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Terms used in the compilation

ADHD: Attention Deficit/Hyperactivity Disorder

CBCL: Child Behaviour Check List, a questionnaire designed to be completed by parents of children or young people; measures different behavioural deviations.

Cohen's d: Measurement of effect size, expressed in parts of a standard deviation. A d-value of 0.2 corresponds to a small effect and 0.8 a large effect.

Denver scale: Developmental test in which the child's linguistic, motor, problem-solving ability is compared with a normal group. The result is expressed as for other intelligence test where the normal value is 100 + /-15.

Epidemiological study: Study of the spread and occurrence of a phenomenon in a population.

Externalisation symptoms: Acting out symptoms, behavioural deviations directed against the environment, e.g. aggression, defiance, theft.

Goodness of fit: That two individuals (e.g. parents and children) are suited temperamentally, intellectually, etc.

HVB: Swedish: "Hem för Vård eller Boende." A residential home within social services receiving individuals for care or treatment.

Infertile: Involuntarily childless.

Internalisation symptoms: Introverted symptoms, psychological symptoms experienced by the individual such as anxiety, depression, psychosomatic disorders.

Cohort: Group of individuals with common characteristics, e.g. age.

Metaanalysis: Compilation analysis of a large number of studies.

Odds ratio (OR): The odds of being deviant/ill in an exposed group compared with the equivalent odds in an unexposed group (odds above 1 imply an increased risk).

Psychomotor: The interplay between impressions, thoughts, ideas and muscle movements.

Regression: Going back in development to a more immature behaviour.

Standard deviation (SD): Expression for spread in a distribution. Higher standard deviation expresses wider spread.

"Special needs" adoption: Concept used in USA and UK. Children/Young people who are adopted have been taken from their biological parents by the authorities who have assessed them as incapable long term of taking care of their children. Because of neglect, assault, misuse, etc. these children are in need of special care. In Sweden children of this kind are placed in long-term foster homes.

Variable: Characteristic that varies between individuals, e.g. age. Expressed in a numerical value and analysed statistically.

WISC-R: Wechler Intelligence Scale, Revised, an intelligence test with normalisation for different ages. .

YSR: Youth Self Report, a self answer questionnaire measuring different behavioural deviations.

§ 12 homes: Institutions for young people cared for according to paragraph 3 of the law (1990:52) with special regulations on care of the young (LVU). The young person may if necessary be locked in. Part of The Swedish National Board of Institutional Care (SIS).

Summary of the report Adoption – but at what price?

Introduction and description (Chapters 1–4)

In Chapter 2 we describe the work on intercountry adoption and the process in an adoption of this kind in Sweden. In Sweden there is a central authority, The National Board for Intercountry Adoptions (NIA), which *inter alia* has the task of authorising associations and exercising supervision over them. In Sweden at present there are six authorised associations. In relation to its population Sweden is a major receiving state, with approximately 1,000 intercountry adoptions per annum and with approximately 43,000 intercountry adoptees in total in the country.

In Chapter 3 we describe adoption work in the ten largest countries of origin with which Sweden has cooperation on adoption. In recent years these countries have mediated approximately 90% of the children who have come to Sweden through an authorised association. The countries depicted are Colombia, India, China, Poland, Russia, South Africa, South Korea, Thailand, Vietnam and Belarus.

Sweden has ratified both the UN Convention on the Rights of the Child and the 1993 Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption (The Hague Convention). The conventions are described briefly in Chapter 4, where the concept of the best interest of the child is also taken up. Our assessment is that it is important that both conventions are active instruments in Sweden's work on questions of intercountry adoption:

Costs and aid work in connection with intercountry adoption (Chap.5)

Sweden has to adopt a position vis à vis what it is ethically defensible for us to accept in terms of costs and aid work in connection with intercountry adoption.

We propose that the authorised associations should specify details of adoption costs in the foreign country, and that the adoption authority should conduct a feasibility assessment of these costs. The trend must be towards only actual costs connected with the adoption of a child forming the basis for the adoption fee. The associations' aid work must be clearly demarcated from their adoption work, and must not compromise the integrity of the adoption work.

The government proposes to

- take the initiative in expanding cooperation at government level between different receiving states in order to bring about a common ethical stance on costs and aid work in connection with intercountry adoption,
- in Swedish development cooperation prioritise the development of indigenous alternatives to orphanages, so that children initially may grow up in good conditions in a family in their country of origin, and
- study more closely the programme of the Permanent Bureau.

In order to reduce the risk of children becoming a commodity in the context of adoption, we propose more and clearer conditions of authorisation (see Chap.6).

The Hague Convention

Article 32 of The Hague Convention states:

1. No one shall derive improper financial or other gain from an activity related to an intercountry adoption.
2. Only costs and expenses, including reasonable professional fees of persons involved in the adoption, may be charged or paid.

3. The directors, administrators and employees of bodies involved in an adoption shall not receive remuneration which is unreasonably high in relation to services rendered.

There is a recommendation added to the regulation which implies briefly the following. Receiving states are encouraged to support efforts in countries of origin to improve national child protection services, including programmes for the prevention of abandonment. However, this support should not be offered or sought in a manner which compromises the integrity of the intercountry adoption process, or creates a dependency on income deriving from intercountry adoption. In addition, decisions concerning the placement of children for intercountry adoption should not be influenced by levels of payment or contribution. These should have no bearing on the possibility of a child being made available, nor on the age, health or any characteristic of the child to be adopted.

Sweden's attitude to The Hague Convention

Since 1997 The Hague Convention has been incorporated into Swedish law. For us it is self evident that Sweden must follow the intentions of the convention even in relation to those countries that are not parties to the convention. This also applies to those recommendations adopted unanimously at the meeting of the Special Commission in 2000.

The text of the convention, with its associated recommendations, is not always clear, and allows room for interpretation, e.g. as regards costs and expenses. It is up to Sweden to adopt a position on how it considers the convention should be interpreted.

As regards adoption, it is first and foremost the best interests of the child that should be taken into consideration, which means that insofar as the child's best interests are compared with e.g. adults' longing for a child, then it must always be what is best for the child that is decisive. This "conflict" can arise at two different levels, on the one hand in an individual case, on the other at an overarching level. There are already regulations in law dealing with the individual case. At the more overarching level e.g. when it is a

matter of attitudes to financial matters in connection with inter-country adoption, no regulation exists in principle apart from The Hague Convention. Here it is a matter of Sweden having a position on intercountry adoption which really does place children's best interests foremost, and which agrees with Swedish values in general. It is important that the state take a clear responsibility and does not hand this over to authorised associations and prospective adopters, who have their own interests to look after. It is also important that Sweden tries to bring about cooperation with other receiving states in order to promote a sound development of intercountry adoption work.

Intercountry adoption – a help in the short term

For the individual child intercountry adoption can be the best solution. As a general solution of the difficult situation of vulnerable children, intercountry adoption is merely a short-term help, which does not solve the underlying global problems causing children to be abandoned.

In order to improve the conditions for vulnerable children in the long term, what is required above all are actions promoting a broad improvement in welfare in the countries of origin, and the receiving states should be contributing to a development of this kind through broad measures. The aim must be that children are able to grow up in their biological family or in another family in their country of origin.

As it is not realistic to believe that all children can have that opportunity, not even in the future, work on improving children's conditions must be pursued with both long term and short-term measures.

If a receiving state such as Sweden is to conduct intercountry adoption work and at the same time be credible in its measures for improving the conditions of vulnerable children, the centre of gravity of the aid measures for children must be help of the kind that in the long term improves social and economic conditions in the countries of origin. This can be considered as reducing the risks of children being abandoned.

Intercountry adoption – an ethical dilemma

There are many childless adults in the world who long for children. There are also many children in the world without families. Many adults want a small healthy child if possible. As there are more childless adults than small healthy children available for adoption, a situation of competition arises in which there is a risk that whoever pays most will get the – from an adult perspective – most “attractive” children, i.e. small healthy children.

Different countries have different cultures for contributing aid for different ends. Some countries have greater openness or tolerance towards paying large sums in order to be able to adopt children. These countries’ willingness to pay and ability to pay in practice creates the norm for the sums it is possible to demand in order for a child to be made available for adoption.

It is quite understandable that the countries of origin receive contributions towards their social work, and that they choose contacts for cooperation who are prepared to contribute large sums to them. It is also understandable that childless adults are prepared to make great financial sacrifices in order to acquire a longed-for child. As long as there are more adults who want to adopt than “suitable” children available for adoption, an adoption market will exist in which financial means have the greatest importance.

The concept of trafficking in children means to most people that adults buy children in order to exploit them in some improper manner. Even if, in the adoption context, the intention is to provide a child with a family, there is an obvious risk that children become pawns in a financial game, driven by adults’ longing for children and difficult financial and social problems in the countries of origin. A financial game of this kind must be characterised as a kind of trafficking in children. The fact that, in certain circumstances, intercountry adoptions can be classified under the term trafficking in children is expressed in The Convention on the Rights of the Child and its Optional Protocol on the Sale of Children, Child prostitution and Child pornography.

When prospective parents have to pay more for the adoption than what the actual costs amount to, the child tends to become a commodity. Even if what is paid over and above the actual costs is used in a good cause, a contribution of this kind must never be a condition for a child being available for adoption.

As fast as the costs of adoption are forced up in the competition between different receiving states, there is also a risk that in the children's countries of origin a dependency is created on the income deriving from intercountry adoption work. When it is a question of large sums being paid over and above compensation for the actual costs, it may be that it is financially more advantageous to mediate children for intercountry adoption than for national adoption or placement in foster homes. In such cases intercountry adoptions can prevent positive local development, which is unacceptable. There is also a risk that intercountry adoptions contribute to the retention of structures with an archaic view of women and a view of illegitimate children and children with handicaps which Sweden cannot accept. A development of this kind can under no circumstances be accepted.

It is of the greatest importance that anyone with any connection to intercountry adoptions strives for high ethical standards in adoption work. Intercountry adoption must be placed in a wider context than has been the case, where it has primarily been seen as an alternative way of forming a family. We consider it essential that Sweden adopts a position on which "rules of the game" we can accept, and on how Sweden may act in order to reduce the risks of trafficking in children in connection with intercountry adoption.

Legitimate foreign costs

Running orphanages from which adopted children come, and administration in connection with intercountry adoption implies, of course, considerable costs for the countries of origin. It is therefore only reasonable that the prospective adopters compensate the countries of origin for actual costs incurred in the adoption of the individual child, or an estimated average cost per child.

What must be questioned is whether the prospective adopters should be forced to pay for the general welfare development of the countries of origin. In our opinion it is unreasonable from the viewpoint of Swedish adopters that they out of their own pocket, have to finance a development of welfare in another country. In this way the children risk becoming commodities, and there is a risk that the countries of origin become dependent on incomes from intercountry adoption work, something that is unacceptable.

Aid work

Combining the ultimate goal of the associations' aid work – which should be that children should be cared for by their biological parents, extended family or in any case by a family in the same country – with the ultimate goal of adoption work – to mediate children for adoption in Sweden – in our view involves clear difficulties. A conflict of aims would always be present in the work.

Nor is it possible to ignore the fact that aid work is a condition for the associations to appear as attractive collaborative partners as regards adoption. The associations' impression is that associations/countries with a large-scale aid programme often receive considerably more children for adoption than those with a smaller scale operation.

This last fact ties in to what has been said earlier about costs and the trade in children, with the difference that here it is the associations and not the individual parents who through aid work are “paying” to make children available for adoption. In that a large proportion of the aid projects are financed with funds from SIDA (Swedish International Development Cooperation Agency), the Swedish state also shares in “paying” so that adults in Sweden will have the opportunity of having a family.

In our opinion it is of the greatest importance that Sweden considers how we can contribute to improved living standards for vulnerable women and children without compromising the integrity of the adoption work.

Proposals of the inquiry on costs and aid work

A first step in order to get to grips with the problems described is for the adoption authority, in connection with decisions about authorisation for a particular country, to assess whether it is suitable for cooperation to be started or to continue e.g. as regards the cost picture. In order to be able to make an assessment of this kind, it is necessary for the Swedish association to present a detailed statement of accounts of all foreign costs. It is important that the costs are judged to be reasonable in relation to the cost levels in the country of origin. The trend should be towards a gradual reduction in that part of the cost relating to things other

than actual costs of the adoption (calculated as an average). If the association cannot provide sufficient relevant and detailed accounts, the authority should state how their accounting could be improved. If the association for various reasons cannot follow the authority's guidance, this may mean that the intermediation contacts in question will be regarded as unsuitable for cooperation.

In the recommendation to The Hague Convention it is stressed that aid to countries of origin must not compromise the integrity of the adoption work. Our understanding is that aid work carried on by authorized associations must be unconditional. If it really is to be regarded as unconditional, the work cannot be linked to a mediating contact. There must not be the least suspicion that Swedish aid is provided on the condition that children are being mediated for adoption in Sweden.

For work on intercountry adoptions to be kept as pure as possible, the associations cannot be allowed to carry on aid work for an organisation from which children are provided for adoption, or for a person helping the association in its adoption work. This should be evident from the conditions of authorisation in the law (1997:192) on intercountry adoption intermediation. Conducting aid work in a country from which the association mediates children for adoption should not be a problem, on condition that the aid work can be kept strictly separate from the adoption work both financially and personally. The association must not be allowed to have a representative (or contact person) in the foreign country who both helps prospective adopters and administers aid work, as this constitutes a great risk for confusing the association's completely separate operations of adoption intermediation and aid work.

As, in relation to its size, Sweden is a major receiving state, it will clearly contribute to the development of welfare in the countries of origin in order in this way to improve the conditions of vulnerable children and women. In our understanding it is important for aid activity to have long-term goals and to keep in mind the principle of subsidiarity. In our view it would be desirable if the Swedish government in its development cooperation were also to prioritise clearly that local alternatives replacing orphanages are developed, so that children are first provided with the opportunity of growing up in good circumstances in a family in their country of origin.

Receiving states can aid countries of origin via programme of the Permanent Bureau within The Hague Conference without risking compromising the integrity of adoption work. We consider that the government should look at this programme more closely.

Consequences

The consequence of demanding an open accounting procedure for costs, of not accepting on principle any other than actual costs within the framework of the adoption fee, and of striving for no direct link between adoption and aid work, may be that fewer foreign children will be available for adoption in Sweden than is presently the case. As a result of this, the work of the Swedish authorised associations may decline. Those children who would have been mediated for adoption in Sweden will instead be adopted by families in other countries when there is no shortage of prospective adopters.

Sweden should, in our opinion, lead the way as a nation in reducing the risks of trafficking in children in connection with intercountry adoption. If Sweden wishes to contribute to reducing the risks of a traffic in children in connection with intercountry adoption, the Swedish government and the adoption authority, as well as taking a position on what attitude Sweden itself should adopt on costs and aid work in connection with international adoption, should actively work in international circles to draw attention to these questions, and to encourage the major receiving states jointly to take up these questions with authorities and associations in the children's countries of origin.

It is our hope that a Swedish position on the matter may stimulate other receiving states to adopt positions as to what costs are ethically defensible in connection with intercountry adoption, and on how aid work can be pursued in a manner that does not compromise the integrity of the adoption work. It is important that Sweden shows clearly that the best interests of the children have priority in connection with intercountry adoption. One stage in this process is for receiving states to aid countries of origin unconditionally in their welfare development, so that the countries of origin to a greater extent have the opportunity of caring for their children within the country.

Authorisation and supervision (Chap.6)

We propose more and clearer conditions of authorisation, above all regarding circumstances in the foreign country. From the law on intercountry adoption intermediation it should also be evident that the association has an obligation to mediate for applicants who have consent, an obligation to provide information and documentation, and an obligation in each instance to be able to reimburse all sums paid and to possess the means to wind up the association. From the same law it must be clear that the adoption authority has the right to obtain information, right of access to the associations' offices and the right to demand redress. The authority should be given increased resources in order to exercise active supervision.

Authorisation should in our opinion be granted in two stages, in which the prerequisites for even acting as an intermediary of intercountry adoptions should be tested first. Thereafter one should test whether the conditions in each individual country are such that cooperation is judged to be suitable.

Authorisation for working with intercountry adoption intermediation in Sweden should only be granted to associations having as their primary aim mediating adoptions. If an association also carries on work other than intercountry adoption intermediation, the other work must not compromise the integrity of the adoption work. The risks of an association working with both adoption intermediation and aid work are discussed in the previous section. Authorisation may moreover only be granted if it is obvious that the association will mediate adoptions in a competent and discerning manner, without thought of gain, and with the best interests of the child as its primary goal. For authorisation it is, what is more, necessary that the association has a board, auditors and statutes implying that it is an open organisation. It is important that the association does not prevent any group of individuals from becoming members.

As regards circumstances in the foreign country there is today no regulation. We propose that a Swedish association be granted authorisation to work with intercountry adoption in another country on condition that the other country has adoption legislation or other reliable regulation based on the basic principles

of the best interests of the child as expressed in The Convention on the Rights of the Child and in The Hague Convention. The other country must also have a functioning administration for intercountry adoption work, and damaging competition for children must not arise, nor competition between Swedish associations operating in that country. The Swedish association must account for how its costs in the country are apportioned, and on the basis of the cost picture, and the balance between the Swedish associations and other general circumstances it should be judged suitable for the association to begin or continue adoption work with the other country. A condition for the Swedish associations to be able to render account for a sufficiently detailed cost picture is that the countries of origin are open and provide financial information to the association.

A Swedish association granted authorisation to work in intercountry adoption in another country will be allowed to work in that country only if the competent authority in the other country has given its consent to this.

We also propose that an authorised association should have an obligation to disclose information, an obligation to mediate, and an obligation to provide documentation. The association must moreover in each instance be able to reimburse all adoption fees paid and possess the financial means otherwise to wind up the association.

Clearer and more detailed conditions of authorisation increase the opportunities of the adoption authority to act. In order to be able to exercise active supervision the authority however needs more supervisory tools. We consider that the authority must be given the right to acquire information necessary for supervision, right of access to the associations' offices and the right to demand redress.

NIA's organisation (Chap. 7)

<p>We propose that NIA be wound up as a board with broad political and civic composition and that the government create a completely new authority with responsibility for intercountry adoption questions. The new authority should have the</p>

management structure of a single director agency with a supervisory board.

In the instructions for the new authority the task of facilitating adoption in Sweden of children from abroad should be changed to the task of supervising the Swedish authorised associations' work in intercountry adoption intermediation and ensuring it is carried on in accordance with the law and the principle of the child's best interest as this has been expressed in The Convention on the Rights of the Child and in The Hague Convention. The authority should moreover only disburse state grants to associations that actually mediate children.

Our brief includes a review of NIA's organisation. NIA is a board with broad political and civic composition run by a committee with eleven members nominated by the Swedish parliament. Six of the members are nominated by the parliamentary parties, of which one is chairman of the committee. NIA's secretariat has nine employees. The government has stated that the management form of a board with broad political and civic composition is appropriate for some activities but should be employed sparingly. Reappraisal of certain existing boards of this kind may be carried out on suitable occasions.

The authority that in future should be responsible for questions of intercountry adoption should in our opinion in principle have the same tasks as NIA today according to its instruction. On the basis of the tasks of the authority we judge however that, from a legal viewpoint, there is no longer any need for the authority to be organised as a board with broad political and civic composition. Nor are there other reasons for retaining its present management form.

Our opinion is that the question of intercountry adoption is best dealt with by its own authority, which has a clear task with responsibility for questions of intercountry adoption and work as a central authority according to The Hague Convention.

International adoption touches on ethically intractable areas, where it is important that Sweden as a nation indicates clear boundaries for what is acceptable from a Swedish perspective. The decisions of the authority in, above all, questions of authorisation could be of a sensitive nature, and the authority works within a complicated field and with many overseas contacts. This should

motivate powerful public control over its work. The management form of a board with limited liability would be possible in this context, but it has been criticised for its vagueness on the question of liability.

The exercise of authority should be characterised by clear managerial liability. In relation to the associations and private individuals to whom the authority's decisions will be directed, it is important that the managerial liability is unequivocal. Against this background we consider that the management form of a single director agency with supervisory board would be suitable for the authority. This would provide the possibility of supervision of the work. At the same time the question of liability would be clearer than at present. The opportunity for supervision can be valuable, as the authority has to deal with questions to do with international cooperation, and in certain cases sensitive questions in which associations and individuals are affected. It is necessary to have clear legislation and a well-balanced supervisory board.

Research results as a basis for our proposals in Chaps. 8–12

Marianne Cederblad, Professor Emeritus in child and youth psychiatry has been commissioned by us to make a compilation of important research in the field of adoption.

The research shows that the great majority of adoptees do not have any major problems. Adoptees are however 2–3 times over represented in the clinical material in child and youth psychiatry and in social day care. The boys show aggression, defiance, hyperactivity and asocial behaviour, while the girls have more depressive symptoms, thoughts of suicide and attempted suicides. Interview studies do not provide such unambiguous results. Several studies have shown that abuse, malnutrition, neglect, emotional and intellectual deprivation before adoption affect the child's adjustment even after several years in the adoptive family. It has been shown that the occurrence of such negative experiences, rather than age on arrival in itself, has a strong link to how the adoptee's life will develop. School problems are often the result of language difficulties, but hyperactivity and attention deficit are also more common among adoptees, which makes schoolwork difficult. Adoptees may have difficulties in integrating their ideas about their

biological family and their experiences of their adoptive family during childhood. It may also be difficult for them for example to identify themselves with two origins and/or cultures. Adoptive parents can facilitate the identification process by involving themselves in the culture of the country of origin etc.

Parental training before adoption (Chap. 8)

We propose that it becomes obligatory for the person(s) wishing to adopt to take part in municipal parental training before adoption for consent to be granted. The municipalities should be responsible for providing this training.

Parental training before adoption is presently provided by the authorised associations. In connection with the municipality's home study into the person(s) wishing to adopt the investigating officer should assure himself that the person(s) investigated has/have sufficient knowledge of children and their needs. The quality of parental training is dependent on the individual circle-leader and can therefore vary considerably. The opportunity of participating in parental training varies countrywide, as does the content of the training and its cost.

In a case of intercountry adoption society is participating in the creation of a family. It is therefore also reasonable that society should make demands of the prospective adoptive parents with the aim that the child will have the best possible conditions in its new home.

All adoptees have the right to come to well prepared parents, who have been made aware of intercountry adoption as a phenomenon and what ethical and personal considerations should be taken into account before adoption. From the research findings in this field it appears important that the person(s) wishing to adopt are made aware of the increased risk of various problems in adoptees, so that they are prepared to recognise and cope with different situations, and so that they can seek help at an early stage. From the viewpoint of the best interests of the child we consider that participation in parental training before adoption should be a condition for consent being given.

All prospective adoptive parents have the right to parental training of such a quality that, after training, they will have the possibility of taking a decision on whether adoption is right in their case. It is totally unsuitable that society trusts that actors with their own interests in adoption intermediation are those associations providing the training. It must be ensured that all prospective adoptive parents receive training of a high standard, that this training is of a similar quality across the country, and that it focuses on the special requirements of adopted children. We cannot therefore arrive at any conclusion other than that society has to provide parental training in order to guarantee independence, objectivity and professionalism in the training. In our view the local municipalities should provide training based on materials produced centrally. The municipalities should have the right to make a reasonable charge for participation in the training. Cooperation between municipalities and municipal cooperation with the county council are desirable in order to achieve a certain scale for the work, and to make use of child health care's knowledge of e.g. attachment.

Home studies before adoption and decisions on consent (Chap.9)

<p>We propose that, in order for consent to be granted, the person(s) wishing to adopt should have participated in municipal parental training before adoption, should have satisfactory knowledge and insights into adoptees and their needs, be less than 42 years of age at the time of application, and on the basis of all circumstances should be suitable to adopt. We further propose that the county administrative board should be the body deciding on consent.</p>
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The home study of the prospective adopter(s) is carried out by the municipal social services department, and decisions on consent are taken by the social welfare board. This type of matter is rare in most municipalities. Even in municipalities with a larger number of adoption cases, the cases for organisational reasons are often unusual for both investigating officers and decision-makers.

We consider that the municipalities have a great deal to gain by cooperating e.g. on home studies for consent to adopt. By cooperating, a smaller number of investigating officers can work more frequently on this type of investigation. There are also greater opportunities to tailor training on adoption-related matters, reach out to affected groups with this training, and also greater opportunities for an exchange of experiences across the country. A smaller number of investigating officers would provide a more even quality of investigation, and the work would also be carried out more efficiently. County administrative board supervision would also be facilitated.

We consider that a condition for consent being granted is that the person(s) wishing to adopt should possess satisfactory knowledge of and insights into adoptees and their needs. As can be seen in the previous section, the person(s) wishing to adopt should also have participated in municipal parental training on adoption. We consider moreover that, from the child's perspective, advanced age in the person(s) wishing to adopt can in itself be sufficient grounds for consent not being granted. Against this background we consider that the person wishing to adopt should be less than 42 years of age at the time of the application for consent to be granted. A somewhat higher age can be accepted in special circumstances. Finally we consider that in the law on social services (2001:453) it should be clear that the person(s) wishing to adopt must be suited to adopt. The assessment of suitability should be made taking all circumstances into account.

There is no automatic right for adults to be able to adopt a child. Assessing whether a person(s) wishing to adopt is/are suited to adopt is difficult, and it is easy to assume an adult perspective, especially when there is no particular child to take a view on.

Against the background of the difficulty of assessing whether a person(s) wishing to adopt is/are suited to adopt, we consider that there are reasons for considering which social actor is best suited to take decisions on consent, and how the decision-maker can be provided with the information on adoptees and their particular need in order to be able to take as their starting point the best interests of the child. We list different possible decision-makers. The decision-makers at local level could be the social welfare board, at a regional level the county administrative board and at central

level the authority responsible for questions of intercountry adoption.

In order to be able to give priority to the best interests of the child, it is our view that those taking the decision on consent must have a good knowledge of both children's needs in general and adoptees' particular needs. In our opinion it is not realistic to demand that the social welfare boards in all of Sweden's 290 municipalities should possess all the particular knowledge of adoptees that we consider is required in order to take well-founded decisions on consent, as this is a question of a small group of cases. If the decisions instead were to be taken regionally, it is our view that a sufficiently good knowledge base of adoption and adoptees' needs can be built up without actions requiring large amounts of resources. The risk is reduced of great variations as regards the processing of the cases, and a more unified practise can develop. We propose therefore that the county administrative board should take decisions on granting consent. In order to meet the high requirement of legality it may be suitable that the county administrative boards create special committees with the task of deciding on consent. Such a committee could be composed of various experts in the field, and it may also be suitable that the public interest is represented.

Support and help after an adoption – post-adoption service (Chap.10)

Society accepts and legitimises intercountry adoptions. It is important that society meets the needs of adoptees and adoptive parents at as early a stage as possible. Since 1998 the municipalities' social welfare boards have had special responsibility for adopted children and young people. The support from the welfare board should include a social worker with a good knowledge of the special circumstances of adoptees and of the adoptive family, who can act as a partner in a dialogue and providing support e.g. in relationship problems within the family, difficulties in the parental role and in life crises deriving from the adoption. We consider that everyone who in their profession meets adoptees and adoptive parents should have a general knowledge of adoptees and that those working with

support and treatment of adoptees and adoptive parents must have special knowledge of adoptees. It is important that the state participates in the development of this knowledge.

By far the greatest numbers of adoptees live their lives in the same way as those who have grown up in their original family. All adoptees have to come to terms with their adoption, however, and at different stages of their lives there may be a need for support from society in order for them to cope with difficulties of various kinds.

Since 1 January 1998 the municipalities' social welfare boards have, according to Chapter 5 paragraph 1 of the Law on Social Services, an explicit responsibility for providing help that may be needed after an adoption. Several social workers state that it is not clear what is meant by support and help. In most municipalities there is no structured activity for support and help after an adoption.

The aim of providing support and help is in our opinion that the donor contributes to the recipient's solution of a problem or to his coping with a situation in a better way. The social welfare board's support and help may include a social worker with a good knowledge of the special circumstances of adoptees and of the adoptive family, providing tips on different attitudes and suitable literature. The social worker can also be a partner in a dialogue. Examples of situations when support may be needed are in relationship problems within the family, difficulties in the parental role and in life crises deriving from the adoption.

The responsibility of the social welfare board according to Chapter 5, paragraph 1 of the Law on Social Services does not include adult adoptees. As the municipality has the ultimate responsibility for provision of support and help to those in need living within its area, it is suitable to make use of the existing knowledge of adoption within the municipality also as regards adult adoptees.

It is important that everyone who in their profession encounters adoptees should have a general knowledge of adoptees, and that everyone who works with e.g. support or treatment of adoptees also has specific knowledge of adoptees, so that the requirements for support and treatment can be met in time and in a good way.

Even as regards support and help we would wish to stress that municipalities have a great deal to gain by cooperating firstly with each other and secondly with the county council. Through this cooperation a regional support and help operation with specialist knowledge of adoptees can be built up.

Organisation and execution in the work on adoption-related questions. (Chap. 11)

We stress that most municipalities have a lot to gain from cooperating firstly with each other and secondly with the county council on adoption-related issues. We propose that municipalities and county councils cooperating on these matters should be able to apply for and be awarded a state incentive grant over several years.

As is evident from the previous section, adoption-related matters rarely arise for most municipalities and for child health care. In order to achieve a certain scale in the municipality's work on adoption-related questions, most municipalities have a lot to gain by cooperating with each other. Municipal cooperation with the county council in parental training and support and help operations can be profitable for both sides. In regional cooperation on adoption-related matters those people working with these questions can receive the specialist knowledge necessary to meet the needs of adoptees and their families.

By the expression "regional adoption counselling" we mean a regional operation in which municipalities in cooperation provide parental training before adoption, home study before approval, and support and help after an adoption. The expression is not tied to any special form of cooperation. The county might comprise a suitable geographical basis for cooperation on regional adoption counselling between the municipalities comprising the county and the county council child health care. A very important task for adoption counselling is also to actively disseminate knowledge about adoption to various professional groups who come into contact with adoptees and adoptive parents. In order to encourage the establishment of cooperation we propose that the municipalities and county councils cooperating with each other on

adoption matters should be able to apply for and be awarded a state incentive grant which should be paid over several years.

Research and development of knowledge (Chap. 12)

We propose that a national centre for research and knowledge on intercountry adoption be established. A centre of this kind may with advantage be linked to already existing operations.

Hitherto the state has not prioritised research and knowledge development in the area of adoption. This is unacceptable when this involves the organised movement of children from one country to another. If Sweden is to have intercountry adoption in the future it will be necessary for the state to prioritise these questions.

We propose the establishment of a national centre for research and knowledge on intercountry adoption. The ultimate goal of the centre would be that adoptees receive the best possible conditions during their childhood and youth in their new home country through a better knowledge base. Some important tasks for the centre may be to maintain contact with the field of adoption in order to understand the needs for research, keep up to date with international research, ensure that new findings are made available to those interested in the field of adoption, and to act as a bank of knowledge for the municipalities' adoption-related work. In order to acquire dignity and legitimacy the centre should be linked to a scientific environment where interdisciplinary research and knowledge development can be pursued, and where a dialogue becomes possible with clinical work. It is important that adoptees themselves can be heard, firstly in prioritising the research projects and secondly in the research itself, so that the situation of adoptees is not only described by adoptive parents and professionals. We provide examples of existing institutions which could house a research and knowledge centre.

Grants towards the costs of adoption – age limit etc. (Chap.13)

We propose that the age limit for the grant towards the costs of adoption should not be raised. We propose that in another regulation the government should consider whether it is still motivated that the grant towards the costs of adoption should be paid in private adoptions.

Since 1 January 1989 a state grant has been paid towards the adoption of children from abroad. The grant amounts at present to SEK 40,000 per adopted child, and is paid out when the adoption is complete. Grant is only paid for children not yet ten years of age when the adoptive parents receive the child into their care. Included in our brief is to examine whether the age limit for the grant should be raised. Most adoptions of children older than nine years are private adoptions. In private adoptions the cost picture, against the background of those situations that might arise, is in all likelihood completely different from an adoption through an authorised association. As a result of this we judge that there is no reason to raise the age limit. The few adoptions of children older than nine years of age mediated through authorised associations do not warrant adopting a different position.

Against the background that private adoptions may now only occur if there are special reasons, it is reasonable to assume that the costs of these adoptions are usually lower than for adoption through an authorised association. We propose that the government should consider whether it is still motivated for the grant towards adoption costs to be paid in cases of private adoption.

Other matters (Chap.14)

The adoptees' interest groups constitute an important complement to the work society is responsible for. The groups are mainly run entirely on a non-profit basis. We propose that these groups should be awarded a state grant for their work.

An association mediating an adoption should also, for a reasonable fee, be able to help an adoptee in seeking his origins. Within the framework of its support and help work, the social

welfare board should provide support as required for coping with those feelings aroused in connection with an adoptee seeking his origins.

The child's rights need to be reinforced in adoptions of a child who is known. We propose that the government reviews the deficiencies existing in this kind of adoption.

Different age limits in The law (1962:381) on national insurance and The law (1978:410) on right of parental leave for care of children, etc. imply e.g. that an individual(s) adopting an older child can have the right to child allowance but not to parental leave. We propose that the government reviews the question of whether there should be total conformity between the age limits.

Consequences (Chap.15)

Our proposals will require new resources. We estimate that the proposals will generate SEK 15 millions in raising standards and SEK 22 millions in one off subsidy. We submit proposals for possible financing.

1 Background

We have endeavoured to familiarise ourselves with the research currently existing in the field of adoption. This attempts, on the one hand on the basis of the research itself, to state what has actually been done by way of research in this field. On the other, with the research findings as a starting point, we have sought to propose adequate measures in this field, both for further research projects and for direct measures relating to adoptees, adoptive families and professionals.

Sweden shares its experience of intercountry adoption with many other Western countries. Even if significant differences exist between different societies, it is conceivable that much of the knowledge and experience gained, for example, in the Nordic countries, the Netherlands and the USA are also relevant in Sweden.

We have given Marianne Cederblad, Professor Emeritus in Child and Youth Psychiatry at the University of Lund, the brief of making a compilation of the more significant national and international research findings in the field. In order to achieve a broad interpretation of the research findings we have also asked some Swedish researchers to analyse those results presented in the compilation. Those who have carried out these analyses are Marianne Cederblad, Dr Anders Hjern, paediatrician, The Karolinska Institute, Stockholm, Dr Frank Lindblad, child and youth psychiatrist, The Institute for Psychosocial Medicine (IPM), Stockholm and Dr Malin Irhammar, PhD in Psychology, The University of Kristianstad.

2 **Compilation of research into adoptees and their life after adoption,** by Marianne Cederblad, Professor

Emeritus in Child and Youth Psychiatry at the University of Lund.

2.1 **Summary**

The survey of the literature shows fairly unanimously that adoptees are overrepresented in the clinical material by a factor of 2 to 3 within child and youth psychiatry. This is the case both internationally and in Sweden. They show above all so-called “externalisation symptoms” during their childhood and youth, i.e. aggression, defiance, hyperactivity and asocial behaviour. This applies especially to the boys. Depressive symptoms, thoughts of suicide and attempted suicides also occur more often, primarily among the girls. In adult adoptees suicide, suicide attempts, psychiatric illness, addiction and criminality are more common than in the rest of the population.

Epidemiological studies of children and young people have not provided as unambiguous a picture. Certain studies have shown higher frequencies of the same types of psychiatric illness as the clinical studies, in the adoptive group compared with groups in the total population in the same age range. The tendency is for younger children to show fewer deviations than teenagers. Several writers have indicated that the adoptive group shows a greater spread than the control groups. It has been found that the majority of adoptees seem to develop well with good mental health and good self-esteem. They are, however, also strongly overrepresented in the psychologically most handicapped group. The main cause of these findings is presumably that adoptees have experienced very stressful events before their adoption. Several studies show that mistreatment, malnutrition, neglect, emotional and intellectual deprivation before adoption still influence the children’s adjustment even after several years spent in the adoptive family, although the children’s recovery from both physical, emotional and cognitive retardation is impressive. It has been shown that the occurrence of negative experiences of this kind, rather than the age

on arrival in itself, has a strong link to the outcome of the adoption. However, the older they are at adoption the greater is the risk that they will have been subjected to negative experiences. As regards intercountry adoptions, one problem is that often little is known about the child's previous history.

Several studies show that physical health, which can be poor on arrival, soon improves and becomes normal. However, problems with early puberty may arise, particularly in girls. This can in its turn influence their final height. Early malnutrition can also increase the risk of becoming overweight in adulthood. Genetic factors can also play a role in this. Early puberty in certain girls can result in their earlier testing of adult behaviour as regards sex and alcohol/drugs.

Scandinavian studies show that adoptees cope with their schooling averagely well in the respective country of adoption. Yet here too the spread was great within the group. Studies in several different countries show that more adoptees needed special tuition. The problems found at school were the result of language problems, language here meaning more abstract concepts and syntax, so-called "school language". Hyperactivity and attention deficit were also more common in the group of adoptees and made schoolwork more difficult. The adoptees have also had to cope with a schooling 1.5–2 years shorter than biological non-adopted siblings and the adoptive parents, which is because the latter as a group are often better educated than average parents.

Research into identity has previously applied to the adoptee's attitude to his biological family. The young person can experience difficulties integrating his ideas of this with his experiences of his adoptive family during his youth. For the adoptees whose origins are in different racial and ethnic groups to his adoptive parents difficulties arise in identifying more or less with two races and/or two cultures. It has been found that the identification process looks very different at different ages. Parents can facilitate this by themselves getting involved in and mediating knowledge about the other race/culture. Pre-teen children are often not interested in this and want to be as similar to their friends as possible, irrespective of race/ethnic group. In their teens their own self-interest develops and the individual takes responsibility for adopting an attitude to their background. The process is different, however, for different individuals; only about half involve

themselves in any active interest in their biological and ethnic background. There would not appear to be any clear link between race/ethnic identity in trans-racial/trans-ethnic adoptees and their mental health and self-esteem.

2.2 Introduction

Adoption has occurred for several thousand years. Hammurabi's Law in Babylon contains a law on adoption. Emperor Sargon I of Babylon was adopted, as was Moses and five of the Emperors of the Rome Empire, e.g. Marcus Aurelius. The most common form of adoption has of course been adoption within the same ethnic group, "invisible adoptions", i.e. the adoptee has not deviated from their adoptive parents' appearance in such a way that people would automatically understand that he had been adopted. In many countries adoption is a secretive business, not revealed to outsiders. This has sometimes meant that people have grown up ignorant of their being adopted, which is sometimes revealed dramatically by people close to them or perhaps only in connection with the death of the adoptive parents. Nowadays completely open adoptions occur in ever increasing numbers in the USA and UK where biological and adoptive parents can meet both before the adoption and later during the years when the child is growing up when the child too can meet the biological parent(s). In Sweden an adoptee has for a long time been able to find out the identity of his biological parents. Social services have also helped trace biological parents and mediated contacts with them and the adult adoptee, or discovered information about the adoptee or the biological parents when one or other party has not wished to make personal contact.

The phenomenon of adopting children from other countries began mostly after the Second World War, when there were thousands of orphans in Europe. About 6,000 of them were adopted into the USA. In connection with the Korean War about 15,000 children were adopted into the USA. Many of these were children of American soldiers and were not accepted by Korean society. During the sixties the motivation for intercountry adoption changed from the humanitarian idea of taking care of an abandoned child to provide it with a home to creating a family for an involuntarily infertile couple (*Altstein & Simon, 1991, Hersov*

1990). In Sweden and other Western countries the supply of adoptive children within the country decreased rapidly as a result of more efficient and readily available methods of contraception, more liberal legislation on abortion and better socio-economic circumstances in society, making it possible for single mothers to keep their children instead of giving them up for adoption.

An estimate of the total number of intercountry adoptions in the 1980s is 170,000–180,000. Estimates from available statistics for the seven largest receiving states indicate that the number is increasing all the time. In 1993 an estimated 16,000 children came to these countries, in 1997 approximately 23,000 children (*Selman, 2000*). It is thought that in total approximately 32,000 children per annum currently move from one country to another for adoption. Most of these children move from poor to rich countries and from poor to very well to do families. In the 1980s most children came from Korea, Columbia and India. In 1990–1991 a large number of children came from Romania. Since 1995 most of the children come from China, Russia, Vietnam, Korea and Columbia. The USA receives most children, followed by France, Italy, Germany and Canada, each with more than 1,500 children each year. If one calculates the number of children adopted between countries relative to the number born within the country in the same year, then Norway, Sweden, Denmark and Switzerland come out highest in 1998. Sweden had the highest proportion of adoptions (number of adoptees per 1,000 children born) around 1980, namely 17.4. Since then the number has dropped to 10.8 in 1998

At present about a thousand children arrive each year for adoption in Sweden. Like Sweden, the Netherlands has also reduced its proportion of adoptions in recent years. In total about 43,000 children have been adopted into Sweden from other countries.

Since 1993 an international convention has existed regulating intercountry adoption, The Hague Convention of 1993 on Protection of Children and Co-operation in Respect of Intercountry Adoption. This has been ratified or joined by 41 countries (February 2000), though not by the USA which receives most adoptees worldwide! At present an intensive debate is being conducted about the ethics of intercountry adoption. A large-scale trade in children has developed, in which adoption intermediaries earn large sums to mediate attractive adoptive children, preferably

as small, blonde and fair-skinned as possible. (*Triselotis 1999, Selman 2000*).

2.2.1 Mental health

Summary: Both Nordic studies and those from other countries show that adoptees are overrepresented in clinical groups. A figure of 2–3 times greater than for non-adopted young people has been registered both for psychiatric problems and relationship problems, school problems and asocial behaviour. The older a child is at the time of adoption, the greater the risk of psychiatric problems and problems of social adjustment.

Nordic and extra-Nordic studies of adoptees of different ages made in population groups, epidemiological studies, show different results. Some researchers have discovered that adoptees both of school age, in their teens and as young adults show an increased occurrence of psychiatric problems, attempted suicides, addiction and asociality. Other researchers have not found any differences. Some have shown that the differences result from a very small proportion of the adoptees showing very severe symptoms, whilst most develop well and are healthy. In these studies too age at the time of adoption and severe experiences prior to adoption vary in proportion to the frequency of psychiatric illness. In some studies the teens and early adulthood seem to be periods of increased difficulties because of identity problems.

Nordic clinical studies

Cederblad 1981, Gunnarby et al. 1982, Tordai 1978 carried out a number of studies in Scandinavia during the first half of the 1970s into the psychiatric and somatic health of non-Nordic adoptees after their arrival in their adoptive family. The studies showed that the children adjusted well to their adoptive families, and that often, on arrival in Sweden, they had different infections, which were however rapidly curable.

Cederblad 1982 followed a group of 52 children who arrived aged three or older. Many children showed initial adjustment problems,

with regression and other symptoms of being in an acute crisis. Both somatic and mental health were, with a few exceptions, normalised within the first year. The symptoms remaining were a tendency to overeat and to demand attention. One girl showed signs of autism.

When the large group of adoptees entered their teenage years, warnings began to come in from schools, social services and child psychiatric clinics, that many problems could be seen in the adopted teenagers.

Dery-Alfredsson & Katz 1986, Cederblad 1991 studied foreign adoptees who had approached child psychiatric clinics in Stockholm or in southern Sweden. In both studies the foreign born adoptees in their teens were overrepresented in the patient material compared with the proportion of the population they constituted in the catchment areas. The most common reason for contact with child psychiatrists was asocial behaviour or acting out behaviour. Problems of relationships with parents and others were common, just as were school problems. The girls showed more symptoms of anxiety and repression than the boys. A high age on arrival brought a greater risk of contact with child psychiatrists.

Vinnerljung 1999 studied the occurrence of young people adopted from abroad and long-term foster children in residential treatment centres. In 1991 in the age group 13–16 the children adopted from abroad comprised 1.65% of the population. That year 4.3% were placed in § 12 homes, i.e. 2.6 times more than expected on the basis of the proportion of the population in these age groups. Foster children in long-term care constituted 0.8–1% of the population and 11.4% were placed in § 12 homes. It was decided to compare these two groups. Such foster children in Sweden are comparable to “special needs” adoptions in the USA and UK. If, instead, initial placements in all forms of social custody were taken into account, then the adoptees were placed 2.4 times as often as expected, and foster children relocated to a new foster home or in another form of social custody 5.5–6.9 times as often. The two groups were very similar as regards age and gender distribution and type of behavioural problem on placement except that the adoptees had been registered more often for psychiatric disturbance and assault, and the foster children has been more often placed because of poor conditions in the biological home, especially alcohol abuse and neglect. 23% of the adoptees and 31%

of the foster children were taken into care compulsorily. Most, approximately 60%, were cared for in foster homes, around 30% were placed in HVB homes (municipal care homes) and less than 10% stayed in § 12 homes. Approximately a third of the placements were terminated in an unplanned manner. As regards these circumstances there was no great difference between the groups.

Extra-Nordic clinical studies

Most studies of adoptees undertaken in Scandinavia have been of children of non-European origin. In British and American studies children born within the country have often been studied. In those cases designated “special needs” adoptions the child has in many cases first been placed for fostering and after a period been adopted by the foster parents. The conditions for adoption are thus rather different and usually considerably more information is available on the biological parents and the children.

Tec et al. 1967, Kim Wun Tung et al. 1988, Zucker & Bradley 1998 found that in the USA and Canada too adoptees have proved to be overrepresented at child psychiatric clinics.

Hoksbergen et al. 1988, Groze 1986 found that an “advanced” age on arrival was a risk factor for developing problems.

Cohen et al. 1993 compared adoptees and biological children between the ages of 7 and 17, where one group of adoptees and the biological children had received psychiatric treatment. In total the study comprised 88 children and their parents. It was found that both the clinical groups had more behavioural symptoms than the non-clinical group. Adoptees in the clinical group had more symptoms than the biological children in this group. Above all this applied to acting out symptoms (92% of the adoptees and 55% of the biological children in this group had “conduct disorders”). A greater proportion of the adoptees had previously received psychiatric treatment, and their symptoms had to a greater degree continued for a long period. The children in the clinical group had been older at adoption than in the non-clinical group of adoptees. The families in both clinical groups indicated more family problems. They also reported more relationship problems between spouses, and the mothers had more psychiatric problems. There

was, however, one difference between the two clinical groups, in that the adoptive families reported fewer problems in the family and a better functioning social network than for the biological families. The adoptive parents considered that the explanation for the child's problems lay in biological factors, or in factors in the child's early development before the time of adoption. The parents of the biological children more often reported problems in the marriage or relational problems between siblings as an explanation for the children's problems.

Hoksbergen et al. 1988, Hoksbergen 1991, 1997, Groze 1986, Hall 1983 have undertaken studies into failed adoptions where the child has been placed in an institution or in another family. Hoksbergen studied the frequency of and reasons for the failure of the first adoptive family in the case of children placed in an institution in Holland. He approached 670 institutions and asked them to report those adoptees they had admitted in a six-month period. The parents were also interviewed in those cases where this was possible. Placement in an institution was seen as an objective measurement of the special difficulties or problems of upbringing there can exist in adoptive families. He found that 5.7% of all children in Holland adopted from abroad have at some time been placed in an institution. 75% of these children did not return to their parents. On average barely 0.5% of all Dutch children are placed in an institution. Their age on arrival had a close link to the breakdown in the adoptive relationship. The older the child is on arrival, the greater is the risk that the child will be placed in an institution. In order to study in greater detail those risk factors that might explain the great difficulties leading to a placement these children were compared with 116 Thai adoptees who were still living in their adoptive families. The children in placements had had poorer physical health on arrival; 2/3 of them had great problems of adjustment even at that stage, especially as regards the difficulty of bonding to the family and food problems (refusing to eat or overeating). 75% continued to have long-term problems of adjustment even after having lived for several years in their adoptive families. Most common were relationship problems, 59%, and acting out, aggressive or sexual behaviour, 49%. School problems, problems with friends, telling lies and theft were also common. Most showed many different problems of adjustment. The adoptive parents in the institution group were two years older

than the parents of the Thai children. 10% were over 40 at the time of adoption. The divorce frequency was twice as high as in the control group (10% as against 5%). The socio-economic situation was higher, and the number of families with biological children twice as high as the average for adoptive families in Holland. Twice as many of the children in placements had come somewhere between these children in age or been the eldest child.

Some studies have focussed more on the relationship between adoptees and adoptive parents.

Hall 1982 studied children placed by an adoption association and their adoptive parents and biological parents. When successful and failed adoptions were compared, it was found that no significant differences existed as regards the biological parents, but on the other hand there were emotional disturbances in the child, difficulties in the child's adjustment to the adoptive parents and other children in the adoptive home and the child's ability to develop mutual relationships.

Grotevant et al. 1988 studied the adoptee's "goodness of fit" with the adoptive family and emotional disturbance in the adoptive child. 50 adoptees and 50 non-adopted young people treated at an institution and their parents were interviewed. A fifth of the adopted young people were described by their parents as children who had early on rejected their parents when they tried to cuddle them or hold them ("elbow babies"). Half of these elbow babies were placed in adoptive homes before the age of six weeks and three of these five were regarded as hyperactive or aggressive from an early age. As for the other five cases of elbow babies, it was probable that the pattern of behaviour was caused by poor relationships in the environment in which the child lived before adoption. The studies have also examined the importance of siblings in the adoptive home, the age of the parents, occupation, etc. but no unequivocal results have been arrived at.

Nordic epidemiological studies

Mikael Bohman 1970, 1973, carried out the best-known study of adoptees in Scandinavia, "Adopted children and their families". The study comprised 168 children who within a two-year period were placed in adoptive homes through Stockholm's adoption office.

The children were 11–12 years old at the time of the first study. Data was collected from adoption investigations, from adoption documents and interviews with adoptive parents and teachers. School grades and school health cards were also used. A control group was formed from children in the same class. Information from the adoptive parents was compared with corresponding data from Jonsson's and Kälvesten's (1964) study of "222 Stockholm boys". All the children except one in Bohman's study were placed in adoptive homes before the age of one year. The adopted boys were more hyperactive, had greater attention deficit and were more often at odds with other schoolchildren than the control group. They also had a lower status in class. Several were assessed as being psychologically maladjusted, 22% as opposed to 12% for the control group. The adopted girls did not differ from the controls in adjustment, but had more problems with reading and writing. The children were studied again at the age of 15. It was then found that there was no difference between the adoptees and the control group as regards behaviour and adjustment. The adopted boys were also studied at age 18 in connection with enlistment into military service. Nor was there any difference on this occasion in comparison with the control group. (*Bohman 1978*). As this study firstly only comprised Swedish-born adoptees and secondly comprised children who did not all know that they were adopted, its results are not directly applicable to the Nordic studies into adoptions of coloured children, i.e. visible adoptions. Bohman found, for example, that psychiatric or social insufficiency in the biological mother or criminality or addiction in the biological father does not reappear in the form of poor adjustment in the children. Children adopted by highly educated families had lower rather than higher school grades than other children. The adoptive parents' age and socio-economic situation did not co-vary with the adjustment of the adoptive children. The attitude of the adoptive mothers to the marriage, but not that of the adoptive fathers, had a link to the children's adjustment, as did the parents' attitude to social contacts. The adoptive parents' own upbringing as children had no link to the children's adjustment. Maladjustment was more common in boys who were only children, but not in girls in the same situation. In Bohman's study the children were later followed up when they were 23 years old (*Bohman & Sigvardsson 1990*) with the help of a register of criminality and addiction. It was found that

with increasing age the adjustment of the adoptees no longer deviated from that of the control group. The conclusion was drawn that the risk of mental disturbance and disturbance in social development was in no way greater for the adoptees than for other children irrespective of biological background.

Smyer et al 1998 undertook a study on the basis of the Swedish twins register. It comprised 351 same sex identical and non-identical twins where one twin had been adopted before the age of ten, and 407 matching control pairs in which the twins had been brought up together. The average age at separation was 2.8 years, half being separated before the age of one year. In the follow up the test group was on average 56 years of age. Social status, education, family circumstances, personality, psychiatric and physical health, alcohol consumption and quality of life were investigated. The adoptees had grown up in better socio-economic circumstances and reported a greater degree of family control in their adoptive family. They had a higher level of education. They reported more neurotic symptoms and feelings of alienation but less over-consumption of alcohol. The authors indicated that there were few statistically significant effects of adoption on adult adjustment (5 out of 27 analysed variables) and stressed the protective effects of a good financial situation in the childhood home. Like those in Bohman's material these adoptions were also domestic invisible adoptions

Cederblad et al. 1993, 1994, 1999 carried out an epidemiological study in Skåne, Sweden into children adopted from abroad comprising 211 young people who had come to their 152 families in 1970–1977, placed there by Adoptionscentrum ('The Adoption Centre'). 84% of the families asked took part. 60% of the young people were between 14 and 16 at the time of the investigation. The youngest was 13, only 10% were over 20, 70% had arrived in their families before the age of one year, only 10% had been more than three years old on arrival. Most of the children came from India (36%) or other Asian countries (in total 73%) and Chile (15%) and other Latin American countries. Only 2% of the adoptive parents were single. Parents and young people were interviewed separately about different aspects of the adoption, questions of identity and mental health. The parents completed a CBCL (Child Behaviour Check List), and the young people over 16 completed an SCL-90 (Symptom Checklist, 90 questions). All the young people

also completed a self-esteem questionnaire ("I think I am"). All the family members individually completed questionnaires about their view of the family's relationships and functions. The results were compared with two epidemiological studies of Swedish-born, non-adopted young people of the same ages, conducted using the same instruments. As in many other studies, the adoptive parents were older, better educated and lived in good socio-economic circumstances, and had a low divorce frequency compared with the national average. Most reported that the children had bonded well to the family, but in 4% of these cases the parents had experienced the attachment to one or both parents as poor, and this applied also to 8% of the siblings. Half of the adoptive mothers and 1/5 of the fathers worked as teachers or in the care sector. The families had more children, adopted and biological, than the national average, and were assessed by the interviewers as being very child-centred. 80% reported involuntary childlessness as their reason for adopting. The mental health of the group did not differ from control groups, whether the information came from the semi-structured interview with the parents, their answers to the CBCL or the young people's own answers on the SCL-90. There was no difference within the age group. Girls had a greater handicap from internalisation symptoms such as anxiety/depression and somatic problems than the boys, both according to the parents and their own reports. Self-reported self-esteem was higher in the adoptive group than in the Swedish norm group as regards total scores and the variable factor "relationships with others" for 13-16 year olds, the only age group for which there were normal values. Total scores according to CBCL, internalisation symptoms such as shyness, social problems and attention-seeking and aggressive behaviour were more common in those children adopted at a more advanced age. The length of stay in orphanages and foster homes in the country of origin before adoption had a greater effect than the age on arrival in itself. Relationships in the adoptive family, problems of identity and friendship explained the differences in mental health and self-esteem within the group. Those who were most exercised by thoughts of identity and felt themselves most non-Swedish had greater psychiatric problems. 90% felt mostly Swedish, 70% felt no attachment to their land of origin. In the follow up, carried out seven years later, on the 42 individuals over 18 at the first study, filled in the SCL-90 and an adult version of "I

think I am” (*Irhammar, unpublished MS 2002*). Mental health was worse in the follow up for those men and women who had come to their families after two years of age compared with a Swedish normal group. The proportion of the group with high and low self-esteem had not changed.

Hjern et al. 2002 has recently conducted two studies in Sweden using registers of very large adoptive groups comprising adolescents and young adults. In the first study results were reported from 11,320 adoptions from abroad. They were compared with 2,243 non-adopted siblings, biological children of the adoptive parents, 4,006 immigrants and the population at large in the same age groups – 853,419 persons. The national cohort comprised all persons born between 1970 and 1979. The comparisons were made on suicides 1986–1995, sentences passed 1986–1993, and hospitalisation for psychiatric illness, attempted suicide and addiction 1987–1994. It was found that the children adopted from abroad had an increased risk of attempted suicide or having committed suicide (odds ratio = OR 3.6/3.6), of being admitted to a hospital for a psychiatric illness (OR 3.2), drug or alcohol addiction (OR 5.2/2.6) and of having been sentenced for a crime (OR 1.6–2.6) compared with Swedish born, non-adopted individuals in the cohort, adjusted for socio-demographic conditions. Compared with the non-adopted siblings the differences were somewhat greater, but on the other hand the risks in the adoptive group were similar to those in the immigrant group. 4.3% of the adopted men and 5.4% of the adopted women had been registered for psychiatric problems (suicide, suicide attempt, psychiatric illness) compared with the others in the cohort (1.6% and 2.3% respectively). The differences were greatest for depression (OR 3,3) and schizophrenia (OR 2.0). 5.9% of the adopted men and 1.0% of the adopted women had been sentenced to prison terms at least once compared with 4.4% of non-adopted men and 0.7% of non-adopted women in the cohort. When the groups were controlled for socio-economic factors the differences increased between the adoptive group and the others. Immigrants had a greater risk as regards crime than the adopted individuals. Adoptees who had come to Sweden at the age of 4–6 years and those born in South America had a somewhat higher risk both of psychiatric illness and of social maladjustment than those who had been younger on adoption and those coming from Asia (OR

1.8/1.6). Those adopted by white-collar families had a somewhat higher risk of social maladjustment than other adoptees. The increased risk of psychiatric illness was approximately as high when the group was analysed, divided into three age groups (< 14, 15–19, 20–24).

Lindblad et al. unpublished MS 2002 have carried out a further register study. It comprised 5,942 individuals adopted from Asia, South America and Africa and born in 1968–1975. They were compared with their non-adopted siblings, biological children of the adoptive parents, a national cohort of Swedish-born non-adoptees of the same age and immigrants of the same age, divided into “European” and Non-European” countries of origin. The intention was to study different aspects of adjustment to adulthood in 1998 and poor mental health in the form of care for psychiatric illnesses, alcohol and drug addiction in 1997–1999. It was found that the adoptive group was less often married and had fewer children compared with the majority group. The adopted men who had children lived together with them to a lesser extent. Several of the adopted women lived as single mothers with their children. More adopted individuals still lived with their parents. There was no difference as regards educational level between the adoptive group and the average population. If one took into consideration the higher social and economic status of the adoptive families, then the adoptive group had not reached the expected level of education. This was also noticed when the adoptees were compared with their siblings. The adoptive group had more often been unemployed and had received social assistance for more than six months. The risk of becoming unemployed was somewhat raised (OR 1.2) and of receiving long-term social assistance (OR 1.5). If one takes into account the adoptive families’ social and economic status, the increased risk of unemployment and dependence on social assistance was as high for the adopted individuals as for the immigrant groups. Poor health was studied by registering sickness pension, handicap compensation and long-term sick pay. All showed an increased risk within the adoptive group (OR 1.8). This applied particularly to psychiatric reasons (OR 2.9 for diagnoses of psychiatric illness and drug addiction and 2.4 for alcohol addiction). All countries of origin except East Asia (completely dominated by Korean children) had higher risks of unemployment, need for social assistance, lower educational level

and poor mental health. Coming to Sweden for adoption at 4–6 years of age increased the risk of sickness pension, social assistance and having finished only compulsory education.

Pruzan 1977 studied 158 children between eight and ten years of age who had lived in Denmark at least two years, and *Gardell 1979* studied 207 children of age 10–18 who had lived in their Swedish adoptive families between 5 and 13 years. Both found that the children to a great extent were as well adjusted as those born and brought up in the country.

Nord et al. unpublished MS 2001 at the Adoption Centre in Århus, Denmark carried out a follow-up in 1999 of the adoptions completed in 1992 and 1993. At the time of the follow-up the children were 7–10 years old. 456 families took part (92%). According to the parents' responses to a questionnaire, 81% of the children were assessed as functioning without any problems. 13% had lasting, moderate difficulties, e.g. some learning difficulties or attention deficit, linguistic difficulties etc. 6% had severe disturbances, e.g. mental retardation, autism, severe DAMP (deficits in attention, motor control and perception), cerebral palsy conditions. All in the last group had received special tuition or attended special schools. The older the children on adoption, the greater the proportion of the children who were assessed as belonging to the middle group. 10% of those who arrived before the age of one year belonged to this group, while 35% of those arriving after three years of age belonged to the group. (This was, however, a small group).

Kvist et al. 1989, Forsten-Lindmann, unpublished MS 2001 have conducted two studies into the adjustment of adoptees in Finland, which has relatively few adoptees. The children in the first study were 10–12 years old at the time of the study. Their adjustment was on the whole good both physically and mentally. The dropout rate in the study was however high. Forsten-Lindmann compared mental health and self-esteem in a group consisting of 17 year olds, both intercountry and national adoptions. They were compared with Finnish non-adopted young people of the same age. The study comprised 161 young people and their parents. The young people completed the SCL-90 and two self-esteem questionnaires, the parents completed the CBCL. The parents of the intercountry adoptees reported more immature, asocial, aggressive and hyperactive behaviour than the parents of the control group. The

girls adopted from abroad were reported to be more immature, hyperactive, lacking in concentration and asocial than the control group. The self-answers given in the SCL-90 showed no difference between the groups, except that the adopted boys reported more phobic anxiety, and the girls reported more paranoid thoughts. There was no difference between the groups as regards self-esteem and self-image.

Dalen & Sætersdal 1988, 1992 carried out a study in Norway of 306 adoptive families with children from India and Vietnam. The work comprised three studies and began with a survey questionnaire to the parents. The second part was a qualitative interview study with young people over 17 from Vietnam, and separately with their parents. The third part was a comparative school study in which both parents and teachers were approached. The aim of the study was to illustrate the conditions under which children adopted from abroad grow up in Norway. Three periods in particular were studied, the first adjustment period in the adoptive family, the school period and the adolescent period. In the epidemiological studies, just as in earlier clinical studies in Scandinavia, it was found that the first adjustment period had been difficult in most families, with different behavioural problems partly determined by age on adoption. These included symptoms such as eating and sleep disorders, anxiety, clinging, attention-seeking and aggression. Most reactions to adjustment disappeared, however, after a time. According to Dalen and Sætersdal it seemed as though children arriving at between one and three years of age were an especially vulnerable group. This applied to both the Indian and the Vietnamese children. They also found that the Vietnamese adoptees' poor physical and mental health almost became a positive help in the emotional attachment process between child and parents. Children of school age before puberty did not show many more symptoms than the Norwegian-born children. The symptoms found were attention deficit, acting out symptoms such as lying, petty theft and thefts or contact difficulties. Many of the children had problems at school partly based on language problems, but where attention deficit also played a part.

Extra-Nordic epidemiological studies

Hoksbergen et al. 1986, Geerars et al. 1996, Rathbun et al. 1958, Kim 1978 stated in their studies that in most adoptions things had "gone well".

Rushton & Minnis 1977 also writes in a survey article that trans-racial adoptees were often well adjusted and had a similar development to children placed in families where parents and children were of the same race. *Tizard 1991* in a review article also draws the conclusion that 75–80% of trans-racial adoptees were well adjusted.

Rathbun et al 1965, Kadushin 1977, Köhl 1985 noted that a high age on arrival was a risk factor.

DeVaney 1983, Hoksbergen et al. 1986, Groze 1986, Köhl 1985, Howe 1997, Fisher et al. 1997 indicated that this had to do with severe earlier experiences before the time of adoption and that the risk of such experiences increased with the increased age of adoption.

Fisher et al. 1997, Levi-Schiff et al. 1997, Marcovitch et al. 1997, who studied pre-school children and younger school children, stated that adoptees placed both within and across racial boundaries developed well compared to non-adoptees.

Brodzinsky et al. 1987c considered, however, that adoptees of 6–11 ran a greater risk of having emotional and behavioural problems and problems at school, but added the reservation that different results might be forthcoming in a longitudinal study.

Wattier & Frydmann 1985 showed that the age on arrival was also significant for the development of intelligence. But this seemed to be compensated for to some extent by the environment. The description of symptoms also seem to chime well with the descriptions made above both from clinical and Nordic epidemiological studies, with asociality, attention deficit and hyperactivity as the most common symptoms.

Spring-Duvoisin 1986 found that all of 41% of the young people in a Swiss study of children with an advanced age on arrival stated that they had had problems in school.

Studies of the adjustment and behaviour of teenagers have shown more problem behaviour.

Fergusson et al. 1995 found more externalisation problems in adopted 16 year olds (of whom 17% were Maoris) in New Zealand than in the non-adopted controls in the study.

Verhulst et al. 1990a,b,c has conducted the largest European study into young people adopted from abroad. They contacted families with 2,148 children adopted from abroad in the age range 10–15 by postal questionnaire. 65% of those approached agreed to participate. The results were compared with 933 Dutch non-adoptees studied using the same method, CBCL, completed by the parents. 16% of the adoptees had symptom scores above the cutting score for problem behaviour, as compared with 10% for the control group. The adoptees had more externalisation problems, especially boys of 12–15, who had twice as many symptoms as the control group. The difference was greatest for the syndromes of asociality and hyperactivity. It was found that children who had experienced several moves and interruptions in care and those subjected to neglect and different forms of mistreatment before adoption had more behavioural symptoms. The older the child was at adoption, the greater was the risk he had been subjected to these experiences. Age on placement in and of itself did not increase the risk of behavioural problems. *Verhulst 1992* indicated that the majority of the children who had experienced such known bad conditions nevertheless adjusted well to their adoptive families. 399 of these children had been placed together with one or more siblings in the adoptive family. Their adjustment was compared with the rest of the adoptive group approximately ten years after the adoption (*Boer et al. 1994*) No statistically significant differences in psychosocial adjustment were found between the groups. In 64% of the cases two siblings had been adopted, compared with the other group they were somewhat older and physically fitter on placement and to a large extent they came to childless families. After three years 1,538 of the adoptees were studied once again. This time the parents completed the CBCL and the youngsters themselves filled in a corresponding self-report questionnaire, YSR (*Versluis-den Bieman et al. 1995*). They were again compared with a group of Dutch youngsters studied using the same methods. 22% of the boys and 18% of the girls had symptom scores according to YSR above the cutting score for psychiatric disturbance. The control group had 11% at the corresponding level. The odds ratio, OR, was calculated at 2.6 for

the adopted boys and 1.8 for the adopted girls. According to the parents' CBCL 29% of the adopted boys and 17% of the adopted girls had psychiatric disturbance, compared with 10% for the Dutch youngsters, OR 4 for the boys and OR 2 for the girls. Of those who had psychiatric disturbance at 10–15 years of age, 51% still had problems three years later (*Verhulst et al. 1995*). On the second occasion for study small age differences were noticed in the group. On the second occasion the competence scales which form part of both YSR and CBCL were analysed. The adoptive group had lower competence scores on both scales, except as regards activities on CBCL and school achievements, according to YSR. There was no gender difference.

Castle et al. 1999 studied 129 children who came to the UK for adoption from Romania before the age of 43 months. In this study the adoptive mothers were asked to describe the orphanage their children had lived in before they were adopted. It was found that the length of time spent in the orphanage before adoption had greater importance for how the child's development quotient increased than the length of time spent in the adoptive home above 2.5 years. The youngest children had been subjected to the worst conditions in the orphanages. The quality of care correlated (0.24) with the development quotient in children at six years of age, when length of stay in the orphanage and degree of malnutrition were taken into account.

Groza & Ryan et al. 2002 compared American "special needs" adoptees and Romanian adoptees. Of the first group, 61 children, 62% had been subjected to physical abuse and 36% also to sexual abuse. They had been 26 months when they were placed in families. 53% of the 230 Romanian children had been living in poor orphanages in their home country before adoption to the USA at 21 months of age. The children were six years of age at the time of the study. The parents completed the CBCL. The results showed that both groups had similar results. 22% of the Romanian children and 34% of the American adoptees had total scores at a clinical level. Both the Romanian children who had been in an institution and the American children who had been sexually and physically abused often had higher scores for disturbance above the clinical level. The parents' level of satisfaction with their relationships with their children was also measured. Both parental groups had high scores, on average "very positive/positive" relationships. Multiple

analyses showed that this relationship had the greatest predicative significance for the outcome of the CBCL, but the stay in the institution in the Romanian group was significant for the symptoms of shyness, anxiety/depression, social problems, thought disturbances and attention deficit. For the children with special needs the parent-child relationship had the greatest predictive significance. Physical and sexual abuse was also important for the outcome as regards anxiety/depression, attention deficit, antisocial behaviour and internalisation, but not as clear as the stay in institutions in the Romanian group. The authors draw the conclusion that traumatic conditions in childhood pre-adoption have significance for behavioural problems lasting several years after placement in adoptive homes.

Bunjes 1991 carried out a study in Holland of the adjustment of preschool children. It comprised 144 children adopted from Korea, India, Bangladesh and Colombia, and matched controls of Dutch children were tested at the age of five. 118 of the adoptees were followed up three years later and were also compared with their controls then. 37% had arrived before the age of one year and 27% after 3 years of age. 20% had been severely malnourished. 73% had experienced more than one separation before adoption, 90% had suffered from different physical illnesses, most commonly infections. At the first testing opportunity the adoptees had worse results on the first IQ test but not on the second. The difference was because the latter was non-verbal. The results were influenced by country of origin (Koreans best, Colombians worst), gender, age at test, age at adoption and physical health. The children from Colombia were on average two years older than the other groups, and several in the group had experienced repeated separations. In the follow-up three years later the differences between countries of origin had disappeared. Nor was there any longer any difference in test results between adoptees and the controls. The adoptive group even had better results in the language test in WISC-R than the Dutch controls! Age at adoption still had significance for the results on the IQ test.

Stams et al. 2000 studied another group of 159 Dutch adoptees who had come from Sri Lanka, Korea and Colombia. They were seven years of age when the study was carried out. The children were compared with a matched control group and a normative population study. Data was gathered from parents and teachers and

the children tested. Country of origin did not influence the results, nor whether the family only had adoptees or whether they also had biological children. According to responses from parents both the adopted boys and the girls had a higher frequency of behavioural problems than the norm group. The differences were greatest for the boys. The teachers did not consider that there was any difference between the groups. The adoptees's results in IQ tests, results in school and adjustment to school did not differ from the norm group. The Korean children had the highest IQ test results, 31% of them had IQs over 120! The adopted girls were considered by teachers to have better self-control and better pro-social competence. They were also more popular in assessments by friends than the control group of Dutch children.

Geerars et al. 1996 followed up 68 Thai adoptees who had also been studied when they were nine years old. The youngsters were 15–17. The focus was Havinghurst's description of the four important developmental factors in the teen years: making friends, feeling secure in their sexual identity, accepting their body and appearance and developing an emotional independence on their parents. Also studied were adjustment to school, mental health, self-esteem and satisfaction with life. It was found that the group had good friendships, many also had a girl/boyfriend. The only negative feature was that several joined different marginal groups. Rather more adoptees had uncertain sexual identity than in the control group of non-adopted Dutch children of the same age. 70% were unhappy with their height, 20% were unhappy with their Asiatic appearance. Otherwise they accepted their appearance, and half thought they looked good. The youngsters thought that friends were more important than parents, whilst the Dutch youngsters thought that friends and parents were of equal importance. (The authors' interpretation was that the adoptive parents were more overprotective, and that the youngsters therefore needed to keep them at a certain distance in order to liberate themselves.) As regards mental health and self-esteem there was no great difference between the groups. Nor as regards school results were there any differences between the adoptees and an average of Dutch youngsters. On the other hand the parents had often chosen too advanced an educational level, which the adopted youngsters had to abandon in order instead to study at a lower level. Their completed education generally was at a lower level than

that of their well-educated parents. The youngsters who had been adopted at the age of 2–3 had had more problems at school. Almost all of them had had to repeat a year. The results were that the similarities between the adoptive group and the Dutch youngsters were more striking than the differences.

Maughan et al. 1991 have carried out the longest longitudinal study on adoption. It comes from the UK and describes the adoptees who were part of the National Child Development Study (NCDS), a prospective cohort study of all 17,000 children born in one week in March 1958 across the UK. The children were studied at 7, 11, 16, 23 and 33 years of age. 543 of the total were born out of wedlock (3.6%). A third of these had been adopted, 180 children. These groups were compared with a 10% random selection of the rest. 1,435 children comprised this control group. 75% of the adoptees had been placed in adoptive families before the age of twelve weeks, only 8% had been adopted after the age of one year. At age seven and eleven the illegitimate children who had remained with their biological mothers showed most behavioural problems, according to interviews with their parents, their teachers and with the children themselves. At seven years of age the adoptees functioned the same as the best functioning legitimate children at the study, but they deteriorated and were similar to the illegitimate children in the study at eleven. This was the case even when the different socio-economic conditions between the groups were taken into account. At the study at 16 the legitimate children were still best adjusted, and the illegitimate children had most deviations in behaviour, while the adoptees lay between the groups. The differences were less clear when socio-economic background factors were taken to account. The authors interpreted this to mean that the deterioration in behaviour between seven and eleven did not continue up to the study at 16. The adoptive group showed the highest frequency of depression and anxiety assessments and problems with friends. At 23 the young adults themselves were interviewed. The adoptees had as high a level of educational attainment as the legitimate group, and a much better education than the illegitimate group. There was no difference between the groups as regards mental health. The adopted men seem to have had lower employment stability than the legitimate men. Otherwise few differences were found as regards pair bonding and adjustment to work. The researchers also analysed whether

different types of psychosocial adjustment problems (behavioural problems at 7, 11 and 16 and, for men, unemployment and employment stability at 23 and, for women, teenage pregnancy and psychiatric symptoms at 23) were stable. They found that adopted men, but not adopted women, showed more stable problems over time compared with the group born legitimate. One of the reports describes the psychosocial adjustment at 33 (*Collishaw et al 1998*). The 180 adoptees were compared with the 363 looked after by their unmarried mothers and a random selection of the rest, as described earlier. The adopted women had a very positive adult adjustment compared with those who had remained with their biological mothers. They belonged to a higher social group and were to a greater extent home-owners. Their assessment of their marriages and themselves as parents did not differ from the legitimate group, whilst those who had remained with their biological mothers had more often got divorced. The adopted women reported a lower frequency of psychiatric problems compared with those who had remained with their biological mothers. On the other hand, there was no difference between the groups as regards the frequency of alcohol problems. The adoptees also considered themselves to have received greater social support from friends and parents. A higher frequency of unemployment for one or more periods was noticed among adopted men. More of the adopted men were unmarried than the whole cohort. The frequency of alcohol problems did not differ from the whole cohort, while those who had remained with their mothers had a higher frequency of such problems. The adoptees stated that they turned to friends to a lesser extent when they had personal problems. The researchers concluded that adoption, especially for women, improved their development compared with having continued to live with a single biological mother.

DeVaney 1983 noted those factors in adoptive families which can have significance for the outcome of adoption. He found that the number of years the parents had been married and their attitude to child rearing had a positive effect on the child's behaviour, whilst other researchers found that adoption by older adoptive parents had a better outcome than by younger parents. This can be compared with Bohman's results which indicated the reverse (see above).

Hoksbergen 1987 found that adjustment problems were more common in families with their own biological children and that these families were less prepared to manage any problems that arose. It was also negative if the adoptee deviated from the natural sibling order and e.g. was placed as oldest child in a group of siblings, and if too short a period elapsed between the first placement and the next adoptee.

In recent years researchers have had the opportunity of studying large groups of adoptees in different mass studies carried out in the USA (and via public registers in Sweden). These studies have comprised schoolchildren, adolescents and young adults.

Miller et al. 2000 compared 1,587 adopted adolescents of 10–19 years of age with the non-adopted adolescents in a large representative national study. “Add Health” comprised 87,165 school pupils in the USA. All pupils completed a questionnaire at school. Standardised average values showed that the adopted adolescents had more school problems (less positive attitude to school, more absenteeism) and more alcohol abuse. They reported lower self-esteem, more depression and less positive hope for the future. They also reported that they had more physical ill health, that they were more often involved in fights and that they lied to their parents. The differences were however rather small, with greater differences between the adoptees and the non-adopted boys than between the girls in both groups. There was no difference between different ages when the material was analysed divided into three age groups. The differences between adoptees and non-adopted were least for young people living in two-parent families and greatest where the adoptive parents were of low education. The distribution of outcome variables was also studied and it was found that in the extreme part of this for the negative criteria, mentioned above, the adoptive children were over-represented. Whilst the ratio of adoptive/non-adoptive children in the middle of the distribution was 1:1 in the extreme part it was 3:1 or more. A correspondingly uneven distribution to the detriment of the adoptive children applied to positive outcome criteria such as good school results, self-esteem, positive attitude to school and belief in the future. The authors drew the conclusion that, whilst the large group of adoptees scored within the normal range for the variables studied, they were also overrepresented in the small group, with great adjustment problems. One weakness of this study is,

however, that one does not know how large a proportion of the group was made up of adoptions by relatives, transracial, intercountry and “special needs”, or the age at adoption.

Slap et al. 2001 in the study “Add Health” interviewed a selection of 6,577 young people and their parents in the home. Of those participating 214 were adopted (3.3%). The young people completed the questionnaire about their psychiatric and physical health, stated whether they had attempted suicide during the previous twelve months, and gave details of impulsiveness, addiction, school adjustment and circumstances in the home. Several adoptees reported that they had attempted suicide (7.6% compared with 3.1%), and that they had received treatment for psychiatric illness (16.9% compared with 8.2%). More girls than boys had attempted suicide in the entire group. Those who had made attempts reported more symptoms of depression, had lower self-esteem and used more tobacco, alcohol and marijuana. They were more aggressive, impulsive, reported more asocial acts, worse school adjustment and weaker family bonding. The only thing that distinguished the adopted and non-adopted groups’ suicide attempts as regards these variables was their degree of depression and self-esteem.

Miller et al. 2000 used the same home interview to illustrate the question whether the higher frequency of psychological advice in the adoptive group was the result of more problems in this group or of a greater tendency to seek treatment on the part of the adoptive parents. They found that the young people who sought treatment had more problems at school, used more alcohol and drugs, had more emotional problems and worse family relationships, even if the differences were small between them and young people who had not received any treatment. If these variables were taken into account the adopted youngsters still had twice the tendency to seek treatment.

Brand & Brinich 1999 came to similar conclusions. Their study was based on the National Health Interview Survey (NHIS), a regular health survey carried out through interviews. 11,840 individuals of 5–17 years of age were included in the study, of which 188 had been adopted by non-relatives. 105 of them had been placed before the age of six months. 37 children in the study were foster children, the rest lived with one or both biological parents. Disturbances in behaviour were measured using an

abbreviated version of the CBCL completed by the parents. Whether the child had received treatment for psychiatric problems during the previous twelve months was also noted. It was found that both the adoptive children and the foster children had more often received treatment. The foster children had most behavioural problems, then the adoptive children, compared with the biological children. Those children who had been more than six months old at the time of adoption had more behavioural problems than those placed earlier. The authors also showed that the difference between the groups was explained by a small group of individuals with severe behaviour problems in both the adoptive and fostered groups. 5% of the adoptive children had behavioural scores lying outside 3 SD compared with 1.7% in the non-adopted group. As in other studies, no details were provided of how great a proportion of the adoptions were transracial, intercountry or "special needs".

Sharma et al. 1996a,b have compared 4,682 adoptees and a matched control group as part of a large study of the attitudes, values and behaviour of youngsters in classes 6–12 in 35 states of the USA. The young people reported personally whether they were adopted. No details were available about the type of adoption apart from age at adoption. The data was collected by means of a school questionnaire completed by all the pupils. The adopted group differed from the non-adopted group in reporting that they used more drugs, had greater anxiety and more depressive symptoms, more antisocial behaviour, lower optimism and self-esteem and worse adjustment to school. The differences were statistically significant but small. (They were measured using "standardised effect size" = the mean of the adoption group – the mean of the non-adopted group / SD for the non-adopted group.) The adoptees also reported more pro-social behaviour. The differences between adoptees and non-adopted were greater for boys than girls, especially as regards drug use and asociality. There were also slightly different effects in the different adopted groups if these were analysed by ethnic origin. The difference between adoptees and non-adopted was greater for Spanish Americans, African Americans and Native Americans than for Asian Americans and Caucasian Americans. The adoptive parents' racial origin was not known. The study therefore does not illustrate the effect of transracial adoption. In the same study the significance of age at adoption was analysed. The older the child was then, the more

emotional symptoms and adjustment problems were reported. Whilst children adopted before one year of age did not differ from the non-adoptees, those adopted after ten years of age deviated most. In this group there were children with "special needs", that is the group that in Sweden often remain as foster children. Gender and ethnic origin did not influence these results in multivariate analyses.

Sharma et al. 1998 studied 881 adopted teenagers (average age 15) and their 78 non-adopted siblings, the biological children of the adoptive parents by means of a postal questionnaire. All of them had been adopted before the age of 15 months, 67% were Caucasian, 23% were Korean. They found that the adoptive group differed from the siblings as regards certain behavioural disturbances. They reported worse adjustment to school and greater drug use but fewer social problems and less reserve and shyness. The authors pointed out that the differences between the groups were the result of the fact that three times as many adoptees had very high disturbance scores. These few individuals pulled up the mean for the whole adoptive group.

Feigelman 1997 used data from the National Longitudinal Study of Youth comprising 12,686 14–21 year olds in 1979. Data from these young people has been gathered annually since the start. 195 of the participants reported that they had been adopted. 101 of these had not been adopted by relatives and had lived continuously with their adoptive parents during their childhood and youth to the age of 17. 84% had been placed before the age of two. These adoptees were compared with children who had grown up with two biological parents, 6,258 individuals, and 3,949 children who had had different backgrounds (step-parents, foster parents, other relatives, institutions or a combination of these), "others". As in other studies, it was found that the adoptive parents had a higher level of education and high status jobs compared with the other groups, while the group of "others" had the parents with lowest levels of education in low status jobs. In the 1980 study the adoptive children and the "others", when compared with the group with two biological parents, had a higher frequency of anti-social behaviour (truancy, absconding, fights), drug and alcohol use and criminality. In 1988 the adoptive children, in comparison with those brought up in intact two-parent families, reported only more drug and alcohol use. Those who had grown up in "other" families

had both more alcohol and drug problems and more asociality. In 1992 adjustment to work, unemployment and incomes were studied. Individuals who had grown up with two parents, biological or adoptive, had had a better education, had less unemployment, higher salary and more prestigious jobs than the other young people who had grown up in irregular types of family. More adopted men compared with non-adopted in biological two-parent families had interrupted college education and reported a higher frequency of unemployment. No differences of this kind appeared for the adopted women. Age at first pregnancy was also similar for these two groups, whilst the young women in the "other" families had children earlier. Other data on relations showed differences between the group of adoptees and the two-parent group, in that the adoptees were often cohabiting, married later and reported a lower satisfaction with their marriage. The frequency of depression did not differ between the two groups, whilst the "other" group often had depressive symptoms, and more had divorced or remained unmarried. The author points out that the adoptive group was most like the two-parent group, whilst the "other" group had poor adjustment in many areas. The problems registered for the adoptive children in their teens had therefore improved in the adult follow-ups.

2.2.2 Attachment

Summary: Studies primarily of adoptive children from extremely bad orphanages in Romania have shown that insecure forms of attachment are more common than in mother-child relationships in groups of children growing up in ordinary circumstances. Most studies show that the frequency and degree of difficulty of the disturbances increases with increased length of stay in an orphanage before adoption. Some normalisation has been described when children have stayed for a couple of years in their adoptive homes, especially for those children who stayed a short time in an orphanage before adoption

John Bowlby's attachment theory is founded on his studies of children cared for in institutions and children who have suffered early separations from their main carer (usually their mother).

Various researchers have described how children can develop secure attachment or three types of insecure attachment (rejecting, ambivalent and disorganised). All the types are found with different frequencies in groups of normal children, but the third kind is unusual in them. About 60% are usually assessed as securely attached in studies of this kind. Children subjected to severe cases of neglect and/or abuse and those whose carers have had psychiatric illnesses can develop with a high frequency of disorganised attachment (up to 80%). This type of seriously disturbed attachment is called “controlling” or “atypical” in the Canadian studies outlined below. It is thought that the parents of children with disorganised attachment themselves often have unresolved emotional loss or traumas. The children can have different types of neurological damage which make them more sensitive. Characteristics of the baby such as irritability, hyperactivity, high emotionality and physiological sensitivity to stress have also been found to occur together with disorganised attachment. In longitudinal studies children with disorganised attachment have been shown to possess lower self-esteem, both internalized and externalized behavioural problems, for example friendship problems, later in their youth. In the ICD 10 diagnostic system (WHO’s international illness classification system) a distinction is made between “Disinhibited attachment disorder” and “Reactive attachment disorder”. The first condition is seen mostly in children lacking an attachment figure or who have been seriously neglected, e.g. because they have been cared for in institutions with too little contact with adult carers and poor social, emotional and cognitive stimulation. Their behaviour is characterised by superficial, uncritical, unselective relationships or quasi-autistic withdrawal, attention deficit and lack of an ability to interact socially. This last diagnosis condition is characterised by ambivalent and contradictory social behaviour, emotional disturbances, sensitivity to stress, easily aroused anxiety and rage and aggression. These symptoms are seen in children subjected to psychological, physical and/or sexual abuse.

Studies of attachment behaviour in adoptive situations have been carried out primarily by Juffer et al in Holland, by Rutter and a British-Romanian adoption research group in the UK and by Marcovitch, Chisholm et al. in Canada, who have studied children adopted from Romanian orphanages.

Juffer & Rosenboom 1997, Juffer et al. 1997 studied attachment in a group of 160 children adopted from abroad who came to their families before six months of age. 74% were securely attached to their mothers at 12 and 18 months of age, which corresponded to other normative studies of biological families. Age differences at adoption within the group, state of health on arrival, pre-maturity, country of origin or whether the family also had biological children or not, did not co-vary with attachment security. Nor did the sensitivity of the adoptive mother towards the child differ from that found in biological families. The authors drew the conclusion that adoption of children who are a maximum of six months old does not imply any increased risk of insecure attachment. When 129 of these families were followed up when the children reached seven (*Stams et al. 2000*), the adoptive mothers were however less sensitive than a group of 30 biological mother-child pairs studied in the same way. The authors speculate as to whether the reduced sensitivity might have to do with the fact that the mother-child pairs in the adoptive group had worse "goodness of fit", because the children's genetically influenced qualities of temperament and personality had become clearer, so that identification and communication had become more difficult. The children's behaviour in the follow up has been outlined earlier. The researchers thought that the fact that parents in this study reported more behavioural problems than the teachers could be explained by more problematic family relationships.

Rutter et al 1998 studied 111 Romanian children adopted into the UK before the age of two. They had all been in poor quality orphanages in their home country before adoption. They were compared with 52 British children adopted within the country before six months of age. The Romanian children differed greatly from this group in height, weight, head size and development quotient. Half were below the third percentile at the time of adoption. Most were in poor health, with recurring gastrointestinal and bronchial infections. Their cognitive development was measured on the Denver scale and the McCarthy scale. 59% had a development quotient of below 50 at the time of adoption. At the first follow up, when the children were four, those who had arrived before six months had normalised on the development tests, while those who had been adopted after six months were still in the lower part of the norm. Only 2% were still below the third

percentile for weight; only 1% were still as low for height and 13% for head size.

O'Connor et al. 1999, 2000, Kreppner et al. 2001, Rutter et al. 2001 followed up 165 Romanian children, of these 111 from the earlier study, when they reached six years of age. The adoptive parents were interviewed and the children tested using both the McCarthy scale mentioned above and an inventory of behaviour. Attachment disturbances were measured in four areas, three measuring uninhibited contact behaviour: unselective contacts with adults, that the child could go off without hesitation with a stranger, and that the child did not seek solace with a parent. Inhibited contact behaviour was measured by the parent reporting whether the child sought protection and consolation from the parent when he harmed himself or felt pain or not. Most frequent were unselective contacts and that the child did not turn to the parent for protection, 14% each. That the child was able to go off with a stranger was reported for 12%. That the child would not seek consolation was reported for 3%. A linear relation was found between the length of stay in the orphanage and frequency of attachment disturbances. All the children showing attachment damage in the four-year study had shown the same behaviour on arrival. There were also many children who improved between arrival and four years of age. Of 22 children who showed initial disturbances eight had improved and seven become normal in their contacts. The disturbance was stable between four and six years of age. 62% of the children then showed no change. 18% of the children adopted before six months showed attachment disturbances. Of those placed after two years of age, 62% had such disturbances. The authors pointed out that attachment damage was also found in children who had only been subjected to deprivation during the first months of life. Those children who had attachment damage were more often hyperactive according to parents and teachers and had attention disturbances, and were rowdy in school according to the teachers. These symptoms also co-varied with the length of stay in the orphanage. The behavioural problems that were linked to the length of stay in the poor institutions were attachment damage in the form of uninhibited forms of contact, hyperactivity and attention disturbances, quasi-autistic behaviour and low cognitive function. Whilst 70% of the children who came for adoption before the age of six months functioned normally as

regards these functions, this applied to only 25% of those adopted between 24 and 42 months of age. In the same study it was also found that 6% showed autistic symptoms and a further 6% characteristics of mild autism (*Rutter et al. 1999*). These eleven children revealed great problems in social relations and communication; they were also obsessed with sensory experience (touch and smell) and had very narrow interests (clocks, vacuumcleaners). Three of the children were MR, the others improved between the studies at four and six, but they still had low cognitive ability (McCarthy GCI, general cognitive index, 76.5). The three MR children were diagnosed as having brain damage. The others were classified as “quasi-autistic” in order to underline the deviant development. It was thought that their long-term experience of perceptual and experiential deprivation with a lack of attachment relationships and cognitive impoverishment explained the condition.

Marcovitch et al. 1997 studied 56 Romanian orphanage children adopted in Ontario in Canada. These researchers also studied attachment behaviour. Of the group 37 had spent less than six months, and 19 between 6 and 48 months in an institution. The children were 3–5 years old at the time of the study. They were studied for attachment by a special method (“the strange situation”) used in a large number of attachment studies of different groups of children. The method was adapted for the age group. The entire adoptive group differed from a control group of Canadian children in that they had a higher frequency of insecure attachment, 70% as against 58%. Those forms of insecure attachment the adoptive children displayed were “dependence” and “controlling”. The length of stay in an orphanage was not related to the frequency of insecure attachment in this study. 36% of the children with “dependence” attachment had high scores for behavioural disturbances. 44% of those with “controlling” attachment also had high scores, compared with 20% of the securely attached children. The risk that those with controlling attachment would have scores for behavioural disturbances was twice as big as for the group with secure attachment. The researchers point out however that the entire adoptive group functioned within normal limits as regards behaviour and general adjustment. Within the group those who had arrived for adoption

before six months of age functioned best as regards both behaviour and development.

Chisholm 1998, 2000 studied 76 Romanian orphanage children adopted in British Columbia, Canada. 46 had been at the orphanage at least eight months (8–68 months, mean 18 months). 30 had been adopted before four months of age. The groups were compared with 46 Canadian children. The children were studied when they had been in their adoptive homes eleven months and then after approximately four years. Attachment behaviour was studied using the same method as in the Canadian study described above. More in the group who had spent a longer period in the orphanage had insecure attachment at the time of the first study. The differences between the groups remained at the time of the four-year follow up (37% secure attachments in the long stay orphanage group, 66% in the early adoption group and 58% in the control group). It was pointed out that all the children had attached to parents, but the most disturbed attachment types, “controlling” and “atypical”, were found in 21% of the children who had stayed for a long period at orphanages, but not in any of the children adopted early or the Canadian children. These types of attachment disturbances are otherwise seen in abused children and those whose parents have psychiatric illnesses. The children showing these attachment patterns had lower IQ, more behavioural problems, and lived in adoptive families where the parents reported greater stress. The author underlines the fact that the development of attachment behaviour is dependent on earlier experiences, the child’s own behaviour and how this was received in the adoptive family.

Kühl 1985 in his German study noted that 1/5 of the parents and teenagers experienced their relationship to each other as “distant” or non-existent.

2.2.3 Growth, puberty

Summary: Studies have shown that those children who are older at adoption grow more quickly after that time if they were undernourished on arrival (“catch-up”). The disadvantage is that children who have very rapid growth reach puberty earlier as a result, which means that they become shorter than their genetic predisposition would have allowed. One study showed that men

from South America are more often overweight compared with the majority of the Swedish population of the same age.

Lemm Proos 1992 has made a series of studies of adopted Indian children's development and growth in Sweden. In one of these 114 children were followed from arrival in Sweden for two years. 62% of the children were less than a year on arrival, 60% were girls. The children lived in different parts of Sweden. 54% of the children had some form of illness on arrival. Most common were malnutrition (45%), anaemia (15%), ear inflammations (15%) and scabies (9%). 44% of stool tests showed the presence of bacteria and/or parasites. 29% of the children had retarded psychomotor development, 60% scored below 2SD (standard deviations, i.e. as low as 2.5% of a normal Swedish group) for weight in relation to age, 54% scored that low for height in relation to age. This last score is considered to be a sign of chronic malnutrition. During the first months in Sweden most of the symptoms disappeared even if a few children after two years still had intestinal parasites, signs of salmonella infection or sub-clinical hepatitis. Otherwise the children showed the same types of infections as other Swedish children, i.e. temporary diarrhoea, acute upper respiratory tract infections or otitis (ear inflammation). Scarcely 5% still had retarded psychomotor development after two years in Sweden. The children began to grow quickly after arrival, to lie just below normal length/age (-0.7 SD) after two years. Weight also increased at the same rate during the first year and then lay at approximately -1 SD (i.e. as low as 16% of a normal Swedish group). After two years the proportion of short children had dropped from 47% to 3.7%. Those children who were oldest on arrival were from the outset shorter than those who came at a younger age. Those children who were very short on arrival showed the quickest growth in height.

In another study by the same author 107 adopted girls from India were studied for age of onset of puberty and final height. These data were also compared with those for Swedish girls and girls who grew up in India in privileged and underprivileged families. The girls in the study had arrived at a slightly higher age, on average 3.7 years. In this group 62% had scored -2 SD on height in relation to age on arrival. After two years in Sweden only 20% were still short. As regards weight 53% of the group scored below

-2 SD on arrival, which dropped to 6% after two years. The shorter the height and lower the weight the child had on arrival, the more pronounced was the increase in height and weight during this period ("catch up"). In this group too the oldest children had had the most extreme height deficiency on arrival. First menstruation (menarche) occurred on average at 11.5 years (between 7.3 and 14.6 years) which is a year or 18 months earlier than for Swedish girls and girls growing up in well-to-do families in India. It is 2–3 years earlier than girls from underprivileged Indian families both in towns and in the countryside begin to menstruate. Those children arriving at the most advanced age had earlier menarche than those arriving at an early age. The final height of the girls was also noted. It was on average 154 cm (between 134 and 165 cm). This means that the adopted girls on average are 1 cm taller than the average for girls in India, but they do not reach the height of girls from well-to-do families (159.2 cm). 7.8% of the girls only measured 134–145 cm when they stopped growing, although they had been well nourished during their childhood in Sweden. This is probably because of intrauterine malnutrition. There was a connection between height on arrival in Sweden and final height as well as between birth weight and final height. The early onset of puberty was also significant in those cases, when it was extremely early.

Johansson-Kark et al. 2002 recently studied the weight development of adult adoptees. The starting point was that international studies had shown an increased risk for children who had been chronically undernourished, which had shown itself in height deficiency, as adults to develop excess weight. The study was of men who had gone through the health examination for compulsory military service at the age of 18 in Sweden. All 275,026 men born between 1973 and 1977 were included. BMI (Body Mass Index) was analysed for 2,094 adopted men and the rest of the cohort. The prevalence of excess weight was higher for individuals born in South America, especially Chile. Whilst 14.1% of non-adopted were overweight, this applied to 21.5% of men adopted from South America and 28.6% from Chile. No equivalent increase was noted for adopted men from Asia or other countries. The result was interpreted such that the cause was probably a genetic vulnerability to develop excess weight, which can vary in frequency in different ethnic groups. Data on birth weight, height at birth or length of pregnancy of the adopted men was not available, which is

why early undernourished or well-nourished groups could not be compared.

2.2.4 Somatic health

Summary: Many adoptees had different infections and parasitic infestations on arrival, which were in most cases easily cured. Physical health during their continued development seems on the whole to have been good.

Berg-Kelly & Eriksson 1997 carried out two major studies into the senior classes of Swedish compulsory school from self-declared health and health behaviour, "Q-90", in the Göteborg area. The questionnaire also covered questions on family and school adjustment, physical health, psychosomatics, depression, thoughts of suicide, contact with friends, health habits/risk behaviour, sexual habits, use of tobacco, alcohol, drugs, diet and exercise. 9,329 young people completed the questionnaire, of whom 125 stated that they were adopted. 72% of these had arrived before 1 year of age, most coming from Korea and India. The adoptees were to a greater extent dissatisfied with their height, and they had reached puberty earlier. The adopted boys had more allergies; otherwise there were no differences in the self-declared physical health. The adopted girls stated that they had more often had thoughts of suicide, had unpleasant sexual experiences, had truanted and tried drugs. The researchers thought that they had adopted "adult behaviour" earlier, i.e. tried sex and drugs. The adopted boys did not differ so much from the other pupils.

2.2.5 The language

Summary: It seems to be primarily in the school situation that the linguistic problems of children adopted from abroad is noticed. Most often it is a question of difficulties in understanding more abstract concepts, which are necessary in order to use the language as "thinking tool".

Gardell 1979 indicated that 47% of the children in her study had linguistic difficulties. These were noticed in the senior classes of compulsory school. It was evident that the children had great difficulties in understanding common, abstract concepts. Although they managed very well in ordinary language situations, they had difficulty in understanding the teachers' instruction when they used a more lecture-type and theoretical teaching method. The difficulties were also evident in essay writing. They had difficulty in writing grammatically correct sentences and had an inadequate vocabulary. Above all this was noticed in the children who had come to Sweden at between 18 months and 3 years.

Dalen & Sætersdal 1992, comparing 93 Indian adoptees with Norwegian children, found that 49% had "school language problems". Half of these children also had difficulty with everyday spoken language. There were strong statistical links between the school language problems and poor school performance both in Norwegian and mathematics. The adoptees mainly had problems in basic concepts such as time, space and distance. The age at adoption had no connection to the school language problems, but difficulties with everyday spoken language did have a connection. Despite the school problems there was no difference between the groups as regards social function and happiness in the school.

De Geer 1992, in a study of the linguistic development of five adoptees and one Swedish-born child, compared what Cummins (1979) has described as "basic interpersonal communicative skills", i.e. basic vocabulary, verbal fluency and mastery of everyday expressions. It is this linguistic ability that is used in ordinary concrete conversation. The adoptees seemed to master this. The other linguistic ability, according to Cummins, is "cognitive/academic linguistic ability", which is used in more abstract language, and is necessary in order to be able to follow tuition in senior school classes. More refined grammar is used here and an extended vocabulary, e.g. synonyms, which is thought to be lacking in certain adoptees. The children were followed over a two-year period from arrival in Sweden. The study showed small differences between the children independent of time of arrival (8 months, 1 year 10 months and 4 years 3 months). Only the child who arrived at 4 years 3 months developed more slowly as regards language than the others. Two years after arrival in Sweden his language was still considerably retarded in relation to his age. The

linguist *Skutnabb-Kangas (1981)* has used the terms “surface fluency” and “thinking tool” for the different forms of language. The same language problems are also found in immigrant children, despite the fact that their linguistic situation is different from that of the adoptees. The difference is that the adoptees change language on arrival in Sweden, if they already possess a language then, (which depends on age on arrival), while the immigrant children continue speaking their first language parallel with learning Swedish.

The linguist *Hene 1987a* has investigated the linguistic development of adoptees in a series of studies. She also found that language problems seemed to be less severe in informal situations than in school. Adoptive parents and teachers of adoptees reported that these children at times could not understand instructions and questions in class room situations, that they had difficulties understanding concepts of space and time and certain grammatical concepts such as case and verb inflexion. They could not retell a story in the correct order. Some of them had problems with pronunciation and spelling. In an analysis of language comprehension and production in a group of adoptees and a control group of Swedish-born children of 10–12, she nevertheless found few differences between the groups. The adoptees had a certain weakness for taking the meaning of words literally and in some cases in understanding sentence structure. She interpreted this as a language delay rather than a language defect.

Henningsen et al. 1987, a linguistic researcher in Denmark, studied 17 Korean adoptees who arrived at between three and seven years of age and who had been at least two years in Denmark at the time of the study. The children, who were of normal intelligence, were vague in defining words and had difficulties understanding idiomatic phrases in e.g. proverbs. They did not however have difficulties in space and time concepts.

Berntsen & Eigeland 1987 carried out a postal survey of parents of 241 adoptees in Norway. The parents reported that 25% of the children were having or had had language problems. These seemed to be associated with adjustment problems at the time of adoption, that the children had changed environment several times before adoption in their home country, and that they were between two and four years old at adoption. This study is similar to Gardell's in that a critical period was discovered when the child is more

vulnerable to interruptions in linguistic development. Gardell considered that it was because children from 18 months to 24 months are developing concepts that are, at that point, being transformed into symbols in a passive vocabulary, whilst the child has just begun to use the words actively. A sudden interruption of this process in order to build up a completely new language would therefore be especially trying. Hene's and De Geer's studies do not provide any clear confirmation of this hypothesis. Nor has the child's intelligence been taken into account in these studies, which makes an interpretation of the findings more difficult.

2.2.6 School achievements and adjustment to school

Summary: Many adoptees have problems at school because of attention deficit and hyperactivity. Many of them have experienced bullying because of their appearance. Their achievements seem to have been roughly comparable to those of non-adoptees in the population. The average schooling does not, for example, differ from the average for Swedish children. This means that the adoptees had a couple of years shorter education than their parents and siblings, as adoptive parents are over-represented in the upper middle class.

Dalen & Rygvold 1999 began a new school study which is still ongoing. They studied the school situation of 193 children adopted from abroad, 44% from Korea and 56% from Colombia, and as many Norwegian-born children from the same compulsory school classes, by means of questionnaires to their class teachers (77 of the teachers asked took part in the study). They studied different aspects of "school competence" defined as knowledge, language (everyday language and school language), social ability (cooperation, self-assertion, self-control) and adjustment to school (following school rules, behavioural problems in school). As regards general knowledge and mathematics, the adoptees had scored lower than the Norwegian controls. This also applied to school language, but not to everyday speech. Adoptees had also scored lower on social ability and its sub-variables cooperation and self-control, but not as regards self-assertion. Nor was there any difference in following school rules. The adoptees, on the other

hand, had more behavioural problems, especially hyperactivity, 25% as against 11% in the control group. The adoptees also had more introverted symptoms. It was also found that the adoptees received more help with homework and greater parental support and special tuition. They were more often assessed as having been bullied, but were considered by the teachers to have enjoyed school just as much. Nor did they differ from the control group as regards school motivation or work input. The range within the variables was greater for the adoptive group than for the control group. Many children coped very well in school, whilst other adoptees managed very poorly. School achievements in the adopted group were explained mostly by school language competence, hyperactivity and behaviour in the school situation. The results for the Korean children differed from those for the Colombian children. As regards general knowledge, language and school adjustment the Korean children managed as well as the Norwegian children, whilst the Colombian children had great difficulties. In this study age at adoption was significant for the school competence of the Colombian children, but not for the Korean children. The researchers have recently followed up those children still at school, but the results are not yet published.

Kvifte-Andresen 1992 studied another group of 151 children adopted from abroad and a similar sized group of Norwegian-born children of 12–13 years of age. In this study too it was found that the adoptees were more often hyperactive in school. There were small differences between the groups as regards learning but the adoptees achieved worse results in mathematics. The children settled down well and enjoyed school. Nor was there any connection found in this study between age at arrival and school achievement.

Verhulst et al. 1990, in their major epidemiological study of children adopted from abroad, compared 148 adoptees with 933 Dutch children of 10–15 years of age, e.g. as regards school achievement. It was found that the adoptees had greater problems. 38% had had to repeat a year as against 20% of the Dutch children. 13.2% went to special schools compared with 4.5% of the Dutch children.

Lipman et al. 1993, in a study of 104 adoptees in Ontario, Canada, reported that boys in the age range 4–16 had more psychiatric problems and poorer school achievement than non-

adoptees of the same age. Adopted girls in the age range 12–16 used more alcohol and marijuana and smoked more. In a four year follow up of the same children the adopted boys still had a higher frequency of psychiatric symptoms if they had also had problems with school adjustment. On the other hand, at this point the adopted youngsters did not differ from non-adopted as regards school achievement or addiction.

In several reports on the children's mental health in the senior classes of compulsory school, problems of school adjustment have been noted as well as relationship problems with friends and teachers.

Moser 1993 compared final grades from compulsory school and upper secondary school for all 156 children adopted from non-European countries to Kronoberg County, Sweden in 1971–1980. The results were compared with all pupils in Sweden who in 1990 completed compulsory school and upper secondary school. They were practically identical (the adoptees's compulsory school grades: 3.3, final grades from upper secondary school: 3.2, national average from compulsory school and upper secondary school 3.2). There was no difference between boys and girls. The mean of the final grades from compulsory school and upper secondary school was independent of social class of the parents. On the other hand 3.2% of the adoptees did not receive a final grade from year group 9 (the final year) of compulsory school, which is true of 1% of the cohort of compulsory school pupils in the country. Those children who had come to Sweden before three years of age had higher final grades than those who arrived later. Those children who had come before one year of age had to a greater extent chosen academic three and four year programmes in upper secondary school. The adoptees had chosen academic three and four year programmes in upper secondary school to about the same degree as other Swedish youngsters. There was no gender difference between them (45% academic courses) whilst for the national average a greater proportion of girls (51%) than boys (43%) had chosen these programmes. The parents' social group had no connection with the choice of programme. Other major studies have previously shown a connection between parents' social group and the child's final grades from compulsory school and upper secondary school and choice of programme. One explanation for adoptive families functioning differently might be that the children are trained and

stimulated more and therefore function optimally in relation to their intellectual opportunities. The fact that there is no genetic and only an environmental connection between the parents' and the children's intellectual abilities can contribute to the levelling of the differences between social groups.

Björklund & Richardson, unpublished MS 2001 are leading an ongoing study in Sweden into the school achievements of children adopted from abroad. The intercountry adoptees were born in 1962–1973 and are being compared with Swedish adopted young adults, immigrants of the same age, who came to Sweden before the age of 17, and Swedish non-adopted adults of the same age. What is more, the biological siblings in the adoptive families were involved as a comparison group. The outcome was completed education in 1996. Only individuals who had been adopted by two parents were included in the analyses. The results showed that the adopted group reached the same educational level as the Swedish-born comparison group and a higher level than the immigrant group, who had come to Sweden before the age of ten. The adoptive parents had a higher level of education than the parents in the other groups, but this did not influence the educational level of the adoptees. On the other hand it did have a positive effect on their biological siblings. The difference between the adoptees and their biological siblings was almost two years of education. The adoptive group also had 1.5 years shorter education than their fathers and mothers. Age at adoption had significance for the level of education. For those who had arrived in their first year of life the difference in the length of education, compared with their biological siblings, was less (1.5 years) than for those arriving later.

Nicolaysen 1998 in Norway studied how 322 children adopted from abroad, and who had completed compulsory school in 1991, had chosen programmes in further education four years later. 62% had continued their education (63% among Norwegian-born children of the same age). More in the adoptive group had chosen an academic programme. More went to Folk High School, and more continued in higher education. Those who had been adopted after four years of age had to a greater extent chosen vocational programmes or vocational training courses (for the handicapped or unemployed).

Maughan et al. 1998 in the NCDS study described above compared the adoptees and non-adoptees from the same birth

cohort who had been born illegitimate with the other as regards school achievements and adult work level. The adoptive parents had the longest education and were very involved in their children's education. This had a positive effect on the children's school achievements. The differences in achievement between the adoptees and those who had grown up with their unmarried biological mothers were most marked among the boys. Some of both groups had attended special schools in their teens because of learning and adjustment difficulties (adopted 6.3%, non-adopted illegitimate 4.5%, legitimate 1.3%). The adult follow up at 33 years of age showed that adopted women had a higher level of education than those in the legitimate group, whilst adopted men had just as high a level of education as this group. School results at seven (reading and mathematics) and eleven (general school performance) predicted school results long-term. The socio-economic level of the family in which the children grew up and the parents' interest in the child's school achievements also had an effect on the young people's level of education as adults. Behavioural problems at seven had a negative effect on this for men but not for women.

2.2.7 Identity

Summary: Most adoptees think about their biological parents and about half of them actively seek more information. Children adopted from abroad also have a different ethnic background to which to relate. It is still unclear whether one should or can develop an ethnic identity based on a country with which one has had no continuous deep contact during childhood and youth. The parents' openness and support in seeking both knowledge about the biological parents and about ethnic background is important for the young person to be able to feel free in their search for identity.

Grotevant et al 1982, 1987, Brodzinsky 1990, Brodzinsky et al 1981, 1986, Schechter & Bertocci 1990, Triseliotis 1989 have all studied the special situation of the adoptee in forming his identity. Their studies have applied to children having the same race and ethnic group as other family members in the adoptive families, "invisible

adoptions". It was thought that their special situation of belonging to two families would make the work of identity more difficult, especially in their teens. Adoptees can feel that they need greater knowledge about their biological and social background in order to complement their self-image. They can feel like a half person where one half is hidden by adoption. This can arouse feelings of low self-esteem, guilt and insecurity. Many young people can experience a conflict between on the one hand a desire to seek out their roots and on the other their loyalty to their adoptive parents.

Triseliotis 1973 claimed that the most important task of the adoptive parents is to help the children integrate and identify themselves with both sets of parents.

Müller & Perry 2001 reported in a survey article that half of adoptees at some time in their lives will seek information about their biological family, and that half of these will also want to meet them. There are no grounds for this being linked to psychiatric problems in the adoptees or poor family relationships within the adoptive family, nor that there are any special problems associated with not being interested in doing this.

Holbrook 1984, Humphrey & Humphrey 1989, Schechter & Bertocci 1990, Triseliotis & Russel 1984 have found that women are more interested than men in seeking their biological roots, and that their interest in this is aroused at an earlier stage.

Rosenberg & Horner 1991 pointed out that adoptive parents often stress that the biological parents loved their child and gave it up for adoption in order for it to have a better future than they could give it. The danger of idealising the biological parents in this way can be that the child imagines that he was "bad" and in some way is to blame for his having been adopted. The authors also discussed the fantasies of adoptees, "the birthparent romance" about the biological family versus reality as a basis for the development of identity. The reality that the adopted youngsters have to be confronted with is that the biological family was not capable of looking after them, or that they were unwanted. Many of their thoughts concern whether they themselves were bad and were abandoned for this reason. The child can have fantasies about siblings, retained by the mother because the sibling was the "good child" while they themselves are the "bad child". A negative image of the biological parents can affect the child's self-image. They can also choose to identify themselves with the negative image in order

to take the sting out of it. The adoptee has to integrate his biological roots with experiences from his upbringing with his adoptive parents into a unified, positive image. Adoptive parents, often out of consideration for the child, withhold facts from the child which can make the youngster's possibilities of distinguishing reality from fantasy more difficult. The attitude of adoptive parents to the biological parents can also influence and interact with the young person's own attitude.

McWhinnie 1967 pointed out that the adoptive parents' attitude to the child's biological parents is important. The only person allowed to be critical of them is the young person himself. As regards the children adopted from abroad, this process is rendered more difficult by the fact that there may be no information to seek. The child can have been left anonymously in a children's home or abandoned on the street. The parent's attitude to the adoption is important. If the child feels that the parents are denying the dissimilarity from biological parenthood which the child experiences from its perspective, this can lead to the child having feelings of guilt for his thoughts and fantasies about his biological parents. If the child has difficulties in raising this subject it can lead to the fact that he represses these questions.

Kirk 1959, 1964, 1966, 1981 described two strategies adoptive parents might choose. They can admit the dissimilarities that exist between a biological parenthood, "acknowledgement of differences", or they can choose to deny these differences, "rejection of differences". Kirk considered that open dialogue about the circumstances of the adoption was a basic prerequisite for a harmonious development of identity in the child and young person. Other researchers (*Kühl 1985, McWhinnie 1967, Kaye 1990, Yoon 2001*) have in their studies conformed Kirk's theory.

Brodzinsky 1987 has criticised Kirk's theory as too static, and thought that the strategies in an adoptive family change over time. At the beginning, when the parents are involved in building up a secure and trusting relationship in the child, "rejection of differences" is a common strategy. As the child grows up and begins to think about what it means to be adopted, the parents can change their coping strategy. He also thinks that there is a third pattern, "stressing of differences". Then the parents stress the differences and see the child's history and genetic background as the reason, for example, for his adjustment problems. Most

adoptive parents find themselves somewhere on a “rejection – acknowledgement” continuum, changeable during the course of the life cycle. Brodzinsky bases these conclusions on his clinical experience.

Feigelman & Silverman 1983, 1984 studied the attitude and openness of fathers to the children’s biological background, and the children’s interest in obtaining more information about their biological family in a questionnaire study of 713 families, in which some families had adopted children from abroad. The children’s interest co-varied with the fathers’ degree of openness. The interest was greater both among fathers and children in “visible” adoptions.

Bagley & Young 1979, Bagley & Coard 1975, Phinney & Alipuria. 1990 have indicated that children adopted from abroad often, but not always, have a noticeably different appearance from other family members within the adoptive family, “visible” adoptions. Apart from their biological origin, they also have a different ethnic origin to relate to their identity. It is important to point out that ethnic identity is not something static and unambiguous. Children belonging to ethnic minorities can belong to two systems which they have access to and take part in. They can possess different degrees of identification with the two systems, and do not need to live between these. Ethnic identity can also be multiple and flexible. Other social identities can sometimes be more important than ethnic identity, and this does not need to be a sign of pathological self-loathing or ethnic alienation.

Tizard & Phoenix 1989, Grotevant et al. 2000 consider that ethnic identity is changeable and dependant on the individual’s experiences of society. At times when racism encroaches on ethnic identity other social identities can become more central and of greater importance for the individual.

Simon & Altstein 1977, 1981, 1987, 1992, 1994, in a longitudinal study over 20 years, have tried to answer the question of how children and young people develop their identity when they are adopted from a minority group into the white Caucasian majority group. They followed 204 families in the USA who adopted 157 children across ethnic boundaries and had 209 biological children. The first study was carried out when the children were between four and seven. 133 families were interviewed seven years later and 96 of them 11,5 years after the original study. The young adults from 76 families were themselves interviewed twenty years after

the first study. On each occasion some families dropped out, primarily because they had moved and could not be traced. Approximately 10% of those approached refused to participate at the time of each study. The focus of the study was how children developed racial identity in families where the children belonged to a different racial group than the parents and the family's biological children. Most children were African American (120), others were Native American, Inuit or from Korea or Vietnam. As in other adoptive studies, the families were upper middle class, the parents were older than average parents, most mothers were housewives when the children were below teen age, the marriages were stable and the parents were religious. 19% were involuntarily childless, 81% had biological children of their own when they adopted. 40% stated socio-political reasons for adopting from abroad, and that the most important thing was to have a healthy child irrespective of race. Most youngsters had attended racially integrated schools, and had both Caucasian and African American friends. It was found that most adopted young adults had an acceptable education and adjustment to work. Fewer had got married (13%) than their non-adopted siblings (40%). Even in the first study, when the children were 4-7, it was found that neither the adoptees nor the non-adoptees had any racial preference. They correctly identified themselves as white or coloured. In the study seven years later 20% of the adoptees had problems with stealing in the family. This behaviour ceased independently before the next follow up, and was regarded as a way of seeking attention and testing the fact that they were loved. The parents were ambitious in communicating racial consciousness and racial identity to their adoptees, something the children were often not interested in. In the study 11,5 years after the baseline study self-esteem was mapped. The youngsters were then between 15 and 18,5 years old. No difference was found between the groups. All of them experienced the same degree of family belonging. Both parents and children were positive about living in a racially integrated family. The researchers drew the conclusion that the transracial adoptees had grown up in an emotionally and socially well-adapted way and with a clear racial identity.

Hollingworth 1997 conducted a meta-analysis of six American adoption studies, which had comprised transracial/transethnic adoptions, focussing on self-esteem and racial identity. The studies

involved comprised African Americans and Mexican Americans. The families were compared with families where everyone was of the same race. It was found that the children's racial/ethnic identity was worse in transracial than in racially/ethnically homogeneous families. The effect was modest according to Cohen's criteria ($d = -.52$, $p = 0.001$). There was no difference between the family types as regards the children's self-esteem. The negative effect of racial identity increased with increasing age and was at its strongest in the late teens (Simon and Altstein's study was not included in the analysis).

DeBerry et al. 1996, whose study is also omitted from the survey above, showed that African American children adopted into white Caucasian families could have high self-esteem, even though they did not identify themselves correctly as to race. In the longitudinal study they showed that the children increasingly identified with their Caucasian parents, but that their psychosocial adjustment parallel with this deteriorated somewhat.

Ladner 1977, Gill & Jackson 1983, Grow & Shapiro 1974, Johnson & Shireman 1986, McRoy et al. 1982, 1984 who have studied African American children adopted by Caucasian parents could show a link between whether the parents had a positive attitude to the children's racial background and actively supported them in developing a black identity and the children's acceptance or rejection of this.

Huh & Reid 2000, in a study of 40 Korean-born adoptees growing up with Caucasian American parents, found that the children's identification with their ethnic origin was facilitated by the parents involving themselves and the children in different Korean activities during their childhood. The process began at 7–8 years of age, and 80% of the youngsters in this group in which the parents had been actively encouraging, had a strong Korean American identity at the beginning of their adolescence. Those children who had not taken part in activities of this kind did not develop the Korean side of their identity in the same way or else this process stopped before it had become an integrated part of the youngster's identity. Only 20% in this group identified themselves as Korean American.

Tizard 1977, Gill & Jackson 1983, McRoy & Zurcher 1983, Tizard & Phoenix 1989 have found that children can have good self-esteem

independent of ethnic/racial identity, if they have good relationships in the adoptive family.

Friedlander 1999 also warned of parents stressing ethnicity too much at the expense of the child's feeling of attachment and belonging to the adoptive family.

Westhues & Cohen 1997, Cohen & Westhues 1995 studied a group of transracial adoptees in Canada. The youngsters had good self-esteem, good contacts with friends and were well integrated into their families. All of them belonged to different races from their parents. 50% considered that ethnically they were Canadian, 10% considered themselves Caucasian, even though they came from Korea, Bangladesh and Haiti. The authors pointed out that one reason for an adoptee not to identify with his ethnic group was that the group belongs to a low status minority. An adoptee does not want to belong to one of these.

Dalen & Sætersdal 1992 found that Norwegian adopted Vietnam youngsters did not want to have contacts with Vietnamese immigrants. They interpreted this in the same terms, that they did not want to identify with a low status group.

Hene 1987b, in a study of 70 adults adopted from abroad, also found that many were worried about being regarded as immigrants. The reason was that they experienced negative attitudes in Sweden to immigrants. Half of those in the study felt themselves to be Swedes and a quarter to be e.g. Swedish-Koreans.

Bagley 1991, when comparing adopted Native Canadian children and children adopted from abroad, found that half of the Native Canadian children but only 10% of the internationally adopted had poor psychosocial adjustment and low self-esteem. He thought this resulted from the racism existing in Canada towards Native Canadian people. This find agreed with *Fanshel's 1972* study of Native American children adopted in the USA. Those children who lived furthest away from the Indian reserve adjusted best. They had not been confronted with racial prejudice, but on the other hand they had lost their Native American identity. Both *Kim 1978* and *Dalen & Sætersdal 1992* think that it is the institutional racism that implies that you have to be extra good to be able to make a career if you belong to a minority group. That influences the young, both in their attitude to their ethnic background and their level of ambition and satisfaction with themselves.

Bayerl 1977, Silverman 1980, Hoopes 1990 and Silverman & Feigelman 1990 considered that the best thing for transracial adoptees was to grow up in multicultural, multiracial surroundings. The ideal was that the families lived in areas of this kind.

Kim 1977, 1995 summarised studies carried out in the USA showing that Korean children were well adjusted and had good self-esteem. The children felt themselves to be more American than Korean. He compared this with *Rörbech's 1989* study showing that Korean children in Denmark felt most Danish. *Kuhl's 1985* study had earlier shown that the Korean children who had been adopted in Germany felt most German. The same year *Botvar 1995* published a study of Korean children adopted in Norway. These children felt most Norwegian.

Cederblad et al. 1994, 1999, Irhammar 1997, in their epidemiological study in Skåne, Sweden described above, also focussed on parents and children's attitudes to the question of adoption and youngster's methods of developing their identity. 48 individuals were 18 years of age and above in the first study. As mentioned earlier, 42 of these were followed up seven years later, when they were 25–34 years old. In the first study it was found that in the whole group (181 adopted individuals) 60% of the parents had some knowledge of the children's background and 42% still had some contact with the orphanages. 58% of the adoptive mothers and 44% of the adoptive fathers occasionally thought about the children's biological family. 70% of the adoptees sometimes thought about this. Of those who were under 18, 30% said they knew nothing about the family or the reasons for their adoption. This applied also to 50% of those over 18. The young people had not demanded any detailed information. Half said however that they would like to know more about their biological family. Only a third had read the adoption documents. A third of the younger ones (under 18) and half of the older ones did not think they could talk to their parents about this. Several of those who could do so, had sought or wished to seek more information. 39% of the parents had fetched their children from their country of origin. Half of them had themselves developed an interest in this. 2/3 had actively tried to create an interest in the child in his ethnic culture with the help of books, TV programmes, by maintaining contact with families who had adoptees from the same country, etc. These activities lessened when the children were older because

the children were not interested. The youngsters (about half) who wanted to know more about their ethnic background acquired information themselves in the same ways. Most could talk to their parents about this, but 30% stated that they did not talk to anyone about their ethnic background. Approximately 10% had visited their country of origin, 80% wanted to. Although 88% stated that they felt like Swedes, over 80% in the older group had experienced being regarded as immigrants or foreigners. 40% had been bullied because of their appearance and as many had felt ill at ease because of their appearance. There is therefore a contrast between the adoptees' internal self-identification and the external identification made by their surroundings.

Irhammar unpublished MS 2002 found in her seven-year follow up that about as many thought about their biological family at times, a small group, 7% (three individuals), were often absorbed by these thoughts. In this, older, group in the study such thoughts were not associated with a lower self-esteem either in the first or second study. In the first study the girls more often thought about their biological families. There was no gender difference in the second study. The fact that one had born children of one's own (which applied to 16 individuals) did not co-vary with thoughts of the biological family. The motives for wishing to have more information about biological parents did not change between the studies. When they were teenagers they sought information to fill gaps in their early life history, and wished to find a mirror to answer the question "Who am I like?" When they were young adults their thoughts touched on genetic questions, e.g. illnesses. They also reflected on what life would have been like if they had grown up in their country of origin instead. The number who wished to seek more information had sunk from half to 20%. According to SCL-90 those who did want more information had more psychiatric problems and lower self-esteem. The interest in ethnic origin had however increased from 35% in the first study to 50% in the second; 26% had now visited their country of origin. In the first interview 39 out of the 42 felt themselves to be Swedish; Six of these at the second interview felt non-Swedish. Just as in the first study, those who felt non-Swedish had poorer mental health and lower self-esteem. More in this group had a greater interest in seeking more information about their ethnic background (6 out of 8 compared with 17 out of 34). Whether they had children had no

significance for the ethnic self-identification, nor whether they had visited their country of origin. Whether their parents during their childhood had tried to interest them in their ethnic origin did not co-vary with identity either (the groups for these analyses are small, which is why the results must be regarded as tentative). As regards external identification, most had been treated as immigrants, often in a negative manner. This applied however mostly to superficial, anonymous encounters in the streets and in shops. They had not felt discriminated against as regards study situations, when seeking work or at places of work. The fact that a non-Swedish identity was linked to more psychiatric problems presumably results from the individual feeling more “different” rather than identifying himself with the country of his birth in a positive way.

Meier 1999, like *Irhammar*, studied adult adoptees, in his case 23 Koreans of 19–35 years of age who had grown up in white Caucasian families in the USA. His interviews showed how their attitude to their Korean identity changed during their formative years. It is a process that changes from period to period. Most had grown up in white Caucasian neighbourhoods with very little contact with Korean circumstances. They had regarded themselves like other white Caucasian playmates and school friends and not pondered their otherness. They often denied their Koreanness. When parents tried to get them to take part in those Korean activities they could find, the children often showed no interest or distanced themselves. They wanted to be like their friends. Most developed their own interest in their Korean identity only when they had left home to live in college. There they met foreign students and other coloured Americans from minority groups who showed their ethnic identification, which enhanced the adopted youngsters’ interest in their Korean culture and language. Some also visited Korea. Some however felt neither at home in America nor in Korea after a visit of this kind. Several also felt that they were not accepted by immigrant Koreans in the USA. Many felt most at home in areas where many different ethnic groups lived together. The author thinks that the development of identity is a lifelong process, which should also be studied when the adopted individuals are approaching middle age.

Baden 2002 also studied the identity development of young adults. The group consisted of 51 transracial adopted individuals

19–36 years old at the time of the study. They included on the one hand African Americans and Latino Americans, on the other individuals adopted from different Asiatic and South American countries. All the adoptive parents were Caucasian Americans. An analysis was made of on the one hand the young people's identification with their parents' race or racial origins, on the other their identification with their parents' ethnic group and with their original culture with the help of a questionnaire MEIM-R (Multigroup Ethnic Identity Measure – Revised). Mental health was also measured using a short version of SCL-90. It was found that on the one hand there was a great range within the group between different combinations of race or ethnic identification (out of 16 possible combinations!), on the other hand mental health did not co-vary with these identifications in any straightforward way. Racial and ethnic identification did co-vary ($r=0.80$). The author thought that the absence of a correlation between mental health and identity type may result from the fact that other factors are more significant for mental health, e.g. relationships with parents, contacts with friends, school achievements and success at work (see also *Kohler et al. 2002*).

Von Greiff 2000 interviewed twelve adopted young adults from Colombia about their views on their life situation and their childhood development. She found that day dreams, dreams and fantasies about their origins occurred very often. But this meant different things to different individuals. Most felt that they had had a childhood in which, because of their appearance, they had been regarded immediately by their surroundings as adopted. Some had got in touch with immigrants from their country of origin to find identification objects. They had, however, often felt that too much divided them, only their appearance was similar. Most felt as if they were something in between Swedes and immigrants. All of them thought that their surroundings ascribed them an identity as immigrants when they had grown up. Three had visited their home country; two were interested in doing so; the others had plans to go. For those who had made a visit, this had been very important. The author pointed out that the way they related to their biological and ethnic background was deeply personal, and thought that their surroundings should not influence this too much, which she thought happens in Sweden today. She thought the debate in adoption circles stresses far too much the fact that the adoptee

should seek his roots. What is required is more individual room for action, sensitivity and respect for the wishes of the adoptee himself.

2.2.8 References

Altstein, H. & Simon, R. J. (1991). *Intercountry Adoption, a Multinational Perspective*. New York: Praeger

Baden, A. L. (2002). The psychological adjustment of transracial adoptees: An application of the cultural-racial identity model. *Journal of Social Distress and the Homeless*. Vol. 11, no. 2, April, pp. 167–191.

Bagley, C. & Young, L. (1979). The identity, adjustment and achievement of transracially adopted children: A review and empirical report. I. GJ-Verma & C. Bagley (Eds). *Race, Education and Identity*. London: Macmillan. pp 192–219.

Bagley, C. (1991). Adoption of native children in Canada. I H. Altstein & R. Simon (Eds). *Intercountry Adoption*. New York: Praeger.

Bagley, C. & Coard, B. (1975). Cultural knowledge and rejection of ethnic identity in West Indian Children. In G. J. Verma & C. Bagley (Eds). *Race and Education across Cultures*. London: Heinemann. pp. 322–331.

Bayerl, J. A. (1977). Transracial adoption: White parents who adopted black children and black parents who adopted white children. *Dissertation Abstracts International*, 38, (6-A) 3280.

Berg-Kelly, K. & Eriksson, J. (1997). Adaptation of adopted foreign children at mid-adolescence as indicated by health and risk taking – a population study. *European Child and Adolescent Psychiatry*, Dec; 6(4), pp. 199–206.

Berntsen, M. & Eigeland, I. (1987). *Intercountry Adopted Children and the New Language*. Oslo: Norwegian Institute of Special Education (Thesis).

Björklund, A. & Richardson, K. (2001) *The Educational attainment of adopted children born abroad: Swedish evidence*. Opubl, manus, Swedish Institute for Social Research, Stockholms universitet.

Boer, F., Versluis-den Bieman, H. J. M. & Verhulst, F. C. (1994). *International adoption of children with siblings-behavioral*

outcomes. *American Journal of orthopsychiatry*, Vol. 64, no.2, April, pp. 252–262.

Bohman, M. (1970). *Adopted Children and their Families: a Follow-up study of Adopted Children, their Background, Environment and Environment and Adjustment*. Stockholm: Proprius.

Bohman, M. (1973). *Adoptivbarn och deras familjer*. Stockholm: Almqvist & Wiksell.

Bohman, M. (1978). An eighteen-year prospective longitudinal study of adopted boys. I E. J. Anthony & Chiland (Eds). *The Child in his Family: Vulnerable children*. New York: Wiley. pp. 473–486.

Bohman, M. & Sigvardsson, S. (1990). Outcome in adoption: Lessons from longitudinal studies. I D. M. Brodzinsky & M. D. Schechter (Eds). *The Psychology of Adoption*. New York: Oxford University Press. pp 93–106.

Botvar, P. (1995). *Når Øst møter Vest. En undersøkelse blant adopterte fra Korea, India og Thailand*. Diaforskning, Rapport nr. 1 Diakonhjemmetts højskolecenter. Oslo

Brand, A. E. & Brinich, P. M. (1999). Behavior problems and mental health contacts in adopted, foster, and nonadopted children. *Journal of Child Psychology and Psychiatry*, Vol. 40, no. 8, pp. 1221–1229.

Brodzinsky, D. M. (1987a). Adjustment to adoption. A psychosocial perspective. *Clinical Psychology Review*, 7, pp. 25–47.

Brodzinsky, D. M. (1987b). Looking at adoption through rose-colored glasses: A Critique of Marquis and Detweiler's "Does adoption mean different? An attributional analysis". *Journal of Personality and Social Psychology*, 52, 2, pp. 394–398.

Brodzinsky, D. M. (1990). A stress and coping model of adoption adjustment. I D. M. Brodzinsky (Ed). *The Psychology of Adoption*. New York: Oxford University Press. Pp. 3–24.

Brodzinsky, D. M., Pappas, C., Singer, L. N. & Braff, A. N. (1981). Children's conception of adoption. *Pediatric Psychology*, 6, pp. 177–189.

Brodzinsky, D. M, Schechter, D. & Brodzinsky, A. B. (1986). Children's knowledge of adoption. I R. D. Ashmore & D. M. Brodzinsky (Eds). *Thinking about the Family; Views of Parents and Children*. New York: Lawrence Erlbaum Associates. Pp. 205–232.

Brodzinsky, D. M., Radice, C., Huffman, L. & Merkler, A. (1987c). Prevalence of clinical significant symptomatology in a nonclinical sample of adopted and nonadopted children. *Journal of Clinical Psychology*, 16,4, pp. 350–356.

Bunjes, L. A. C. (1991). Born in the third world: To school in the Netherlands. I Hibbs, E. D. (Ed.) *Adoption: International Perspectives*. International Universities Press. Madison Connecticut. pp. 279–287.

Castle, J., Groothues, Ch., Bredenkamp, D., Beckett, C., O' Connor, T., Rutter, M. & the ERA study team. (1999). Effects of qualities of early institutional care on cognitive attainment. *American Journal of Orthopsychiatry*, 69 (4), Oct., pp. 424–437.

Cederblad, M., Irhammar, M., Mercke, A.M. & Höök, B. (1993). God psykisk hälsa hos utländska adoptivbarn. *Läkartidningen*, 90,16, pp.1537–1542.

Cederblad, M. (1981). Utländska adoptivbarns psykiska anpassning. *Läkartidningen*, 78, pp. 816–819.

Cederblad, M. (1991). "Hög" ålder vid adoption – största risken för att utveckla anpassningsproblem i tonåren. *Läkartidningen*, 88,12, pp.1081–1085.

Cederblad, M. (1982). Utländska adoptivbarn som kommit till Sverige efter tre års ålder. Stockholm: Nia – Statens nämnd för internationella adoptioner.

Cederblad, M., Höök, B., Irhammar, M. & Mercke, A.-M. (1999). Mental health in international adoptees as teenagers and young adults. An epidemiological study. *Journal of Child Psychology and Psychiatry*, Vol. 40, no. 8, pp.1239–1248.

Cederblad, M., Irhammar, M., Mercke, A.-M. & Norlander, E. (1994). Identitet och anpassning hos utlandsfödda adopterade ungdomar. No. 4 *Forskning om barn och familj*. Avd. för barn- och ungdomspsykiatri, Lunds universitet, Lund.

Chisholm, K. (2000). Attachment in children adopted from Romanian orphanages. Two case studies. I P. McKinsey Crittenden & A. Harti Claussen (Eds.) *The Organization of Attachment Relationships. Maturation, Culture and Context*. Cambridge University Press.

Chisholm, K. (1998). A three year follow-up of attachment and indiscriminate friendliness in children adopted from Romanian orphanages. *Child Development*, 69, pp. 1092–1106.

Cohen, N. J., Coyne, J. & Duvall, J. (1993). Adopted and biological children in the clinic: Family, parental and child characteristics. *Journal of Child Psychology and Psychiatry*, 34, 4, pp. 545–562.

Cohen, J. S. & Westhues, A. (1995) A Comparison of self-esteem, school achievement, and friends between intercountry adoptees and their siblings. *Early Child Development and Care*, Vol.106, pp. 205–224.

Colloshaw, S., Maughan, B. & Pickles, A. (1998). Infant adoption: psychosocial outcomes in adulthood. *Social Psychiatry, Psychiatric Epidemiology*, 33, pp. 57–65.

Cummins, J. (1979). Cognitive/academic language proficiency, linguistic interdependence, the optimum age question and some other matters. *Working papers on bilingualism* 19, Ontario institute for studies in education. Pp. 197–205.

Dalen, M. & Saetersdal, B. (1988). *Utenlandsadopterte barn i Norge: Sommerfugler i vinterland*. Oslo: J W Cappelen.

Dalen, M. & Saetersdal, B. (1992). *Utenlandsadopterte barn i Norge: tilpasning – opplaering – identitetsutvikling, empirisk undersokelse og teoretisk videreutvikling*. Spesiallaererhögskolen, Universitetet i Oslo.

Dalen, M. & Rygvold, A.-L. (1999). *Hvordan går det på skolen?* Nr 3, Institutt for specialpedagogikk, Universitetet i Oslo.

DeBerry, K. M., Scarr, S. & Weinberg, R. (1996). Family racial socialization and ecological competence; Longitudinal assessments of African-American transracial adoptees. *Child Development*, 67, pp. 2375–2399.

De Geer, B. (1992). *Internationally adopted children in communication. A developmental study*. Lund: Dept. of Linguistics and Phonetics. Lund University. Working Papers 39.

Dery-Alfredsson, I. & Katz, M. (1986). *Utländska adoptivbarn på PBU*. Psykologiska institutionen, Stockholms universitet.

De Vaney, N.M. (1983). *Adjustment of the older adopted child: Process and relationship*. The University of Alabama. Dissertation in Abstracts International.

Fanshel, D. (1972). *Far from the Reservation: The Transracial Adoption of American Indian Children*. New York: Scarecrow Press.

Feigelman, W. & Silverman, A. R. (1983). *Chosen Children. New Patterns of Adoptive Relationships*. New York: Praeger.

Feigelman, W. & Silverman, A. R. (1984). The longterm effects of transracial adoption. *Social Service Review*, pp. 588–602.

Feigelman, W. (1997). Adopted adults: Comparisons with persons raised in conventional families. *Marriage & Family Review*, 25: 3–4, pp. 199–223.

Fergusson, D. M., Lynskey, M. & Horwood, L. J. (1995). The adolescent outcome of adoption: A 16-year longitudinal study. *Journal of Child Psychology and Psychiatry*, 36, pp. 597–615.

Fisher, L., Ames, E. W., Chrisholm, K. & Savoie, L. (1997). Problems reported by parents of Romanian orphans adopted to British Columbia. *International Journal of Behavioral Development*, 20, pp. 67–82.

Forsten-Lindman, N. (2001) Psychosocial adjustment and mental health of intercountry and domestic adopted teenagers in Finland. Abstract. Nordic Research Conference. 35 years with intercountry adoptions. Göteborg, September.

Friedlander, M. L. (1999). Ethnic identity development of internationally adopted children and adolescents. *Journal of Marital and Family Therapy*. Vol. 25, No. 1, pp. 43–60

Gardell, I. (1979). Internationella adoptioner. En rapport från Allmänna barnhuset, Stockholm.

Geerars, H., Hoksbergen, R. & Rooda, J. (1996). Adoptees on Their Way to Adulthood. Adoption Center, Utrecht University, Utrecht, The Netherlands

Gill, O., & Jackson, B. (1983). *Adoption and Race: Black, Asian and Mixed race Children in white Families*. London: Batsford Academic and Educational Ltd.; St. Martin's Press.

Grotevant, H. D., Thorbecke, W. & Meyer, M. L. (1982). An extension of Marcia's identity status interview into the interpersonal domain. *Journal of Youth and Adolescence*, 11,1, pp. 33–47.

Grotevant, H. D. (1987). Toward a process model of identity formation. *Journal of Adolescent Research*, 2, 3, pp. 203–222.

Grotevant, H. D., McRoy, R. & Jenkins, V. Y. (1988). Emotionally disturbed adopted adolescents: Early patterns of family adoptions. *Family Process*. 27, pp. 439–457.

Grotevant, H. D., Dunbar, N., Kohler, J. K. & Lash Esau A. M. (2000). Adoptive identity: How contexts within and beyond the family shape developmental pathways. *Family Relations*. 49, pp. 379–387.

Grow, L. & Shapiro, D. (1974). *Black children, white parents: A study of transracial adoptions*. New York: Child Welfare League of America (CWLA).

Groze, V. (1986). Special needs adoption. *Children and Youth Service Review* 8.

Groze, V. & Ryan, S. D. (2002) Pre-adoption stress and its association with child behavior in domestic special needs and international adoptions. *Psychoneuroendocrinology*, 27, pp. 181–197.

Gunnarby, A., Hofvander, Y., Sjölin S. & Sundelin, C., (1982). Utländska adoptivbarns hälsotillstånd och anpassning till svenska förhållanden. *Läkartidningen*, 79, pp. 1697–1705.

Hall, J. A. (1982). A comparative analysis of successful and disrupted adoption in a private welfare agency. *Dissertation Abstracts International* 42,10, 45–89A.

Henningsen, N. J., Kulpa, L., Funder, N. & Rasmussen, L. (1987). Fra koreansk till dansk – en sproglig undersøgelse af en gruppe adoptivbørn, der har skiftet kultur efter det 3 leveår. København: Center for Audiologopaedi, Københavns universitet.

Hene, B. (1987a). De utländska adoptivbarnen och deras språkutveckling. Sprinsrapport 36. Göteborg: Institutionen för Lingvistik, Göteborgs universitet.

Hene, B. (1987b). Vuxna utlandsadopterade i Sverige, en intervjuundersökning. Sprinsrapport 37. Göteborg: Institutionen för Lingvistik, Göteborgs universitet.

Hersov, L. (1990). The seventh Jack Tizard memorial lecture: Aspects of adoption. *Journal of Child Psychology and Psychiatry*, 31,4, pp. 493–510.

Hjern, A., Lindblad, F. & Vinnerljung, B. (2002) Suicide, psychiatric illness, and social maladjustment in intercountry adoptees in Sweden: a cohort study. *The Lancet*, Vol. 360, August 10, pp. 443–448.

Hoksbergen, R. A. C., Juffer, F. & Waardenburg, B. C. (1986). *Adopted Children at Home and at school*. Lisse: Swets & Zeitlinger BV.

Hoksbergen, R. A. C., Spaan, J. & Waardenburg, B. C. (1988). *Bitter Experiences*. Lisse: Swetz & Zeitlinger BV.

Hoksbergen, R. A. C. (1997) Turmoil for adoptees during their adolescence? *International Journal of Behavioral Development*, 20, pp. 33–46.

Hoksbergen, R. A. C. (1991) Understanding and preventing "Failing adoptions". I Hibbs, E., D. (Ed.) *Adoption: International Perspectives*. International Universities Press. Madison Connecticut. pp. 265–278.

Holbrook, D. (1984). Knowledge of origins, self-esteem and family ties of long-term fostered and adopted children. Report to Holden Trust.

Hollingsworth, L. D. (1997). Effect of transracial/transethnic adoption on children's racial and ethnic identity and self-esteem: A meta-analytic review. *Marriage & Family Review*, 25:1–2, pp. 99–130.

Hoopes, J. L. (1990). Adoption and identity formation. In DM. Brodzinsky (Ed.). *The Psychology of Adoption*. New York: Oxford University Press. Pp. 144–166.

Howe, D. (1997). Parent-reported problems in 211 adopted children; some risk and protective factors. *Journal of Child Psychology and Psychiatry*, 38, pp. 401–411.

Huh, N. S. & Reid, W. J. (2000). Intercountry, transracial adoption and ethnic identity. *International Social Work* 43(1) pp.75–87.

Humphrey, H. & Humphrey, M. (1989). Damaged identity and search for kinship in adult adoptees. *British Journal of Medical Psychology*, 62, pp. 301–309.

Irhammar, M. (1997). Att utforska sitt ursprung. Doktorsavhandling, Psykologiska institutionen. Lunds universitet. Lund.

Irhammar, M. (2002) Att som utlandsfödd adopterad utforska sitt ursprung. Opubl. manus.

Johansson-Kark, M., Rasmussen, F. & Hjern, A. (2002). Overweight among international adoptees in Sweden: a populationbased study. *Acta Paediatrica* 91. pp. 827–832.

Johnsson, P. R. & Shireman, J. F. (1986). A longitudinal study of black adoptions. Single parent, transracial and traditional. *Social Work*, May–June, pp.172–176.

Juffer, F. & Rosenboom, L. (1997). Infant-mother attachment of internationally adopted children in the Netherlands. *International Journal of Behavioral Development*, 20,1. pp. 93–107.

Juffer, F., Hoksbergen, R. A. C., Riksen-Walraven, J. M. & Kohnstamm, G. A. (1997). Early intervention in adoptive families: Supporting maternal sensitive responsiveness, infant-mother

attachment, and infant competence. *J. Child Psychol. Psychiat.* 38, 8, pp.1039–1050.

Kadushin, A. (1977). Adopting older children. I A. M. Clarke & A. D. B. Clarke (Eds). *Early Experience: Myth and Evidence*. London: Open Books. pp 187–210.

Kaye, K. (1990). Acknowledgement or rejection of differences? I D. M. Brodzinsky (Ed). *The Psychology of Adoption*. New York: Oxford University Press. pp 121–143.

Kim, Wun Yung, Davenport, C., Joseph, J., Zrul, J. & Woolford E. (1988). Psychiatric disorder and juvenile delinquency in adopted children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27,1, pp. 111–115.

Kim, D.S. (1977). How they fared in american homes: A follow-up study of adopted Korean children. *Children Today*, 6 (March–April): 2–6, pp. 31.

Kim, D. S. (1978). Issues in transracial and transcultural adoption. *Social Case Worker*, October, pp. 477–486.

Kim, W. J. (1995) International adoption: A case review of Korean children. *Child Psychiatry and Human Development*, 25, pp. 141–154.

Kirk, H. D. (1959). A dilemma of adoptive parenthood: Incongruous role obligations. *Marriage and Family living*, November, pp. 316–328.

Kirk, H. D. (1964). *Shared Fate. A Theory of Adoption and Mental Health*. New York: Free Press

Kirk, H. D. Jonassohn, K., & Fish, D. (1966). Are adopted children specially vulnerable to stress? *Archives of General Psychiatry*, 14, 3, pp. 291–298.

Kirk, H. D. (1981). *Adoptive Kinship*. Toronto: Butterworths.

Kohler, J. K., Grotevant, H. D. & McRoy, R.G. (2002). Adopted adolescents' preoccupation with adoption: The impact on adoptive family relationships. *Journal of Marriage and Family*. 64 (February) pp. 93–104.

Kreppner, J. M., O'Conner, T. G., Rutter, M. and the English and Romanian Adoptees Study Team. (2001). Can Inattention/Overactivity Be An Institutional Deprivation Syndrome? *J. Abnormal Child Psychology*, vol. 29, nr. 6, dec., pp. 513–528.

Kühl, W. (1985). *When Adopted Children of Foreign Origin Grow up. Adoption success and the psychosocial integration of teenagers.* Osnabruck: Terre des Hommes.

Kvifte-Andersen, I. L. (1992). Behavioral and school adjustment of 12–13 year old internationally adopted children in Norway. *Journal of Child Psychology and Psychiatry*, 33, pp. 427–239.

Kvist, B. Viemerö, V. & Forsten, N. (1989). Barn adopterade till Finland från utomeuropeiska länder. *Nordisk psykologi*, 41,2, pp. 97–108.

Ladner, J. A. (1977). *Mixed Families. Adopting across Racial Boundaries.* New York: Anchor Press/Doubleday.

Levi-Shiff, R., Zoran, N. & Shulman, S. (1997). International and domestic adoption: Child, parent, and family adjustment. *International Journal of Behavioral Development*, 20, pp. 109–129.

Lindblad, F., Hjern, A. & Vinnerljung, B. (2002). Inter-country adopted children as young adults – A Swedish cohort study. (opubl. manus)

Lipman, E. L. Offord, DR., Boyle, M. H. & Racine, Y. A. (1993). Follow-up of psychiatric and educational morbidity among adopted children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32,5, pp. 1007–1012.

Marcovitch, S., Goldberg, S., Gold, A., Washington, J., Wasson, C., Krekewich, K. & Handley-Derry, M. (1997). Determinants of behavioural problems in Romanian children adopted in Ontario. *International Journal of Behavioral Development*, 20, pp. 17–31.

Maughan, B. & Pickles, A. (1991). Adopted and illegitimate children growing up. In Robins, L. & Rutter, M. *Straight and Devious Pathways from Childhood to Adulthood.* Cambridge University Press. pp. 36–61.

Maughan, B., Collishaw, S. & Pickles, A. (1998). School achievement and adult qualifications among adoptees: A longitudinal study. *Journal of Child Psychology and Psychiatry*, Vol. 39, no. 5, pp. 669–685.

McRoy, R., Zurcher, L. A., Lauderdale, M. L., & Anderson, R.N. (1982). Self-esteem and racial identity in transracial and inracial adoptees. *Social Work*, 27, pp. 522–526.

McRoy, R., Zurcher, L. A. (1983). *Transracial and Inracial Adoptees. The Adolescent Years.* Springfield IL: Charles C.Thomas.

McRoy, R., Zurcher, L. A. Lauderdale, M. L. & Anderson, R. N. (1984). The identity of transracial adoptees. *Social Casework: The Journal of Contemporary Social Work*, January, pp. 34–39.

McWhinnie, A. M. (1967). *Adopted Children: How They Grow Up; a Study of Their Adjustment as Adults*. London: Routledge and Kegan Paul.

Meier, D. I. (1999). Cultural identity and place in adult Korean-American intercountry adoptees. *Adoption Quarterly*, Vol. 3(1) pp.15–48.

Miller, B. C., Fan, X., Christensen, M., Grotevant, H. D. & van Dulmen, M. (2000). Comparisons of adopted and nonadopted Adolescents in a large, nationally representative sample. *Child Development*, September/October. Vol. 71, no. 5, pp. 1458–1473.

Miller, B. C., Fan, X., Grotevant, H. D., Christensen, M., Coyl, D. & van Dulmen, M. (2000). Adopted adolescents' overrepresentation in mental health counseling: Adoptees' problems or parents' lower threshold for referral? *J. Am. Acad. Child Adolesc. Psychiatry*, 39:12, dec., pp. 1504–1510.

Moser, G. (1993). *Adoptivbarns skolprestationer och val av studieväg*. Stockholm: Institutionen för pedagogik, Stockholms universitet.

Müller, U. & Perry, B. (2001) Adopted persons' search for and contact with their birth parents I: Who searches and why? *Adoption Quarterly*, Vol. 4(3) pp. 5–37.

Nicolaysen, J. (1998). Når eblet faller langt fra stammen-utenlandsadopterte og skolegang. *Norsk Skoleblad* nr. 22, pp. 26–28.

Nord, L., Ellegaard, V., Raunskov, J.-U. & Primdahl, M. (2001) Survey made by Småbørnscentret in Århus and Adoption center Århus, Denmark concerning children placed in adoption with Danish families through AC Denmark in 1992 & 1993. Abstract. *Nordic Research Conference, 35 years with intercountry adoptions*. Göteborg, September. pp. 13–15.

O'Connor, T. G., Bredenkamp, D. & Rutter, M. (1999). Attachment disturbances and disorders in children exposed to early severe deprivation. *Infant Mental Health Journal*, 20, 1, pp. 10–29.

O'Conner, T., Rutter, M. & the English and Romanian Adoptees study team. (2000). Attachment disorder behavior following early severe deprivation: Extension and longitudinal

follow-up. *J. Am. Acad. Child Adolesc. Psychiatry*, 39:6, June. pp. 703–712.

Phinney, J. & Alipuria, L.L. (1990). Ethnic identity in college students from four ethnic groups. *Journal of Adolescence*, 13, pp. 171–183.

Proos, L. (1992). Growth and Development of Indian Children Adopted in Sweden. Doctoral dissertation. Uppsala: Department of Pediatrics, Uppsala University.

Pruzan, V. (1977). Födt i utlandet, adopteret i Danmark. Köbenhavn: Socialforskningsinstituttet, Publikation 77.

Rathbun, C., Di Virgiliol, & Waltfogel S. (1958). The restitutive process in children following radical separation from family and culture. *American Journal of Orthopsychiatry*, 28, 2, pp. 408–415.

Rathbun, C., McLaughlin, H., Bennet, C. & Garland, J. A. (1965). Later adjustment of children following radical separation from family and culture. *American Journal of Orthopsychiatry*, 34, pp. 604–609.

Rushton, A. & Minnis, H. (1997). Annotation: Transracial family placements. *Journal of Child Psychology and Psychiatry*, 38, pp. 147–159.

Rutter, M. and the English and Romanian Adoptees (ERA) study team. (1998). Developmental catch-up and deficit following adoption after severe global early privation. *Journal of Child Psychology and Psychiatry*, Vol. 39, No. 4, pp. 465–476.

Rutter, M., Andersen-Wood, L., Beckett, C., Bredenkamp, D., Castle, J., Groothues, Ch., Kreppner, J., Keaveney, L., Lord, C., O'Connor, T. & ERA study team. (1999) Quasi-autistic patterns following severe early global privation. *Journal of Child Psychology and Psychiatry*, Vol. 40, no.4, pp. 537–549.

Rutter M. L., Kreppner J. M. O'Connor T. G. (2001). Specificity and heterogeneity in children's responses to profound institutional privation *Br J Psychiatry*. Aug, 179, pp. 97–103.

Rosenberg, E. B. & Horner, T. N. M. (1991). Birthparent romances and identity formation in adopted children. *American Journal of Orthopsychiatry*, 61, (1), January, pp. 70–77.

Rygvold, A.-L., Dalen, M. & Saetersdal, B. (Eds) (1999). Mine – yours – ours and theirs. International conference at Lysebu, Oslo.

Rörbech, M. (1989). Mit land er Danmark. En undersøgelse af adopterede fra Asien, Afrika og Latinamerika. Köbenhavn: Socialforskningsinstituttet, rapport 14.

Schechter, M. D. & Bertocci, D. (1990). The meaning of search, I D.M. Brodzinsky (Ed). *The Psychology of Adoption*. New York: Oxford University Press. pp 62–92.

Selman, P. (2000). The demographic history of intercountry adoption. I P. Selman (Ed). *Intercountry Adoption Developments, Trends and Perspectives*. pp. 15–39.

Sharma, A. R., McGue, M. K. & Benson, P. L. (1996a). The emotional and behavioral adjustment of United States adopted adolescents: Part I. An overview. *Children and Youth Services Review*, Vol.18, Nos. 1/2, pp. 83–100.

Sharma, A. R., McGue, M. K. & Benson, P. L. (1996b). The emotional and behavioral adjustment of United States adopted adolescents: Part II. Age at adoption. *Children and Youth Services Review*, Vol. 18, Nos. 1/2, pp. 101–114.

Sharma, A. R., McGue, M. K., Benson, P. L. (1998). The psychological adjustment of US adopted adolescents and their nonadopted siblings. *Child Development*, vol. 69, nr. 3, pp. 791–802.

Silverman, A. R. & Feigelman, W. (1990). Adjustment in interracial adoptees: An overview. I D. M. Brodzinsky (Ed). *The Psychology of Adoption*. New York: Oxford University Press. Pp. 187–200.

Silverman, A. R. (1980). Transracial adoption in the United States: A study of assimilation and adjustment. *Dissertation Abstracts International*, Nov. 41,5A,2311–2312.

Simon, R. J. & Altstein, H. (1977). *Transracial Adoption*. New York: Wiley- Interscience.

Simon, R. J. & Altstein, H. (1981). *Transracial Adoption: A Follow-up*. Ashland, MD: Lexington Books.

Simon, R. J. & Altstein, H. (1987). *Adoptees and Their Families*. Westport, CT: Praeger.

Simon, R. J. & Altstein, H. (1992) *Adoption, Race and Identity*. Westport, CT: Praeger.

Simon, R. J. & Altstein, H. & Melli, M. (1994) *The Case for Transracial Adoption*. Washington, D.C.: The American University Press.

Skutnabb-Kangas, T. (1981). *Tvåspråkighet*. Lund: Liber läromedel

Slap, G., Goodman, E. & Huang, B. (2001). Adoption as a risk factor for attempted suicide during adolescence. *Pediatrics*, Vol.108, no. 2, August. pp.1-8.

Smyer, M. A., Gatz, M., Simi, N. L. & Pedersen, N. L. (1998) Childhood adoption: Long-term effects in adulthood. *Psychiatry*, Vol. 61, Fall, pp.191-205

Spring-Duvoisin, D. (1986). *L'adoption Internationale*. Lausanne: Editions Advimark

Stams, G.-J. J. M., Juffer, F., Rispens, J. & Hoksbergen, R. A. C. (2000). The development and adjustment of 7-year-old children adopted in infancy. *Journal of Child Psychology and Psychiatry*, Vol. 41, no. 8, pp. 1025-1037.

Tec, I. & Gordon, S. (1967). The adopted child's adaptation to adolescence. *American Journal of Orthopsychiatry*, 37, 2, pp. 402-412.

Tizard, B. & Phoenix, A. (1989). Black identity and transracial adoption. *New community*, 15, 3, pp. 427-437.

Tizard, B. (1977). *Adoption: A Second Chance*. London: Open Books.

Tizard, B. (1991). Intercountry adoption: A review of the evidence. *Journal of Child Psychology and Psychiatry*, 32, 5, pp. 743-756.

Tordai, G. (1978). *Utländska adoptivbarn i Norrköping 1978*. Norrköping: Barnmedicinska kliniken, Lasarettet, stencil.

Triselotis J. (1973). *In Search of Origins: The Experience of Adopted People*. Boston: Routledge and Kegan Paul.

Triselotis, J. (1980). *New Developments in Foster Care and Adoption*. London: Routledge and Kegan Paul.

Triselotis, J. & Russel, J. (1984). *Hard to Place. The Outcome of Adoption and Residential Care*. London: Heinemann.

Triselotis, J. (1999). Inter-country adoption: Global trade or global gift? I Rygvold, A.-L., Dalen, M. & Saetersdal, B. (Ed.) *Mine- yours- ours and theirs*. International conference. Lysebu, Oslo. pp. 14-31.

Von Greiff, K. (2000). *Adopterade från Latinamerika*. Doktorsavhandling. Pedagogiska institutionen. Stockholms universitet, Stockholm.

Verhulst, F. C., Althaus, M. & Versluis den Bieman, H. J. M. (1990a). Problem behaviour in international adoptees. *An*

epidemiological study. *J. Am. Acad. Child Adolesc. Psychiatry* 29,1, pp. 94–103.

Verhulst, F. C., Althaus, M., & Versluys den Bieman, H. J. M. (1990b). Problem behaviour in international adoptees. II Age at placement. *J. Am. Acad. Child Adolesc. Psychiatry*, 29,1, pp. 104–111.

Verhulst, F. C., Versluys den Bieman, H.J.M., van der Ende, J., Berden, G. F. M. G. & Sanders-Woudstra, J. A. R. (1990c). Problem behaviour in international adoptees. III Diagnoses of child psychiatric disorders. *J. Am. Acad. Child Adolesc. Psychiatry*, 29, 3, pp. 420–428.

Verhulst, F. C., Althaus, M. & Versluis den Bieman, H. J. M. (1992). Damaging backgrounds – Later adjustment of international adoptees. *J. Am. Acad. Child Adolesc. Psychiatry*, Vol. 31, No.3 (May), pp. 518–524.

Verhulst, F. C. & Versluis den Bieman, H. J. M. (1995). Development course of problem behaviors in adolescent adoptees. *J. Am. Acad. Child Adolesc. Psychiatry*, 34, pp. 151–159.

Versluis-den Bieman, H. J. M. & Verhulst, F. C. (1995). Self-reported and parent reported problems in adolescent international adoptees. *Journal of Child Psychology and Psychiatry*, Vol. 36, no. 8 (Nov.), pp. 1411–1428.

Vinnerljung, B. (1999). Förekomst av adoptivbarn och långtidsvårdade fosterbarn bland placeringar av tonåringar i dygnsvård. *Socialvetenskaplig tidskrift*, nr 4, pp. 313–328.

Wattier, B. & Frydman, M. (1985). L'adoption internationale. *Etude Clinique d'un groupe d'enfants d'origine asiatique*. *Enfance* I, 85.

Westhues, A. & Cohen, J. S. (1977). A comparison of the adjustment of adolescent and young adult inter-country adoptees and their siblings. *International Journal of Behavioral Development*, 20, pp. 47–65.

Yoon, D. P. (2001). Causal modeling predicting psychological adjustment of Korean-born adolescent adoptees. *Journal of Human Behavior in the Social Environment* Vol. 3 pp. 65–82.

Zucher, K. J. & Bradley, S. J. (1998). Adoptee overrepresentation among clinic-referred boys with gender identity disturbance. *Canadian Journal of Psychiatry*, Dec; 43: (10), pp.1040–1043.

3 Analysis of compilation of the research

3.1 Analysis carried out by Marianne Cederblad

3.1.1 Methodological shortcomings

Adoptees are a heterogeneous group. Most studies have failed to take account of this. Sometimes the subgroups involved in the study have not been described or else results have not been analysed in such a way that different subgroups can be compared. The results that exist show e.g. that there is a great difference between psychological and social adjustment depending on the age when the child was adopted, and above all on what he experienced before adoption. One example is children from extremely bad orphanages in Romania, where the length of stay in the orphanage co-varied arithmetically with the frequency of behavioural deviations. An example of the opposite is Korean adoptions, in which the child before adoption is looked after in a well-functioning foster home instead of staying in an orphanage. Many studies show that the adopted Korean children are managing well, which perhaps is because of the quality of care before adoption. If one lumps together children of such different backgrounds in the same study the results of different studies can vary dependent on how many children of each kind one has in a particular study.

Nor have people always analysed interracial/interethnic adoptees separately compared with children placed within the same racial/ethnic group. When one considers that the identity process becomes more complex when the child has been adopted across a racial/ethnic boundary this should be important. Those studies in which separate analysis was carried out have not given unanimous results.

American studies often include both adoptions by relatives and "special needs" adoptions. The first group is special as it is dominated by children adopted by a stepparent, and therefore the

child does not change family. Those children have not been subjected to as traumatic a separation as children adopted outside the extended family. It is probably not possible to draw conclusions from these adoptions applicable to the children adopted from abroad who are under discussion in Sweden. The group of "special needs" adoptions corresponds to the group of foster children in long-term care in Sweden. These children have been taken into care in both the USA and Sweden because of their parents' inability to be proper parents. Often the parents have had psychiatric illnesses or alcohol/drug addiction. The children have often been subjected to neglect or psychological, physical and/or sexual abuse. Children adopted from abroad may also have a history of this kind.

One special problem as regards children adopted from abroad is that very poor information is often all that is available on what has happened to the child before adoption. Many psychiatric problems have a genetic cause, mother's behaviour and health during pregnancy affects the development of the foetal brain, injuries during birth and care of the new born infant can produce brain damage, and often there is no information about these things. In one study Castle made an attempt at assessing the quality of the stay in orphanages by asking the adoptive parents to describe the child's situation in the orphanage at adoption. But that is not enough if the child has stayed for a longer period in an orphanage. Circumstances change and most children are moved between different departments.

In most studies children have not been selected from a particular environment, e.g. a country with an explicit policy of adoption. There are exceptions, e.g. the research groups studying children from Romania. They have had information about the quality of the orphanage and studied variations in length of stay. More studies of this kind are needed in order to analyse which factors can affect the outcome after adoption.

A general problem is being able to study large groups with more costly methods in Sweden, e.g. interviews, which are necessary if one wants to study attachment, identity, language and quality of life.

3.1.2 Areas in which information is lacking

Surprisingly few studies have been made of attachment between adoptive parents and adoptees. Studying the interplay between type of attachment in adoptive parents and their ability to create secure attachment to adoptees, especially those arriving older than six months to one year, would be valuable to find clues as to how one can create the optimal conditions for good attachment in families adopting older children, 30% at present.

It would also be important to study how the adopted adults function in close emotional relationships as husbands/wives and parents in relation to age on arrival. (Other factors may however affect the development of attachment. Behavioural-genetic research has found that attachment is 35% genetically determined.)

More studies of identity development need to be undertaken. Is it realistic to believe that someone can develop an ethnic identity based on the fact that someone was born in a country with which they have had no deep or long-lasting contact?

How is identity affected by growing up in such a mono-cultural country as Sweden? This should be studied over time, e.g. by comparing those growing up during the 1970s and during the 1990s, as during this period Sweden has experienced vastly increased immigration, so that now 20% of the population comprises immigrants.

Are adoptees more sensitive to separation? How are they affected by divorce, living alternately with different parents, repeated moves, changes of playschool and school? Does a greater age at adoption make the children more sensitive to separation?

Is moving away from home a particularly difficult period for adopted young adults? In this case is age on arrival a vulnerability factor?

How does adoption of two children simultaneously work (siblings, twins, unrelated children) compared with adopting one child at a time?

Studies of Swedish adoption policy. Older adoptive parents and single parents often receive the older children. Research has shown that they constitute a risk group. What does the policy look like; has it changed over the years?

The new homosexual adoptions should be followed up carefully.

A comparison between the adoptions where things have gone wrong (abuse, criminality, suicide) with those where they have gone well (psychiatrically and socially well adjusted, high level of education, successful adjustment to work) can provide ideas for preventative action and treatment.

3.1.3 Conclusions on need for support and treatment

The investigation: The investigators from social welfare services who must provide a basis for consent to adopt need updated evidence-based training. This can, as at present, be conducted by NIA (Swedish National Board for Intercountry Adoptions).

Preparations for adoption: Group discussions with information and advice before the adoption are today held by the different adoption organisations and some social welfare services. Participation in these group discussions should be obligatory and a condition for acquiring consent to adopt. What should be discussed in particular are the situations that may arise in adopting older children. The group leaders should have ongoing training e.g. on evidence-based new information in the field. NIA can be responsible for the transmission of this information to the group leaders.

Policy issues: The present policy that older adopters and single adopters should receive the oldest children should be changed. These specific adoptions are high-risk adoptions, and one should try to place these children in the most competent homes with two younger parents, as the problems are usually most serious when the children are in their teens.

Prevention: Most adoptive parents consult a paediatrician after coming home to check whether the newly arrived child is healthy or needs some somatic treatment. It would be desirable to gather together both paediatric and child-psychiatric expertise in some medical practices to which new adoptive parents could turn. Then there is an opportunity to establish early contact in those cases where the child seems to be having attachment problems or shows initial behavioural difficulties, e.g. marked aggression, ADHD (Attention Deficit/Hyperactivity Disorder), FAS (foetal alcohol syndrome). Adoptive parents, like other parents, visit a well baby clinic repeatedly during the early years of childhood, it is important

that the child care nurses are trained in the area of adoptees, particularly in the increased risk of problems in adopting older children.

Treatment: Within child and youth psychiatry there are in many places special baby teams used to working with attachment difficulties. They can also be used for these problems in adoptions of older children with this type of problem. Otherwise adoptees and their families can be treated in open and closed care within child and youth psychiatry in the same way as Swedish-born children with the same diagnoses. There are however reasons for training personnel within child and youth psychiatry, social welfare services' individual and family care units and schools in the special problems that can arise precisely in adoptive families. Apart from attachment problems there is also an increased risk of ADHD and FAS because of early brain damage, relationship problems because of a lack of "goodness of fit" between parents and children because of great differences of temperament, intelligence, ability to control impulses, etc. Language problems and unrealistic demands for school achievements can also create special problems. In this small group where the youngster's problems are extreme, the parents can also derive benefit from special parental support groups in order to cope with maintaining contact with the youngster so as to prevent a lasting breakdown in parent-child contact. This is especially important in those cases where the youngster has developed criminal tendencies and addiction, as these are such alien phenomena in those middle-class environments where the children are adopted.

As adoptees are also overrepresented in adult psychiatry, criminal and social care, there is also a great need for training here. There is therefore a great need to provide information to many different categories of care provision and to schools. This need should, of course, be met in the basic training in each field. There is, however, a need for additional training of those individuals working with adoptees in different fields. This could perhaps be provided at the same time as new research-based information is made available through the establishment of a new national centre for information, training and consultation.

3.1.4 Studies providing the best guidance

No studies in the survey of the literature dealt directly with preventative measures or treatment. Several studies such as those by Hjern, Lindblad, Miller, Brand & Brinich and Sharma of large groups of adoptees have shown that depression, suicide attempts/suicides and addiction are more common among adoptees. This information should attract special attention on the part of parents and those treating the children. Several researchers, such as Dalen & Sætersdal and Gardell have indicated the importance of special language difficulties as a cause of problems at school. This should result in schools and parents being aware of this reason for poor school results especially in adoptees who arrived at 18 months or older.

3.2 Analysis conducted by Anders Hjern, Frank Lindblad and Bo Vinnerljung

3.2.1 Recurrent methodological shortcomings

A broad panorama of different methodological approaches is described, each with its own advantages and disadvantages. In what follows we will primarily discuss recurrent shortcomings:

a) Small scale research populations. Even if some kinds of research require that the number of cases studied has to be limited, it is striking that the field of research is dominated by studies based on small research groups. Only the Dutch studies of Verhulst and Versluis den Bieman and our own studies have population sizes over 500.

b) Most studies are based on one occasion for measurement, so-called "cross-sectional studies". Studies following the adoptees over time, so-called "longitudinal studies", are largely lacking.

c) Most studies are of children and young people; there are, for obvious reasons, few studies of young adults.

d) Selection problems in recruitment of study populations. It is of great significance for interpreting results of individual studies to know how the participants were recruited, via e.g. an adoption organisation, former patients/clients of some form of social/care organisation or constituting a random selection of the population. To recruit via an adoption organisation in one country, for

example, excludes both adoptees from any other possible organisations and those adopted privately, which may mean that the selection is not representative of the receiving state as a whole.

e) The significance of selective dropout. It is not unreasonable to assume that adoptive families with problems decline to take part in interviews because the problems are more than for other families regarded as a personal defeat. This may possibly explain some of the differences between the epidemiological study from Skåne led by Marianne Cederblad and our own recently published register-based study (which has overlapping study populations).

f) Lack of information on background factors. Only a few studies contain data describing circumstances before and at adoption, so-called "baseline data". This is worrying in several respects. It creates problems for handling heterogeneity in the population. It is also difficult to carry out realistic risk analyses linked to outcomes later in life. Studies of the effects of interventions are also made more difficult.

3.2.2 Areas where vital information is lacking

We would especially stress the following areas:

a) The presence of different types of risk factors in the countries of origin. By this we mean, for example, long-term placements in orphanages, malnutrition, abuse and neglect in early childhood and genetic predisposition. The presence of different factors of this kind appears to vary with socio-cultural circumstances in the donor countries, perhaps primarily those types of motives underlying the adoptions.

b) A more detailed analysis of different risk factors (see above), weighted for outcomes and the opportunities of preventing these.

c) Studies evaluating care and treatment of adoptees and adoptive families (cf. the Juffer group's studies under point 3.2.5.)

d) Longitudinal studies and above all studies illuminating different phases – with identification of especially critical periods – of the adoptees' adaptation to life in their new country. Here we include studies following the adoptees up into adulthood with family formation and entrance into working life and the effects of accumulated potential traumatic conditions.

e) Studies of the adoptive family including how parents and children adjust to each other's personalities and how bonds grow between them.

f) The importance of different treatment because of non-Nordic appearance as a background factor for different types of difficulties for adoptees.

3.2.3 Need for support and treatment

It is obvious that the group of internationally adopted children runs a much greater risk of developing certain psychiatric and social symptoms and problems compared to the general population. One important question which has still not been answered conclusively is whether these additional risks apply to a limited group of adoptees who can be assumed to be especially vulnerable, and who as a result have developed serious psychosocial problems, – this is a common interpretation today – or whether it is a question of a more general increase in risk.

The problems of early childhood seem in many cases to be temporary, with a recovery in different respects, but one cannot rule out the fact that temporary symptoms during this period can predicate later problems. Juffer's studies (see below under point 3.2.5.) illustrate the fact that this is a possible age for preventative intervention, with e.g. individualised parental advice based on video filming. The teen years seem to be most obviously problem-laden. Opportunities for quick and effective interventions in this period appear important, not least against a background of a risk of suicide. There are also certain results that appear to indicate that entrance into adult life with its requirements of liberation, forming families and supporting oneself can imply continued or new difficulties, which is why the demands on the care organisation during the teen years also apply to young adults.

It seems that neuropsychological/development-related queries are often raised during the first years of life in relation particularly to some Eastern European countries – if not earlier then at least in connection with starting school – and there is therefore also a need for an easily available opportunity for expert consultation with specific competence in this area of adoption.

It is difficult to draw any other definite conclusions as to what these results should mean for Swedish care organisations. In our opinion the combination of additional risks and the complexity as regards the origin of deviant behaviour supports a need for specialist resources as a complement to the existing provision within social services and the health service.

3.2.4 Best studies for identifying needs for support and treatment

a) The studies by Verhulst, Versluis den Bieman et al. are pioneering, with large study groups, follow-up over time and the use of well-established instruments for symptom evaluation. One limitation is the drop out, which, following the reasoning under point 3.2.1, might mean that the additional risks of psychiatric symptoms have been underestimated.

b) The epidemiological study by Marianne Cederblad et al. uses the same category of instrument as Verhulst, but also employs other methods, e.g. instruments reflecting self-esteem. A smaller group has also been followed over time. As it is a Swedish study, it is particularly important for the Nordic situation. Its limitations are, however, the selective recruitment of study participants and drop out.

c) Among the Swedish studies Berg-Kelly and Eriksson's study of pupils adopted from abroad in the senior classes of compulsory school provides valuable information, despite the relatively small size in this study of the study population (125 pupils). The design of the study means that one does not need to fear problems with selection problems in the recruitment of the study population.

d) At the risk of being accused of being immodest – but with support from the editorial commentary made in *The Lancet* at its time of publication – we wish to mention our own study. It is based on (as far as we aware) the largest population of children adopted from abroad in the world literature. The drop out is carefully specified. The outcomes are based on aggregated data and are relevant for the needs of adoptees for different forms of psychiatric and social intervention. One limitation is that the study is based on data on rare events such as consumption of hospital care and appearance in criminal records.

e) Rutter, O'Connor et al., in their studies of the Romanian adoptees, focus on the needs of a special group of children, with the particular difficulties which can be caused by their specific background. These studies are examples of an important methodological approach with clear limitation of the problem area, which can ensure more reliable results. The children are being followed up over time.

f) Maughan's study is interesting in a different way. It demonstrates the positive effects of (national) adoption and illustrates how the pattern of adaptation can change over time.

3.2.5 Other important research

a) Several Swedish studies have been presented in recent years describing difficulties for internationally adopted children as young adults on the labour market. In one thesis on economics Torun Österberg showed that individuals adopted from abroad have lower incomes than other Swedes of a similar social background. In another study the economist Dan-Olof Rooth has shown that international adoptees have a higher level of unemployment at age 20–32 than one might expect when taking into account the group's education and general social background. Rooth focuses on discrimination because of adoptees' differences in appearance as a possible explanation for this. In our study our research group has described a similar picture, with higher unemployment and dependence on social security than expected, in individuals of 25–30 adopted from abroad.

References:

Österberg, T. Economic perspectives on immigrants and intergenerational transmission. *Ekonomiska studier*, nr 102. National-ekonomiska institutionen, Handelshögskolan vid Göteborgs Universitet, 2000.

Rooth, D-O. Adoptees in the labour market – Discrimination or unobserved characteristics. *International Migration Quarterly Review* 2002: 40:71-98.

Lindblad, F, Hjern, A, Vinnerljung, B. Inter-country adoptees as young adults – A Swedish cohort study. *American Journal of Orthopsychiatry*, 2003: Vol.73, No.2, 190–202.

b) An as yet unpublished Swedish study of adoptees from Eastern Europe was presented as a poster at the AGM of the Swedish Society of Medicine 2002 by Magnus Landgren et al. 76 children had been studied. The authors summarize: "Exposure to alcohol and growth inhibition during pregnancy, malformations, development of neurological deviations and learning difficulties are common occurrences among children adopted from Eastern Europe. Planned paediatric follow up for adoptees from Eastern Europe is recommended." These results indicate that the adoptees from Eastern Europe have a considerably greater need for support input than groups of adoptees received earlier.

Reference:

Landgren, M. Andersson-Grönlund, M. Elfstrand, P-O. Simonsson, J-E. Strömland, K. Barn adopterade från Östeuropa: Hälsodata. Poster at Läkarsällskapets Riksstämma 2002.

c) The Dutch research group with Femmie Juffer at ADOC at The University of Leiden in their research have drawn particular attention to the interplay between adoptees and adoptive parents in the period immediately after adoption. This research is particularly important by virtue of its consistent linking to the possibilities for intervention in this interplay. Their published results show that it is possible to identify early insecure attachment patterns in adoptive families predicting behavioural problems in the children at seven years of age, and that these attachment patterns can be improved through counselling. In another Dutch research project linked to this research group Klein Velderman and Beijersbergen have tried to describe and evaluate in a scientific way the support given to adoptive families after the adoption. These studies are important as examples of how one could proceed in order to evaluate these aspects of adoptions in Sweden.

References:

Stams, GJ, Juffer, F van IMH. Maternal sensitivity, infant attachment, and temperament in early childhood predict adjustment in middle childhood: the case of adoptees and their biologically unrelated parents. Dev Psychol 2002;38(5):806-21.

Stams GJ, Juffer F, Rispen J, Hoksbergen RA. The development and adjustment of 7-year-old children adopted in infancy. *J Child Psychol Psychiatry* 2000;41(8):1025-37.

Juffer F, Hoksbergen RA, Riksen-Walraven JM, Kohnstamm GA. Early intervention in adoptive families: supporting maternal sensitive responsiveness, infant-mother attachment, and infant competence. *J Child Psychol Psychiatry* 1997;38(8):1039-50.

Juffer F, van Ijzendoorn MH, Bakermans-Kranenburg MJ. Intervention in transmission of insecure attachment: a case study. *Psychol Rep* 1997;80(2):531-43.

van Ijzendoorn MH, Juffer F, Duyvesteyn MG. Breaking the intergenerational cycle of insecure attachment: a review of the effects of attachment-based interventions on maternal sensitivity and infant security. *J Child Psychol Psychiatry* 1995;36(2):225-48.)

Beijersbergen, M A child adopted.... what is next? Dutch adoption-aftercare in European perspective. Akademisk avhandling. Leiden; ADOC, 2002.

3.3 Analysis carried out by Malin Irhammar

3.3.1 Introduction

In what follows I discuss on what grounds one can draw conclusions about support and treatment input on the basis of existing research, what shortcomings exist in this research, and identification of areas of research lacking today in relation to the main areas of focus in adoption research.

What is it that causes us to develop into the individuals we are, and what affects our ability to cope with the different things that happen in life? Within modern development psychology one points to the importance of the interplay between more constitutional, individual factors and environmental factors, primarily considering the interplay between the individual and significant others.

Without doubt experiences in childhood and youth have a decisive importance for the individual's ability to manage his life as an adult, but what happens during the life journey is also importance.

3.3.2 Mental health and social adjustment

In order to understand why things go well for certain adoptees while others have problems we need information about the experiences of adoptees before and after adoption, based on their conditions. We also need to study the development of individuals over time. This is however not that easy to do, partly because there is not always information available about the child's life before adoption, partly because it requires quite considerable research resources.

The majority of the adoption research has focused on the mental health and social adjustment of adoptees when they are growing up. The conclusion one can draw of the research as a whole is that those children born abroad run a higher risk of developing poorer adjustment, assuming they were older at adoption and had experienced privations before adoption. The type of research pursued does not give direct answers to the question of what support and treatment measures should be developed, but point to the importance of paying specific attention to those children adopted at a more advanced age and their families. Starting from information on development psychology one would assume that it would be valuable to support in particular the attachment process in the adoptive family.

We also need to understand better why, despite these risk factors, certain children do not develop psychiatric conditions or have defects in their social adjustment. In other words, identify what salutogenic factors cause the child to cope well, despite everything. It may be a question of studying both constitutional factors in the child and the processes of interplay and emotional attachment patterns in the adoptive family.

3.3.3 Somatic health

There are relatively few studies of the somatic health of children adopted from abroad. Those studies undertaken show that initial problems soon improve. Early puberty with shorter growth as a consequence has been noticed in one study. But information is lacking here on the psychological consequences of early puberty over time.

3.3.4 Language, school and the labour market

At school the child's intellectual and social abilities are tested and it is at this stage that the language problems of the child adopted from abroad are often identified. Within this field of research the focus has often been on language, the need for special tuition and level of education attained.

The results are not as valuable in those cases where only the child's linguistic ability is illustrated, without linking this to cognitive and social development.

Within this field research is needed analysing the reasons behind the different abilities of adoptees in entering the labour market.

3.3.5 Identity

The development of identity becomes more complex when different dimensions of otherness such as appearance, ethnic and cultural origin or handicap are to be found in an individual's life. For adoptees this is also a matter of integrating parts of their history which predate the adoption, a history which may be a matter of different kinds of vulnerability.

Often research has studied the attitude of the adoptee to his origin and has related this to mental health and self-esteem, but also to factors making it easier for the individual to research his origins. The conclusion one can draw from the research is that the adoptee's interest in his origins either seems to be an expression of an inquisitiveness caused by a lack of information, comprising part of a normal development of identity, or an expression of an unsatisfactory life situation, something that can be based in experiences of lack of belonging to the adoptive family or the society he lives in. The results point to heterogeneity in the experience of being adopted. It is rare that the focus falls on the importance for the individual of being confirmed to be the person one feels oneself to be. There is a great danger in drawing simple, generalised conclusions about which actions best benefit adoptees. One difficulty as regards interpreting the results in identity research is found in many cases in vague theoretical approaches, but also in the variety of disciplinary bases (psychology, sociology, anthropology, ethnology), without attempting inter-disciplinary

approaches. What is more the distinction is not made in the conclusions drawn between visible and invisible adoptions.

One field where there is a need for research today is the significance of emotional attachment in relation to development of identity. Another is how adoptees as parents themselves use their unique background in the upbringing of their own children.

3.3.6 Summary

We know quite a lot about the outcome for adoptees born abroad and what may be thought to cause their problems, but we do not know very much about the personal resources that allow adoptees to cope despite different risk factors. There is surprisingly little research into early interplay processes between children and adoptive parents. Nor do we know what the answers to many of the questions asked look like from the perspective of an entire life cycle and generation. Longitudinal studies should be able to contribute to identifying more critical phases in the lives of adoptees and adoptive families. Studies are also needed which in their design take into account mediating or moderating factors. Finally research is needed illustrating the effects of ongoing support and treatment measures as regards adoptees/adoptive families.

Information forming a basis for certain measures of support and treatment can be found today in traditional psychology and psychiatry, but is not always identified and clarified in relation to professional work with adoptees and their specific life situation. Madeleine Kats has in her book *Adoptivbarn växer upp* (Adoptees grow up) shown how a theoretical and professional knowledge, paired with great experience of adoption questions, has resulted in applicable knowledge in the field. There is also a great deal of information in the existing research, but there seem to be obvious problems in systematising and communicating the results so that they are usable in different measures for support and treatment.