

## The Adoption of Indian Children by Norwegian Parents

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## The Adoption of Indian Children by Norwegian Parents

### Executive Summary

This study was an empirical inquiry into the adoptions of Indian children by Norwegian families. The information gathered in the study includes data on the process of international adoptions, the outcomes of those adoptions for Indian children and their Norwegian families, and program evaluation data particularly concerning those adoptions facilitated by Children of the World Norway. The theoretical framework that guided this research was a family systems model of adoption informed by the strengths perspective.

The study begins with a review of some of the empirically-based literature on international adoptions in Norway and adoptions of Indian children internationally to set the stage for the current research.

All children adopted from India by Norwegian families formed the sample frame for the current research and approximately half of those families participated in the study. Specifically, 192-Indian adoptees from 142-Norwegian families were represented in the responses to a mailed questionnaire.

Among the many findings in the study, some of the most significant results included the following: the majority of children adopted from India by Norwegian families in the sample are physically healthy, appear to be displaying normal developmental trajectories, have experienced healthy attachment with their adoptive families, do not display marked behavior problems, have not experienced negative reactions to their adoptive status or concerning their biological origins, and adoptive families were able to identify many strengths in their children. The difficulties children displayed at the time of adoption have alleviated or disappeared over time. Most parents reported a high level of functioning in their families, healthy adaptation to the adoption by Indian child, and sustained stability of most of the adoptions represented in the study..

No major gaps in services were identified by the majority of adoptive parents during or after adoptions. Parental reports concerning the services received by those families served by Children of the World Norway were overwhelmingly positive. Parents report they were provided mostly accurate information about their children. Their contact with CWN prior to, during and post-adoption was rated as helpful by most respondents. Ongoing contact from CWN personnel during the adoption process was noted as very helpful by most parents to whom it was offered so this contact is encouraged in the future. Those who did not experience ongoing contact with CWN personnel generally wanted more. In short, most of the adoptive parents were quite satisfied with the services they received from CWN. Therefore, maintaining and in some instances increasing CWN's high-level of services to adoptive families and children is recommended.

One striking difficulty many of the children in the study have experienced relates to prejudicial attitudes concerning their skin color. Public education concerning diversity appears to be called for by these findings.

Recommendations concerning organizations in the public sector include increased examination of the school difficulties some of the children and their families have experienced. In addition, adoption preparation appears to be an effective means to assist families who wish to adopt children from other countries in preparing themselves for the difficulties and obstacles they may face throughout the adoption process. A

recommendation is made to require adoption preparation for all potential internationally adoptive Norwegian families. Post-adoption contact can also be improved in order to more effectively respond to adoptive families' and children's needs.

The final set of recommendations concerns BSSK in Pune, India. The pursuit of accurate and complete information concerning adoptees should be a greater priority in order to enable adoptive families to account for the risks they may encounter in the adoption and the types and quantity of services they may need to recruit in order to help them raise their children in the healthiest manner possible. Another enhancement would be the addition of monthly updates concerning adoptive children that could be sent through CWN to their future parents. These updates could take the form of videotapes of the children accompanied by written reports.

The researchers' hope the findings and recommendations in this report will be useful for agencies and professionals involved with the adoption of Indian children by Norwegian families. With the exception of the prejudicial societal attitudes experienced by many of the children, the recommendations in this study emanate from the experiences of relatively small numbers of families in the study. Overall, the research findings in the present report are overwhelmingly positive and can be viewed as support to continue offering the high level of services provided by CWN.

## The Adoption of Indian Children by Norwegian Parents

### Norwegian Adoptions: An Overview

Domestic adoptions are very rare in Norway (Saetersdal & Dalen, 2000). However, Norway has been referenced as the worldwide leader “per capita” in international adoptions, since one-percent of the annual ‘birthrate’ is currently composed of internationally adopted children (Botvar, cited in Howell, 2001). This translates into between 500 and 600 infants and toddlers arriving each year from other countries to Norway (Howell, 2002). Haugland (1999) indicates that Norway has the highest rates of international adoptions per 100,000 people. However, Yngvesson (2002) makes the same claim concerning per capita supremacy for Sweden. No matter which country may actually lead in comparative proportion of international adoptions, it is clear that international adoption is an important aspect of Norwegian family life. Selman (2000) lists Norway as having the highest overall adoption rate (14.6) compared to Denmark (11.8), Sweden (10.4), Switzerland (10.2), France (6.4), the USA (5.7), the Netherlands (5.3), Italy (4.6), Finland (3.5), and Australia (1.3).

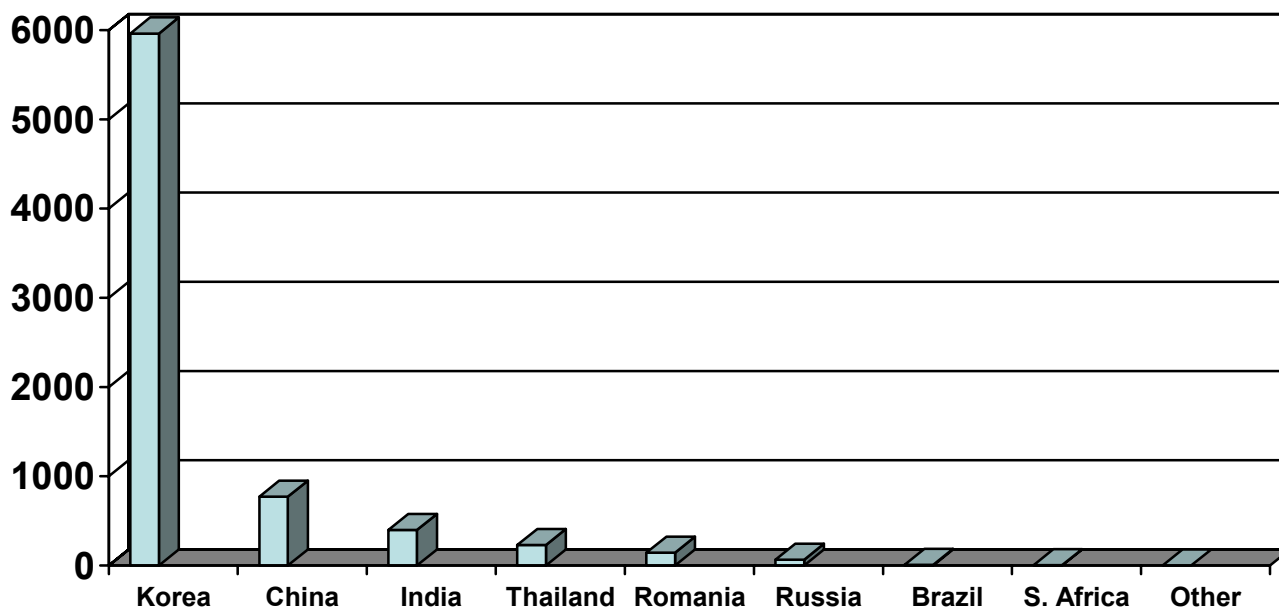
The number of international adoptions has steadily increased in Norway over the past decade. The trend revealed by national statistics is a steady decline in “in-country” adoptions countered by such a large increase in international adoptions that the overall level of adoptions in Norway has risen over the past decade (Statistics Norway, 2000). Selman (2000), drawing from data provided by the United Nations, indicates the adoption rate increased from 11.3 per 100,000 in 1995 to 14.6 per 100,000 in 1998. Kalve (1996) provides additional data about the increase; for instance, in 1995, there was a 14% increase overall in adoptions compared to the previous year and two out of three children adopted in Norway that year were originally from other countries.

There has also been a steady flow of children from India who are adopted by Norwegian parents. Unlike the overall rise in international adoptions in Norway, there does not appear to be a clear trend over the past decade of Indian children adopted in Norway. The number of children adopted from India in 1995 = 47, represented an increase over the previous year (Kalve, 1996). However, from 1997 through 2002 the number of children from India fluctuated within approximately a 30-child range. The numbers of Indian children adopted in Norway annually during that time frame were as follows: 1997 = 23; 1998 = 44; 1999 = 54; 2000 = 49; 2001 = 40; 2002 = 37 (Statistics Norway, 2001, 2002). The data reveal a rise and then, over the three most recent years, a slight decline in the adoption of children from India.

Children of The World Norway (CWN) is one of the three authorized agencies for international adoptions in Norway and one of two that accounts for 96% of all international adoptions (Saetersdal & Dalen, 2000). CWN has been an important international adoption organization for 5 decades in Norway. CWN has been involved in over 7500 international adoptions since 1969. By far, children from Asia (n=7363 or 97%), in general, and Korea specifically (n=5963 or 79%), represent the largest pool of international adoptees to Norway through CWN. Korea has the longest history as a source country followed by Thailand starting in 1979, India in 1982, Romania in 1989, China in 1991, Russia in 1992, and South Africa is the newest, starting in 2003. Brazil and South Africa have contributed few adoptions as of 2002, with 6 children having

come from Brazil and 2 from South Africa. The following figure (Figure 1) summarizes all adoptions from 1969 through 2003 by country of origin.

**Figure 1: Number of Adoptions in Norway through Children of the World-Norway by Country of Origin**



From 1982 through 2003, CWN has facilitated the adoption of 398 children from India by Norwegian families. During all but a few of those years the vast majority of Norwegian adoptions of Indian children were facilitated by CWN. During those years, almost half of the children adopted from India (52%, n=206) were from Mumbai and 45% (n=179) were from Pune.

Several factors have led to the rise in international adoptions in Norway, including: the decline in the rate of Norwegian babies available for adoption, the cultural expectations generated by the strong endorsement of family as an important aspect of life in Norwegian society (which leads to, “enormous pressure on those couples who find themselves unable to have their own children” Howell, 2001, p., 205), and the generous “birth leave” act that provides for 12-months of paid leave for either parent, includes adoptive families, and covers the family with other benefits until the child is three-years of age (Howell, 2001, 2002, 2003; Morgan & Zippel, 2003).

### **Norwegian Adoptions: Research Review**

One of the earliest studies of international adoptions in Norway was conducted by Dalen and Saetersdal (1987). Drawing from a national sample of 226 Vietnamese and Indian adopted children, they received questionnaires on 182 children (81% response rate). They supplemented the survey with intensive interviews. The article is mainly

based on a population of 80 young adoptees from Vietnam, all of them over 17 years of age (Dalen, 2004). The researchers attempted to compose a sample with young adoptees from all parts of Norway. They traveled throughout Norway, interviewed 41 adoptees in their homes and interviewed their parents separately (n=98). The Vietnamese-adoptees were mostly female (75%). About 20% were adopted before the age of 1 year, 44% were adopted between 1 and 3 years of age, and 34% were adopted after age 3. Focusing on the Vietnamese children, they found that the older the child at adoption, the more language difficulties they had. This led subsequently to academic difficulties. Of the 41 adoptees interviewed, 17% (n=7) succeeded well in school, 41% had average performance, and 41% had below average performance. In addition to the academic difficulties, they highlight the complex feelings the Vietnamese adoptees had about their ethnic identity. Adoption seemed to be less of an issue than the desire to distance their misidentification as Vietnamese refugees. Dalen and Saetersdal (1987) and Saetersdal and Dalen (2000) raise an interesting perspective about the meaning of ethnicity in a society that is very homogenous. Their work provokes serious questions about the issues surrounding identity development among international adoptees that may be different, depending on the country to which they are adopted. The comments of these researchers are quoted here because they indicate some Norwegians may view the issue of bicultural socialization, that is the process whereby children acquire norms, attitudes, values and behaviors of two ethnic groups—their own and another (Rotheram & Phinney, 1987; Tessler, Gamache, & Liu, 1999), differently than researchers in England and the U. S. They write, “. . . Should Indian adoptees’ ethnic identity be based on the reality they originally came from, i.e., usually low-caste groups? Should the starting point be Indian history as it is imparted through literature and art, i.e., a high-cast culture, or Indianness as it is perceived by small groups of low-caste Indians who have emigrated to Norway quite recently? . . .” (p., 168).

Even if bicultural socialization is of less concern in a homogeneous society, the adoptees’ appearances are ethnic markers that set them apart. This may lead to difficulties in their acceptance by others due to prejudicial attitudes or racism even when they experience high levels of acceptance of their biological and ethnic backgrounds. However, many adoptive parents are most concerned that their children not be viewed as immigrants—suggesting that some negative attitudes exist about those who are different, in their traditionally homogeneous society. The other issue these researchers identify is that Norway has few established ethnic minorities; this poses a challenge to adoptees who might want to try to connect with someone locally from a group of their ethnic background.

Other studies on identity provide broadened perspectives, adding insight into the complicated issues of identity development. Brottveit (1999, 2003) studied adult Korean and Colombian adoptees utilizing a qualitative research design. Through interviews, Brottveit gathered both retrospective and current information concerning their ethnic and social identity development. He concluded that adoptees in his sample could be categorized into three-groups: “Double-ethnicity, Cosmopolitan and Norwegian.” The double-ethnic group was primarily comprised of “root-seekers” who made trips to their countries of origin. Some were “driven by psychological problems or problems with their relations to the adoptive parents” while others were “well adapted” and had “a solid identity and high self esteem” (Brottveit, 2003, p., 23). The cosmopolitan group did not



embrace the ethnicities associated with either Norway or their country of origin. Some of them seemed well adapted to a “multicultural context” while others appeared “more passive.” The later type could be characterized as reminiscent of Erikson’s and Marcia’s conception of identity diffusion (Brottveit, 2003). Those characterized as Norwegian identified entirely with a Norwegian ethnic identity. Brottveit speculates that some in this group were influenced by a rejecting attitude in the adoptive family towards their culture of origin. Others appear to have settled on their Norwegian identity after a great deal of exploration, visits to their birth-countries, etc. (Brottveit, 2003).

Although Brottveit (2003) discusses the unique internal struggles international adoptees face in terms of identity development, especially related to ethnicity, one of his most helpful contributions is the emphasis on the social element of development. He stresses that ethnic identity is “better understood as a kind of social identity and primarily explained by actual social relations” than by intrapsychic dynamics (Brottveit, 2003). These formative social relations often include broad and specific discrimination that can lead to what Brottveit (2003) calls an “ethnic role disability.”

Among the studies on international adoptions in Norway, Howell’s (2001, 2002, 2003) work has focused on identity formation and kinship. The creation and maintenance of kinship when Norwegian parents adopt children from other countries is viewed as a “mystical” process (Howell, 2003). Howell (2001) refers to kinship as the parents, “...symbolically transforming the blood of their children to their own...” (p., 220). The “transformation” of internationally adopted children into Norwegian is accomplished by the tendency to “ignore the differences” in parents and children (Howell, 2002).

Howell (2001, 2002, 2003) also finds that the majority of adopted children in Norway do not identify with their country of origin or people from that country. One piece of evidence for this conclusion arises from “birth land” tours in which children and their adoptive parents travel to their birth countries. As Howell (2003) studied these tours she arrived at the conclusion that the adoptive parents showed much more interest in finding their children’s biological relatives, former orphanages or institutions (such as the hospitals in which they were born) than the children did. Adoptees on these trips often confirm their Norwegian identities. In fact, because these trips are often made with groups of other adoptees (who were all originally from the same country) and their adoptive parent(s), the trips often become an “extended family adventure” which result in the adoptees expressing the feeling that, “...they had much more in common with the other adoptees than with the Indian or Korean youths whom they met in their birth countries” (Howell, 2003, p., 481). When one contemplates the difference in cultures encountered by the adopted children on “birth country” trips, many of whom have no or little memory of their country of origin, the tendency to cling to the familiar upon experiencing the shock of the unfamiliar is not surprising. According to Howell (2003), some children wish to seek out biological relatives during “birth country” trips. However, upon meeting them, “...the fact of shared natural substance often seems to lose its significance. There is so little else that the adoptees and their biological relatives have in common” (Howell, 2003, p., 481). Howell’s (2003) conclusion is the “relationship of nature by itself is no basis for significant sociality” (p., 481).

Howell (2003) suggests that adoptive parents may have the following underlying motives for these trips, first, “...the confirmation of the child as a kinned Norwegian person” and second, to “...confirm the reality of the new family they have made” (p., 477

& 478). It appears these desires are often realized during birth-land trips for most adoptive parents. As Howell (2003) puts it, differences between adoptive parents and their children may be “glossed over” and, “. . .the biological parents emerge only as minor characters in the adoptees’ (sic) personal trajectory” (p., 481).

The in-depth information gathered by both Howell (2001, 2002, 2003) and Brottveit (2003) expands the knowledge-base concerning identity formation among adoptees (especially ethnic identity) and offers unique perspectives for thinking about these issues.

In contrast to the research on identity, Andresen (1992) focused on behavioral, emotional and school adjustment issues. His inclusion of a comparison group of native-born Norwegian children (who are in the same class at school and are the same age and sex as the subjects) in this study is a helpful way to contrast the development of adopted children to non-adopted children. The strength of this approach is that all of the subjects experienced the same school environment and were often in the same class. The majority of the children were Korean born (72%) 12-13 year old internationally adopted children in Norway while the origins of all other adoptees in the sample were not explicated. Overall, the adopted children were evaluated by their teachers as well-adjusted. They had no major problems with reading or writing. However, adopted children had more difficulty in math than their non-adopted counterparts. Language capabilities were equivalent between adopted and non-adopted children. The adopted children did not demonstrate more emotional or behavioral problems than non-adopted children but they were rated as significantly more hyperactive. No differences in adjustment were attributed to the child’s age at adoption in this study but country of birth did account somewhat for differences in adjustment among the adopted children. Children originally from Korea appeared to exhibit fewer problems than those from other countries. Adopted boys displayed more problems than adopted girls.

Dalen (1995, 2001) studied many of the same variables investigated by Andresen (1992) concerning internationally adopted children in Norway. Dalen (2001) compared children originally from Korea and Colombia to non-adopted Norwegian children. In contrast to Andresen’s (1992) findings, Dalen’s (2001) study revealed poor outcomes among the participants. She discovered internationally adopted children experienced lower educational achievement, displayed more “problematic behavior” (especially hyperactivity), and demonstrated poorer “school language skills” than non-adopted children. However, no differences resulted between the two groups on “day-to-day” language skills. When the children adopted from Korea and Colombia were considered differentially compared to non-adopted Norwegian children, those born in Colombia fared most poorly in virtually all categories. , In contrast, the children who had been born in Korea had higher scores on both school performance and “day-to-day language skills” than native born Norwegian children when all three-groups were compared.

Results also varied between children adopted at different ages, no matter the country of origin. Those who were adopted as older children displayed worse outcomes in many areas than those who were adopted at younger ages. However, the differences were not great enough for the author to conclude that age played a “crucial role” in the outcomes (Dalen, 2001). Interestingly, Dalen (1995, 2001) also found that adoptive parents were much more actively supportive of their children’s efforts in school than parents of Norwegian-born children. Dalen (2001) speculates that this may lead either to

positive academic outcomes due to involvement in the children's schooling, or negative outcomes due to the high or unrealistic expectations of the adoptive parents.

Dalen's (2001) study includes a strong design with the use of three comparison groups. Analysis of 'within group variation' was possible because two of the groups were comprised of adopted children from two specific countries of origin (Korea and Colombia). Dalen (2001) also used a comparison group of native-born Norwegians.

In a recent study of depressive symptoms among 12-14 year old Norwegian children (Sund, Larsson, & Wichstrom, 2003), internationally adopted children were included in the sample of children (n=2,465). The researchers found that children from "third world countries," including those children who had been adopted (n=22), had higher mean depressive symptoms than others in the sample. There may have been some interaction with the "presence of both parents" in the home since those who had lost both parents also rated more highly on depressive symptoms than those who lived with both parents. In fact, those who did not live with both parents had the highest scores on depressive symptoms of the entire sample. However, definitive conclusions about internationally adopted children drawn from this study would not be justified since the findings for both immigrant children and children who were adopted from other countries were combined, obscuring the results for adoptees

There are at least two ways to interpret the findings of the Norwegian studies of international adoptions reviewed here. We may view the results from a strengths perspective and point up the positive outcomes for many internationally adopted children in the face of the obstacles they have had to overcome (problematic pre-adoption experiences, post-adoption acculturation, language acquisition, etc.). For instance, internationally adopted children in Norway appear to be well-adjusted overall (Andresen, 1992) and to acquire a solid grasp of "day-to-day language" (Dalen, 2001). Another way to approach the data is from a problem oriented perspective. From this point of view, the research tends to paint a portrait of many difficulties experienced by internationally adopted children in Norway compared to native-born Norwegian children. For instance, some of these children experience challenges with identity formation, particularly concerning ethnic identity (Brottveit, 2003; Howell, 2001, 2002, 2003). Two of the studies (Andresen, 1992; Dalen, 2001) reveal a high incidence of hyperactivity among international adoptees. In addition, these children often struggle with "school language skills," may demonstrate lower educational achievement, and display more behavior problems (Dalen, 2001) Also, there is some evidence they may experience higher rates of depression than native-born Norwegians (Sund, et. al., 2003). So interpretations of research findings are dependent, in part, on the perspective the interpreter applies.

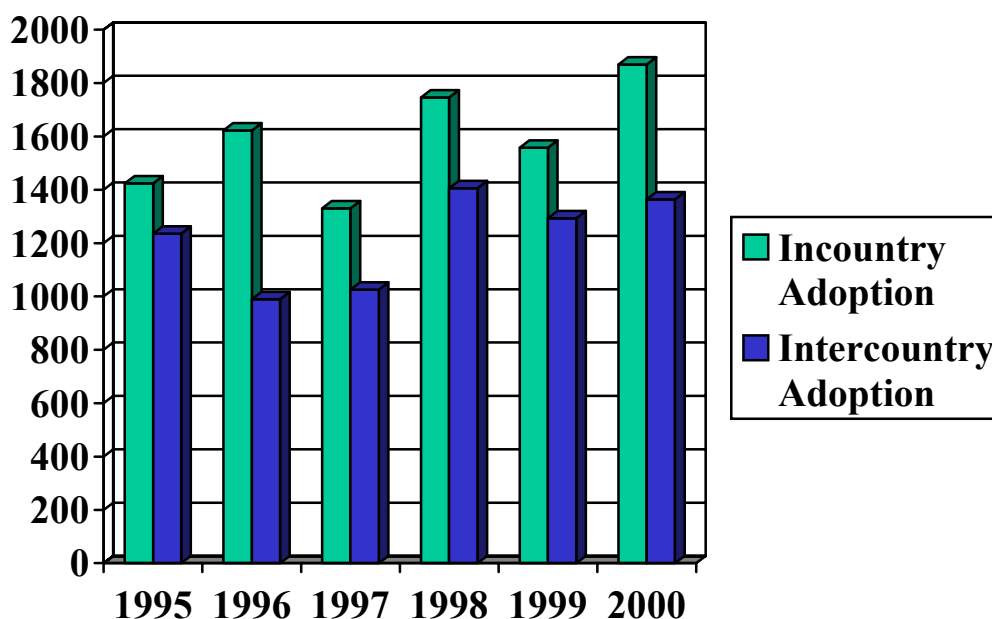
### **Adoptions from India: Research Review**

Since there appears to be little extant literature (in the English language) that focuses primarily on Norwegian adoptees who were originally citizens of India, the focus of the present review will shift from internationally adopted children in Norway to the children of India who have been internationally adopted by families in countries other than Norway. India was one of the first countries to allow the promotion of international adoptions as a 'giving' or resource nation (Yngvesson, 2002). The countries involved in the earliest international adoptions were Sweden, Norway, Denmark, Switzerland and

Holland (Damodaran & Mehta, 2000). While there were many adoptions to the U. S., they were often not considered international adoptions because the families were comprised of at least one person of Indian origin (Damodaran & Mehta, 2000).

The practice of placing children from India with foreign families (especially from Western countries) for adoption that began in the 1960s, accelerated considerably by the 1970s (Apparao, 1997; Damodaran & Mehta, 2000). This trend abated somewhat in the late 1980s due to the passage of a law in 1984 requiring 50% of the adoptions involving Indian children to be carried out domestically (Damodaran & Mehta, 2000; Yngvesson, 2002). (Special needs children were exempted from this quota). Overall in India, there has been a steady increase in the number of adoptions. According to the data provided by Central Adoption Resource Agency (CARA)<sup>2</sup>, the steady increase in adoptions is due largely to the increase in domestic or incountry adoptions. For example, of the 2660 adoptions in 1995, 1424 were from domestic, incountry adoptions (54%). In 2000, of the 3234 adoptions, 1870 were domestic, incountry adoptions (58%). The following figure (Figure 2) summarizes the adoption data for India from 1995 to 2000.

**Figure 2: Total Adoptions in India from 1995 to 2000**




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<sup>2</sup> CARA is an autonomous agency under the Ministry of Social Justice and Empowerment, Government of India. It was established in 1990 to deal with all matters concerning adoption in India. For additional information, see their website at <http://www.adoptionindia.nic.in>

By the year 2000, single-year data for the entire country reveal that 1364 Indian children were adopted internationally (Groza & the Bharatiya Samaj Seva Kendra Research Team, 2002). Children from India are free for international adoption only when there are compelling circumstances, such as they are member of a sibling group who should not be separated (Macedo, 2000), and it is not possible to locate suitable adoptive parents within India ((Damodaran & Mehta, 2000). The child or children first must have been presented to prospective Indian adoptive families. Children are only made available for international adoption after 3-attempts are made to affect an incountry adoption. . Adoptive parents in Norway have been the recipients of some of those children, but the largest numbers of international adoptions are to the United States. (Damodaran & Mehta, 2000).

The outcomes among children from India who have been adopted internationally have received some attention in the research community. Many of the children adopted from India arrive in their new countries and homes having experienced developmentally difficult early months or years. Most of them have spent time in Indian orphanages or other institutions that are generally viewed as less than ideal for the overall health and development of young children. Groza and the BSSK Research Team (2002), in a study on incountry adoptions in India, found that 95% of a large sample of adopted children had spent an average of approximately five-months in an orphanage or institution prior to adoption. When they are adopted, many of these children have or are at-risk for health, developmental, emotional, or behavioral problems.

In an effort to include relevant findings from studies on children adopted from India to countries other than Norway, studies from the United States, Belgium, the Netherlands and Sweden were examined. The last study is important to include since, by comparison, the Swedish culture is likely to be more similar to Norwegian culture than the cultures represented in the other studies explored in this section.

First, two studies from the United States will be reviewed. A study of health issues was conducted among a sample (N=200) of children from India adopted in one state in the USA (Oregon) during the 1980s (Smith-Garcia & Brown, 1989). Short-term health problems (such as, lice, parasites, fungal infections, etc.) were quite common but also fairly easy to treat. The sample also included a very high incidence of diseases with possible long-term effects such as tuberculosis (57.5%) and hepatitis-B (38%), as well as a fairly high incidence of developmental delays (18%), compromised growth (17.5%), and cerebral palsy (7%) (Smith-Garcia & Brown, 1989).

This study provided helpful research on the medical issues that are commonly faced by children from India and their adoptive parents subsequent to placement, little of which was available previously. However, the applicability of the findings to recently adopted children from India must be tempered by the fact that the subjects were all placed prior to the regulation of international adoptions in India.

Goodman and Kim (2000) investigated the young adult adjustment of adoptees from India by querying both the adoptees and their parents in a retrospective manner. They used a mixed methods approach that allowed some rich qualitative data to fill out the subjective portraits of the participants' experiences. All of the subjects had been adopted by parents in the USA from Mother Theresa's orphanages, the Missionaries of Charity, in India. Parents were asked to report on difficulties they deemed to be above average when they adopted. Through the parents' responses, 46% of the 146-adoptees

were identified as having “special needs” that were characterized as physical, intellectual, and emotional “deficits.” The majority of the children (88%) arrived from India with physical problems requiring medical attention (Goodman & Kim, 2000). However, the majority of these medical difficulties were overcome in a short period of time. Most parents also reported that the children did not exhibit major attachment problems.

On the one standardized, objective measure utilized in the study, the Achenbach, Child Behavior Checklist-Youth Self Report Profile, the majority of the adoptee self-reported behavior within the average range. Only five of the fifty-seven adoptees who completed the measure scored in the “clinical range”—that is, (similar to children receiving outpatient mental health services, Goodman & Kim, 2000). According to the parents, most of the children were able to learn English quickly. However, they also reported a high incidence of intellectual difficulties (29%), especially when they reached elementary school. According to the parents, emotional and social difficulties increased substantially when the children were in their secondary and post secondary years in school (Goodman & Kim, 2000).

The adopted children as young adults (age 15 and older, the majority in their early 20s) were surveyed. Most, but not all of them, were greatly appreciative of being adopted. For instance, in the qualitative section of the survey, subjects were queried about their feelings concerning their adoptions. One subject proclaimed they would “be dead by now” if they had not been adopted.” (Goodman & Kim, 2000, p., 24).

The subjects also tended to view current satisfaction with their lives and their prospects for the future quite positively, whether or not their parents identified them as having “special needs.” All of the adoptees (91%) indicated they got along with their parents “the same or better” than others and only slightly fewer (86%) provided the same rating concerning their relationships with their siblings. Scores on the family-related questions were even higher for the group identified as having “special needs” by their parents than those who were not. Most of the adoptees indicated “high or very high” optimism about their chances of “having a happy family life in the future.” Once again, the “special needs” group provided higher ratings on this answer than those considered not to have special needs. Clearly, for the majority of the Indian adoptees studied, strong family ties were created within their adoptive families and those ties have contributed to optimism concerning their ability to have “happy” families of their own as young adults (Goodman & Kim, 2000).

In research completed in Europe, Schaerlaekens, Huygelier, and Dondeyne (1988) studied 118-children from India who were adopted by families in Belgium. The focus of the study was the children’s ability to adapt to the use of Dutch as their new primary language. Parents reported that large numbers of the children arrived at their new homes in Belgium with health issues including malnutrition, intestinal disorders, skin diseases, and ear disorders. Ear and hearing difficulties were of special interest to the authors since these problems often compromise speech and language acquisition. They also draw the conclusion from adoptive parents’ comments that it is highly likely, “...a number of children remained linguistically deprived in their original surroundings and were only marginally verbal...” in India prior to being adopted (Schaerlaekens, et. al., 1988, p., 255). For those children, Dutch would become their “true first language.”

Overall, Schaerlaekens and colleagues found that children who were younger than two and a half-years of age upon adoption were no longer different than their non-

adopted peers (Dutch speaking Belgian children) in their mastery of Dutch, after two-years or more in the country. However, those children who were older than two and a half-years of age tended to experience many linguistic difficulties and lagged behind their peers in mastery of Dutch, after two or more years in Belgium. This, in turn, appeared to adversely affect the later group's academic performances in school and required the services of speech therapists and language teachers. On the other hand, another finding appears to offer some evidence for an alternate interpretation of the impact difficulty with language acquisition had on the children's school careers. By comparison, 13% of the sampled children had to repeat a year of school by the time the research was completed, yet the national average for repeating a year of school was 14% for Dutch-speaking Belgians and 16% for French-speaking Belgians (Schaerlaekens, et. al., 1988). So, adoptees may not have more problems that affect school outcomes than other children in Belgium.

This study offers focused analysis on a problem common to almost all international adoptees who were more than a few months old at the time of adoption: language acquisition in a new country and culture. The researchers chose to depart from the case-study technique often used by linguists and other observers who preceded them and studied a fairly large sample of adopted children from India. This choice yielded valuable information that addressed gaps in the knowledge-base concerning challenges with language acquisition experienced by adoptees from India. For instance, beyond what has already been reported here, the researchers were able to posit some stages of language acquisition most of the sample experienced in a common progression.

A longitudinal study completed in the Netherlands explored the outcomes of a large group of internationally adopted children (n=2,148) utilizing Achenbach's, Child Behavior Checklist (Verhulst, 2000). The author reports that children originally from India composed the third largest group of participants at 9.5% of the total sample. Therefore, approximately 204 of the children in the sample were adopted from India. Though the study did not focus on children from India as a subgroup analysis, a sizable group of them were included in the investigation.

The Time-1 study compared internationally adopted children to randomly selected non-adopted Dutch children (Verhulst and Versluis-den Bieman, 1995; Verhulst, 2000). Parents reported more problem behaviors, particularly of an "externalizing" type, for the adopted sample than the comparison sample. This was true of both boys and girls but much more pronounced among boys than girls and greater among children in the 12-15 year-old age range than those in the 10-11 year old range. In fact, the problems for adopted children increased with age while problems among non-adopted children declined with age (Verhulst, 2000).

The placement age of internationally adopted children was also "significantly associated with an increased risk for later maladjustment" (Verhulst, 2000, p., 34). In other words, the older the child was at adoption, the more likely they were to have problems in later childhood. However, Verhulst (2000) concludes from the data that this may have less to do with age at adoption than it has to do with the notion that higher age at adoption represents greater potential to have experienced multiple adverse occurrences that became risk factors for later difficulties. These risk factors included neglect, multiple placements, abuse and health issues prior to arrival in the Netherlands. Among these risk factors, abuse appears to have had the greatest impact on ensuing problems. However, it

must be pointed out that information on the children's environments prior to adoption was gathered entirely from their adoptive parents. An important question to raise concerning this data is how accurate the parents' knowledge was of their children's pre-adoption experiences. The histories of internationally adopted children are notoriously difficult to verify. So, the results correlating past deleterious experiences with current problems in this population should be interpreted with caution.

A three-year follow up study was completed at time-2 that revealed a significant increase in total problem scores among both boys and girls that corresponded to the increasing ages of the children. The comparison group scored just the opposite with significant decreasing total problem scores correlated to increasing age (Verhulst, 2000). The effects of the children's pre-adoption environments that were so significant in the cross-sectional approach at time-1 did not persist at time-2 as the sample aged into adolescence. According to Verhulst (2000) "Although early environmental adversities were found to be associated with higher levels of later problems, the preadoption influences were *not* significantly related to the longitudinal increase in problem behaviors across time" (p., 41). The researcher was also unable to discover any effect due to the difference in ethnicity between the subjects and their families.

One of the strengths of this study was the use of both parent reports and the Youth Self Report part of the CBCL at time-2. By self-report, the internationally adopted children portrayed themselves as having even higher levels of problem behaviors than their parents did. They also rated themselves much higher than the non-adopted sample (Verhulst, 2000). It should be noted that Verhulst (2000) points out the results of the overall study must be tempered with the recognition that the majority of internationally adopted children "seem to function well as adolescents" in that his findings concerned less than 50% of the sample on any given indicators.

The most important aspects of this study were the longitudinal nature of the study and the large sample sizes utilized for comparison. However, it did not provide detailed data on the adoptees from India.

In sharp contrast to Verhulst's (2000) findings, research on a sample of internationally adopted children in Sweden revealed overall positive outcomes for many of these children (Cederblad, Hook, Irhammar, & Mercke, 1999). Cederblad and colleagues compared 211 international adoptees in Sweden to non-adopted children using several standardized measures including the CBCL. Among the sample, children originally from India comprised the largest group differentiated by country of origin at 36% (approximately 75 children) of the sample.

Compared to a random stratified sample of non-adopted Swedish children of the same age range as the subjects, the internationally adopted children showed no marked differences in mental health or behavior problems. Adopted children in the upper age groups showed significant but only slightly higher scores than the non-adopted children on the obsessive compulsive sub-scale of the CBCL. However, that was the only scale that revealed a statistically significant difference among all of the CBCL scales including comparisons of total scale scores. These findings, of course, vary widely from Verhulst and Versluis-den Bieman's (1995) and Verhulst's (2000) results. However, like Verhulst (2000), the authors found that the conditions the child experienced prior to placement for adoption and the duration of those environmental influences, not just age at placement, had an impact on the participants in later childhood and adolescence. In the



study by Cederblad and colleagues (1999), the impact was harmful, specifically with adoptees having greater “social problems” and being “withdrawn.”

Cederblad and colleagues (1999) identify their most important finding as follows: Identity development, including ethnic identity, appeared to be a struggle for many of the participants because identity correlated highly with symptom loading (i.e., behavior problems) on the CBCL and with lower self esteem. However, since the sample in the study went up to 27 years of age, researchers were able to review the results among young adults and found that these correlations all but disappeared among young adults. This led the researchers to conclude that identity formation during adolescence (a tough proposition for all adolescents) is particularly difficult to navigate for those adopted from other countries. However, this is a transient period and once young adulthood is reached, identity related problems appear to become much less pronounced.

One of the strengths of Cederblad and colleagues (1999) study was the use of several standardized measurement instruments, normed with Swedish populations, to measure multiple variables. These researchers were able to compare their subject sample’s results on the CBCL to Verhulst and Versluis-den Bieman’s (1995) findings. Cederblad and colleagues (1999) concluded both the sample and the comparison group in their study had lower total “problem scores” than either of Verhulst and Versluis-den Bieman’s (1995) groups, and the scores of the Swedish internationally adopted youth were closest to those of the non-adopted Dutch youth.

### **Summary Of The Research Studies Related To Adoptions From India**

In summary, the studies reviewed combine qualitative and quantitative research findings from several countries on children adopted from India. The research examined here produced some conflicting findings. However, many, but not all of the findings were consistent with what has already been discovered by researchers in Norway concerning children adopted from India. Children among this population are likely to arrive in their adoptive country with medical problems, most of which are fairly quickly resolved (Goodman and Kim, 2000; Smith-Garcia & Brown, 1989). Length of stay in India prior to adoption, because it indicates the duration of negative environmental experiences, may lead to behavior problems in later childhood and adolescence that are likely to be resolved by young adulthood (Dalen, 2001, Verhulst, 2000). Identity formation is particularly difficult for these children as they seek to develop ethnic identity (Brottveit, 2003; Cederblad et. al., 1999; Howell, 2001, 2002, 2003). Most of them are likely to encounter language acquisition difficulties and many are likely to struggle with academic achievement (Dalen, 2001; Goodman and Kim, 2000; Schaerlaekens, et. al., 1988 ). Some of these children, particularly boys, may exhibit behavior problems, including elevated levels of hyperactivity (Andresen, 1992; Cederblad et. al., 1999; Dalen, 2001; Verhulst, 2000).

On the other hand, most of the studies support the hope that Indian international adoptees will overcome the adverse experiences they may have encountered prior to placement and difficulties they may have experienced through acculturation to their adoptive families and countries. In fact, the lack of problems discovered among these children found in some of the studies (in Norway and other countries) is remarkable when the pre and post adoption experiences they have encountered are considered (Andresen,

1992; Cederblad et. al., 1999). Many of the children adopted from India report solid attachment to their adoptive families and optimism about the future (Brottveit, 2003; Goodman & Kim, 2000). When problems are present the apparent trend toward resolution by early adulthood is also striking (Cederblad et. al., 1999; Goodman & Kim, 2000; Verhulst, 2000).

In summarizing the research on adoption outcomes for international adoptees, Freundlich (2002) suggests findings can be organized into three major categories:

1. There are no significant differences between adoptees and non-adoptees
2. There are significant differences between adopted and non-adopted children, especially in terms of higher rates of maladjustment among adopted children.
3. Adopted children actually fair better than non-adoptees on some variables related to emotional and behavioral adjustment and functioning.

The studies which have been completed on internationally adopted children in Norway (and in other countries) reveal a blend of the results characterized by Freundlich's (2002) categories. The most common results appear to reveal that internationally adopted children in Norway have more difficulties in some areas than children who were not adopted, but overall have fared quite well.

The studies reviewed above provide a research context for examining the aims and results of the current study. Like previous researchers, we have attempted to build on some weaknesses in past research. For instance, Brottveit's (1999, 2003) results, though informative and helpful, are based on a very small sample size (n=36) so the generalizability of the results is limited. Howell's work (2001, 2002, 2003) is rich in detail and interpretation but does not include additional quantitative research to support the qualitative findings. Some of the studies suffer from selection bias that may have skewed the results. In the Andresen (1992) and Dalen (2001) studies, the comparison groups were not randomly assigned but chosen by the teacher completing the survey. Many of the studies (Dalen & Saetersdal, 1987; Goodman & Kim, 2000) either do not specify their sampling frame or use convenience samples, again limiting the ability to generalize results beyond the specific group studied. In one study (Sund, Larsson & Wichstrom, 2003), although the sample size was large, the number of "foreign adopted" adolescents in the study was quite small (n=22). They represented only about 1% of the sample and this small number limited the statistical power in analyzing the data or providing specific implications for international adoptees. Finally, many of the studies do not include standardized measures in the methodology that have well established validity and reliability.

This study fills a gap in Norwegian adoption research by using survey methods to examine adoptees from one specific country: India. The research represented in this study includes standardized measures and a scientific sampling strategy. Items on the questionnaire include open-ended questions that can be content analyzed, thus employing a mixed qualitative-quantitative approach in the research. The questionnaire was pretested with a group of families in Norway. The sample size is robust, allowing for some sophisticated statistical analysis (although for the purpose of this report we relied mainly on descriptive and bivariate analysis).

In addition to the research review, we wanted to offer a conceptual model for thinking about this research. The following section outlines the theory that oriented this research project.

### **The Conceptual Context—A Family Systems Model Of Adoption**

The theoretical perspective used is a family systems model. The model embraces the strengths perspective. A focus on strengths encourages a conceptualization of the child and family as powerful, resourceful, and resilient (Saleebey, 1992). It is important to recognize that adoption is a greatly improved situation for virtually all children in need of a family environment. Many children become available for adoption because their environment and situations have been problematic and often abandonment, neglect or abuse have been aspects of their pre-adoptive history. Problems certainly exist in adoptive families, but their occurrence is most often related to trauma from pre-adoptive experiences—not to the child's status of being an adoptee. In addition, a focus on problems may obscure the commitment of families to the adoptee, the stability of adoption, satisfaction with the adoptive experience, and the many successes in adoption (Groze, 1996).

In thinking conceptually about adoptive family systems, one approach used in previous research (Groze, 1996, 1994) is a resource and stress model. Briefly, this model views all families as using capabilities (resources and coping behaviors) to meet its demands (stressors and strains) in order to maintain family balance (Patterson, 1988). When stress occurs, the family musters the resources to deal with it. In a sense, it balances each stressor with a resource. Crisis occurs when there are too many stresses and not enough resources, or when there is a build up of stressors such that the family can't accommodate quickly enough to garner its resources. Family difficulties or stressors also can occur during transitional times such as when the structure of the family and the developmental requirements of the child do not coincide, or when the pace of family reorganization is too fast or too slow such that individual family members are not able to get their needs met inside the family system (Falicov, 1988). Finally, difficulties are encountered when there is a mismatch between the child and family, the most serious being when parental expectations are incongruent with child capabilities. Sometimes this mismatch does not become apparent until later in the adoptee's and adoptive family's development.

As part of an adoptive family system model, it was recognized that in the adoptive family life cycle, adoptive families may encounter different types of stressors than other types of family systems (Talen & Lehr, 1984; DiGiulio, 1987; Rosenberg, 1992) and have unique life cycle issues (Rosenberg, 1992). Stressors in the adoptive family include those from the community, those coming from the service system, those that the child as a subsystem brings to the family as well as those the family system brings to the new adoptive family system (Barth & Berry, 1988). The following is a brief discussion of the system issues in adoptive families.

### **The Community in the life of the adoptive family**

A major resource for all families, and particularly adoptive families, is community support. Support from family, friends and neighbors for the adoption is important. Several authors have tried to specify the different components of social support (Pattison, 1977; Gottlieb, 1978). Barrera and Ainely (cited in Streeter & Franklin, 1992, p. 8) conceptualized social support as follows:

- 1) *Material aid*: providing tangible materials in the form of money and other physical objects to families when they need it;
- 2) *Behavioral assistance*: sharing of household tasks and activities;
- 3) *Intimate interaction*: displaying listening, caring, expressing positive esteem and understanding towards others;
- 4) *Guidance*: offering advice, information, or instruction;
- 5) *Feedback*: providing individuals with feedback about a parent's or child's behaviors, thoughts, or feelings;
- 6) *Positive social interactions*: engaging in social interactions for fun and relaxation.

Social support is acquired through two sources. First, there is the informal or natural system, which develops spontaneously from family, friends, work associates, school colleagues, or neighbors. When people need help, the first sources of assistance are usually those in the informal networks (Gottlieb, 1978). Second, there is the formal system. This is the support received from social workers, doctors, lawyers, clergy and other professionals (Caplan, 1974; Maguire, 1991; Cochran, 1990). This is the system that families are more reluctant to involve in their lives.

The way people believe, act and feel are affected, in part, by the people with whom they are interconnected in various ways. Making sure that families have adequate sources of support, both formal and informal, are essential building blocks for promoting strong, successful adoptive families. Social support serves as a buffer against stressors (Gore, 1981; House, 1981; Caplan, 1974; Froland, 1979). Feeling supported and cared for decreases the negative effects of all stressful life events. Strong community support is a resource for adoptive families.

### **The Service System**

The service system is often a stressor to families. First, the adoptive family must deal over an extended period with one or more child welfare agencies in order to become adoptive parents. Once a family decides to adopt, a social worker conducts an evaluation of the family to determine eligibility and appropriateness. Unfortunately, the approach to home studies has drifted away from a strengths-based perspective that uses the home study to explore areas in which the family needs assistance to be successful in adopting. Instead, it has become a vehicle for screening people out of the adoption process, a practice that discourages and disqualifies many families who would be good adoptive families. However, many families survive the process. If the family is judged acceptable and a child or children are placed in the family, a social worker makes periodic visits to the family so as to supervise the placement. This prolonged involvement with an agency can become a stressor to the family.

Second, besides the process that can provoke stress in families, other specific agency practices can become stressors. Potential adoptive families do not receive enough or sufficient structured training. So, an additional source of stress becomes insufficient pre-adoptive placement training (Aldridge & Cautley, 1975; Chestang & Heyman, 1976; Meezan & Shireman, 1982; Nelson, 1985; Katz, 1986; Barth & Berry, 1988; Selman, 1999). Pre-adoptive training helps families begin the process of cognitively processing what it means to be parents and, more specifically, what it means to be adoptive parents. The lack of training before adoption cannot be compensated for once a child is placed.

A third source of stress is incomplete information about the child (Nelson, 1985; Schmidt, Rosenthal, & Bombeck, 1988; Groze, 1994; Selman, 1999). The lack of complete information can result in poor matching of children and families, which places tension on the family system (Unger, Dwarshuis, and Johnson, 1977; Donley, 1990). The lack of complete information means that families cannot locate agencies or services that might be able to help them once the child joins a family, delaying access to needed services. Whether the information was withheld, poorly recorded or unavailable, the lack of complete information serves as a stressor.

A fourth source of stress is the lack of adoption sensitive social services. The shortage of post-placement services which support and assist the family can result in more negative adoption outcomes (Barth, Berry, Carson, Goodfield, & Feinberg, 1986; Nelson, 1985; Groze, Young & Corcran-Rumppe, 1991; Selman, 1999). Adoption is not a time-limited process and adoption-related issues surface throughout the life cycle (Bourguignon & Watson, 1987, 1989; Winkler et al., 1988; Rosenberg, 1992). Conventional therapy and service-provision methods can be ineffective with adoptive families if adoption issues are ignored or minimized. On the other hand, viewing adoption as the problem or ending the adoption as the solution can undermine the inherent confidence and strengths of adoptive families. Therapists and other service providers with expertise concerning both adoption and child welfare issues are rare but vital resources. Therefore, a cadre of practitioners and services that are adoption sensitive is badly needed.

### **The Family System**

There are several family system resources that promote successful adoptive families. First of all, realistic expectations must be encouraged in adoptive families (Rosenthal, Schmidt & Conner, 1988; Partridge, Hornby, & McDonald, 1986; USRE, 1985). All parents develop expectations for the "dream" or "fantasy" child. Imbued with popular myths about adoptees (Sandmaier, 1988), parents develop dreams and expectations about the child they adopt. These dreams and expectations can be reinforced by socioeconomic status, with middle and upper class families holding more rigid, high aspirations for their children. Often times, parents imagine the child will be a loving, happy "orphan" willing and grateful to be adopted. In professional career families, there may be implicit or explicit expectations that the child will pursue a similar career path. Expectations are natural in parent child relationships. However, when expectations are rigidly held or higher than children's capabilities, difficulties develop in adoptive families.

Second, families that are flexible have a greater capacity to deal with the stress of

integrating an adopted child into the family (Boneh, 1979; Cohen, 1984; Dalen, 1999). In order to accomplish family integration, the adoptive family and the adopted child must change to develop a third system, much like the experiences of blended families (Carter & McGoldrick, 1988). When a family system is too rigid, the tasks associated with integration become problematic.

### **The Child Subsystem**

Genetic makeup accounts for about 50% of the differences found in children. Adoptees who are at genetic risk are more sensitive to the environmental effects of stress in the adoptive family (Cadoret & Stewart, 1991; Cardoret, Troughton, Bagford, & Woodworth, 1990). Conversely, adoptees who have genetic risks may have these risks buffered by being raised in a healthy, adoptive family (see Mednick, Gabrielli & Hutchings, 1984). The buffering effect may be accounted for by children from poor social classes being adopted into the middle and upper classes (Fergusson, Lynskey & Horwood, 1995).

Children who enter adoptive families often have an extensive history with their birth families as well as a child welfare system when they are cross-nationally adopted. Many have also spent considerable time early in their development in institutional or group care settings. Though these children have faced multiple risk factors, they can be characterized best as survivors. With some countries reporting high child mortality rates for children in group care (Groza, Ileana & Irwin, 1999), not unlike the rates reported early in the 20<sup>th</sup> century in the U. S. (Chapin, 1911, 1916, 1917) the ones who live to be placed in adoptive families are clearly survivors.

An understanding of strengths and resilience is particularly imperative when exploring the experiences of children adopted internationally. These children face many challenges as they move from institutionally-based care to family care. They may have missed early experiences that contribute to the process of becoming healthy, happy, fully functioning adults. In group care, children's needs are secondary to requirements of the group's routine. Relationships with adults may have been superficial and brief, with the adults providing little continuous warmth and affection. Often, too many children and too few staff in these settings results in little individualized attention or care and emotional (Miller, 2000), if not physical neglect. Yet, these are children who can overcome the challenges they have faced with the help of the experiences available to them in loving adoptive families. .

Specific risks and difficulties faced by internationally adopted children include delays in emotional, social, and physical development (Bowlby, 1951; Dennis, 1973; Freud & Burlingham, 1973; Kaler & Freeman, 1994; Provence & Lipton, 1962; Spitz, 1945; Tizard & Rees, 1974, 1975; Tizard & Hodges, 1977), increased risk for adult psychiatric problems (Frank, Klass, Earls, & Eisenberg, 1996), learning problems (Goldfarb, 1943) such as poor reading ability (Mapstone, 1969; Pringle & Bossio, 1960), emotional and behavioral difficulties (Ames, 1997; Rutter & Team, 1995, 1998), and deficits in intellectual functioning (Goldfarb, 1943, 1944, 1945). Attachment difficulties (Barth & Berry, 1988; Kirgan, Goodfield, & Campana, 1982; Aber & Allen, 1987), behavior problems (Yates, 1981; Green, 1978; Rosenthal & Groze, 1992; Groze, 1996), and learning problems (Sandmaier, 1988; Rosenthal & Groze, 1992) are the result of

spending formative years in compromising family or institutional care (Groza, Ileana & Irwin, 1999). These difficulties are stressors to the adoptive family system. However, many children with delays at the time of placement recover from them after a year or more in their adoptive families, and two-thirds completely overcome such difficulties (Bascom & McKelvey, 1997; Groza, 1997; Jenista, 1997). The family environment is critically important in affecting children's development and socio-emotional functioning, particularly early in life.

In addition to the difficulties mentioned above, the individual coping style of the child can be a stressor (Barth & Berry, 1988) in some families. To create familiarity in the new family, it is not unusual for a child to promote coalitions and triangulation to diffuse intimacy and increase their control in the family environment. Sometimes the strongest coalition will be between siblings; other times they will target one parent in a two parent family to build a coalition against others in the family system. It should be kept in mind, while this negatively affects family functioning, the behavior is the child's attempt to retain control over the situation. This is one coping style children develop in order to survive (Donley, 1990). Children may not have developed the interpersonal and social skills to live successfully with others or may not have a very good idea about how families function. This may be particularly true if the child has spent an extended period of time in group or residential care. They often have questions about boundaries. For instance, who is inside the family system, who is outside the family system, and what is the appropriate way to relate to each other inside the family system? Sexually abused children may not have healthy boundaries concerning their bodies, with people inside the family and, in many cases, with people outside the family. The physically abused and neglected child may not respect personal space, including property. They may hoard items or not place much value on property. Boundary ambiguity may create or exacerbate demands on the developing family system.

Children may also struggle with role identification (Reitz & Watson, 1992). Sometimes they have difficulty with role conflict, particularly for children who have experienced parentification. Parentified children may not be able to make the transition back to the role of simply being children. Role ambiguity may also pose problems. This may be particularly true for the child who has been in multiple placements and has occupied several role positions. For example, a child may have been the oldest child in the birth family, the youngest in the foster family, and a middle child in the current adoptive family. Occupying several role positions in various family systems can be very confusing to a child. Difficulty adjusting to the family system and some unhealthy or unwelcome behaviors may be attempts by the child to discover their role in the new family system.

### **Summary of the Conceptual Model**

This systems approach to examining adoptive families is a helpful framework for organizing the various issues explored in this study. Resources when they are missing or not well developed can be stressors to the adoptive family system. In some ways, the systems approach organizes knowledge in a new way but does not rely on psychoanalytical or post-psychoanalytical interpretations. It offers a perspective more

easily embraced by parents and social work professionals in unraveling and understanding the issues families and adoptees may encounter on multiple levels.

## Project Aims

The purpose of this project is to gather empirical information on Indian adoptions in Norwegian families and eventually to conduct a cross-national comparison of adoptees placed in-country (from a project in 2001 in India) and adoptees placed internationally.

The project is designed primarily as a program evaluation. The specific aims are to: 1) describe the positive aspects of international adoptions 2) identify stressful or problematic facets of international adoptions 3) describe helpful post-adoption resources and gaps in services; 4) evaluate the successes in international adoptions and, 5) compare adoptions by agency to determine if there are differences.

This is a descriptive cross-sectional study. Descriptive studies are also called observational, because observations are made and reported concerning the study subjects (i.e., children or families) without introducing interventions. In cross-sectional studies (that is, studies conducted once at a specific point in time) variables of interest in a sample are examined and the relationships between different variables are analyzed (often driven by a theory or a conceptual model). There are specific values to conducting descriptive research. First, descriptive research reports "what is." It describes the current (and often retrospective) state of the participants concerning particular variables (i.e., related to the adoption process) and portrays how the subjects (families) feel about specific issues. In evaluating programs, data from such studies are often the most helpful in generating specific policies and practices that can be established to improve programs. Existing policies and procedures may also be reevaluated and altered in response to the findings of descriptive studies. Second, description facilitates prediction because past behavior is often a good predictor of future behavior. Thoroughly depicting the issues that adoptive families and children experience at various stages is helpful in developing some understanding of what others may experience during equivalent time periods in the adoptions process. Finally, description facilitates explanation because once we know what happens, we may take steps to find out why it happens. Finally, description suggests that more research needs to be pursued once we have significant findings in a specific area or areas.

## Research Questions

The evaluation was organized around the following questions:

- What issues do families face related to international adoptions/internationally adopted children?
- What post adoption resources have they accessed/would families like to access?
- How can the international adoption program be improved?
- What are the indicators of success in international adoptive placements?



## **Human Subjects**

Human subjects approval for the pilot and larger project was secured in Norway June 10, 2003 from the Norwegian Data Inspectorate. Approval for the pilot study was obtained from Case Western Reserve University on April 24<sup>th</sup>, 2003 (IRB# 20030406) and approval for the larger study was obtained on October 3, 2003 (IRB#20030804).

## **Methodology**

A pilot study pre-testing the questionnaire and translation was conducted in summer 2003 with 6 families who adopted from countries other than India. Based on the pilot data, we verified that the translations were good and only a few typographical errors were noted. These errors were corrected.

Data were collected through a mailed survey. Two hundred seventy six 276 adoptive families of Indian children in Norway were sent a mailed questionnaire in October 2003. These families contained 398 children. Mailed surveys were returned to the participating adoption agency (Children of the World-Norway) in stamped envelopes that were enclosed with the questionnaires. Reminder notices were sent to families to prompt them to return the questionnaires; they were mailed 30 days after the questionnaires were mailed. All questionnaires were mailed to the investigators in the United States for data entry and analysis. No individual family response was able to be tracked back to a specific family. Responses were anonymous and confidential.

## **Measures**

In previous research, we used a questionnaire similar to the one developed for this project for adoptive families in the United States, Romania and India (see Rosenthal & Groze, 1992; Groze, 1996; Groza and the Bucharest Research Team, 1999; Groza & the Bharatiya Samaj Seva Kendra Research Team, 2002). Standardized measures included the Child Behavior Checklist (CBCL), the Behavioral and Emotional Rating scale (BERS) and the Parenting Scale.

The CBCL has a reliability of .9 (Achenbach, 1991; Achenbach & Edelbrock, 1983). The CBCL provides measures that contain 5 subscales assessing internalizing problems plus a summative Internalizing Scale, and 3 subscales assessing externalizing problems plus a summative Externalizing Scale. Over a one-year period, the mean  $r$  was .75; over a two-year period, the mean  $r$  was .71. Subscale alphas ranged from .54 to .96. The 5 subscales assessing internalizing problems are withdrawal, somatic complaints, anxiety/depression, social problems, and thought problems. The 4 subscales assessing externalizing problems are attention problems, delinquency, and aggressiveness. Scores on the subscale can be classified as in the clinical range—similar to scores for children receiving outpatient mental health services—and the nonclinical range that is akin to the typical child.

The Behavioral and Emotional Rating Scale (BERS) is a standardized, norm-referenced scale designed to assess the behavioral and emotional strengths of children ages 5 to 18. It is a 52 item checklist normed on children not identified as having

emotional and behavioral disorders and on children with emotional and behavioral disorders. It assesses 5 dimensions of childhood strengths: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning and Affective Strength. The BERS subscales have alphas ranging from .87 to .96; it has an overall reliability of .97 (Epstein & Sharma, 1998).

The Parenting Scale (Arnold, O’Leary, Wolff, & Acker, 1993) is a 30-item instrument developed to assess problematic discipline practices. The PS comprises 3 subscales: laxness, over-reactivity, and verbosity. The PS has good internal consistency with alphas for the total scale of .84, .83 for laxness, .82 for over-reactivity, and .63 for verbosity. It has good test stability with a test-retest correlation of .84 for the total scale, .83 for laxness, .82 for over-reactivity, and .79 for verbosity. It also has good concurrent and discriminant validity. The PS distinguishes between mothers attending a behavior clinic to improve their child management skills and non-clinic mothers. These two groups are designated as “Clinic Mothers” and “Nonclinic Mothers.” Nonclinic Mothers are akin to the typical mother. Scores on the PS are significantly correlated with the CBCL (see also Irvine, Biglan, Smolkowski, & Ary, 1999).

The CBCL assesses behavior issues, the BERS assesses the behavioral and emotional strengths of children, the PS measures discipline practices, and measures of attachment, development, service usage and service needs are included in the questionnaire. Multiple indicators of adoption outcomes are separate questions on the survey (disruption, out-of-home placement, family satisfaction/impact of adoption, thoughts of ending the placements, etc.). All norms are based on North American families and children.

The open-ended questions were adapted from the Minnesota/Texas Adoption Research Project conducted by Grotevant and McRoy (1989). Drawing from the research on bi-cultural socialization (Tessler, Gamache, & Liu, 1999), several items were added to the questionnaire that Tessler and colleagues found predictive of bi-cultural socialization of Chinese children adopted by American families. Drawing from the research of Dutch researchers (Juffer, Stams & van Ijzendoorn, 2004), we added items about cultural identity. A copy of the questionnaire and instruments are included in the Appendix.

## Results

Percents are rounded up and valid percents (that do not take into account missing data) are reported as are the total numbers. Missing data were not a major problem in this study.

### **Response Rates**

Data were collected on 192 children from 142 families, representing 52% of the families who received the survey and 48% of the children adopted from India in the Norwegian sampling frame. We consider the response rate to be quite good for several reasons. This was also the first time researchers who were not Norwegian conducted a study of Norwegian adoptive families, which might have influenced some parents about their participation. There is some indication from adoption workers that Norwegian adoptive families may be experiencing research fatigue—they feel that they have been

studied too much. As such, some chose not to participate. Finally, the questionnaire was long compared to other questionnaires used in previous research in Norway; the length affected response rates.

A response rate of 81% is considered very good (Mangione, 1995; Salant & Dillman, 1994). Mangione (1995) and Salant and Dillman, (1994) raise concerns about the quality of data when response rates are 60% or lower. In contrast, Babbie (1973) indicates that a response rate of 50% is adequate for analysis and reporting, a rate of 60% is good, and a rate of 70% or better is considered excellent. Visser and colleagues (2000) indicate that the response rate for mailed surveys is often less than 50% and techniques to increase rates are complex and costly, seeming to indicate that responses of less than 50% are not problematic. Thus, there are multiple ways to evaluate the response rate. As such, given all the factors outlined above, we evaluate the response rate as good.

To test for systematic bias in the data, census data were obtained on the gender of each child, age at adoption, age at time of the study, and city of origin in India on all adoptions from India. These data were compared to the same data obtained from respondents to determine if there were any differences. From the census data, 70% of adoptions were female, children were .94 years (std. dev.=1.0) at the time of adoption, 8.9 years (std. dev.=5.8) at the time of the study, and 47% of adoptions were from Pune, India. There is no difference between the sample and population for child gender, age at the time of study, or location in India from which the child was adopted. There is a statistically significant difference in age at adoption with the sample containing children who were older at adoption than the population. Since the children in this study were adopted when they were older, the results must be considered with the overall differences in age as the context. We would expect some results to be more negative for this sample, since the children were older at adoption.

### **Description of the Adoptive Families**

Most questionnaires (73%, n=139) were completed by the adoptive mother. Adoptive father completed 23% (n=44) of the questionnaires and both parents completed the questionnaires together in 4% (n=8) of the cases. At the time of the study, adoptive moms were 43.3 years old, on average, and adoptive dads were 45.5. At the time of adoption, adoptive moms were 34.9 years old, on average, and adoptive dads were 37.2.

Most families had more than one child in the home (80%, n=147). When there were other children in the home, most often, at least one of those children was an adoptive child (90%, n=132).

The adoptive families were mostly two-parent, first marriage families (91%). A few were second marriage families (6%) and an even smaller number were single parent families from separation, divorce or widowhood (3%). Family incomes ranged from 140,000 to 1,800,000 Norwegian kroner; average family income is 610,276 kroner (std. dev.=254, 952). [As of March 2004, this was equivalent to 70,461 Euro].

When asked about the reason for adoption, most families (54%) indicated they adopted due to infertility. The other two most frequent reasons provided were wanting a bigger family (13%) or wanting a sibling for their child (13%). Although not explicitly stated, in all likelihood infertility was an issue for these families also, indicating that in at least 80% of the families infertility was a motivation for adoption. Only 4% of the

families expressed humanitarian motivations for adoption. That is not to say that infertility is the only reason the participants adopted. Decision-making about adoption is complex and often multiple factors lead to the decision. However, in Norwegian families who adopt from India, infertility appears to be a major reason families adopt..

### **Description of the Children and their Histories**

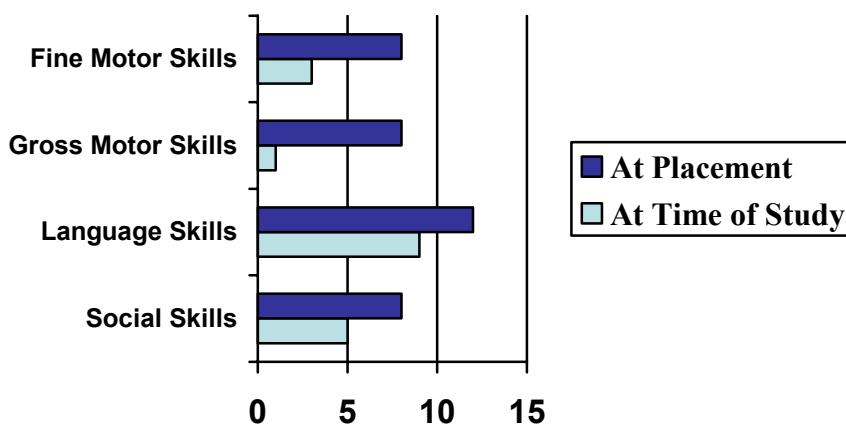
Most of the adopted children (69%, n=132) were females; males made up 31% (n=59) of the sample. Almost all of the children (99%, n=188) had been in an orphanage prior to adoptive placement. The majority of the orphanage placements (70%, n=132) were evaluated as excellent or good. About one-fourth of the children (n=43) had spent time in their birth family prior to adoption and 11% (n=19) had been in a foster home. Children were adopted from under one year of age to 9 years of age; average age at adoption was 1 year, 6 months. The majority of the children (87%) were placed by age 2 or younger and 96% were placed by age 3 or younger. At the time of the study, adoptees were 1 to 23 years old; on average, they were 9.8 years old. Twenty percent of the children were under the age of 5, 40% were latency age (5 to 12), one third were adolescent (13 to 18), and 6% were older adolescents/young adults (over age 18), at the time of the study. Children have been in their adoptive home on average 8.1 years. Only a few children (8%, n=17) had been in their adoptive placements a year or less. About one-third had spent more than 10 years in their adoptive homes.

### **Health, Disability and Other Developmental Descriptions of Children**

For the most part, health problems, disabilities and other difficulties were not reported for the children. No children had vision impairments, 2 children (1%) were reported as deaf or hearing impaired, 9 (5%) were reported to have physical disabilities, and 2 children (1%) were reported to be mildly retarded. Families reported that over the last year the health problems in 8 of the children (4%) had gotten worse. Still, overall, these children do not have special physical or health needs.

Parents were asked to evaluate lags in developmental skills for their children at placement and at the time of the study. The following figure (Figure 3) presents a summary of their reports.

**Figure 3: Percent with Developmental Delay by Area of Delay**



Less than 15% of the children had a developmental delay at placement and less than 10% had any delay at the time of the study. The only developmental areas in which some children demonstrated dramatic improvement were language development followed by social skills. There were no statistically significant differences for whether there was a delay in any of these 4 areas by age at placement, although the trend was in the expected direction of older age at placement linked directly to children demonstrating delays. About 14% of families (n=27) reported that their child was malnourished or underweight at adoption. No families reported their child as having genetic problems.

Parents were asked to evaluate sensory information for their children at placement and at the time of the study. Following is a summary of their reports in Table 1.

	Percent with behavior at placement	Percent with behavior at time of study
Oversensitive to touch, Movement, sights or sounds	4%	2%
Under-reactive to stimulation or pain	3%	0
Activity level too high for age	5%	3%
Activity level too low for age	3%	<1%

For the most part, there were no reports of sensory difficulties at placement or at the time of the study. For the few children entering the family with some sensory difficulties, most of these children had improved at the time of the study. There was no

statistically significant difference for whether there was a sensory difficulty in any of these 4 areas by age at placement, although the trend was in the expected direction of older children's age at placement indicating more likelihood for the existence of these issues at placement.

### Attachment Relations

Families were asked to report on a series of indicators of parent and child relations. The following table (Table 2) summarizes their responses. (Due to rounding, the percents do not always equal 100).

**Table 2: Assessment of Parent-Child Attachment Relations**

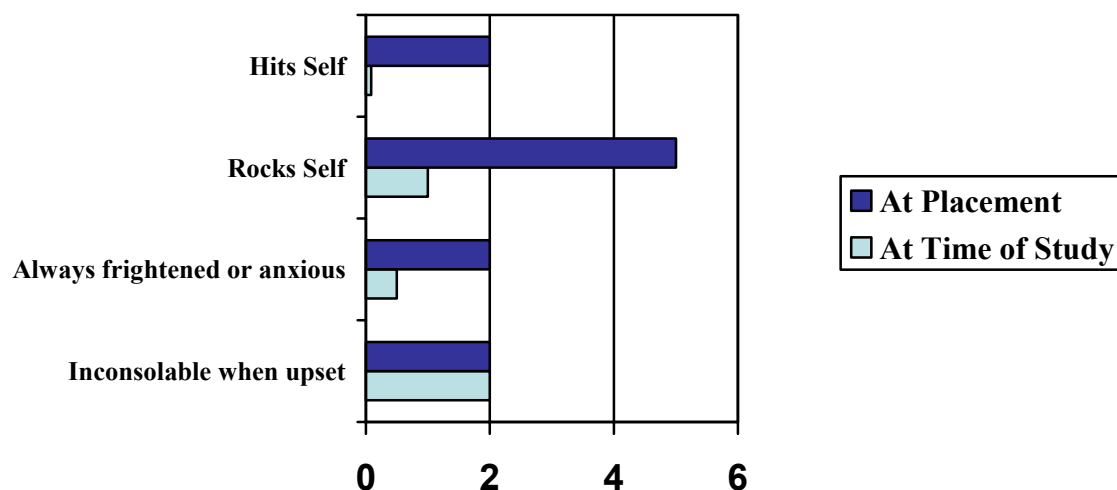
How well do you and your child get along?	
Very well	83%
Fairly well	15%
Not so well	3%
How often do you and your adoptive child enjoy spending time together?	
Just about every day	85%
2-3 times a week	11%
Once a week	3%
Once a month	1%
Less than once a month	1%
How would you rate the communication between you and your child?	
Excellent	67%
Good	28%
Fair	4%
Poor	2%
Do you trust your child?	
Yes, very much	66%
Yes, for the most part	30%
Not Sure	4%
No	1%
Do you feel respected by your child?	
Yes, very much	70%
Yes, for the most part	26%
Not Sure	4%
No	1%
Do you feel close to your child?	
Yes, very much	83%
Yes, for the most part	14%
Not Sure	4%

Overall, attachment relationships were very positive. The majority of parents reported getting along well with their children, spending (enjoyable) time together every day, good communications with their children, trusting their children, feeling respected by their children and feeling close to their children. There was a significant correlation between age at the time of study and getting along ( $r=.31$ ,  $p<.01$ ), spending time together ( $r=.43$ ,  $p<.01$ ), communication ( $r=.21$ ,  $p<.01$ ), respect ( $r=.17$ ,  $p<.05$ ), and closeness ( $r=.29$ ,  $p<.01$ ) so, as age increases, there is a decrease in positive reports on each of these variables. That means that as children get older, parents report getting along less well, spending less time together (that they enjoy), poorer communication, feeling less respect and feeling less close. The correlations for getting along, spending time together and closeness were moderate; the correlations for communication and respect were weak. There was no correlation with placement age. These correlations are similar to other data collected on adoptive families and suggest a life cycle change; as children get older, relationships with their parents change. This finding probably has very little to do with adoption and has more to do with the changing nature of parent-child relationships that indicates a natural change in the family life cycle.

### Behavior Concerns of the Children

Families were asked to report on a series of behaviors reported to be of concern to American families who adopted children with a history of institutionalization. The following figure (Figure 4) summarizes this information.

**Figure 4: Percent with Behavior Concern**



For the most part, there were no behavior concerns at placement or at the time of the study. For families that reported problems at placement, this changed over time with the exception of a few children (n=4) who remained inconsolable when upset. There was no statistically significant difference for whether or not there was a behavior difficulty in any of these 4 areas by age at placement, although the trend was in the expected direction. Those children who were older at placement were more likely to demonstrate these behavior issues at placement.

A second measure of behavior was the CBCL. The CBCL subscales for children 4 to 18 years of age assessed withdrawal, anxiety/depression, somatic complaints, social problems, thought problems, attention problems, delinquency, and aggressiveness. Data were analyzed for the percentage of children scoring in the clinical range of each of these scales—the clinical range includes those scores indicative of severe emotional and behavioral disorders. The scales do not have norms for children under the age of 4 or over the age of 18, so those children are not considered in this analysis. The following table (Table 3) summarizes the data for the percentages of children scoring in the clinical range for each subscale.

Table 3: Percent of Indian Children Adopted to Norway Scoring in the Clinical Range on the CBCL

	Males 4-18	Females 4-18
Withdrawal Behavior	1%	1%
Somatic Complaints	2%	2%
Anxiety/Depression	3%	1%
Social Problems	3%	5%
Thought Problems	1%	1%
Attention Problems	2%	4%
Delinquency	3%	3%
Aggressiveness	1%	1%

The results indicate that most children do not have high enough scores that would be indicative of severe emotional and behavioral problems. There was a significant correlation between age at the time of study and somatic complaints ( $r=.22$ ,  $p<.05$ ) and anxiety/depression ( $r=.18$ ,  $p<.05$ ) so that as age increases, there is an increase in scores on these two scales. This means that older children had more somatic problems and anxiety/depression as reported by their parents. However, the correlations were weak. There was no correlation with placement age.



### Educational Functioning

The majority of school age children (87%) are in school. About 15% of the children are enrolled in special education classes. Only 3% of the children are enrolled entirely in special education classes. There was no correlation between placement age and whether or not the child was enrolled in special education.

### Strengths of the Children

Drawing from a strengths perspective and in order to give balance to the project, we asked families about the strengths of their adopted children. The research instrument we used measures 5 areas of strength. All families easily identified strengths. The following tables (Tables 4-8) provide the data on strengths. Numbers are rounded, so percents do not always equal 100. Parents choose to indicate whether the characteristic was “very much like the child,” “like the child,” “not much like the child,” or “not at all like the child.”

Table 4: Interpersonal Strengths of the Indian Children Adopted to Norway

<b>Interpersonal Strengths</b>	Very much like the child	Like the child	Not much like the child	Not at all like the child
Uses anger management skills.	30%	48%	19%	3%
Expresses remorse for behaviors that hurts or upsets others.	48%	39%	13%	1%
Reacts to disappointments in a calm manner.	25%	48%	25%	1%
Considers consequences of own behavior.	31%	44%	22%	2%
Accepts criticism.	20%	59%	19%	1%
Accepts responsibility	45%	44%	10%	1%

for own actions.				
Loses a game gracefully.	22%	50%	27%	1%
Listens to others.	47%	48%	6%	1%
Admits mistakes.	24%	56%	18%	2%

Table 4: Interpersonal Strengths of the Indian Children Adopted to Norway (continued)

Accepts no for an answer.	35%	51%	14%	
Respects the rights of others.	55%	40%	6%	
Shares with others.	69%	27%	3%	1%
Apologizes to others when wrong.	45%	43%	10%	1%
Is kind towards others.	73%	27%	1%	
Uses appropriate language.	65%	33%	2%	1%

Table 5: Family Involvement Strengths of the Indian Children Adopted to Norway

<b>Family Involvement</b>	Very much like the child	Like the child	Not much like the child	Not at all like the child
Demonstrates a sense of belonging to the family.	93%	6%	1%	
Trust a significant person with his or her life.	89%	10%	1%	
Participates in community activities.	76%	19%	5%	
Maintains positive family relationships.	81%	18%	1%	
Communicates with parents about behavior at home.	54%	39%	7%	1%
Interacts positively with parents.	64%	32%	3%	1%
Participates in church activities.	19%	26%	23%	32%
Interacts positively with siblings.	44%	44%	9%	3%
Participates in family activities.	75%	22%	3%	
Complies with rules at home.	50%	46%	4%	1%

Table 6: Intrapersonal Strengths of the Indian Children Adopted to Norway

<b>Intrapersonal Strengths</b>	Very much like the child	Like the child	Not much like the child	Not at all like the child
Is self-confident.	61%	33%	6%	
Demonstrates a sense of humor.	82%	13%	5%	
Demonstrates age-appropriate hygiene skills.	72%	23%	6%	
Requests support from peers or friends.	42%	45%	11%	2%
Enjoys a hobby.	67%	27%	4%	2%
Identifies own feelings.	45%	49%	6%	
Identifies personal strengths.	44%	51%	5%	
Is popular with peers.	62%	32%	6%	1%
Smiles often.	82%	15%	2%	1%
Is enthusiastic about life.	69%	26%	6%	
Talks about the positive aspects of life.	55%	39%	6%	1%

Table 7: School Strengths of the Indian Children Adopted to Norway

<b>School Functioning</b>	Very much like the child	Like the child	Not much like the child	Not at all like the child
Completes a task on first request.	13%	58%	27%	2%
Completes schools tasks on time.	68%	21%	8%	2%
Completes homework regularly.	63%	28%	7%	2%
Pays attention in class.	56%	32%	9%	3%
Computes math problems at or above grade level.	32%	35%	23%	10%
Reads at or above grade level.	36%	35%	17%	13%
Studies for tests.	51%	32%	9%	6%
Attends school regularly.	89%	8%	1%	2%
Uses note-taking and listening skills in school.	42%	40%	13%	6%

Table 8: Affective Strengths of the Indian Children Adopted to Norway

<b>Affective Strength</b>	Very much like the child	Like the child	Not much like the child	Not at all like the child
Accepts a hug.	82%	16%	2%	
Acknowledges painful feelings.	47%	45%	8%	1%
Asks for help.	73%	23%	4%	
Shows concern for feelings of others.	61%	32%	7%	1%
Discusses problems with others.	39%	41%	16%	3%
Accepts the closeness and intimacy of others.	66%	32%	1%	1%
Expresses affection for others.	58%	39%	3%	

There was a significant correlation between age at placement and school functioning ( $r=-.26, p<.01$ ) so that as age increased, there was a decrease in the score on school functioning. There was a significant correlation between age at the time of study and family involvement ( $r=-.26, p<.01$ ) so that as age at the time of the study increased, there was a decrease in scores on family involvement. The correlations were weak. The decrease in family involvement suggests a life cycle change; as children get older, their involvement in family activities change.

### **Bi-Cultural Socialization**

Families were asked a series of questions about various aspects of Indian culture. The following table (Table 9) and figure (Figure 5) summarizes their reports.

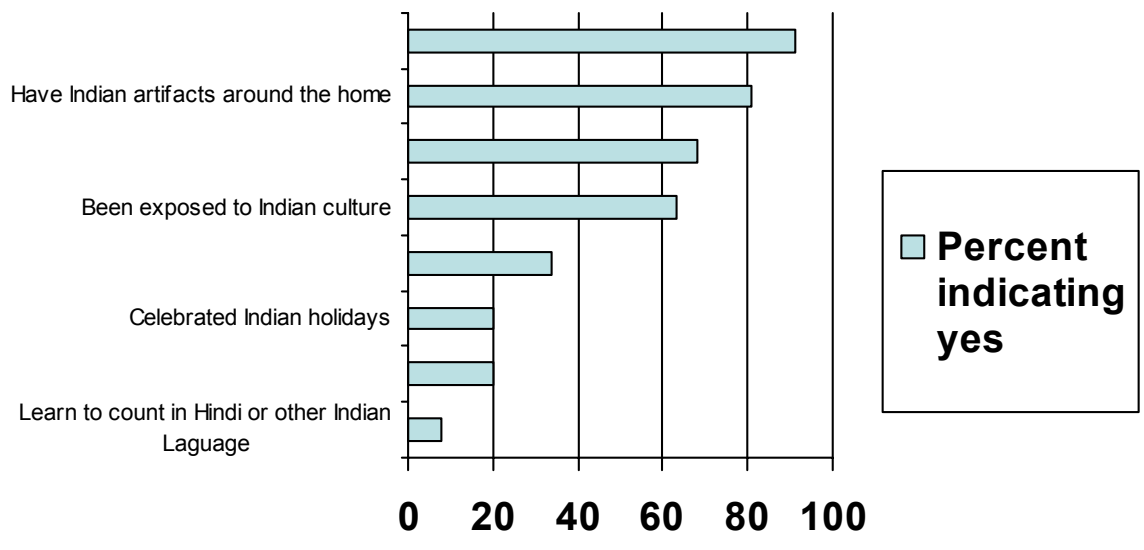
Table 9: Importance of Various Aspects of Indian Culture to Adoptive Parents

**How important is it that your son/daughter:**

	Not at all important	A little important	Somewhat important	Very important
Learns to count in Hindi or some other Indian language	74%	19%	5%	2%
Learns some words and phrases in Hindi or some other Indian language	55%	35%	9%	2%
Is exposed to Indian culture	10%	28%	34%	28%
Likes Indian food	35%	42%	16%	6%
Celebrates Indian holidays	79%	15%	5%	1%
Becomes friends with other Indian children	24%	41%	22%	12%
Has Indian artifacts around the home	21%	44%	26%	10%
Visits India as a child	25%	19%	29%	27%
Learns about the area of India from which she/he came	4%	30%	40%	26%
Is proud of his/her Indian heritage	1%	11%	25%	63%

Parents were asked whether their son or daughter have ever engaged in the following bi-cultural socialization activities.

**Figure 5: Bi-cultural socialization activities**



Families were asked how many adult friends they had that were Indian. Most had none (74%), 16% had 1 or 2, 3% had 3 or 4, and 6% had 5 or more friends.

Further analysis examined the relationship between parental attitudes about biculturalism and bicultural socialization activities. The following table (Table 10) compares the mean score of the various bicultural socialization attitudes to bicultural socialization activities.



**Table 10: A Comparison of Bicultural Attitudes by Top 5 Bicultural Activities**  
 (Range= 1-Not at all important to 4-Very Important:  
 Higher mean indicates more importance)

	<b>Activities</b>									
	Eat Indian food		Have Indian artifacts		Made Indian friends		Been exposed to Indian culture		Visited India	
<b>Attitudes</b>	Yes	No	Yes	No	Yes	No	Yes	No	Yes	no
Learns to count in Hindi or some other Indian language	1.3	1.0*	1.4	1.3	1.4	1.2	1.4	1.2*	1.4	1.3
Learns some words and phrases in Hindi or some other Indian language	1.6	1.2*	1.6	1.4	1.7	1.4*	1.7	1.4*	1.7	1.5
Is exposed to Indian culture	2.9	2.1*	3.0	2.0*	2.9	2.5*	3.1	2.3*	3.3	2.5*
Likes Indian food	2.0	1.7	2.0	1.5*	2.0	1.9	2.0	1.8	2.0	1.9
Celebrates Indian holidays	1.3	1.1	1.3	1.1*	1.3	1.1*	1.4	1.2*	1.5	1.2*
Becomes friends with other Indian children	2.2	2.2	2.3	1.8*	2.5	1.6*	2.3	2.0	2.3	2.2
Has Indian artifacts around the home	2.3	1.8*	2.5	1.3*	2.3	2.1*	2.4	2.0*	2.6	2.1*
Visits India as a child	2.6	2.0*	2.7	1.9*	2.7	2.3*	2.9	2.1*	3.2	2.5*
Learns about the area of India from which she/he came	2.9	2.6	3.0	2.6*	3.0	2.7*	3.0	2.6*	3.1	2.8*
Is proud of his/her Indian heritage	3.5	3.3	3.6	2.9*	3.6	3.2*	3.5	3.4	3.5	3.5

p<.05

Of the possible 55 associations between bicultural attitudes and bicultural activities, 32 (58%) were statistically significant with higher activities associated with more positive bi-cultural socialization attitudes. These data suggest that Norwegian families of Indian children assign less importance to birth culture (Indian) socialization than American families with children from China (Tessler, Gamache & Liu, 1999). In

making this comparison it is impossible to determine if the differences are due to growing up in Norway versus the USA, or due to adopting from India versus China. Neither conclusion can be drawn from this data analysis. It is clear that there is an association between attitudes and activities. Either parents with more positive attitudes are engaged in more bicultural activities or parents engaged in more activities have more positive bicultural socialization attitudes.

### **Identity and Adoption-related Issues**

Collaborating with Dutch researchers, we included questions about identity and adoption-related issues such as whether the child had experienced negative reactions or discrimination from others, how adoption is discussed in the family, and the child's feelings about adoption. These data are described in the following table (Table 11).

**Table 11: Did your child (recently or in the past) experience negative reactions about:**

	Never	Almost never	Sometimes	Often	Very often
Being adopted	56%	32%	10%	1%	1%
His or her origin (biological family/country)	66%	24%	8%	1%	0
His or her skin color	35%	38%	23%	3%	1%

On a positive note, most children do not appear to experience negative reactions about being adopted or about their biological family/country, although two-thirds have had some negative experience due to the color of their skin. When children have experienced negative reactions, they were expressed by classmates (35%), unfamiliar children/unfamiliar adults (35%), peers in their neighborhoods (22%) or by others (7%). Almost half of the families (49%) either never or almost never worry about these reactions, while 38% sometimes worry, 8% often worry and 6% very often worry.

Families were asked whether their child recently or in the past experienced negative racial discrimination. Most (70%) reported-never, 21%-almost never, 7%-sometimes, 1%-often and 1% reported-very often. When children have experienced racial discrimination, it was expressed by classmates (44%), unfamiliar children/unfamiliar adults (31%), peers in neighborhood (18%) or by others (7%). Almost half of the families (45%) either never or almost never worry about these reactions, while 39% sometimes worry, 9% often worry and 7% very often worry. While most children (56%) did not express a wish to be white, many did (44%). Those children who did express the wish to be white, were 5.9 years old on average with a median age of 5 years.

Families were questioned about whether their child received more attention, presents, etc. compared to non-adopted children. Families reported: never (36%), almost never (17%), sometimes (38%), often (8%), and very often (1%).

Families were asked to characterize how their family dealt with disclosing their child's adoption status to them, either as an "early telling family" or a "late telling family." Only 4% of the families had not talked about adoption with their child at the time of the study. Most (81%), started talking about adoption with the child at the time of placement. Some (15%), started talking with the child when he or she grew older. A small percent (5%) of the families have never talked about adoption. When they talk to their child about adoption, most families (59%) report that the parent and child initiate the discussion with equal frequency. In 25% of the families parents broach the subject of adoption and in 11% of the families children bring it up. Most children (87%) understand the difference between being adopted in a family and being born in a family. Eleven percent of the families report that the child has no interest in his or her adoption and 4% indicated the child is very much interested in his or her adoption. Most families report that the child is a little bit/sometimes interested (59%) or quite a bit interested (26%) in his or her adoption. About one-fourth of the children expressed a wish that he or she was born in the adoptive mother's "tummy." For those who expressed this wish, they were 4.6 years old on average with a median of 4 years.

Parents were asked to rate their child's interest in different aspects of adoption. They used a scale of 0 for not interested at all to 10 for very much interested. The following table (Table 11) summarizes this data. Higher scores reflect more interest.

Table 12: Rating of Child's Interest in Different Aspects of Adoption

	Mean (Std. Dev)	Median	Mode
The story of his or her adoption	6.9 (2.7)	8	10
The photobook of his or her adoption	8.0 (2.6)	9	10
The video of the parents' trip to India to get the child	7.0 (3.4)	8	10
Children's books on adoption	2.8 (2.8)	2	0
Boos/films about adopted children/animals	2.9 (2.9)	2	0
(Symbolic) play about adoption (e.g., with dolls and toy animals)	.9 (1.7)	0	0

Adoption stories, photo-books of adoptions and videos of the parents' trip to India are very popular with adopted children. Neither placement age or age at the time of the study had any correlation with the ranking of these various interests.

Finally, families were asked to choose from a scale of 1 (negative) to 10 (positive) how their child feels about being adopted. The average score was 8.8 (std. dev.=1.4); the median was 9 and the mode was 10. While scores ranged from 4 to 10, only 6% of the children had a score of 6 or lower.

Results from a Dutch study of international adoptees by Juffer, Stams and van Ijzendoorn (2004) found similar results on the items included in this section. In that study, which included children from Sri Lanka, South Korea and Columbia, 37% "sometimes" to "often" experienced negative reactions about their skin color compared to 26% in this study. In the Dutch study, 46% expressed the wish to be white, comparable to the 44% in this study. In the current study, 25% expressed a wish to have been born in the adoptive mother's tummy; this is the exact percentage reported by the Dutch researchers. Since Juffer and colleagues found a relationship between the wish to be white and negative reactions about their skin color as well as a relationship between the wish to be white and behavior problems, we replicated their analysis with Indian children adopted in Norway.

The data were recoded since it was skewed; data were coded so that "never" was one category, "almost never" was another category, and "sometimes", "often" and "very often" formed a third category for gauging whether or not the child ever experienced negative reactions about their skin color and, if so, the frequency of those experiences. Results were statistically significant (chi-square=19.02,  $p < .001$ ), suggesting that there is a significant relationship between those children who experienced discrimination due to their skin color and those more likely to express a desire to be white. There was also a significant relationship between the desire to be white and scores on the withdrawal, anxiety/depression, aggressiveness and externalizing problems scales of the CBCL. This suggests an association between children with some behavior problems and children who have expressed a desire to be white.

These findings point up the need for adoptive families to be concerned about their children's experiences outside the family and the manner in which these experiences, both positive and negative, affect issues of identity. Denying that children may be treated differently based on their skin color is to ignore reality for many of these children. This does not mean that having a strong ethnic identity will necessarily protect them or that not having one causes harm.

A way to frame this issue from a strengths perspective may be to stop considering the lack of a strong racial or ethnic identity as a deficit but consider having a strong identity as a strength (Groza, Wood, and Houlihan, in press). If having a strong identity is seen as a strength and not as a deficit, having one may help an adoptee navigate difficult circumstances. However, the lack of a strong ethnic identity does not suggest an inability to successfully cope with life challenges. There is no empirical evidence to suggest that Caucasian families cannot build the knowledge and skills needed to help their minority children navigate successfully in life and deal with discrimination and prejudice. They may struggle with how to approach these issues and not want to try to deal with them. However, especially in a homogenous society like Norway, an adoptee who looks different will have to deal with the obvious differences in their appearance at

some point in their life. Parental support can be a strong contributor to their child's healthy adaptation to being "different" yet the same as others in Norwegian society.

### Parenting Scales

The authors of the parenting scale provide comparison data of Norwegian adoptive families to 2 groups of American families. One group was mothers attending a clinic because of extreme difficulties in handling their children (designated as "Clinic Mothers"). The nonclinic group was composed of mothers whose children attended a university pre-school or volunteered to participate in the study (designated as "Nonclinic Mothers"). For comparison in this study, we also used the scores from a study of Indian adoptive mothers (Groza & the BSSK Research Team, 2002). The following table (Table 13) provides the means, with standard deviations in parenthesis, for the three groups (range= 1-More to 7-Less).

Table 13: Scores on the Parenting Scales

	Clinic Mothers	Nonclinic Mothers	Norwegian Adoptive Mothers
Laxness	2.8 (1.0)	2.4 (.8)	2.4 (.70)
Over-reactivity	3.0 (1.0)	2.4 (.7)	2.6 (.67)
Verbosity	3.1 (1.0)	2.6 (.6)	3.2 (.81)
Total	3.1 (.7)	2.6 (.6)	2.8 (.55)

Results suggest that Norwegian adoptive mothers are similar in laxness but different in over-reactivity, verbosity and overall parenting compared to nonclinic American mothers. The findings also suggest that Norwegian adoptive mothers are different on every subscale compared to clinic American mothers. Since the scale was normed with American mothers, the differences may be due to cultural differences between mothers from Norway compared to the United States rather than any difficulty in parenting skill.

We used the same scale in examining Indian adoptive mothers. The following table (Table 14) compares Norwegian and Indian adoptive mothers.

Table 14: Mean Scores on the Parenting Scales for Norwegian and Indian Adoptive Mothers

	Norwegian Adoptive Mothers	Indian Adoptive Mothers
Laxness	2.4 (.70)	3.5 (.88)
Over-reactivity	2.6 (.67)	2.7 (.96)
Verbosity	3.2 (.81)	4.2 (.96)
Total	2.8 (.55)	3.2 (.62)

Results suggest that Norwegian adoptive mothers are significantly different (statistically) on every subscale compared to Indian adoptive mothers. These differences further support the notion that the scale is picking up cultural differences rather than problems in parenting.

While placement age was not associated with any of the parenting scales, age at the time of the study was positively correlated. As age at the time of the study increased, there was a corresponding increase in scores on the laxness ( $r=.30$ ,  $p<.001$ ), over-reactivity ( $r=.20$ ,  $p=.01$ ), verbosity ( $r=.28$ ,  $p<.001$ ) and total parenting scales ( $r=.34$ ,  $p<.001$ ). This suggests that adoptive parents behave differently when children are different ages, a finding to be expected in all families and unlikely to be related uniquely to adoption. These associations indicated above are weak.

### The Adoption Process

Families were asked about the people they spoke with before they reached the decision to adopt. Often, they spoke with multiple people. The most frequent conversants were spouses (22%) and other adoptive families (22%). Many (18%) spoke with family and friends and with professionals (14%). Some (12%) indicated they spoke with a variety of different people. In the vast majority of conversations (98%) the response was positive; only 2% of the time did families get a mixed response. Most adoptive families (89%) reported receiving positive support from their relatives in their decision to adopt and 92% indicated they receive continued positive support from relatives concerning their adoption.

Almost half of the adoptions (47%,  $n=91$ ) were facilitated by BSSK in Pune, India. One way to access data about the adoption process is to examine how families feel about the information provided about their adoptive children prior to the adoption. While most families report they obtained accurate information about their child (48%), one-fourth reported that the child's health problems were more serious than the information they were given indicated. Only about 20% of families participated in an adoption preparation group. For those who did participate, most found it very (47%) or somewhat (35%) helpful. During the adoption process, about half (44%) of the families reported that Children of the World contacted them to ask how things were going. The vast majority (96%) evaluated that contact as helpful. Most (82%) reported that CWN showed an interest in their adoption and most (89%) indicated that the agency personnel were always kind and courteous when they would call with questions. Families were asked to evaluate how satisfied they were with services from CWN and their local child welfare agencies. The following table (Table 15) summarizes their responses.

Table 15: Evaluation of Services by Adoptive Families

	Children of the World	Local child welfare agency
Very satisfied	38%	28%
Mostly satisfied	56%	54%
Mostly dissatisfied	3%	8%
Very dissatisfied	2%	10%

Overall, the majority of families were satisfied with services from CWN (94%) and their local child welfare agency (82%). Families were asked to evaluate the adoption process. While most (68%) report the process was as they expected, almost one-third (29%) reported that it was more difficult than they expected.

The majority of families (80%) had been in contact with the agency since placement; while most report that contact was very (26%) or somewhat helpful (55%), about one-fifth did not feel it was helpful. About one-third of the families have participated in a support group; for those who did, most report that it was very (44%) or somewhat helpful (45%).

In reflecting on the adoption process and their expectations about the process, while a slight majority (47%) reported it was as they expected, many (46%) reported that it was more difficult than they expected. Only 6% reported that it went as they expected.

### Adoption Stability

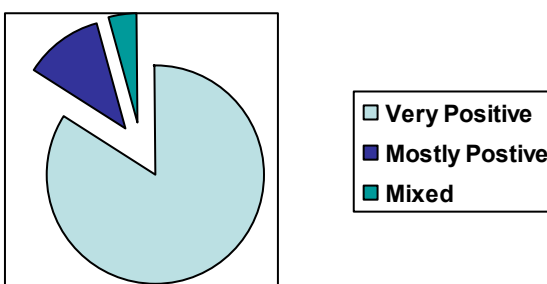
Several items were used to assess adoption stability. Families were asked to evaluate the impact of the adoption, the smoothness of the adoption over the last year, and how often they think of ending the adoptive placement. The following figure (Figure 6) summarizes

Families to evaluate adoption went year. Most went as they almost another reported it went expected. Ten parents reported had more ups they expected.

Finally, asked if they ending the (92%) did not. When asked in a different way about how often they thought of ending their adoption, most (85%) reported “never,” 13% reported “not very often,” and 2% reported “most of the time.”

There is no association between placement age and impact of adoption or how often families think of ending the adoption. There is a correlation with study age and thoughts of ending the adoption ( $r=.17$ ,  $p=.04$ ) such that, as age increases, families are more likely to think about ending the adoption. Mean scores were also higher on the behavior problems for withdrawal, anxiety/depression, social problem, aggressiveness, internalizing problems and total problems for families who considered ending the placement compared to families who never considered ending the placement.

**Figure 6: Overall impact of the adoption on the family**



the data. were also asked overall how the during the last (60%) reported it expected and third (30%) better than percent of that the adoption and downs than

families were ever thought of adoption; most

### **Birth Family Information**

Only a few pieces of birth family information are reported in the quantitative data. Birth mothers ranged in age from 13 to 33; on average they were 20.1 years of age when the child was born. Over half of the birth mothers were under the age of 20 years when the child was born. Birth fathers ranged in age from 18 to 40; on average they were 23.9 years of age when the child was born. However, a great deal of data on birth families were missing. Only a third of the respondents reported the age of the birth mother and about 15% reported an age for the birth father.

Few families (15% to 35% percent depending on the specific variable) had any background information on birth mothers. For birth moms, 17% were students and 72% were reported as blue collar/farmer/temporary workers. Sixty percent of birth moms had less than a middle school education. Seventy percent of birth mothers were unmarried and another 13% were divorced or widowed. This suggests that 83% of birth moms were single. The primary reason (56%) provided for relinquishing the child was social stigma about the marital situation (i.e, being a single parent) followed by poverty-related issues (29%). Very few children (8%) were relinquished due to rape or incest.

Even fewer families (5%) had any background information on birth fathers. For birth dads, 33% were students and 44% were reported as blue collar/farmer/temporary workers. There was virtually no information on birth fathers' educational status.

### **Adoption Disclosure**

Overall, Norwegian adoptive families were very open about discussing their adoption and their adoptive child's birth family (those who had any relevant information). When probed about the kinds of information they think the adoptee should have about themselves, most indicated that the adoptee should know all the parents know (49%) or, according to the adoptees age and maturity level, what the parent feels is appropriate for them to know at the time (32%). Some felt that the adoptee should only know the positive information (9%) while other felt only some information should be shared with the adoptee (8%).

Families were asked what the birth parents should know about their child. Most (31%) indicated that the birth parent should know the child is well and the country where the child was adopted. Many (22%) felt that they should be given some limited information about how the child and family are doing. A sizeable group (18%) indicated birth parents should have whatever they want to know or all information. The same percent (18%), however, suggest the birth parent should know nothing or very little. Overall, families were mostly open to this idea.

The vast majority (86%) would support their child if she or he decided to search for his or her birth parents. Very few (1%) were negative about their child pursuing such a search or didn't know (3%) how they would respond. We also probed how they would handle it if the agency notified them that their child's birth mother wished information about the child or pictures of the child. Again, the vast majority (61%) were positive with no caveats. Only 8% were negative and another 2% would provide only minimal information.



The picture that emerges from an analysis of the written comments is one of adoptive families who are quite open in their adoptions concerning issues of their children searching for their birth parents and sharing information with birth parents.

## Service Importance, Use and Needs

### Importance of Services to Adoptive Families

The questionnaire prompted families to evaluate the importance of the following types of services, as described in Table 16

Table 16: Description of Various Types of Services Evaluated by Adoptive Families

TYPE OF SERVICE	DESCRIPTION OF SERVICE
Information About Child	Information about the child's placement experiences prior to adoption as well as current health, educational, and social needs.
Information About Services	Information about services and help in locating needed services such as subsidy, therapy, support groups, medical care, educational services, etc.
Medical and Health Services	Ongoing medical and dental care as well as specialized care to meet child's needs (medical care for disability, physical therapy, mental health services, etc.).
Educational Services for Child	Ongoing and specialized educational and academic services.
Parent Education and Counseling	Education or counseling about special-needs adoption including behavior management skills, helping the child adjust to a new family, dealing with a handicaps, stresses and rewards of adoption, planning for child's future, etc.
Respite Care and Other "Helping" Services	Planning some time away from the child as well as parenting tasks such as transportation, in-home nurse care, day care, etc.
Contacts with Other Adoptive Families	Adoptive parent support groups as well as informal contacts with families who have adopted

Families were asked to evaluate the importance of each of these services. The following table (Table 17) presents the results for respondents.

**Table 17: Parent Evaluation of the Importance of Various Services (percents)**

	<u>Essential</u>	<u>Very Important</u>	<u>Somewhat Important</u>	<u>Not Important</u>
Information about child	69	23	6	2
Information about services	35	32	27	16
Medical and health services	30	30	21	19
Educational services for child	15	28	27	31
Parent education and counseling	22	28	32	19
Respite care and other services	7	13	27	54
Contacts with other adoptive families	13	33	42	12

The majority of families evaluated information about the child, information about services, and medical and health services as essential or very important, but did not view educational services, parent education and counseling, and contact with other adoptive families as important. Respite care was seen as not important by most families.

Some parents provided written comments about service needs although the vast majority offered no comments. While only a few families (less than 10%) took the time to write comments, we decided to summarize them in anticipation that other families (less motivated to write) may have had similar concerns.

Families wrote about the need to know more information about what to expect in India prior to traveling there. They indicated how important it is to have pre-adoption preparation to better understand the issues that may come up both while in-country and after they return home. Some also suggested that better information needs to be gathered and shared about what happens to the child from the point of referral to when they arrive in the country to obtain the child.

A concern expressed most often (by over 70% of families) was about full disclosure of the child's background. Families felt that all available information about the child should be disclosed as well as specific information such as how the child responded in the child care center, how he or she responded to positive reinforcement, health information, his or her eating and sleeping habits, etc. In general, as we read the analyzed written comments, the theme seemed to be that more information is better.

### **Post-Adoptive Services Used and Needed**

Parents reported on the services they received after adoption, as well as services

they needed but could not get. This data is presented in the following table (Table 18).

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**Table 18: Parent Report of Services Used and Services Needed**

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<i>Services Used</i>	
Financial support for one year leave	77%
Information about child	56%
Information about services	23%
Medical and health services	43%
Speech Therapy	5%
Educational services for child	15%
Parent education and counseling	9%
Respite care and other services	4%
Contacts with other adoptive families	70%
<i>Services Needed</i>	
Information about child	6%
Information about services	8%
Medical and health services	2%
Speech Therapy	2%
Educational services for child	2%
Parent education and counseling	7%
Respite care and other services	2%
Contacts with other adoptive families	<1%

---

Several points stand out. Most families used the financial support for the one year leave and many used information about the child and had contacts with other adoptive families. There were few service needs for the majority of families.

### **Comparison of girls and boys adopted from India**

The sample in this study included 132 females and 59 male with the gender of one child not reported. Bivariate analysis was used across all variables in the study to see if there were any significant differences between the girls and boys in the sample. There were very few differences. The following discussion includes those variables that yielded significant differences.

Some of the data that are demographic in nature revealed differences. For instance, the respondent's age at the time of the study and the age of the respondent's spouse were significantly different among those who adopted girls or boys. Differences ( $p=.040$ ,  $t=-2.08$ ) reflect a higher average age among those who adopted girls ( $M=44.6$ ) than those who adopted boys ( $M=42.5$ ). The age of the respondent's spouse also revealed an average difference of about two-years with those who adopted girls reporting older spouses ( $p=.007$ ,  $t=-2.8$ ). Those who adopted boys averaged 43.2 and those who adopted girls averaged 45.8 years of age.

The ages of the children at the time of the study were also significantly different for females and males ( $p=.003$ ,  $t=-3.1$ ). Females were older than males by approximately 2.5 years ( $M=10.6$  vs  $M=8.1$ ). A finding that appears to be consistent with the older age of the females was the difference in length of time children had been in their adoptive homes ( $p=.003$ ,  $t=-3.0$ ). Once again the difference was approximately 2.5 years with females averaging 8.9 years in their adoptive homes and males averaging 6.3 years in their homes at the time of the study.

There was no significant difference between families with females or males concerning satisfaction with CWN. Overall both groups tended to be highly satisfied with services.

There were several significant differences across variables denoting behavioral or mood related issues (see Table 19 below).

**Table 19: Differences in Females and Males Adopted from India**

	$\chi^2$	$p$	$df$
Anxious	8.2	.017	2
Guilty	3.9	.047	1
Pays attention in class	14.5	.002	3
Can't concentrate	6.8	.033	2
Accepts responsibility for own actions	13.5	.004	3

Females appear to be somewhat more likely to be anxious and to feel guilty than males adopted from India. In fact, on the item designated “feels too guilty” virtually 100% of the parents of male children indicated “not true (as far as you know).”

Females were more likely to pay attention in class. The highest possible choice on this item was “very much like the child” which was endorsed much more often by parents of female adoptees than male adoptees (63% vs 32%). In contrast, the ability to concentrate presents a mixed picture among the females. Some of them appear to be more likely to be able to concentrate than the males (58% vs 52%) while a subset of females have more difficulty concentrating than the males do (13% vs 2%). However, the middle option entitled “somewhat or sometimes true” concerning the “can't concentrate” item on the survey was endorsed more often by parents of males than females (46% vs 29%).

There was also a significant difference in ratings of females and males concerning their willingness to accept responsibility for their own actions. Females were more likely overall to accept responsibility for their actions than males (50% vs 32%).

In general, the differences were few and any discernable patterns appear to reflect some of the differences on these variables which might be found among boys and girls from the same age range who have not been internationally adopted.

### Children adopted from Pune compared to those from other locations

In order to explore any differences between children adopted from the Pune area of India through BSSK compared to children adopted from other areas of India through alternate agencies, bivariate analysis was utilized. Children adopted from Pune (through BSSK) were compared to all other children in the sample across all of the variables in the study. Overall, there were no great differences in the two groups of children. There were, however, statistically significant differences across a small number of variables. The differences which seem most important to this study are reported here.

As has been stated, almost half of the children in the study were adopted from Pune through the BSSK agency (47%, n=91). Other children in the sample were adopted from Bombay/Mumbai (49%, n=94), Delhi (n=5) and two were originally from an unspecified location. Of the children adopted from Pune, 66 were females and 25 were males.

There were significant differences between the two groups of children concerning where they spent the initial 6-months of their lives ( $p=.013$ ,  $\chi^2=12.7$ ,  $df=4$ ). During the first 6 months of life, the children from Pune were slightly more likely to have lived with their birth families (Pune=20% vs. Others=14%) and less likely to have lived in orphanages (Others=85% vs. Pune=68%).

Another significant difference between groups was the age of the birth mother at the birth of the child as reported by the adoptive parents. The difference between groups ( $p=.009$ ,  $t=2.7$ ) indicates lower ages among birth mothers of the children from Pune ( $M=19$ ) than the mothers of children from other cities ( $M=22$ ).

Children's ages at placement with their adoptive families and the ages of the children at the time of the current study were also significantly different. The children from Pune were somewhat older when they were placed for adoption ( $M=1.8$ ) than the children from other areas of India ( $M=1.4$ ) by an average of 4-months ( $p=.012$ ,  $t=-2.6$ ). The difference in average age at the time of the study ( $p=.01$ ,  $t=-2.6$ ), was approximately 2-years. The children from Pune were almost 2-years older than the children from other areas ( $M=10.8$  vs  $M=8.9$ ).

Some differences were noted in cultural activities between families who adopted from Pune compared to other locations. More of the children from places other than Pune (69%) have been exposed to Indian culture than those who adopted from Pune (56%), ( $p=.05$ ,  $\chi^2=3.9$ ).

Respondents also differed on reporting "who initiates discussion about adoption" ( $p=.02$ ,  $\chi^2=11.4$ ). Those with children from areas other than Pune were more likely to say discussions about adoption were equally initiated from the parent or child (66% vs 50%) while those with children from Pune were more likely to say both the child (18% vs 6%) and the parents (30% vs 20%) were most likely to initiate discussions about adoption.

Finally, some of the variables indicating satisfaction with services or gaps in services revealed significant differences in the two groups. Table 20 presents this data.

**Table 20: Children from Pune (BSSK- agency used was yes/no)**

	$\chi^2$	<i>p</i>	<i>Df</i>
Sat. with CWN	21.318	.000	3
Sat. with local agency	8.7	.03	3
Needed info. on child	5.4	.02	1

The groups varied significantly in their ratings of satisfaction with Children of the World (see table above). Parents with children from Pune were more likely to be “mostly satisfied” (73% vs 42%) while those with children from other areas were more likely to be “very satisfied” (50% vs 25%). No parents with children from Pune were “mostly dissatisfied” while six-respondents with children from other areas indicated this choice. More parents of children from areas other than Pune thought they needed further information about the children they adopted compared to the group with children from Pune (see tables on pages 45 & 46). This may be an indication that BSSK has been successful in some of their efforts to provide adoptive parents with information about their children.

While we found some differences between the children from Pune and those from other areas of India, it is not clear that these are substantial differences. Children adopted from various places in India and the families who adopt them display many more similarities than differences, and overall results are very positive concerning adoption outcomes, regardless of whether the children came from Pune or other areas of India.

## Summary of Findings

### Resources

- Children are doing well.
  - Most children are healthy, developmentally appropriate and have good attachment relations.
  - There were few behavior concerns. For those few children with some problematic behaviors at placement, most improved. Very few children have significant behavior problems.
  - Families easily identified many strengths in their children.
  - Most children do not experience negative reactions about being adopted or about their biological family/country of origin.
- Families are doing well; adoptions are very stable.
- Families received a great deal of support both before and after adoption from their relatives.
- There are no major gaps in services.
- CWN evaluated well by families.
  - CWN gave most families accurate information about their children.
  - About half of the families had contact with the agency during the adoption process and most felt that this contact was very helpful.

- Most families reported a positive evaluation of their post-adoption contact with the agency.
- Most families were satisfied with services from CWN.

## **Stressors**

### **Suggested Areas of Improvement For CWN**

- Most of the children have had some negative experiences related to the color of their skin, suggesting that prejudicial attitudes are still a significant part of Norwegian culture. This suggests that more needs to be done to educate Norwegians about diversity and how to respond to people of other ethnicities than their own. CWN could take an active role in bringing this issue to the attention of the public, adoption professionals and policy makers.
- There is an association between bicultural activities and attitudes. While it can't be determined which comprises cause or effect, it is easier to engage families in bicultural activities than to affect attitudes directly. CWN could sponsor and support such activities and encourage active participation of families in these events.
- CWN should make an effort to remain in contact with all adoptive families during the adoption process. Families find this contact very helpful and it builds better connections with the agency for families.

### **Suggested Areas of Improvement For The Public System**

- While problems are few, every effort should be made to reach out to those families who have children with problems to see if there is any additional support or guidance the public system could provide them.
- School functioning was one area in which some issues need to be addressed. The public system might want to probe more deeply in order to achieve a more thorough understanding of the school related problems adoptive families may encounter.
- Adoption preparation groups should be a requirement for all families adopting. Preparing families for adoption helps them to cognitively orient themselves to the obstacles they may encounter. Many families reported that the process was more difficult than they expected. Adoption preparation should assist parents with greater readiness to confront the difficulties they will face.

#### ***What is Adoption Preparation?***

- A series of activities designed to gather information as part of the home study/family assessment

- Adoption preparation assists the family in understanding the unique issues in forming a family or adding to a family through adoption
- Preparation is both a process and outcome
- Inadequate preparation cannot be compensated for later
- Successful adoptions depend less on the child and more on parental characteristics that allow a child to be incorporated into the family without an intolerable level of family distress or chronic crisis

### ***What do Families Experience During Adoption Preparation?***

- Most families benefit from preparation and begin to grapple cognitively and emotionally with the many tasks in adoption
  - Some families, given accurate information, screen themselves out from pursuing the adoption because it is not a good choice for them
  - Other families will be able to make any changes necessary for them to be successful adopters
- Post-adoption contact could be improved. The public system can improve assessment and understanding of adoptive families' needs post-adoption so that they can address those needs in a more effective manner.

### **Suggested Areas of Improvement For BSSK**

- Families need complete and accurate information about the health and other difficulties their children experience, including the absence of such information, when it is incomplete, inaccurate or impossible to obtain, so they can better prepare for the risks inherent in many international adoptions.
- During the period of time when a match is made to the time a child is placed with the adoptive family, monthly updates about the child should be sent to CWN so they can be forwarded to adoptive parents. In the age of digital technology, monthly videos of the child should be made, downloaded onto the computer, and sent as a compressed file so that families can get a visual image of their child. The video should be accompanied by a written report that highlights such things as illnesses, developmental milestones reached, etc., to keep the family informed.

### **The Norwegian Adoptive Family System**

The following resources and stressors were identified in Norwegian adoptive families with children from India through this study. Resources: the majority of



international adoptions of Indian children by Norwegian families are healthy matches between children and families that are stable over time.

According to Norwegian parents' reports, most of the children adopted from India are currently physically healthy (become healthy shortly after adoption), appear to be displaying normal developmental trajectories, have experienced healthy attachment with their adoptive families, do not display marked behavior problems, have not experienced negative reactions to their adoptive status or concerning their biological origins and their families were able to identify many strengths in the children they adopted. The difficulties many of the children displayed at the time of adoption have alleviated or disappeared. Most parents report high levels of functioning in their families, characterized by primarily positive parent child interactions.

Overall, the picture which emerges of Norwegian international adoptions from this study is one of healthy adaptation by adopted Indian children and appropriate adjustment among adoptive Norwegian families.

### **Weaknesses of this Study**

This is a descriptive study which limits interpretation of the information allowing for little explanation. The study employs a cross-sectional design. No control group or matched comparison groups are used. The cross-sectional design produces a reflection of one point in time. The adoptive parents are asked to answer many questions retrospectively. This requires good memories and excellent historical reporting in order for the data to be as accurate as possible. A longitudinal design with multiple measurements would have yielded more accurate data and taken time into account. Since no control or comparison groups are used, it is difficult to draw conclusions from the study that the outcomes are due solely to the fact that these children were internationally adopted from India by Norwegian parents. Matching a comparison group of non-adopted Norwegian children would have allowed differences and similarities to emerge. The differences might be able to be attributed to the samples' international adoption status if such a design was implemented.

The only responses included in the data are from those who voluntarily responded to the survey. Those who elected to respond could be more motivated than others in this population. It could be that the other half of the families who adopted children from India are, for example; extremely unhappy with the adoption agencies which facilitated their adoptions or their children may have much greater or fewer behavioral difficulties, etc., than the sample of families who did respond to the survey. Since they did not respond this information remains unknown.

Finally, the response rate though justified by the researchers may be characterized as moderate to low. A higher response rate, would of course allow for a better picture of the sample and therefore the population they represent.

### **Concluding Remarks**

We want to thank all the families who participated in this project, the staff who gave their time and efforts to helping with various aspects of the project, to Mr. Kim for his support of the research, and to the encouragement from BSSK to conduct this evaluation. This project was the second component of a multipart project, building from

research conducted in 2001 to examine domestic adoptions in India through BSSK. We plan to expand this report to several articles and pursue future research examining Indian children adopted in the U. S. The one lesson that is continually reinforced across many studies is that adoption works. It is apparent from this study that the adoption of Indian children by Norwegian families is working very well!

## References

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