domestic infants (Smith, 2006). Thus, a majority of adoptions are from the child welfare system—these are often special-needs adoptions (Forbes & Dziegielewski, 2003): These children tend to have heightened needs developed from challenging life circumstances. Yet, as with other adoptees, it is easy to overly pathologize these concerns. Interventions that use strengths-based positive coping models, which are fundamental to counseling psychology and so focus on promoting resilience, have significant potential to serve adoptive families (O'Brien & Zamostny, 2003). Furthermore, families look to counseling psychologists to help make meaning of their adoptive experiences (Grotevant, 2003). This article assesses an educational group intervention for special-needs adoptive couples that focuses on building healthy adjustment skills.

The practice of adoption has dramatically changed in the past few decades because of societal changes and progressive movement within the child welfare system. Such changes include the demographics and unique needs of the children being adopted and the effort made to create permanent placements for children (Rosenthal & Groze, 1990). Many children are available for adoption because of histories of abuse or neglect at the hands of chemically addicted, intellectually challenged, criminal, or mentally ill parents (Friedlander, 2003). Maltreatment in the United States child welfare system includes neglect (68.1%), physical abuse (17.6%), sexual abuse (7.6%),

medical neglect (2.4%), psychological abuse (2.2%), and other (2.6%; U.S. Department of Health and Human Services, 2006). Such children are commonly removed from the home, and they usually enter the foster care system before being available for adoption. Children in the foster care system can be considered *special needs* based on any one or more of the following reasons: history of physical/sexual abuse or neglect; multiple foster placements; 8 years of age or older; emotionally, physically, or mentally handicapped; member of a sibling group; and minority status (Forbes & Dziegielewski, 2003). The frequency of these special-needs children becoming adopted has been accelerated by the U.S. government's Adoption Incentives Program, which started in 1998. From that year onward, a total of more than 490,000 children have moved from foster care to adoptive families (U.S. Department of Health and Human Services, 2009). Providing appropriate support for these special-needs children and the parents who adopt them is an ongoing challenge for counseling psychologists, social workers, and other professional therapists.

Although the number of children who have recently been placed has increased, many adoptive parents are unprepared to deal with their adopted children's elevated level of needs, which creates substantial obstacles and stress for the parents to manage. Additional stresses that adoptive families encounter include experiencing greater financial strain, not knowing how to cope with new challenges, not knowing the histories of their newly adopted children, and having little or no postadoption agency support for coping with the stresses (Forbes & Dziegielewski, 2003). Additionally, because these new adoption stresses tend to take up significant amounts of time and energy for the parents, there exists a tendency to overlook any negative family dynamic changes created by the new adoption (Mullin & Johnson, 1999). Furthermore, as Brodzinsky (1990) suggested, the adoption experience exposes parents and children to a unique set of psychosocial problems and tasks that may interact with or complicate normative developmental family tasks and dynamics. Thus, counseling psychologists are challenged to find supportive ways of helping special-needs adoptive couples care for their adoptive children and face complicated dynamics that can develop within their families.

Intervention

With this understanding of the challenges of special-needs adoptive families, we set about to build an appropriate educational group intervention to support adoptive couples. Because of the issues discussed above, we wanted our

intervention to include insight into the areas of (a) resolving past hurts, as related to an increase in forgiveness; (b) strengthening the marriage dyad, as related to increased marital satisfaction; and (c) providing a supportive group context, as related to preventing depressive symptoms.

Forgiveness

The importance of including education about resolving past hurts evolved from the frequency of past traumas in the lives of special-needs children and from our knowledge of adoptive couples who had been challenged with supporting these children. Our experience with special-needs adoptive families regarding resolving past hurts included (a) adoptive parents whose children had experienced issues of neglect and abuse before being adopted such that the adoptive parents struggled to forgive the perpetrators; (b) adoptive parents who expressed rage at the child welfare system because of a felt sense of lack of support, lack of information, and inexperienced case managers who the parents felt unfairly criticized them; and (c) grandparents who welcomed the biological children but not the adoptive children, which not only required proactive behaviors on the part of the adoptive parents to limit this hurtful behavior but also cultivated their interest in forgiveness after this occurred, as opposed to holding the resulting anger within the family. Consequently, we saw education about resolving past hurts through forgiveness as a potentially beneficial part of our prevention intervention.

Recent theory and research supports this focus of helping families resolve past hurts through forgiveness. Enright and Fitzgibbons (2000) cited forgiveness as a person's internal psychological response to another person's (or other people's) injustice. A person who forgives also reduces one's resentment and offers beneficence to an offender, without condoning, excusing, or forgetting the offense. Interventions involving forgiveness have resulted in reduced anger, bitterness, depression, dysfunction, distress, physiological stress, and coronary heart disease as well as increased hope, self-esteem, and overall mental health and satisfaction with life (Strelan & Covic, 2006). Whereas some interventions have focused on populations where there is one clear person to forgive (e.g., incest survivors; Freedman & Enright, 1996), others have worked with at-risk populations where their status does not clearly dictate one person to forgive but, rather, where they have found the exploration of forgiveness to be beneficial (e.g., substance-dependent clients; Lin, Mack, Enright, Krahn, & Baskin, 2004). Thus, although being a special-needs adoptive parent does not universally dictate one person to forgive, the adoptive families are at risk on the basis of the potential challenges discussed above.

Research has supported the importance of resolving past hurts within families, which applies to adoptive families. Gordon and Baucom (1998) successfully created a process model to help members of dyadic relationships forgive betrayals that might lead to lasting harm if left unresolved. Gordon, Hughes, Tomcik, Dixon, and Litzinger (2009) recently reinforced the importance of this type of model. Specifically, they found that higher forgiveness in a marital dyad is associated with greater marital satisfaction, a stronger parenting alliance, and higher levels of a child's perceptions of parental marital functioning. Thus, forgiveness for adoptive parents has the potential to benefit the marriage dyad and the ways that marriage partners parent their adoptive children.

DiBlasio (1998) suggested that forgiveness has substantial benefits for couples and families, including improved conflict resolution, relationship outcomes, and overall well-being. That said, we are aware of only one forgiveness-based marriage intervention with both treatment and control where both dyad members were present. Ripley and Worthington (2002) accomplished a forgiveness intervention with married couples, but forgiveness did not improve; however, the intervention lasted only 6 hours during one weekend. In a meta-analysis of forgiveness interventions, Baskin and Enright (2004) reported that long-term forgiveness interventions had strong results for individuals and were significantly more powerful than short-term interventions. Thus, we believed that longer-term forgiveness-based marriage interventions still had the potential to be effective.

Although we saw forgiveness education as being potentially potent, we were aware that we could not assume that forgiveness increases would come only from the forgiveness components of the intervention but rather from a variety of other sources. This was also true of the outcomes of marriage satisfaction and depressive symptoms, as explored below. Thus, although there are three main factors to the intervention and three related outcomes, each factor may influence each outcome.

Marital Satisfaction

Education about healthy marriages, as related to improved marital satisfaction, was another goal of our intervention. There is a clear link among high marital distress, poorer parenting, and poorer child adjustment (Erel & Burman, 1995). Thus, for children who are already having difficulty adjusting, marital difficulties can compound this challenge. Because marital distress can affect the entire adoptive family, helping couples to resolve this distress in healthy ways can be an appropriate way to support both the couples and the children.

Furthermore, a meta-analytic study by Hawkins, Blanchard, Baldwin, and Fawcett (2008) supports the efficacy of marital education interventions. Across 117 studies, the authors found that improvements were significant, with an overall impact on relationship quality (estimated $d = .30-.36$) and communication skills ($d = .43-.45$).

Regarding elements with which to build our curriculum, we were aware of research by John M. Gottman as related to aspects of marriage that we believed were important to special-needs adoptive couples—such as the role of conflict in marriage (Gottman, 1993), the influence of marital conflict on internalizing and externalizing child behaviors (Katz & Gottman, 1993), factors in long-term marital satisfaction when couples become parents (Shapiro, Gottman, & Carrere, 2000), and the application of these and other factors to building strong marriages (Gottman & Silver, 1999). Thus, we relied heavily on Gottman's insights for the marriage education aspects of our intervention.

Depression

A third aspect of our intervention was the broadly supportive factors of the group experience, which related to preventing depressive symptoms of the participating adoptive parents. Our efforts at prevention are consistent with Hage and colleagues' (2007) advocacy for psychologists to pursue more prevention interventions. Specifically, the current intervention follows their best practice guidelines through being proactive, addressing risks as well as strengths, and using psychological education and training. According to prevention theory, our approach is that of secondary prevention; that is, we are working to delay the onset of problems within a targeted at-risk population (Caplan, 1964). Furthermore, our intervention is consistent with Caplan and Caplan's (2000) encouragement to support prevention with at-risk subpopulations.

In helping to prevent depression, we looked toward the therapeutic factors of a supportive group, including universality (e.g., not feeling alone in the challenge of adopting a special-needs child), imparting information (e.g., dealing with the child welfare system), and altruism (e.g., sharing potentially hard-earned expertise in situations unique to special-needs adoptive children; Yalom, 1995). Furthermore, if the adoption is interracial, parents face a pressure and need to address racial characteristics (e.g., skin color) and the dynamics of race in society with not only their children but also themselves (McRoy & Grape, 1999). Discussions of this nature were considered an ongoing, integral, and important part of the group process in our intervention, as well as a further therapeutic component.

The measure that we used for depressive symptoms included questions related to valuing of the self, sleeping and eating habits, general levels of interest, and levels of energy. These had value even when not revealing clinical levels of depression. Although our participants were generally in the normative range for depression, we were concerned with monitoring and improving even low levels of symptoms. Appreciating depressive symptoms, even at a relatively low level, is consistent with the preventative nature of our intervention. Additionally, Pan, Neidig, and O'Leary (1994) found an interrelationship among depressive symptoms, family functioning, and aggression. Using a large sample, they reported that a 20% increase in depressive symptoms in a marriage dyad increased the odds of having toxic levels of aggression by 74%. Thus, we saw depressive symptoms as a valuable aspect of our intervention.

Hypotheses

We constructed an intervention taking into account the issues mentioned above. We hypothesized that our intervention would enhance forgiveness, increase marital satisfaction, and prevent depressive symptoms for our special-needs adoptive parents.

Method

Participants

Data were analyzed for 112 parents who participated in the intervention and evaluation and gave usable data. For a couple to qualify for the intervention, they had to have at least one special-needs adoptive child. Parents were not required to have elevated levels of distress (although some did), which is consistent with the preventative nature of our intervention. Of the 112 parents, 10 were African American and 102 were European American. No couples were biracial. Couples had a total of 98 special-needs adoptive children: 46 European American, 28 African American, 14 Latino, 9 biracial, and 1 Native American. Table 1 presents other demographic information.

Instruments

Enright Forgiveness Inventory. The Enright Forgiveness Inventory (EFI; Enright & Rique, 2004) is an instrument that was developed to measure forgiveness for young adolescents, young adults, and adults. The EFI was

Table 1. Participant Demographics Across Groups

Variable ^a	Treatment	Comparison	Test Statistic	<i>p</i>
Families, <i>n</i>	27	29	$\chi^2(1, n = 56) = 0.071$	.789
	<i>M</i>	<i>M</i>		
Age of wife	43.0	43.6	$t(51) = -0.211$	.834
Age of husband	43.8	46.0	$t(51) = -0.838$	.406
No. children per family	3.41	2.83	$t(54) = 1.098$	.277
No. adopted children per family	1.89	1.61	$t(53) = 0.833$	.409
Age of adopted children	9.86	8.82	$t(93) = 1.483$	.141
Foster placements per adopted child	2.70	3.00	$t(79) = -0.795$	.429
	%	%		
Adoptive children, female	52	45	$\chi^2(1, n = 94) = 0.397$	.529
Families with interracial adoption	41	48	$\chi^2(1, n = 56) = 0.294$	.587
Families with a behavioral diagnosis ^b	59	71	$\chi^2(1, n = 56) = 0.884$	.347

^aData from parent report.

^b*Behavioral diagnosis* meant that parents reported having one or more adoptive child with attention-deficit/hyperactivity disorder or reactive attachment disorder or both. Although we encouraged parents to base their reports on the opinions of professionals, these diagnoses were not independently verified.

used in this study to measure interpersonal forgiveness through 60 self-reported items related to positive affect, negative affect, positive behavior, negative behavior, positive cognition, and negative cognition (10 items each). Total scores range from 60 to 360, with high scores representing high levels of forgiveness. Validity for this instrument has been documented as being significantly and positively correlated with self-esteem and significantly and negatively correlated with depression and anxiety (Al-Mabuk, Enright, & Cardis, 1996). Validity is further supported by the design of the measure, which does not mention forgiveness in the 60 items given but adds one question at the end, asking to what degree the person has forgiven, which has yielded consistently significant correlations to the overall scale (Subkoviak et al., 1995). Internal consistency has been documented above .90, with 4-week test-retest reliability measured at .86 (Enright &

Fitzgibbons, 2000; Enright & Rique, 2004). The EFI has successfully been used to measure forgiveness in interventions targeting specific populations, including incest survivors (Freedman & Enright, 1996) and substance-dependent clients (Lin et al., 2004). Cronbach alpha (α) in our sample was .98 for wives and .99 for husbands.

Beck Depression Inventory–II. Depression was measured with the Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996), a self-report measure of 21 depression-related symptoms and attitudes. The instrument was developed for use with adolescents and adults and specifically constructed to be consistent with criteria for diagnosing depressive disorders (i.e., per the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition; American Psychiatric Association, 1994). Each item is scored 0 to 3 based on the existence of specific symptoms and their level of severity. Total scores range from 0 (indicating no depression) to 63 (indicating high depression). It is one of the most often used measures of depression. Validity is supported by solid correlations to other depression measures and by high scores for those meeting criteria for major depression (American Psychiatric Association, 1994). Extensive use in research has demonstrated high 1-week test-retest reliability and high internal consistency ($\alpha = .91$). Atkins, Dimidjian, Bedics, and Christensen (2009) successfully used the BDI-II to measure depression in couples involved in therapy. Furthermore, Cohen, O’Leary, and Foran (in press) used the BDI-II to measure depression as specifically targeted in couple therapy. Cronbach alpha in our sample was .88 for wives and .92 for husbands.

Dyadic Adjustment Scale. Marital strength was assessed with the Dyadic Adjustment Scale (DAS; Spanier, 1976, 1989), a 32-item self-report measure of marital satisfaction, including questions about agreement, conflict, enjoyment, and overall satisfaction related to the marriage dyad. Scores range from 0 to 151, with higher scores indicating higher levels of satisfaction. This measure has reported excellent internal consistency ($\alpha = .96$). Validity is supported by a strong positive correlation to the previously established Locke–Wallace Marital Adjustment Test. Validity is also suggested by low scores found in couples considering divorce. Furthermore, Smolen, Spiegel, and Martin (1986) found low scores on the DAS to be consistent with weak communication skills and problematic marital functioning. This scale has been extensively used in marital research; see Graham, Liu, and Jeziorski (2006) for a meta-analysis of 91 studies using the DAS, including 25,035 participants. Cronbach alpha in our sample was .94 for wives and .93 for husbands.

Procedures

Testing procedure. Participants were recruited through fliers in state government adoption assistance checks, an informational invitation mailing, word of mouth, personal phone call invitations, and advertisements in an adoption agency monthly newsletter. All recruitment, including fliers, emphasized the supportive aspects of the intervention. Support was seen as a combination of personal support by the staff, peer support from other participants, and the support found in gaining knowledge from an appropriate educational experience. It was also made clear that the intervention would be free to participants and would include financial help with child care costs incurred while attending the workshops. The university's institutional review board approved the study. Figure 1 shows a flow chart of couple's participation in the evaluation, showing retention vis-à-vis dropout. In addition to the 112 parents who completed the program, 12 parents chose (from the start) to participate in the intervention but not the evaluation.

Parents participated as couples and were placed in either a treatment group or a waiting list comparison group. Recruitment took place during three summers, over the course of 3 years. Treatment group couples received the intervention in the fall, whereas comparison group couples waited during the fall and received the intervention in the spring. We were careful in creating the comparison group in such a way as to maximize its research value. The 36 hours of intervention time, plus time for assessments, was a substantial undertaking for families who were already highly stressed. If family schedules dictated fall or spring, then parents were placed in that group. This was usually due to a parent's work schedule or a child's sports schedule, which did not appear to reveal a pattern of more enthusiastic parents in one group or other such biasing. If schedules allowed for either session, then parents were randomized to groups according to a table of random numbers, which was the case for 34 of the 112 parents. As Table 1 shows, our two groups were well balanced demographically, with no statistically significant differences.

Parents completed pretests in person with an evaluator before the start of the intervention. Data in this study were taken from a larger data set, which included other questions for parents that changed on a year-to-year basis. For a few parents (those with a one-way commute of 3 hours or more), pretesting procedures were explained over the phone and instructions, informed consent forms, and measures were sent by mail. Before completing pretest measures, all participants completed informed consent documents and were given the opportunity to ask questions. To prevent order effects, the measures were given in random order. The three outcome measures were given at data

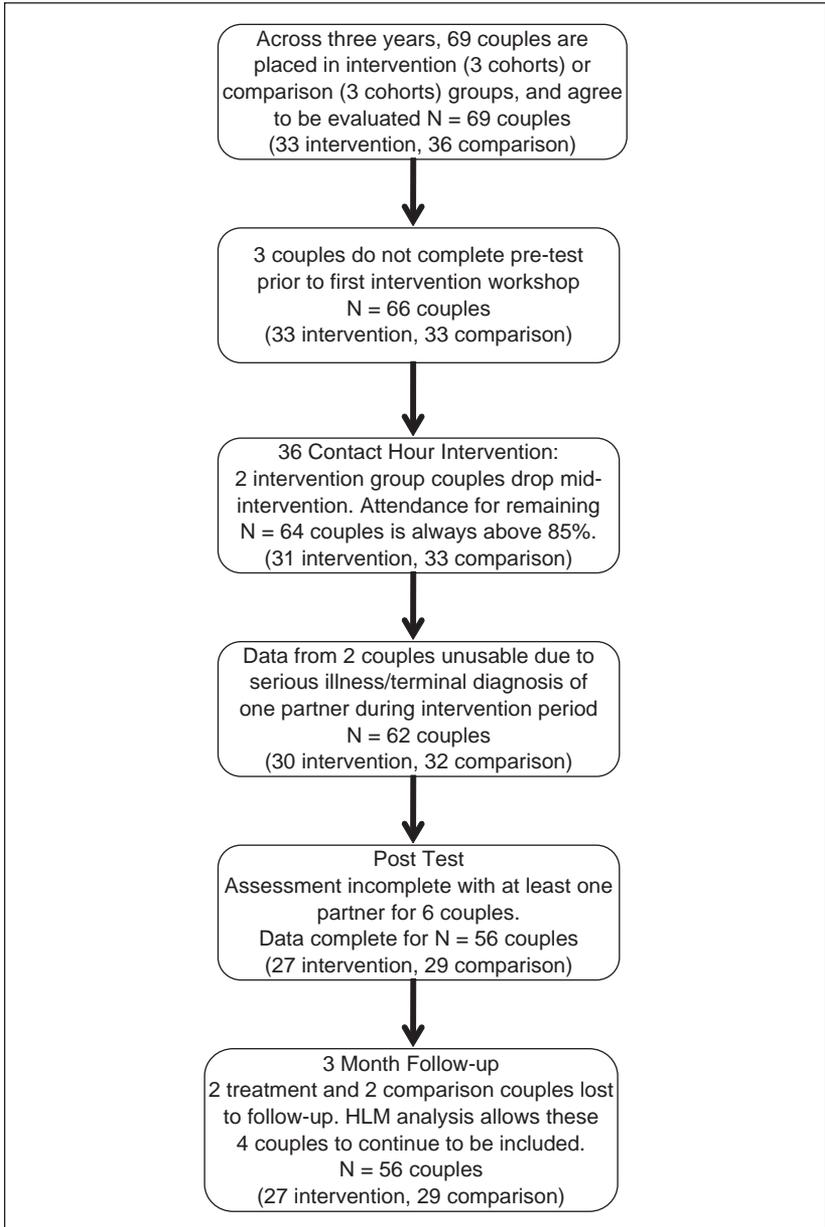


Figure 1. Flowchart of evaluation participation.

collection time points approximately 3.5 months apart (one semester). Pretests were given before the fall semester began (Pretest 1); then, after the fall semester when the treatment group had received the intervention, both groups were again assessed (Posttest 1). In a like manner, the comparison group received the intervention during spring semester, whereas the treatment group did not receive additional services; then, both groups were reassessed (Posttest 2). Finally, after a similar period (3.5 months), the comparison group was given a follow-up assessment (Posttest 3).

Intervention procedure. The intervention involved couples participating in a forgiveness and marriage educational group for a total of 36 contact hours. The intervention included a combination of leader-facilitated discussions and processing, as well as prewritten curriculum from a workbook. Each group met for six or seven Saturday sessions over a 3-month period. The hours of each session were divided evenly between the forgiveness and marriage-strengthening components of the intervention. In both components, all couples met in a group format for most the time, which allowed for discussion of the specific forgiveness and marriage-strengthening aspects of the intervention and for topics to emerge as appropriate, such as the importance of racial issues within the context of adoption. Issues of culture and race for transracial and inracial adoptive placements were commonly discussed and were valued by the presenters, as suggested by McRoy and Grape (1999). Additionally, a small amount of time was spent in couples- or individual-based learning tasks, which occurred for fall and spring over the course of 3 years, for a total of 6 cohorts. In recruitment, we emphasized the importance of consistent attendance and worked toward offering high-quality workshops; consequently, attendance was high—at least 85% in all cohorts. A workbook of materials was given to each group member such that participants could work to make up the material when they missed a session. Each year, the intervention was anchored by two therapists who served as presenters, one having primary responsibility for the forgiveness aspects and the other for the marriage-strengthening aspects. In the first year, both main presenters were licensed doctoral-level psychologists (one clinical and one counseling). In the second year, both main presenters were master's-level therapists (social workers). In the third year, both main presenters were master's-level therapists (one social worker and one counselor). Therapists for the second and third years observed an intervention before becoming a main presenter, and master's-level presenters had doctoral-level therapists available for help.

During most of the intervention time, participating adoptive couples sat in a circle to facilitate group discussion. Thus, the most common group dynamic was that of the presenters introducing a topic by giving information and

examples about the topic. Then, participating adoptive couples would continue with the application of the topic to their specific circumstances, which would lead to extended group discussions of the topics introduced, as well as application of the topics to the specific multicultural and family contexts of the participants. As the authors of this study, we have training in counseling psychology or social work, but we were not therapists or presenters for the intervention.

The forgiveness curriculum was developed in the pilot year based on the Enright forgiveness process model (Enright & Fitzgibbons, 2000) and was used with all six cohorts. Dr. Enright designed the curriculum and ensured that it was implemented consistently. This included videotaping of the training sessions, which Dr. Enright viewed and gave feedback to trainers, based on fidelity with his model. Thus, all cohorts received training that was consistent with the Enright process model of forgiveness. In the intervention, parents were encouraged to choose a person who had hurt them deeply and unfairly and to work toward forgiveness. Parents often selected a birth parent of one of their adopted children, another family member, or a coworker. While working through the forgiveness process with this person, parents received lessons to teach their children about forgiveness. Workshops included defining forgiveness and distinguishing forgiveness from forgetting, condoning, reconciliation, justifying, and so on; the moral basis of forgiving; uncovering anger; deciding to forgive; working toward forgiveness by building understanding, compassion, and accepting the pain; discovery and release from an emotional prison; and seeking forgiveness. More information on the model used for forgiveness can be found at: <http://www.forgiveness-institute.org/>

The marriage-strengthening curriculum was based on the research of Dr. Gottman (Gottman, 1993; Gottman & Silver, 1999; Katz & Gottman, 1993; Shapiro et al., 2000), and it incorporated facilitated instruction, discussion, and activities for reflection and skill development. Therapists directly trained by Dr. Gottman helped to design the curriculum. Furthermore, training sessions were videotaped, and these Gottman-trained therapists were able to give feedback so that all cohorts were able to receive marriage-strengthening training consistent with Dr. Gottman's research. Topics covered included postplacement adoption realities, what children do to a relationship, staying close, constructive relationship problem solving, reaching your boiling point, healing emotional wounds, emotion coaching, working toward compromise, relationship warning signs, relationship recovery conversations, and honoring your partner's dreams. In the third year, additional information was added regarding child development stages and adoption. Additionally, over time

Table 2. Dependent Variables: Means (Standard Deviations)

Dependent Variable	Treatment Group ^a			Comparison Group ^b			
	Pretest	Posttest 1	Posttest 2	Pretest	Posttest 1	Posttest 2	Posttest 3
Enright Forgiveness Inventory	256.3 (63.6)	295.1 (47.9)	290.6 (52.4)	254.6 (52.7)	263.6 (60.5)	291.0 (51.7)	288.5 (45.9)
Dyadic Adjustment Scale	108.4 (17.7)	113.0 (13.6)	111.5 (17.2)	108.0 (16.2)	105.0 (19.8)	110.0 (17.1)	110.1 (16.5)
Beck Depression Inventory	9.0 (7.3)	6.8 (7.4)	7.1 (8.6)	8.6 (7.5)	8.9 (7.6)	6.9 (6.1)	6.4 (6.9)

^a*n* = 54 parents.

^b*n* = 58 parents.

DVDs were created of couples (volunteer completers) talking about experiences related to key points from the curriculum that future participants could then discuss. More information on the curriculum can be found at: <http://www.ourhome-ourfamily.org/>

Results

We used hierarchical linear modeling (HLM; Raudenbush & Bryk, 2002) to analyze our results, specifically using the software program HLM 6 (Raudenbush, Bryk, & Congdon, 2000). We used HLM methods because of their ability to accurately account for the interdependence of scores between husband–wife pairs; also, they are useful in the analysis of data taken at different time points, which was important to our study. Furthermore, this method is helpful in that it can account for missing data, such as when couples report some but not all time points. We used a three-level model proposed by Atkins (2005), which was crafted for the analysis of data from married couples. Level 1 accounts for repeated measures, Level 2 for individuals, and Level 3 for couples (Equation 5 in Atkins, 2005). This model properly accounts for the nonindependence of dyadic data, as emphasized by Kenny, Kashy, and Cook (2006).

Table 2 presents means and standard deviations. In analyzing our data, we discovered that the EFI was not well correlated to either the BDI-II (Pearson $r = -.121, p = .203$) or the DAS (Pearson $r = .050, p = .602$) but that the BDI-II and DAS were well correlated to each other (Pearson $r = -.410, p < .001$) at pretest across all participants. Thus, for our alpha levels, we used .05 for our EFI analyses and divided .05 in half (.025) for our BDI-II and DAS analyses.

We first address the impact of the intervention on forgiveness as measured by the EFI. We used our HLM model to explore the difference in pretests for the treatment group vis-à-vis the comparison group and found that the difference was not significant, $B = 1.694$, $SE = 11.116$, $t(54) = 0.152$, $p = .880$. Next was the question of whether the treatment group improved in forgiveness in relation to the comparison group, which revealed a significant improvement/increase in forgiveness of approximately 30 points, $B = 29.759$, $SE = 7.850$, $t(216) = 3.791$, $p < .001$. Effect sizes were calculated following Feingold (2009): $d = B(\text{time})/SD_{\text{raw}}$. The effect size for the improvement in forgiveness was $d = .511$. Also, we wanted to determine if, during this period, the therapist effect had a significant influence on outcomes, and its impact explained 6.7% of the variance. Although the first-year therapy team had the largest increase, it was not significantly different from that of the other therapy teams.

We then examined the overall impact of the intervention on forgiveness by combining the periods where both groups received the intervention (for the treatment group, Pretest 1 to Posttest 1; for the comparison-turned-treatment group, Posttest 1 to Posttest 2). We found that, across both groups, the intervention led to a significant improvement in forgiveness, $B = 32.848$, $SE = 3.613$, $t(216) = 9.093$, $p < .001$, with an effect size of $d = .564$. As expected, there was no significant difference based on treatment group vis-à-vis the comparison-turned-treatment group for this period, $B = -11.414$, $SE = 7.27$, $t(216) = -1.569$, $p = .118$. Additionally, these improvements remained significant at 3.5-month follow-up (Posttest 2 for the treatment group and Posttest 3 for the comparison group), $B = 28.705$, $SE = 3.675$, $t(207) = 9.093$, $p < .001$.

Next, we conducted a similar HLM analysis of the impact of the intervention on depressive symptoms, as measured by the BDI-II. Using the HLM model, we did not find a significant difference in BDI-II pretest scores for the treatment group vis-à-vis the comparison group, $B = 0.396$, $SE = 1.483$, $t(54) = 0.267$, $p = .790$. We then explored the core question of whether the treatment group improved in depressive symptoms in relationship to the comparison group, which revealed a significant improvement/decrease of 2 to 3 points, $B = -2.514$, $SE = 1.082$, $t(216) = 2.322$, $p = .021$. The effect size was smaller than that of forgiveness, $d = .340$. Therapist impact explained 3.9% of the variance and was not statistically significant. We then examined the overall impact of the intervention by combining the periods where both the treatment and comparison-turned-treatment groups received the intervention, and we found that, across both groups, the intervention led to a significant improvement in depressive symptoms, $B = -2.098$, $SE = 0.630$, $t(216) = -3.329$, $p = .001$, with an effect size of $d = .284$. As expected, there

was no significant difference based on treatment group vis-à-vis the comparison-turned-treatment group for this period, $B = 0.203$, $SE = 1.257$, $t(216) = 0.162$, $p = .872$. Additionally, these improvements remained significant at 3.5-month follow-up, $B = -2.326$, $SE = 0.640$, $t(211) = -3.631$, $p = .001$.

Finally, we conducted an HLM analysis of the impact of the intervention on the construct of marital satisfaction, as measured by the DAS. Using our three-level HLM model, we did not find a significant difference in DAS pretest scores for the treatment group vis-à-vis the comparison group, $B = 0.460$, $SE = 4.089$, $t(54) = 0.113$, $p = .911$. We then explored the question of whether the treatment group improved in marital satisfaction in relation to the comparison group, which revealed a significant improvement/increase of 7 to 8 points, $B = 7.603$, $SE = 2.272$, $t(214) = 3.346$, $p = .001$. The effect size was about equal to that of forgiveness, $d = .450$. Therapist impact explained 3.6% of the variance, which was not statistically significant. We then examined the overall impact of the intervention by combining the periods where both groups received the intervention. We found significant improvement, with an average of about 5 points of improvement across both groups, $B = 4.896$, $SE = 1.121$, $t(214) = 4.368$, $p < .001$, and an effect size of $d = .290$. In this time frame, there was not a significant difference based on the treatment group vis-à-vis the comparison-turned-treatment group, $B = 0.550$, $SE = 2.243$, $t(214) = 0.245$, $p = .807$. Additionally, these improvements remained significant at 3.5-month follow-up, $B = 4.153$, $SE = 1.098$, $t(210) = 3.784$, $p < .001$.

For our 112 parents, from pretest through 3.5-month follow-up and across the three outcome measures, we had usable data for 1,156 of 1,182 points. Missing data did not appear to be a threat, given that our percentage of missing data was low (2.2%) and did not appear to form a pattern.

Discussion

We hope that this study helps to break the silence that has been associated with adoptive families and mental health professionals. We served a substantial number of special-needs adoptive couples with a preventative group intervention that included forgiveness education, marriage-strengthening education, and a supportive group environment. This is, to our knowledge, the first study to demonstrate the impact of this type of program with special-needs adoptive families.

HLM analysis suggests a positive impact for this intervention, based on the outcomes measured: The treatment group significantly improved when analyzed against the comparison group. This finding held true for

forgiveness, marital satisfaction, and depressive symptoms. It was augmented by the finding that when the comparison group received the treatment and both groups were analyzed during the interval of intervention, the entire group enjoyed significant improvement on all three outcome measures, as reinforced at 3.5-month follow-up, where increases remained significant.

Effect sizes for all comparisons were encouraging, with forgiveness measures showing the largest change. As mentioned above, Hawkins et al. (2008) found effect sizes for marital interventions to be in the range of .30 to .36 for relationship quality and in the range of .43 to .45 for communication skills. Improvement in our study for relationship quality (DAS) was $d = .450$ for the treatment group and $d = 0.290$ for the combined group, which puts our intervention in the range of that expected for an efficacious intervention. Our forgiveness results were slightly above this level (treatment group, $d = .511$; combined group, $d = .564$), and our depression results were slightly below it (treatment group, $d = .340$; combined group, $d = .284$). Overall, these levels support the value of this intervention for special-needs adoptive couples.

Forbes and Dziegielewski (2003) proposed the need for a "tool kit" to deal with the day-to-day issues encountered through adoption. The best components of this tool kit remain a work in progress and would benefit from empirical research. Our intervention appears to show that the tool kit for special-needs adoptive families can be useful if it includes at least some parts related to enhancing forgiveness, increasing marital satisfaction, and preventing depression.

Again, we can make no claims about which factors influenced which outcomes. However, in addition to discovering the encouraging outcomes listed above, we witnessed our participants using the intervention in multiple strengths-based ways specific to being special-needs adoptive parents. In regard to healing past hurt and forgiveness, our participants were able to increase their forgiveness of past situations where their children had been treated poorly, including a number of families where there had been a prevalence of illicit drugs in the homes of the adoptive children while they were still in their birth parents' care. The children were not currently in such danger, and parents found that forgiveness of this past helped to reduce anger in the family; it also helped improve the quality of current contacts with the birth parents. Many were also able to forgive the child welfare system in general, which facilitated better ongoing relationships with these workers. Furthermore, resolution of this anger toward the system appeared to generally reduce tension within the marriage dyad and levels of frustration within the family. In addition, needy adoptive children often lashed out and hurt other adoptive children within the same family, which required parents to limit this hurtful behavior; as such, it was

helpful for them to forgive the incidence after it occurred rather than hold any anger within the family. Consequently, couples affirmed the preventative nature of the group by using it effectively in these ways.

Couples also used the marriage education and supportive group context in effective ways specific to their status as special-needs adoptive parents. Most parents resonated with the need to make more time for themselves as a couple. Almost all the parents stated that they had not been on a “date” for many years, and they were encouraged by guidance to do this on a regular basis. Furthermore, the idea of having more of an awareness of their partners’ needs was widely helpful. Many parents admitted to having been so focused on the needs of their adoptive children that they had ignored the needs of their spouses. In terms of the group context, the therapeutic factors of universalism, imparting information, and altruism were all expressed in ways specific to being adoptive parents. Participants talked about postadoption parent depressive symptoms, a general lack of support, overwhelming family needs, and ways of navigating the child welfare system. They also found that many of their adoptive children had the common behavior of hoarding food. Furthermore, they discovered that most families had been forced to move from therapist to therapist to find someone qualified to work with the specific needs of their children. They commonly reported that most therapists had little or no training or experience with special-needs adoptive children. By working through these issues together, the parents no longer felt so isolated. They found answers to many of their questions and were encouraged by giving support to couples with similar needs as their own. Hence, these dynamics affirmed the values of counseling psychology in encouraging couples to address their concerns in strengths-based ways and to focus on normative solutions for them and their children.

A limitation of this study involved the measures used. Although all three measures were well established for the constructs they assessed, they were all self-report. There were no independent observations of couple interactions, which may have given a different perspective on the impact of this intervention. Furthermore, the measures included effects of only the couples. This study does not show how the entire family may or may not have changed and what the impact the intervention had on the adoptive children. An additional limitation involved the low percentage of non-European American parent participants. Although we made special efforts to recruit African American parents, only 5 of our 56 couples were African American and none were biracial. Although many of the children were African American and although we covered cultural issues in our intervention discussions, we had hoped to have a more diverse sample of participants.

Another limitation was that all our adoptive couples were recognized as being married by the state where the study was conducted, which included heterosexual couples only. Consequently, caution should be used in extending these results to lesbian and gay adoptive couples, and future research on this and other interventions with these couples would be valuable. Also of note, we were able to be inclusive of lesbian and gay parents and children in the development of the curriculum. This included using lesbian and gay parents as positive role models when discussing case examples of family functioning. Furthermore, in our “Respecting the Child” module, we emphasized respecting the sexual orientation of all children. Finally, we had 12 lesbian and gay parents review our modules and give us feedback on ways to enhance the curriculum.

Overall, future research could answer not only whether these types of interventions are effective but what makes them effective. Methods could be devised to measure the contribution of different factors to the outcome of the intervention, such as the forgiveness components, the marriage education components, the supportive group in general, the relationships built with presenters, and the relationships built with other families. Other outcomes of interest include whether this type of intervention reduces adoption disruptions and divorce, which would require a long-term follow-up and be a valuable part of any future research. Additionally, studies would be valuable that measure whether this type of intervention affects family dynamics.

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Declaration of Conflicting Interests

The authors declared no potential conflicts of interests with respect to the authorship and/or publication of this article. A modified version of the curriculum is available for sale from the fourth author. In light of this, the evaluation of data and writing of the manuscript was accomplished by the first three authors. Again, statistical analyses were aided by Alan G. Schnebly.

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