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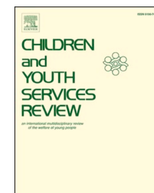

“If only we knew…”: An exploratory study of parents of adopted adolescents seeking residential treatment

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ABSTRACT

Adopted children are overrepresented in higher levels of clinical care (e.g., residential treatment centers), yet little is known about adoptive parents’ experiences parenting children with serious emotional disturbance, and the precursors to and aftermath of choosing out-of-home care—particularly in families formed via domestic private adoption. The current exploratory study used focus groups (11 adoptive parents, 9 families) to examine parents’ experiences of parenting and navigating care for their children, with attention to how children’s challenges and placements impacted and were impacted by all family members. The findings underscore a variety of institutional challenges and barriers (e.g., lack of preparation by adoption agencies; inadequate mental health care services and insurance coverage) faced by adoptive families with a child with a severe emotional disturbance. The findings also highlight multifaceted strains to the family system associated with child mental health challenges, including strains on parents’ own well-being, their couple relationships, and sibling well-being. Implications for adoption agencies, family practitioners, school administrators, and researchers are discussed.

1. Introduction

The goal of the current exploratory study, which used data from focus groups, was to gain insight into the experiences of adoptive parents of teenagers with serious emotional disturbance, with attention to personal and contextual factors that contributed to, and the familial aftermath of, placing their children in out-of-home care, including residential treatment centers (RTCs). We aimed to contribute to a slowly-growing literature in this area, with the ultimate goal of improving understanding and services for adoptive families and children.

1.1. *Adopted youth’s adjustment during adolescence*

Research suggests that adopted children are at elevated risk for emotional, behavioral, and academic difficulties (Duncan et al., 2021; Keyes et al., 2008). Child maltreatment and other early adverse experiences can trigger chronic stress, which may have lasting physiological effects on adjustment, including learning and emotional-behavioral regulation (Forkey & Szilagyi, 2014). Prenatal substance exposure can also help to explain the higher rates of psychological and academic challenges observed in adopted children (Forkey & Szilagyi, 2014). Yet even if children are placed with their adoptive parents early in life and do not have a known history of prenatal substance exposure, they still experience the loss of their first family, which can lead to difficulties associated with unresolved grief and longing (Powell & Afifi, 2005). In fact, all members of the adoption constellation confront issues related to loss, rejection, shame and guilt, grief, identity, intimacy, and mastery and control (Roszia & Maxon, 2019; Silverstein and Kaplan, 2011). Adoptive parents’ denial or ignorance of such issues—for example, amidst an expectation that children placed as newborns should not experience loss—may exacerbate attachment issues. Yet of note is that adoptive family processes such as cohesion and communication also impact adjustment; pre-adoptive risk factors are only one component of children’s well-being (Pace et al., 2021).

The emotional intensity and turbulence of adolescence may amplify existing challenges, and can be an especially stressful time for adopted youth and families (Goldberg & Virginia, 2022). Adolescence is often associated with an increase in emotional/behavioral problems in adopted children, especially those with adverse early experiences; such experiences can impact brain development, which undergoes major changes during the teen years (Loman et al., 2014; Pace et al., 2021). Further, compared to non-adopted adolescents, adopted teens may have

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more conflictual relationships with their parents, as evidenced by research finding that both adopted teens and their parents reported higher levels of family conflict than non-adopted teens and their parents; and, independent observers rated adopted adolescents as less warm and, in families with two adopted children, more conflictual, than non-adopted adolescents (Rueter et al., 2009).

Emotional/behavioral challenges and family conflict may coincide with issues related to identity exploration (e.g., who am I, where do I belong), and increased interest in and curiosity about birth family (Goldberg & Virginia, 2022; Messina & Brodzinsky, 2020), including information related to health, medical background, and physical characteristics (Wrobel & Grotevant, 2019). The normal or typical developmental tasks of adolescences are intensified by adoption, especially if teenagers are a different race than their adoptive parents (Goldberg et al., 2022). In turn, nationally representative data suggests that adopted adolescents tend to report more challenges than non-adopted adolescents in a number of areas, including mental health, suicidality, physical health, fighting, and lying to parents, as well as school achievement (Miller et al., 2000; Slap et al., 2001).

Indeed, turning to the school domain, in addition to the intensified emotional/behavioral challenges that they may experience during adolescence, adopted youth may also show worsening academic performance and more school-related challenges during their teenage years, particularly if they are attending schools with limited adoption-specific supports and resources (AdoptionUK, 2014; Best et al., 2021). Parents and their adopted children often describe school as a challenging place for their children (Best et al., 2021; Goldberg et al., 2017, 2021), which parents frequently attribute to schools' lack of adoption competence and inclusivity, children's emotional reactivity and dysregulation, and children's unrecognized (or unattended to) needs (Best et al., 2021; Goldberg et al., 2017).

1.2. Adoptive families and out-of-home care

A minority of adoptive parents perceive their children as having emotional/behavioral challenges that are so pronounced that they consider out-of-home care (Hanna et al., 2017). Several studies (Brown et al., 2018; Hanna et al., 2017; LaBrenz et al., 2020) have focused on adoptive parents who place their children in RTCs, which appear to be disproportionately utilized by adoptive families, as are other types of inpatient and out-of-home care settings (Bettmann et al., 2015). Adoptees may represent 25–30% of youth at RTCs, despite constituting slightly over 2% of the U.S. population (Brodzinsky et al., 2016). Adoptive parents' high use of out-of-home care may reflect their high level of treatment-seeking, greater emotional disturbances in adopted children, or both (Brodzinsky et al., 2016; Cohen et al., 1993).

Studies of adoptive families often examine predictors of mental illness (e.g., prenatal, pre-adoptive, post-adoptive) in children (Duncan et al., 2021), but rarely examine how adoptive parents cope with or manage mental illness in their children (but see Brown et al., 2018; Hanna et al., 2017; LaBrenz et al., 2020). Their experiences are likely similar to those of biological parents of children with serious emotional disturbance, but may differ in key ways—such as their consideration of loss and attachment issues as they debate whether, and what type, of out-of-home care to pursue (Brodzinsky et al., 2016; Roszia & Maxon, 2019). Biological parents often report experiencing severe stress related to parenting a child with serious emotional disturbance, manifesting symptoms of grief and trauma (e.g., hopelessness, loneliness) as they seek to cope with their children's behaviors, including violence, outbursts at school, and police involvement (Herbell & Breitenstein, 2021; Mohr & Regan-Kubinski, 2001). One study of 71 biological parents of teens in RTCs found that many parents reported symptoms of depression, anxiety, and PTSD, as well as high levels of parenting stress, suggesting that parent and adolescent mental health is bidirectional, and providing support to parents may benefit teens (Herbell, Breitenstein, Ault, & Eisner, 2022).

Building on the literature on parents of biological children with serious emotional disturbance, Hanna et al. (2017) conducted 24 interviews with adoptive parents (9 couples, 14 mothers, 1 father) who had placed their children in RTCs. Parents noted a range of maladaptive behaviors in their children (who ranged in age from 7 to 16), who were most frequently diagnosed with reactive attachment disorder, but also with ADHD, oppositional defiant disorder, conduct disorder, PTSD, and bipolar disorder. Parents voiced disappointment in the various systems (e.g., school, law enforcement) aimed to help them and their children, and endorsed a variety of trauma symptoms themselves as they navigated parenting their children. RTC was seen as a last resort by parents, chosen to achieve safety for their child and family. It was often emotionally exhausting and financially taxing to achieve, and preceded by a long road paved by frustration and sadness,

Brown et al. (2018) also sought to understand the experiences of families whose adopted children were placed in RTCs. They studied 10 families with 21 children, 13 of which were in RTCs. Most children were 0–5 when placed in their home, and about 14 when they were placed in an RTC. Brown et al. found that escalating problematic behaviors, including suicidal remarks, stealing, and drug use, were often the impetus for seeking RTCs. A common theme across families was a need for more training and services to support parents post-placement. Few parents had extensive information about their children's background, and 1 in 5 said they might not have adopted had they known how severe their children's challenges and parenting would be.

A final study of note is a survey of 113 adoptive parents with at least one child in an RTC that aimed to learn more about their experiences with RTCs (LaBrenz et al., 2020). Many parents used family therapy and other traditional services, but few had access to adoption-competent therapists or trauma-informed care. Parents emphasized the need for providers to gain training in trauma-informed approaches and shift toward prevention in supporting adoptive families. Notably, Brodzinsky et al.'s (2016) survey of directors of RTCs found that most clinical staff had received at least some training in adoption, which is important given that not only are adopted youth overrepresented in RTCs, but also, within them, adopted youth may show more adjustment challenges than nonadopted youth (Brodzinsky et al., 2016) and have more significant trauma histories, poorer academic histories, and a greater likelihood of having biological parents with mental illness (Bettmann et al., 2015).

1.3. Research gaps

Research on adoptive parents of children whose needs are so great so as to warrant out-of-home care is still in its infancy, and more work is needed. In particular, there is a need for research on parents who adopted via domestic private adoption—which made up about 38% of all adoptions in the United States in 2005–2009, when the current sample adopted their children (Vandivere & Malm, 2009)—since these parents, having adopted their children as newborns, may be less prepared for the challenges that may unfold. Further, most research on adopted children in out-of-home care focuses on children adopted from foster care: 80% or more of the children in Brown et al. (2018), Hanna et al. (2017), and LaBrenz et al. (2020) were adopted via foster care. Parents who adopt via foster care are often cautioned about the range and severity of difficulties their children might experience due to early adverse experiences (although many still desire more training in specific areas; Barnett et al., 2018; Kaasbøll et al., 2019). National survey data confirm high rates of mental health service use among adopted children ages 5–17 years, albeit with lower rates among private domestic adoptees (41% of boys, 24.8% of girls) than public domestic adoptees (52.4% for boys, 36.3% for girls), with rates being 40% and 30.9% for internationally adopted boys and girls (Tan & Marn, 2013). Thus, rates are indeed lower but still relatively high among private domestic adoptees, particularly boys. Likewise, rates of diagnoses of ADHD and behavior/conduct disorder are lower among private domestic adoptees than public domestic adoptees (19% vs. 38% for ADHD, 11% vs. 25% for

conduct problems), but they are still higher than the general population of children (10% for ADHD, 4% for conduct problems) (Vandivere & Malm, 2009).

Adoptive parents need more preparation for parenting children with complex needs and/or serious emotional disturbance—issues that are overrepresented in foster care, but also present in domestic private adoption (Barnett et al., 2018). Prospective adoptive parents describe wanting as much background information as possible about potential children so they can make an informed decision about adoption, and also be more prepared to parent the child(ren) they do adopt (Brooks et al., 2002; Lasio et al., 2021). Notably, prospective adoptive parents who are more informed about potential child issues (e.g., prenatal drug exposure) are not less open to parenting children with such issues (Edelstein et al., 2017); and, parents feeling more prepared for the adoption has been linked to fewer child behavioral issues (Goldberg & Smith, 2013).

There is also a need for research on parents with varying levels of experience with out-of-home placements, including parents of children with multiple placements and those with limited exposure and/or who are considering such placements. Such inclusion may enable a fuller picture of the decision-making process related to, and emotional aftermath of, out-of-home placements.

Further, there is a need for more work that examines the family dynamics of navigating children's severe emotional disturbances within adoptive families: specifically, the ways in which parents, and siblings, navigate and make sense of a child's severe challenges. Very little attention has been paid to siblings at all in this context. Research on biological families suggests that siblings of youth with mental illness often report conflict with and physical victimization by their sibling, and often perceive their parents as favoring their sibling (Deal & MacLean, 1995; Ma et al., 2015). Further, the stress of parenting a child with mental illness can indirectly influence parents' relationships with that child's sibling(s) (Kilmer et al., 2010).

Finally, among adoptive parents who have ongoing contact with birth family, little is known about whether and how they discuss children's mental health challenges and out-of-home placements with birth family members. Such discussions might be emotionally charged given the heritability of many mental health disorders and developmental challenges (Jami et al., 2021) and adoptive parents' internalized sense of responsibility to mitigate such challenges amidst a belief in the power of "nurture" (Goldberg et al., 2021). They may also carry a sense of having promised (themselves, the birth parents) to give their child a "better life" (Chatham-Carpenter, 2012) and this narrative could generate guilt over not realizing that promise.

1.4. *Methodological and theoretical framework*

We used a phenomenological qualitive approach in the current study, in that we sought to understand the shared experience of individuals who have experienced the same phenomenon, with attention to similarities and differences across participants' experiences within the phenomenon (Creswell & Poth, 2018; Giorgi et al., 2017; Patton, 2015). The shared experience in this research constituted that of parenting adopted children with severe emotional disturbance—so severe that parents were considering or had already pursued out-of-home care. Although phenomenological approaches do not necessitate the use of theory to inform study questions and interpretation, theoretical lenses can be useful in contextualizing and communicating the findings. In this study, a systems framework—and specifically an ecological model (Bronfenbrenner, 1988, 1999)—informed the development of our interview questions, and to some extent the organization of our findings. An ecological model acknowledges the role of multiple intersecting, overlapping systems, from the macrolevel (e.g., culture) to the microlevel (e.g., schools, health care) in individuals' development, well-being, and relationships. Thus, we interrogated parents' interpretation of multiple systems and their impact on their families—such as the role of adoption agencies in their preparation for parenting and the role of school and health care (and the macro-context of COVID-19) in their children's trajectories and outcomes.

We also draw specifically from family systems theory (Montgomery & Fewer, 1988; Whitchurch & Constantine, 2009), which developed out of systems theory, and centers on how family members function and impact each other within the family system. Family systems theory asserts that families are systems of interconnected, interdependent persons, none of whom can be understood in isolation. A central tenet of family systems theory is the notion that a change in one part of the system (e.g., escalating child behavioral challenges; a child's placement in an RTC) impacts the entire system (e.g., siblings, parents) (Katz, 1977). In turn, such changes require readjustment of the entire system, which may fluctuate between disorganization and stability as members strive to (re)gain equilibrium (Whitchurch & Constantine, 2009). Crucially, this framework recognizes the reciprocal nature of influence: children do not simply affect their adoptive parents and siblings, but are impacted by them as well—and are impacted by other (sometimes ambiguous or contested) members of the family system, such as birth family (Kim & Tucker, 2020). This theory also recognizes the family as containing subsystems, including the couple, parent–child, and sibling relationships (Montgomery & Fewer, 1988).

1.5. *The current study*

This study used data from focus groups with 11 adoptive parents of teens, most of whom had prior or current out-of-home placements, to explore their experiences of parenting children with severe emotional disturbance. We attended in particular to the role of systems, such as adoption agencies, schools, and health care, in child and family functioning, and how children's challenges and placements impacted and were impacted by all family members.

2. Method

2.1. *Sample*

The sample consists of 11 parents who are members of nine families (i.e., both partners in two families participated) (see Table 1). All parents had one child (most aged 15 or 16) who was in, on the cusp of, or approaching RTC placement. Two parents (Carrie, Christa) of children with extensive mental health treatment histories were considering an RTC. Two families (Pam/Rayna, Molly) were actively seeking an RTC; in one of these cases, the child was currently hospitalized. Two families (Celia, Nadine) were on the cusp of RTC placement; one was awaiting a bed at an RTC, and one was in a therapeutic wilderness program and would enter an RTC after discharge. Three families (Layne/Dennis, Darren, Sharon) had children currently in RTCs, two of whom had been in prior RTCs. In seven families, these "target" children had siblings, who in six cases were younger. Five had one sibling, and two had two siblings.

Four children were boys: that is, they were assigned male at birth and identified as male. Two were trans girls, one was a trans boy, one was nonbinary and assigned female at birth (AFAB), and one was "gender expansive" and AFAB. The overrepresentation of trans youth in this sample of adopted teens with serious emotional disturbance is important and is discussed in our Findings. Three children were White, three Latino/a/x, two multiracial, and one Black. Six were adopted via private domestic adoption, one via international, and two via public adoption.

In the context of the focus groups, parents shared that their children had been diagnosed with a number of mental health conditions, including: reactive attachment disorder (four); ADHD (four); anxiety disorders (four); post-traumatic stress disorder (PTSD) (two); bipolar disorder (two); developmental disabilities (e.g., autism) (two); learning disabilities (e.g., dyslexia) (two); oppositional defiant disorder (one); obsessive compulsive disorder (one); major depressive disorder (one);

Table 1
Focus Group Participants: Key Child Demographics and Out-of-Home Care History and Status.

Focus Group #, Parent ID	Parent Name	Child Race	Siblings	Out of Home Care History and Status
FG1, P2A	Pam	Latinx	1 younger	Actively looking for and evaluating RTCs and other out-of-home care options
FG1, P2B	Rayna	Latinx	1 younger	Actively looking for and evaluating RTCs and other out-of-home care options
FG1, P1	Christa	Latinx	1 younger	Prior intensive outpatient treatment Considering RTC
FG1, P3	Darren	Latinx	1 younger	Prior RTCs Current RTC
FG2, P3	Sharon	White	1 older	Current RTC
FG2, P1	Carrie	African American	1 younger, 1 older	Multiple prior short-term hospitalizations Considering RTC
FG2, P2A	Layne	White	1 younger	Prior RTCs Current RTC
FG2, P2B	Dennis	White	1 younger	Prior RTC Current RTC
FG3, P1	Celia	Multiracial	None	Multiple prior hospitalization Currently awaiting bed at RTC
FG4, P2	Molly	Multiracial	2 younger	Currently hospitalized inpatient Actively looking for RTC
FG4, P1	Nadine	White	None	Prior hospitalizations Currently in wilderness program Placement in RTC planned post-discharge

Note: FG = focus group, P = parent, RTC = residential treatment center. Limited demographic information is given to preserve confidentiality.

Tourette's (one); and autism (one). Some parents also mentioned "issues" that their children had that did not necessarily constitute diagnosed conditions, namely: aggression (four), trauma (three), suicidality (three), self-harm (three), behavioral issues (two), and sensory issues (two). All parents noted multiple issues/diagnoses, usually 3–4. These data should be viewed with caution given that parents were not systematically asked about a specific set of diagnoses or issues; indeed, certain parents likely did not share all diagnoses that their children had received as evidenced by the fact that, for example, three mentioned suicidality but only one explicitly stated that their children had been diagnosed with major depressive disorder.

All parents were White; one had a Latinx partner, and one had a Black ex-partner (the child's other parent). Families reported a family (combined) income of $100,000-$200,000. Two parents had PhDs/MDs/JDs, four had Masters, four had Bachelors, and one had some college.

2.2. Procedure

The sample of 11 parents participated in a longitudinal study of lesbian, gay, and heterosexual adoptive families, ongoing since 2005. The original sample was recruited primarily via adoption agencies and adoption professionals, and, like the current sample, is mostly White and well-educated (e.g., see Goldberg & Garcia, 2020). In early 2022, the research team reached out to the full sample of 128 families who participated in prior waves of data collection (beginning pre-adoption and, most recently, as children entered puberty) about interviewing their children (M age = 15.5) for the current wave of data collection. Some families responded by telling us that their children could not participate because they were in an RTC, hospitalized, or on the cusp of placement in out-of-home care. Struck by this, we put a call out to the full sample about our intention to form focus groups to enable parents in this situation to talk about their experiences. We heard from 13 parents (11 families) who wished to participate; two could not make their schedules work to accommodate the groups. Our final sample was 11 parents.

Focus groups were facilitated by the PI, a clinical psychologist, and doctoral students in clinical psychology with training in interviewing and group facilitation. Focus groups lasted 1.5 h on average. There were four focus groups, one consisting of five parents, one of three parents, one of two parents, and one with a single parent (another participant was expected to show up but had a conflict). Focus groups were conducted via Zoom, recorded with participants' permission, and transcribed verbatim. Focus groups were approved by the Clark University IRB, Protocol #66 (Adoptive Parents and Teachers' Perspectives and Experiences with Adoption and Family Diversity), date of approval March 4, 2022.

2.3. Data collection

We chose to use focus groups for this study, as these are a useful method for collecting qualitative data on a particular topic in a semi-structured group setting (Stewart & Shamdasani, 1990), and may be especially helpful when tackling complex or sensitive topics, as they create a safe atmosphere and allow opportunities for connection (Morrow et al., 2000; Nabors et al., 2001). Group dialogue can achieve a synergistic effect, generating data not obtained in individual interviews (Stewart & Shamdasani, 1990). Focus groups capitalize on the power of human interaction, eliciting rich experiential data and generating insights (e.g., via discussion and brainstorming) that might not otherwise emerge (Ashbury, 1995). For this research focus (experiences of parenting children with severe emotional disturbance that warranted decisions about out-of-home care), group interaction proved a valuable tool in facilitating the sharing of stories and experiences and providing a means of support and validation.

Interview questions were informed by our knowledge of the challenges in participants' lives, as well as the literatures on adoptive families and families with children with severe emotional disturbance. Several questions were refined and some additional questions were added after the first focus group, based on themes and issues that emerged. The overarching purpose of the groups was to allow adoptive parents who were navigating a particularly challenging time a space to talk about and respond to several general topics.

Focus groups began with introductions (e.g., names, location). Each session then tackled a variety of topics. Participants responded to a variety of prompts, including the following, which generated free-flowing conversation that was not constrained by facilitators: (1) What are the main struggles you have had in the past 2–3 years related to your child? (2) What are the biggest challenges you have encountered related to school? Who/what has been helpful? What about mental health services? (3) What have your experiences been with different RTCs or higher levels of care? How was this challenging for your family/other children/relationship with your partner? (4) What information did you receive about your child's pre-placement history? Did the professionals you worked with during the adoption process explain the implications of your child's pre-placement experiences for their future development? (5) Do you have contact with birth family? What form has it taken? What is your relationship with birth family like? (6) How has COVID (and

remote schooling, social distancing) impacted your children's mental health?

2.4. Data analysis

Each focus group was recorded and transcribed, with the exception of names, locations, and potentially identifying information. The words and conversations of the participants were therefore the text data used in our analysis (Lincoln & Denzin, 1994). We pursued an inductive analysis, whereby transcripts of the four focus groups were reviewed multiple times, and key statements that spoke to participant experiences and perspectives were identified and grouped in larger themed units (Creswell & Poth, 2018). Our phenomenological approach and systems framework informed our approach to data analysis: We remained open to the ideas that emerged, but attended especially to the interactions among systems, child, and family.

In coding the data, we drew from Giorgi et al. (2017) descriptive phenomenological method of data analysis (see also Malterud, 2012). All five authors read through each focus group transcript alone and alongside other transcripts, multiple times, to develop a wholistic sense of the data. We made note of, and bracketed, our own experiences and preconceptions so as not to interfere with our ability to approach the data with a fresh perspective. We initiated the coding process with line by line coding, at which point we identified a number of general but related ideas, such as: a lack of preparation for children's problems; the failure of traditional systems to accommodate children; exhaustion and helplessness; and the complex ways that families had adapted to a high level of ongoing distress and dysfunction, such that children's removal generated a unique blend of emotional reactions, from guilt to relief to sadness.

As we identified themes, we began to assign codes or labels to these themes to index and organize them. Codes were further condensed and synthesized such that similar experiences and ideas were grouped, but we also captured tensions between experiences/perspectives (e.g., relief/guilt; love/frustration). We aimed to organize the final codes into a meaningful, phenomenologically informed "storyline." As our goal was to capture the diversity and nuances of experiences while also telling a coherent story (Goldberg & Allen, 2015), effort was made to not only identify coherent and rich themes but to place them logically and meaningfully in relation to one another. In turn, our Findings are organized around several major themes, which contain a number of subthemes. Indeed, phenomenological analysis often results in a system of several superordinate, descriptive themes, within which there are a large number of subordinate or minor themes (e.g., Shelton & Bridges, 2021; Smith & Osborn, 2003). Throughout the coding process, we examined our evolving scheme against the focus group transcripts. Consistent with Morgan et al. (1998), we not only pursued a transcript-based analysis but also incorporated an audio-taped based analysis (i.e., we listened to the audio recordings of the focus groups).

To enhance trustworthiness, five authors, including three individuals who conducted the focus groups and two individuals who did not, coded the data and collaborated on the analysis. That is, we independently coded the data, and then came together to examine our coding collaboratively, facilitating a deep individual understanding of and shared intimacy with the data (Goldberg & Allen, 2015). Our iterative process of assessing the fit between the data and the emerging analysis, and our efforts to render "thick descriptions" of phenomena, enhanced the credibility of the analysis (Goldberg & Allen, 2015; Lincoln & Denzin, 1994).

3. Findings

Our findings reflect themes that emerged from focus group data from 11 parents who were at various stages of RTC placement, from considering (2), actively looking for (2), on the cusp of placement in (2), or currently in (3) an RTC (Table 1). We first discuss the intersection and compounding nature of stressors (COVID-19; puberty) that may have exacerbated the challenges already present within children in the sample, a subset of whom were trans/nonbinary (TNB) and thus faced unique issues during puberty. We then address the perceived impact of children's challenges on the family system. Next, we address parents' perceptions of how adoption agencies, a key system, failed to prepare them for children's challenges. We then discuss the systems (e.g., schools, health care) that parents navigated in their attempts to obtain care for their child. Finally, we discuss parents' decision-making about out-of-home care, how such care shifted the family system, and parents' feelings about children's futures.

3.1. A "constellation of stressors": Challenges escalate amidst puberty and COVID-19

In six families, the child who was experiencing severe emotional disturbance was 15 or 16. Two were 14, and one was almost 13. While all children had emotional/behavioral challenges prior to adolescence, most parents (all but one) noted that such challenges worsened with puberty. Puberty typically coincided with the onset of COVID-19, which was regarded as a contextual stressor in terms of the challenges of remote learning and associated isolation, and the disruption to the educational and mental health services that children received. Thus, COVID served to aggravate, but not jump-start, the challenges that children experienced.

Indeed, most parents reported an escalation in challenges, both in terms of anxious and depressive symptoms (and suicidal ideation and self-injury, in a few cases) as well as outbursts and aggression (sometimes resulting in physical violence against family members and/or police involvement) during puberty, which coincided with COVID. Christa (FG1, P1)[1], a heterosexual mother, shared: "At puberty, Rowan started getting very depressed. He has ADHD, depression, gender dysphoria, potentially borderline personality disorder. He started cutting, was depressed, didn't want to be around people." For Celia (FG3, P1), a heterosexual mother, puberty "amplified the dysregulated mood" associated with her child's bipolar disorder, which made it harder to focus in school and to draw on emotion regulation skills. Yet even though children's challenges were seen as having worsened, most parents described consistency in the nature of such challenges. Rayna (FG1, P2b), a lesbian mother, described her son as having impulsivity and intense anger for years: "I think the emotional regulation piece is really underdeveloped."

Over half of parents mentioned that remote schooling was a key challenge, insomuch as it coincided with puberty. "He graduated middle school, COVID hit, and everything shut down for him; he started self-harming, and [there were] several trips to the hospital", said Layne (FG2, P2a), a gay father. Noted Celia (FG3, P1): "Remote learning was a shit show. It was so terrible…the school did an amazing job and still it was a lonesome [period], it was really hard." For a few children, reintegration into the traditional school setting after remote schooling during COVID "did not go well", and set in motion a cascade of social, learning, and behavioral challenges.

According to a few parents, adolescence was also marked by an increase in complex or angry feelings towards birth parents, as youth grappled with their identities as adoptees and in some cases struggled to identify the origins of their emotional, neurological, or developmental challenges. Molly (FG4, P2) said that Sloan was "angry because she just feels like it's her mom's fault for the way she is…Of course, we've never expressed that [prenatal drug exposure] is the reason she has Tourette's or is impulsive—never. But she definitely knows about drugs—she's learned about it in school." Dennis, a gay father (FG2, P2b) shared that

[1] FG = focus group number (1, 2, 3, or 4) and P = parent number in that group. A and B are denoted where there are two parents within one family. All names are pseudonyms.

as his son started to have "more issues, I think he really started resenting the birth mother and blaming her a lot—like, 'Why doesn't my brain work like everybody else's? It's all my damn birth mother's fault.'"

3.1.1. Gender identity and adolescence

Five of these children were trans/nonbinary (TNB) or gender expansive, and thus navigating puberty and the intensification of emotional and behavioral issues while also dealing with gender dysphoria, gender identity exploration, and/or decisions about hormones. Celia (FG3, P1) noted: "Every identity piece that has required a new kind of individuation and differentiation has presented some kind of crisis," noting that both adoption and gender had presented complex "crises" to be navigated during puberty.

For one parent, the reality that her trans daughter had recently gone off puberty blockers and was going to experience male physical puberty gave her pause, as she recognized the challenges this might engender as she continued through adolescence in general, and transitioned to an RTC specifically. Molly (FG4, P2) said, "Once that voice starts to lower, it could cause her major trauma…I wish I had [a therapist] who could just move into the house—who does a little bit of everything, but I don't have that, so it's very difficult to navigate."

3.1.2. Positive parent–child relationships

It is notable that despite the challenges that they had encountered with their children, half of parents emphasized that they adored their children, spoke passionately about their good qualities, and had positive relationships with them. Said Dennis (FG2, P2b): "With both our kids, even our more problematic kid, we have good relationships. That's one of the things I'm grateful for." Molly (FG4, P2) said, "She's super fun, super sweet, very affectionate. She carries a 3.5 at school when she's doing well. She's got this great side, but then this other side that's just so scary. I have totally unconditional love for her, and I like her personality. That helps; if you don't like your kid, it's much harder."

3.1.3. Impacts on the family system

Most parents described how the roller coaster of navigating their children's challenges had impacted their families, marriages, and other children. Acknowledging the anxiety she felt at the prospect of her child living at home as opposed to an RTC, Molly (FG4, P2) noted, "When Sloan is around, the whole house changes. Everything changes, and not for the best." While just two mentioned that they were in couples counseling, most parents said their relationships had been strained. Celia (FG3, P1) said, "We've necessarily been in a parenting marriage for the last few years. And it's taken everything we have. We sit on the couch at the end of the evening and just…hold hands and just sink into the couch and watch something together. It's been incredibly stressful." Nadine (FG4, P1), a heterosexual mother, described the ramifications of her son Jasper's emotional and behavioral challenges for the entire family:

> It has shaped every single thing our entire family and extended family has done in the last 16 years. I don't think I would trade the joy he gave me for anything, but I would be so thankful to…to know the damage he would have done to my relationships with my siblings, friends…my relationship with my husband, which nearly didn't survive. If I had known then what I know now, I probably would not have chosen adoption.

Significantly, the majority of parents also spoke to the impact on their other children, and their guilt about the things that these siblings had witnessed (e.g., police being called): "I feel like she's just been exposed to a lot of stuff that she shouldn't have had to experience," said Pam (FG1, P2a), a lesbian mother, who also described her younger daughter as having "bystander trauma" as a result of being around her brother. Dennis (FG2, P2b) shared:

> I think we're so aware and concerned about the effect on our younger son, who's a very sensitive soul already. We've done a good job of really keeping his needs in mind and focusing on him and getting him the people to talk to that he needs, but I'm always worried about… what's going on in his mind. He's experienced way too much that a little kid should have never had to witness, or heard, or had to have explained to him.

3.2. "This wasn't what we expected": Lack of preparation and support from agencies

Most parents reflected on how they had "arrived" at the current moment—that is, the journey (or rollercoaster) that led them to consider, seek out, or place their child in an RTC. They reflected on their children's adoption, the supports they did or did not receive during their children's lives, and their own role as parents—for example, not recognizing their children's challenges as rooted in adoption-related loss. All but two families had adopted their children via private adoption, and all but two adopted their children as newborns. These parents generally felt that they had not been adequately prepared for the level and type of challenges their children experienced. Celia (FG3, P1), for example, felt "misinformed" by her social worker, noting that.

> she said, "We think she's got depression and she smoked some during the pregnancy, but that's inconsequential," and basically said, "This is about as good as it gets." It turns out it wasn't unipolar depression, it was bipolar, and they think there's schizophrenia in the family history, and the birth mother smoked cigarettes and cannabis during her pregnancy. So, we're seeing some of the neurological effects of that.

Several parents pointed out, too, that the adoptive parents, adopted adults, and birth parents whom they had seen speak on panels (e.g., those sponsored by their agencies) did not seem to represent the full spectrum of adoptive family experiences and outcomes, but painted an overly rosy picture of what they as adoptive parents might expect. Layne (FG2, P2a) said, "They chose folks to come talk to us that seemed to be getting through life on their own pretty well. So, I think that might have planted a little false sense there." Yet significantly, while he cited an inadequate level of preparation as fostering "false hope", Layne acknowledged that he and his husband were also primed to view adoption through rose-colored glasses:

> The doctors did tell us, "There's no drugs in his or the mother's system right now," but warned us: "Kids who are exposed to some of the things that she admitted to taking during pregnancy, a lot of them end up having issues later on." We'd been waiting [for a child] for months, and were caught up in that excitement, so I think part of that dampened the bad news I think the doctor was probably trying to give us. I don't know that [having all information] would have changed anything, but looking back, I feel uninformed.

Most parents who adopted infants had assumed that because of their children's young age at placement, they would not have attachment issues. They believed that adopting children at birth meant circumventing many of the types of challenges that children who were adopted at an older age were at risk of experiencing. Said Pam (FG1, P2a), "We definitely had the idea that he came to us before he was a year old, so how could there be…? It was not until we started seeing a therapist who specialized in adoption that we started even really considering…that his reactions to things might be that he was reacting to trauma triggers." Darren (FG1, P3) shared:

> We assumed that since we adopted at birth that attachment issues didn't apply to us. Every summer we went to a camp for adopted children of color and there was always this attachment specialist there and we never went to any of her workshops. We were like, "That doesn't apply to us." And people have been like, "Hey,

adoption is itself a trauma and just because you were there at the birth doesn't mean that you're not at risk for this."

The two parents who adopted through foster care felt that although their children had presented with extraordinary challenges, social services had indeed prepared them as well as they could. Carrie (FG2, P1), a lesbian mother with several teenaged children, said: "My experience was different because we were being trained for foster-adoption. I think they are more realistic about 'This is the range of things you're going to see.'"

3.3. Systemic stressors: Schools, health care, and beyond

Parents described the role and impact of schools, health care, and other systems in their children's educational and mental health trajectories. Amidst systemic failures, individual educators and providers were identified as supportive and having a positive impact.

3.3.1. Schools

Notably, half of parents described placing their children in small, specialized schools that worked reasonably well for their children up until adolescence, when their challenges intensified. This intensification of challenges corresponded with the COVID-19 pandemic. Observing that schools "are just so COVID overwhelmed," parents acknowledged that schools simply did not have the bandwidth for their children's behavioral challenges or emotional needs. Said Rayna (FG1, P2b), "I feel like terrible things happen and they're like, 'OK, you got your five-day suspension, here's your Chromebook back.' No conversation, no 'OK, phase 2; we expect you to do this and that when you're upset.'"

Many parents described a general lack of adoption competence in schools, which had resulted in their increasing alienation from schools over time and a narrowing of options for their child and family. Noting an absence of adoption-specific resources and supports in the schools Jasper had attended, Nadine (FG4, P1) said, "Kids who come from an adoption experience are different and they need to feel community." Layne (FG2, P2a) said, "There are just no resources for these kinds of kids. It's kind of disheartening." Coupled with a general lack of adoption competence, schools' special education services—which were utilized by most children, who had individualized education plans (IEPs)—were regarded as insufficient to meet their children's learning and socio-emotional needs. In turn, some parents felt that they were constantly agitating for more and/or better supports and services, and disliked feeling "pitted against" the school as opposed to working together to figure out the best plan for their child. Three families hired educational consultants to help them to figure out school options for their children, and two became embroiled in legal battles with their children's school or district to get them to pay for out-of-district placements (e.g., RTCs). In sum, parents described time and effort involved in seeking educational supports and resources that would meet the needs of their children: "The theme is, you just have to continually keep fighting for your kid, and you have to keep doing it even though structurally, everything is trying to make that more difficult" (Celia; FG3, P1).

Not all parents were entirely disappointed in and disheartened by their children's schools. Half described how, amidst challenges at the school or district level, they connected with individual administrators, teachers, or counselors who engaged with them in supportive ways: getting to know them as individuals, checking in and offering resources, and paying for out-of-district services without forcing them to engage in challenging "back and forth" negotiations or litigation. Layne (FG2, P2a) said: "We're very lucky that our district is very friendly to IEP placements like this, so the district paid for his therapeutic boarding school and is offering to pay whatever is next as long as it's approved by the state." Such examples of support helped to offset the systemic indifference and ineffectiveness that families described facing on an ongoing basis.

3.3.2. Health care

System-wide stressors extended beyond schools to encompass mental health treatment. Most parents described years of navigating a mental health care system that was bureaucratic, inaccessible, and expensive. As Darren (FG1, P3) noted, "insurance companies are a generic nightmare and don't really embrace mental health as a priority." Most described their children as having seen many providers over the years, in part because as children's mental health profile changed or grew more severe, this warranted a leveling-up in provider training or type, and/or intensity of care. Parents detailed how their reliance on providers who lacked a trauma/adoption lens had at times meant delayed or incorrect diagnoses (e.g., children were put on medication that exacerbated their emotional dysregulation; parents were delayed in their awareness of attachment issues or trauma-informed parenting techniques). Layne (FG2, P2a) said:

> By the time our son got diagnosed with reactive attachment disorder, everybody was like, "Duh! Like that's really common with adopted kids." We felt like we were so clueless… if [only] we knew at 4 years old, that it wasn't ADHD or maybe we didn't have to put him on all those meds that made him cranky and melt down and get dysregulated. We could've maybe helped him in a different way at a younger age. That would've been such helpful information, and to not know that until he was 13 years old, that was a *big* deal.

Parents appreciated it when they did find trauma- and adoption-informed therapists. Said Molly (FG4, P2), about Sloan's current therapist: "This one is trauma-based, knows a lot about adoption, and does these movements that work on the primitive brain [which] helps them to be able to access these skills later." Finding providers who were attuned to issues of racial identity was also important to some parents; as Carrie (FG2, P1) said, "We have an amazing psychiatrist who is Black, and whose specialty is Black children's mental health and the stress of racial microaggressions and stuff, which has been really helpful." Parents were also grateful when practitioners got to know their children beyond their diagnosis, taking an interest in them as people (e.g., reading the same book series as their child). Said Pam (FG2, P2a): "The professionals that have been the most helpful are the ones who really took the time to get to know our kid, who bonded with him and figured out 'here's how you get through to him.'"

3.4. Choosing out-of-home care: Navigating a web of (imperfect) decisions

Participants described the experience of parenting their children as intense, with most detailing years of difficult behaviors and interactions that intensified during puberty against the backdrop of COVID, and were preceded by chronically frustrating interactions with adoption uninformed schools and mental health providers. In describing the events that led up to their children's hospitalization or out-of-home placement, most emphasized concerns about safety—their children's or their own. More than half of children had made suicidal remarks and/or were engaging in escalating self-injurious behaviors. Four parents had been assaulted, sometimes repeatedly, by their children ("he got very upset and basically attacked [other parent]"). Concern for their other children also motivated consideration of out-of-home care. A few youth had had run-ins with law enforcement, which were typically the culmination of a series of what parents described as "bad judgments" and in some cases involved attorneys and/or diversion programs.

Although RTCs and other out-of-home care settings might have initially seemed like a "last resort," for some parents, they ultimately emerged as the only seemingly viable option, after all other intervention attempts had become or were ineffective, and/or when their child's current treatment team told them that their child's needs were beyond the care they could provide. As Molly (FG4, P2) said, "The therapist said they couldn't treat Sloan anymore, and dropped Sloan, and then the other therapist said the same thing: 'Sloan needs a higher level of care.'"

Of note is that Sloan was currently hospitalized for violent behavior and self-harm, and Molly was in turn "looking for residential treatment, but it's so hard to find someone that will take Sloan."

Several families had tried several RTCs and other out-of-home care settings before their current one. Darren (FG1, P3) said that his child was at her third RTC, prior to which she was at a wilderness program, a therapeutic boarding school, and had two inpatient hospitalizations. Celia (FG3, P1) shared that Avery had been hospitalized for suicidal thoughts, depression, and self-harming behaviors five times in the past year, and had recently been accepted into several RTCs, one of which seemed "very adoption literate", was highly-regarded, and seemed "very warm." The family was waiting for a bed at this center and looking into "alternative caregiving resources [while we wait] because we're pretty spent; we're exhausted."

Parents considered a variety of factors when debating various out-of-home care options. For example, Pam (FG1, P2a), who was actively evaluating several out-of-home care options, including RTCs, a wilderness program, or a therapeutic boarding school for her son, worried about both his willingness to go—especially somewhere far away ("for all of his conflicted feelings about us, he does not want to leave home") and their already tenuous attachment ("I worry…about damaging the connection"). Pam and others also considered program "fit" (e.g., adoption sensitivity and inclusiveness; trans inclusiveness), as well as cost. Finances were a significant stressor for most families, who never anticipated how much they would spend on specialized schools and programs. Layne (FG2, P2a) said, "He's blown out all of our savings, we've cashed in our college fund, we have this huge loan to pay for a wilderness program. [We paid for] an educational consultant." Molly (FG4, P2) said, "I know people who have mortgaged their homes [to pay for RTCs]. We're not willing to do that. Fortunately, we have adoption assistance that'll pay for her treatment, but only specific ones."

Notably, Carrie (FG2, P1), whose child had been hospitalized over a dozen times, had not yet pursued residential treatment actively because of her perception that it would be a very expensive "holding pen." In turn, she held some hope that in keeping her child at home, she could "do a better job…at keeping her from turning into her [birth] mom."

3.4.1. *Private struggles: navigating fear of conflict and guilt in determining "how much to tell"*

Some families shared how they navigated sharing their family's struggles, and the decision to place their child in out-of-home care specifically, with people outside the immediate family. In particular, they discussed the tensions and fears that arose when deciding how much to disclose to birth family. Of five families who said they had ongoing contact with their children's birth families, three said that they did not disclose much of what was going on to birth family members because of prior responses to their disclosures ("We tried sharing…her response was, 'Oh, he's just doing it to get attention; he needs a firm hand") or they already had challenging relationships with them. Said Sharon (FG2, P3), a lesbian mother, about the birth mother:

> There's mental illness, and she tries to exert control over me like, "You can't talk to the birth father." I've tried to ask her about her prenatal situation and family history and she's very anti-medicine. And she doesn't even know that he's in an RTC because she would just like, curse me out in text and try to call me and give me hell. So (sigh), I don't know.

Nadine (FG4, P1) acknowledged keeping certain things from her son's birth family because of "how bad it is." "I said, 'Jasper is having some issues with internet use, and he's got himself in some trouble. So, we'll see how things go.' That's what she knows, that's all she knows. But the truth of the matter is, is that …he will go to residential treatment.'"

Others felt a sense of guilt about the fact that their children had struggled so much in their family—which the birth parents had chosen. Said Layne (FG1, P2a): "I feel kind of deeply ashamed, with both kids' birth families, like, you trusted your kids with us and look where they're at." Likewise, Rayna (FG1, P2b) mentioned feeling imbued with "a sense of responsibility to the birth family," and expressed her desire to "do right by the incredible sacrifice and trust [birth parents] made," which clashed with her current sense of guilt over not having delivered fully on her goal of creating the best possible life for her son.

3.5. *Immediate aftermath of placement: Guilt, relief, and a shifted family system*

Parents described a range of feelings subsequent to their children's placement in an RTC. Many described a sense of relief—but also guilt surrounding this relief—once their children were no longer living at home, at least temporarily. Said Sharon (FG2, P3): "I mean, I was shocked I didn't miss him at first. I was just like, 'Huh.'" Layne (FG2, P2a) shared: "There's the guilt factor that we feel, from just the *exhale*—just the 10 layers of "ahhh." Even though things are still hard, we're dealing with it in a remote capacity. We can sit down at dinner and have a normal meal…I definitely just constantly feel guilt about that."

Some felt a deep sense of anguish, emphasizing their love for their children, and their sadness that they had reached a point where they felt that they had to choose out-of-home care. Celia (FG3, P1), whose child Avery was waiting for an RTC bed, shared that the "idea of separation is terrifying to all of us. We're all just really emotionally close. The separation will be a crisis…but it just feels like at this point we don't have a choice." A few children were on their third, fourth, or fifth RTCs; in turn, parents were aware that they might be "kicked out" of their current RTC, which would render them yet again back to "square one." Layne (FG2, P2a), who was currently preparing to transition his child to a new placement, expressed feeling anguish over "the amount of effort and time and money we put into things, just to have them fall apart."

One of the most powerful findings was how parents generally described their other children as receiving less attention over the past few years amidst the target child's difficulties—in part because they were better adjusted or not exhibiting the same type or level of challenges. Yet when the target children left home—an "event" that caused readjustment and renegotiation of family roles and relationships—parents sometimes became more aware of their other children's distress. Parents often described guilt as they realized the impact of the target children's behaviors on their siblings, and the ways in which parenting the target children had occupied much of their energy at the expense of their other children's well-being, which became apparent when the target children were removed. Darren (FG1, P3) described how his younger child was currently having migraines and wondered if she was "finally showing the stress of the past few years," now that her older sibling was in an RTC. Sharon (FG2, P3), shared:

> It's definitely been tough. I feel like [sibling] just hid out in her room and a lot of times we'd have to be like, "Go to your room, now. Take the dog, go. Lock your door."…And like now that he is at residential, we thought we were going to get a break and just chill and recover, and then [sibling] starts having panic attacks at school. I think she's finally not in fight or flight mode like we all were, and so she's just relaxing enough to have all this stuff come up. I mean, we knew that it wasn't good but….

3.6. *"It's very hard to imagine what success will look like": Thinking about the future*

Looking ahead to the future, parents described a range of feelings, including worry, defeat, and cautious optimism. Some voiced a sense of futility and hopelessness as they imagined a life of caring for their adult children who would be in and out of jail, struggling with drugs, and/or stealing from them or others. Said Layne (FG2, P2a): "I don't have a lot of hope—I'm getting choked up—It's hard to admit that out loud. He's been given every opportunity in life just to make some progress, and just

nothing has gotten through to him." He further conceded that, "We used to think that maybe he would need help or financial assistance, or that he would be, like, a stylist, but after failure after failure, the wires aren't connected; I can't picture that happening." Several acknowledged that their children might never be fully self-sufficient, and/or would be reliant on them for housing and/or assistance accessing mental health services. Said Carrie (FG2, P1): "The goal is to transition her into a group home situation, but she's completely resistant to that because she thinks she's already ready to live independently, [but] her most recent hospitalization was two months ago." She added: "I don't see any career in her future, so my hopes are mostly hopes of, don't let her get arrested, get caught doing drugs, get pregnant."

Speaking about her son Jasper, whom she had recently taken to an out-of-state RTC, Nadine (FG4, P1) said that he was "never coming home." She seemed resigned to the fact that the easy family life she had long imagined and hoped for was never going to happen. She shared her sense of disbelief about why things "ended up like this," saying, "I am just grasping at straws to try to figure out where the happy family slipped through my fingers. I just can't figure it out."

A few parents had more optimism for the future. Molly (FG4, P2) was "trying to find residential treatment for her, because I feel like that might help her navigate through school. She says, 'I want to go to college…I have to have good grades, and I'm trying to take the right classes.' She is motivated to get through school. Her mental health just gets in the way."

4. Discussion

The current study builds upon existing literature (Brown et al., 2018; Hanna et al., 2017; LaBrenz et al., 2020) on the experiences of adoptive parents of adolescents with severe emotional disturbances. It makes several unique contributions, in that it (a) focuses on the experiences of adoptive parents of children with severe emotional disturbances who adopted via domestic private adoption, (b) examines the ways in which siblings were impacted by and navigated their sibling's challenges, (c) addresses interactions with birth parents vis a vis children's challenges, and (d) captures a range of experiences within families who were at various stages in the process of considering and seeking out-of-home care (i.e., pre, current, and post RTC placement). The sample is also unique in that it contained a disproportionate number of TNB children, who may experience unique issues during puberty. Our findings hold implications for improving both pre-and-post adoption services for families.

The parents in our focus groups all described their children as having emotional and behavioral challenges, but many noted that puberty marked an escalation in such challenges, consistent with other research on adoptive families (Goldberg & Virginia, 2022; Messina & Brodzinsky, 2020). Further, these youth were experiencing the transition to puberty during a global pandemic marked by uncertainty, isolation, and interruptions to academic and mental health services; indeed, youth in the general U.S. population have also been found to experience increased mental health symptoms during the COVID-19 pandemic (Racine et al., 2020).

More than half the children in the sample were TNB. In part due to minority stressors (discrimination, internalized transphobia), TNB youth in general are at heightened risk for severe mental health concerns (e.g., suicidality), which may result in the need for inpatient or residential treatment (Walton & Baker, 2019). Adolescence can be an especially difficult time for TNB youth, who may experience increased gender dysphoria in response to the development of secondary sex characteristics that occur during puberty (Rew et al., 2021). The high number of TNB teens in our sample is consistent with preliminary data indicating overlap among adopted and TNB youth, such that a disproportionate number of TNB youth seeking gender-affirming healthcare are adopted (Shumer et al., 2017). The overlap between trans identities and adoption could, as Shumer et al. (2017) suggest, reflect adoptive parents' higher tendency to seek support and intervention services; alternatively, this correlation may reflect a difference in identity formation processes between adopted and nonadopted youth, such that adopted children tend to actively reflect on their identities by nature of their adoption histories. As such, there may be a more intentional exploration or consideration of their multiple identities, including gender identity, throughout adolescence. It is significant that among adopted children with serious emotional disturbance specifically, a disproportionate number may identify as trans—or, perhaps, parents of trans children were simply more likely to volunteer for the focus groups. Still, this overlap suggests that at the very least, RTCs and other out-of-home care settings need to be prepared to address not only adoption-related but gender identity-related issues, and should provide access to trained medical and counseling professionals who can provide care and support to TNB youth, for whom adolescence may be especially challenging.

In detailing their children's challenges, parents described a range of impacts to the family system, including strains to their couple relationships and sibling well-being. Similar to research on biological families in which a child has a serious mental health issue, parents reported high levels of chronic family conflict, chaos, and distress (Herbell, Breitenstein, Ault, & Eisner, 2022; Ma et al., 2015). Although high levels of parenting stress among parents of children with mental health issues are well-documented among biological (Herbell, Breitenstein, Ault, & Eisner, 2022; Mohr & Regan-Kubinski, 2001) and to some extent adoptive (Brown et al., 2018; Hanna et al., 2017) families, little work has examined the impacts to parents' intimate relationships and the other children in the family. In their review of the few studies on how a child's serious emotional disturbance affects biological siblings, Ma et al. (2015) found that biological siblings of children with mental illness often report high levels of conflict in their sibling relationships, as well as violence at their siblings' hands. Our findings related to siblings within adoptive families underscore the complex ways in which a child's emotional challenges and need for out-of-home care may impact (and be impacted by) all family members (Whitchurch & Constantine, 2009). Clinicians should include all members of the family system in treatment to support each member's mental health and learn skills to create more ease and stability following the transition to, and out of, out-of-home care.

A unique aspect of our study is that most of these parents had adopted newborns via private adoption. Most felt that they had not been adequately prepared for the range and severity of difficulties their children might experience. Parents spoke to both agency failure (i.e., showcasing adoptive families who seemed to not be having problems; not addressing adoption loss as a 'thing' that newborns might experience) as well as their own wishful thinking as components of their lack of preparation. Notably, Barnett et al. (2018) found that both foster and adoptive parents consistently ranked their children's mental health concerns as their most difficult challenge and reported feeling that few therapists were equipped to treat their children.

In addition to better preparing all adoptive parents to accept, anticipate, and address the reality that their children experience and are impacted by loss, regardless of adoption type (Powell & Afifi, 2005; Roszia & Maxon, 2019), adoption agencies should also provide parents with as much information as possible about the children they are considering adopting. Preparation is highly valued by prospective adoptive parents and does not appear to lessen their willingness to adopt (Edelstein et al., 2017), and, may be linked to fewer child behavioral problems over time, likely because parents are sensitized to recognize and address challenges as they occur (Goldberg & Smith, 2013). Pre- and post-adoption training and coaching by agencies would ideally enable parents to detect, and address, challenges in their children (e.g., attachment issues, emotional dysregulation) earlier on, thus enabling children to receive interventions as soon as possible which could potentially mitigate children's need for residential treatment in their teenage years. Agency training would also, ideally, enable adoptive parents to develop a more nuanced vocabulary and understanding vis a

vis adoption loss, such that they are able to recognize that adoption loss does not necessarily constitute trauma (Brodzinsky et al., 2022). Agencies can further prepare them to encounter a range of practitioners with divergent viewpoints on and approaches to treating problems in adopted children and families (Brodzinsky et al., 2022), and help them to identify adoption-competent clinicians with the skills to provide individualized, tailored assessment and interventions to adoptive families (Atkinson, 2020).

Beyond preparation, many parents invoked the failures of several key systems, most notably school and mental health, to adequately support their children—which they attributed to a lack of training in trauma or adoption, inability to accommodate the severity of their children's needs (e.g., due to lack of training), and general bureaucracy. A lack of synergy among and ineffectiveness within various overlapping systems (adoption agencies, education, health care; Bronfenbrenner, 1988) compromised parents' confidence in their ability to find appropriate care for their child and family. Parents' frustration with such systems echoes other work on adoptive parents (Hanna et al., 2017), as does their high level of engagement and advocacy on behalf of their children (Brodzinsky et al., 2016; Cohen et al., 1993; Goldberg et al., 2017). Yet parents voiced appreciation for individual providers who, despite the inadequacy of the broader systems, supported their children and families through practices such as getting to know their children as people and conceptualizing their children's difficulties through an adoption-informed lens. Given the overrepresentation of adopted children in clinical settings, including RTCs (Brodzinsky et al., 2016), alongside evidence that the mental health care system is inadequately prepared to meet the needs of adoptive families, there is clearly a need for specialized training and adoption informed practitioners at every level of care (Brodzinsky et al., 2022; Brown et al., 2018; Hanna et al., 2017). Practitioners should, ideally, engage strengths-based and family-oriented approaches with adoptive families (Atkinson, 2020), while recognizing the need for individualized treatment interventions—since a one-size-fits-all approach rarely works with such families, as our participants alluded to and prior research also suggests (Hanna et al., 2017).

With respect to schools, some parents voiced concern over the lack of adoption-related resources and community available to their children, underscoring the invisibility of adoption-related issues in most educational settings, and highlighting the potential benefits of school-based affinity spaces and support groups, and parent-teacher collaboration, for adopted children (Stother et al., 2019). Amidst high levels of advocacy on behalf of their children in schools, parents were also exhausted by the time and energy it took to pursue appropriate assessments, and find (and fund) alternative schooling options, echoing other work (Hanna et al., 2017). A few noted gratitude for their school districts that covered their child's out-of-home care, an act that helped to mitigate their emotional and financial stress. An implication of this is for school districts to consider encompassing policies and supports (e.g., pro bono educational consultants) that can aid adoptive families who struggle to navigate and pay for out-of-home care. Peer (parent) mentors or parent navigators might also be recruited to support parents in navigating educational and therapeutic options (Hanna et al., 2017).

Parents described their decision to seek out-of-home care as triggered by concerns about safety, as well as escalating emotional/behavioral problems more generally, which echoes other work on adoptive families who chose RTCs for their children (Brown et al., 2018). Significantly, we documented complex feelings and strategies related to sharing the severity of their children's needs, and possibility or actuality of their placement in out-of-home care, with birth family. Parents often avoided sharing the full extent of children's challenges, either because of guilt or a sense of failure, or prior experiences that left them feeling that birth family would react negatively or offer unwelcome input. Shame and guilt represent powerful and common feelings that adoptive parents may experience (Roszia & Maxon, 2019), both in general and in relation to birth parents specifically. Complicating this dynamic, birth parents' relationship to the adoptive family system is often ambiguous, prompting uncertainty related to whether and how to communicate about difficult topics including those concerning the child (Kim & Tucker, 2020; Powell & Afifi, 2005). One implication of this finding is that agencies, via both pre- and post-adoption training, might seek to prepare adoptive parents and birth parents in open adoptions for the possibility that children may experience serious emotional disturbance in the future. Agencies should also consider how to provide continual guidance and support related to how to enact communicative openness, as such openness may help to strengthen relationships and soften tensions related to discussions of the child's challenges (Brodzinsky, 2006; Goldberg, 2019).

Finally, it is notable that parents, in thinking about their children's (and their own) futures, sometimes expressed little hope. All were emotionally and financially exhausted, and most could not imagine a future where their child was an independent young adult and did not rely on them for some level of care. Many grieved the futures that they could no longer hope for, highlighting again how loss and grief may show up not only for children but adoptive parents as well (Roszia & Maxon, 2019). Parents also experienced powerful feelings of guilt (e.g., in relation to their other children). This finding has implications not only for adoption agencies, which should seek to prepare adoptive parents for these complex feelings and offer post-adoption support resources, but also RTCs, which have a role to play vis a vis adoption awareness not only in terms of meeting children's needs but also supporting parents (e.g., helping them to process guilt and grief) which will likely benefit children as well (Herbell, Breitenstein, Ault, & Eisner, 2022). Both family and group-based supports have the potential to support adoptive parents' understanding of their children, compassion for themselves, and confidence and competence in parenting children with severe challenges (Atkinson, 2020; Downes et al., 2022).

5. Limitations and conclusions

One strength of this study is our focus on parents who adopted via domestic private adoption, whereas most similar studies of parents of adopted youth in RTCs have focused on families formed through foster care. An additional strength is that our sample was homogenous in terms of age, in that all children were teens and at a similar developmental phase, unlike some prior studies of adoptive parents of children in RTCs, wherein children spanned a wide age range (Hanna et al., 2017). Another strength is our inclusion of parents of diverse sexual orientations, which is reflective of the diversity of adoptive parents (Goldberg, 2019).

Yet our study also has limitations. Our sample consisted mostly of middle-to-high income, highly educated, and racially homogenous parents, which could explain the high level of treatment seeking in our sample, limiting the generalizability to underresourced adoptive families. Also, participant selection was conducted via participant availability, rather than via intentional grouping of members, which resulted in focus groups of varying size and may have impacted the nature and richness of the data. Future work should explore the experiences of adoptive parents of color, who may face added barriers navigating the mental health care system, given the historical mistrust, and documented underutilization, of therapy among peope of color (Atdjian & Vega, 2005). Another limitation is that we did not explicitly ask parents to report on their chilren's diagnoses. In turn, although parents mentioned these in the context of discussing their children's challenges, our ability to interpret or draw conclusions related to children's diagnostic profiles is limited by the fact that we did not obtain such data intentionally or systematically. Also of note is that our participants demonstrated a wide range of apparent impressions of constructs such as "attachment", and we did not provide them with or guide them towards any particular definitions. Nor did we probe the specific origins of their understanding of these constructs; doing so may have research and clincal utility, and future work may engage this topic. Finally, our sample size is small and our study exploratory, and our findings are not

intended to be representative and nor should they be interpreted as such.

Despite these limitations, the current study contributes to the growing body of literature examining the experiences of adoptive parents with adolescents whose severe emotional disturbances require out-of-home care. Our study extends prior literature in its focus on adoptive parents who adopted privately and its exploration of how the entire family system, especially siblings, were impacted by children's challenges. The findings underscore the institutional challenges and barriers that are met by adoptive families with a child with a severe emotional disturbance. Efforts should be made to increase knowledge of and access to adoption-specific services, given that most parents in the sample expressed confusion and difficulty with finding services tailored to their adopted children's specific and nuanced challenges. Given that adopted children are overrepresented in clinical settings and more likely to have emotional, behavioral, and educational challenges, family practitioners, school administrators, and researchers must make efforts to achieve true adoption competency.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The data that has been used is confidential.

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