

Post Adoption Depression

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Adoption is a cultural and political practice that happens within local, domestic and global contexts. There are approximately 1600 adoptions annually in the province of Ontario (MCYS, 2010; McKay & Ross, 2011). Researchers have shown that adoptive parents experience depression at an equal or greater rate than biological parents, up to one in four adoptive parents will experience post adoption depression (Foli et al., 2012; Foli, South & Lim, 2014; Senecky et al., 2009). Post Adoption Depression (PAD) is a term coined by June Bond in 1995. Defined as a mood disorder that includes both blues and depression, Bond's initial description of PAD emphasized the experiences of: infertility, a completion of a life goal and subsequent let down, the unique stressors of the process of adoption, loss of the birth experience, loss of the ideal of the "dream child" and the legal uncertainty that can accompany the post adoption period. In addition, adoptive parents experience similar stressors to birth parents such as loss of sleep, less marital satisfaction, impact of colic, reflux and crying babies (Mott et al., 2011; Payne et al., 2010; Senecky et al., 2009). Together these factors create a unique set of stressors for adoptive parents.

It is important to recognize the unique nature of PAD because children who are adopted are at a higher risk of adverse outcomes as a result of their environments prior to relinquishment and the psychological transition to a new family (Foli et al., 2014; Foli, 2012; McKay & Ross, 2011; McKay, Ross & Goldberg, 2010). A review of the literature listed in the attached references has revealed five main themes pertaining to PAD. These include: (1) the unique experiences of adoption and the impact on parental mood, (2) barriers to accessing services, (3) tools and measurements for PAD, (4) the need for "adoption smart" professionals and, (5) gender differences with PAD. The following sections will describe each of these five themes.

Unique Experiences of Adoption & Foli's Theory on PAD

The post adoption period has shared and unique characteristics when compared to the postpartum period for biological families (Foli et al., 2014; Foli, South & Lim, 2012). Common risk factors may include: sleep or rest, self-esteem, relationship satisfaction, social support, history of depression and parental expectations (Foli, 2012).

The main difference lies in the final shared factor: parental expectations. Parental expectations in the context of the adoption process create a unique experience for adoptive parents (Foli et al., 2014; McKay, Ross & Goldberg, 2010). Foli's Theory on PAD details these unique factors and includes four main expectations that impact parents post adoption experiences. These are: (1) expectations of self (such as "I have to be the world's best parent" or "I will feel like a real parent"), (2) expectations of the child (such as "my child will be OK" or "my child's needs will be disclosed"), (3) expectations of friends and family (such as "my child will be welcomed into the family" or "I will receive support in the same manner I would with a birth child"), and (4) expectations of society (such as "society will understand my decision to adopt" or "adoption professionals are there to get me a child and a licence to parent"). Foli's Theory has explained that the difference between parental expectations versus parental reality can come as a result of a child's medical, or behavioral issues that may or may not be disclosed during the adoption process, or as a result of lack of support or the surveillance of the adoptions process itself. Foli's Theory has provided an understanding of the differences in risk factors between PAD and PPMD which may act as cues in assessing and opening dialogue with adoptive parents (Foli et al, 2014; Foli, South & Lim, 2014, 2012; Foli, 2012; Foli & Gibson, 2011).

Barriers to Services

Similar to PPMD, fear, shame and guilt are noted as significant barriers to accessing services for PAD (Foli & Gibson, 2011). More specifically, McKay & Ross (2011) have outlined barriers that are both external and internal to the adoption system.. Externally they have cited: (1) parents being unprepared for the stress of the special needs of their children, (2) non disclosure of issues by parents due to the pressure to be the perfect parent, (3) the surveillance of parents both pre and post placement, (4) lack of adoption smart professionals, (5) community supports that are focused on biological parenting and are often exclusionary of adoptive parents, and (6) limited access to services for physical, mental or medical issues because of adoption status. McKay & Ross (2011) have reported internal barriers to be: (1) no provincial mandate for post placement support, and (2) perceived over involvement in the immediate post adoption

period, experienced as surveillance that abruptly ends at six months post placement. By acknowledging these barriers there is the potential to find strategies to overcome these challenges. Post adoption depression is an important issue that requires awareness, advocacy and education for both health care providers and parents (McKay & Ross, 2011).

Tools and Measurements for PAD

While PAD shares many similarities to PPMD, it should not be assumed that the constellations for PPMD outlined by Beck (2006) can be universally applied to adoptive parents. For example, anxiety and self harm are symptoms that are less likely to present in an adoptive mother (Foli, 2011). Because of this Mott et al. (2011) have argued that tools such as the PASS CAN quick assessment tool may not be appropriate for adoptive parents. Notably, the Edinburg Perinatal Depression Screening (EPDS) is not a validated tool for use with adoptive parents (Foli, 2011; Foli & Gibson, 2011; McKay, Ross & Goldberg, 2010). The EPDS can still be used in the context of using common sense about what the measures can tell you. (email communication with Dr. Cory Flanders & Dr. Lori Ross, CAMH, Toronto).

Most commonly, Foli and her colleagues (Foli, South & Lim, 2014, 2012) have used a combination of the EPDS and the Center for Epidemiologic Studies Depression Scale (CES-D) to measure PAD within the context of their research. In addition, the Dyadic Adjustment Scale (DAS) designed to measure relationship satisfaction (Foli, South & Lim, 2012) and the Parenting Stress Index (PSI) (McKay, Ross & Goldberg, 2010) were also used.

In addition, the temporal boundaries for PAD may extend beyond that of PPMD due to the developmental, medical and behavioral issues that may arise with an adoptive child over time. This means that the window of time in which an adoptive parent may experience PAD could be much longer than that of PPMD (Foli et al., 2014).

“Adoption Smart” professionals

Foli has defined an “adoption smart” or “adoption competent” professional as someone who understands the culture of adoption and clearly knows the differences in

risk factors between PAD and PPMD (Winship, 2011). In addition, adoption smart professionals can assist in stabilizing the family post adoption through non-judgemental support that gives parents “permission” (Foli, South & Lim, 2014; Foli, 2011) to express emotions they may perceive to be socially unacceptable in the context of the adoption process. These skills may facilitate the adjustment process and help prevent PAD (McKay & Ross, 2011). In addition, adoption smart professionals can use language that is inclusionary and supportive, such as “adoption adjustment period” instead of “adoption probation” (McKay & Ross, 2011; Winship, 2011). McKay & Ross (2011) have advocated for training and education for adoption professionals, governed by Ontario’s Ministry of Child and Youth Services, and mental health professionals working under the Ministry of Health and Long Term Care.

Gender Differences with PAD

Foli & Gibson (2011), Goldberg, Kinkler & Hines (2011), and McKay, Ross & Goldberg (2010) have all reported on risk factors and depressive symptoms unique to the male gender experience of PAD. This information will be integrated into the literature review on fathers.

Conclusion

Post adoption depression is an important issue. In the province of Ontario there are approximately 1600 adoptions annually, all governed, legislated and regulated by the Ministry of Child and Youth Services (MCYS, 2010; McKay & Ross, 2011). More than half of adoptions in the province of Ontario are public adoptions, handled by the Children's Aid Societies across the province (McKay & Ross, 2011). It has been shown that 26% of adopted children experience moderate to severe health problems and 60% of adopted children receive ongoing medical care (Foli et al., 2014). These statistics place 400 families a year at risk of undetected or untreated PAD. This information will contribute to the creation of the Northern Ontario PPMD Strategy.

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