Coping with the effects of deprivation

Development and upbringing of Romanian adoptees in the Netherlands

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INTRODUCTION

Adoption is a longstanding practice, which has changed much in the last four, five decades. In most European countries, domestic adoption is the most common form of adoption no longer. In the second half of the twentieth century, the number of international adoptions increased strongly (Selman, 2000). Children who could not be raised by their natural parents due to cultural factors, war or poverty were, and are, adopted by families in other countries. Families hoping to give them a better life than they would have had in their country of origin.

Adopting a child that is not biologically related to the family may bring about specific psychosocial problems. If a child is not genetically related to the adoptive parents, the adoptive parents do not know the genetic traits, which may be highly different from their own. In addition to these differences, the early-life history of the child may also cause specific challenges. The biological parents of the child were unable to take care of him (for reasons of legibility, we speak of children in the male form when referring to both boys and girls). Circumstances surrounding conception and pregnancy may have been stressful, and the child has already experienced at least one significant loss (of the biological parents) before adoption. Most children have also spent some time in a children's home before they were adopted, institutions where they may have experienced (severe) neglect and deprivation. Adopted children may experience difficulties in their identity formation due to factors such as being abandoned by the biological parents, and differing racially and culturally from the adoptive parents.

Once adopted, the children may find themselves in three different upbringing situations: they are educated by the parents at home, by the teachers at school, and often also receive guidance from a mental health worker, since professional help is relatively often engaged for adopted children and their families (Peters, Atkins, & McKernan-McKay, 1999).

The circumstances of deprived adopted children make the upbringing of an adopted child a challenge for the adopted parents, which demands much of their parenting skills. The same applies for the teachers and mental health workers of these children, who are also confronted with the specific psychosocial problems of (deprived) adopted children.

In this thesis, we will describe the children's problems, and attempt to take a step forward into gaining more insight into the way in which those directly involved cope with these specific psychosocial problems. The triptych of parents, teachers and mental health workers will be approached to relate their

experiences. We will focus on children adopted from Romania. These children have often experienced (severe) deprivation in the Romanian children's homes (Ames, 1990; Federici, 1998). Their complex background makes their upbringing extra challenging for parents, teachers and mental health workers. The central theme of this thesis will be how to deal with the psychosocial problems of (severely) deprived adopted children.

Adoption from Romania

Adoption from Romania started almost immediately after the fall of Ceauşescu in 1989. His regime left thousands of children in orphanages, under very poor conditions (Ames, 1990). When the media started to pay attention to the circumstances of these children in 1990 and 1991, thousands of couples in the USA, Canada, the UK, and the Netherlands expressed their wish to adopt a child from Romania. In 1990, a stream of adoptions of Romanian children started that wouldn't stop until 2002. Romania, pressured by the European Union, placed a moratorium, ending possibilities for international adoption of Romanian children (U.S. Department of State, 2004). This moratorium became a permanent law in early 2005 (Graham, 2006).

Despite this law, international adoption remains a subject of discussion in Romania. Reasons for this can for example be found in a recent letter by several Romanian orphans who were in the process of being adopted by foreigners, but whose adoptions were halted due to the moratorium. They claimed to have suffered severe neglect, deprivation and abuse because they stayed in Romanian orphanages (Graham, 2006).

Adoption as a natural experiment

When studying adoption and adopted children, two aspects are of importance. Firstly, how children, often from depriving backgrounds, develop in caring adoptive families. It is relevant for adoptive parents, but also for professionals caring for deprived children, to see the possibilities these children have to overcome the developmental delays they may have as a consequence of their deprived early childhood. Secondly, how adoptive parents and others involved are able to optimally stimulate the development of the child, optimizing their possibilities for recovery.

While it is by no means meant to be an experiment involving the child or the adoptive parents, to researchers these circumstances can be seen as an interesting natural experiment (Haugaard & Hazan, 2003; McGuinness & Dyer, 2006). A child is deprived in his early childhood in Romania, and is subsequently placed in a healthy and caring environment. This offers a unique possibility to study the influence of these experiences on the development of the deprived child. The "experiment" may also help to shed light on the traditional question of the importance of nature and nurture on the development of the child. A natural experiment, however, has its limits. Unlike a clinical experiment, the environmental circumstances of a natural experiment cannot

be completely controlled. This makes it harder to discern the specific roles of different environmental factors.

The effects of pre-adoption influences

Adopted children experience different influences in the period before they are adopted. These may affect them in different ways and through different processes:

Genetic
One of the limitations of adoption research is that there is often a lack of information about the genetic makeup of the biological parents. It is conceivable, however, that psychosocial problems occur more frequently among parents who are not able to care for their child (Peters et al., 1999). Therefore, certain congenital vulnerabilities may occur more frequently among adopted children. Conclusive evidence of the mediating role of genes in vulnerability to the effects of deprivation is, however, not (yet) available (Taylor & Rogers, 2005).

Prenatal
The influence of prenatal circumstances on the functioning of children is becoming clearer due to relatively recent developments in research. Nutritional deficiencies of the mother during pregnancy can lead to developmental delays in children (Taylor & Rogers, 2005). The same is true for substance abuse and excessive alcohol intake by the mother during pregnancy (Peters et al., 1999; Schoenbrodt, 1999). The psychological condition of mothers during pregnancy may also affect the functioning of the child at a later age. Stress and fear during pregnancy lead to a higher prevalence of behavioral problems in children (Gutteling, de Weerth, Willemsen-Swinkels, Huizing, Mulder et al., 2005). The biological mothers of adopted children most likely struggle during their pregnancy with their decision to give up the child, and sometimes even have to hide their pregnancy. It is conceivable that this stressful situation influences the unborn child as well.

Early life deprivation
A large group of the Romanian adopted children experienced deprivation during their stay in a Romanian children's home or hospital (Ames, 1990; Hoksbergen & co-workers of the Romania project, 2002; Rijk, Hoksbergen, ter Laak, van Dijkum, & Robbroeckx, 2006). Deprivation can occur on different levels, which occur separately and together. Gunnar, Bruce and Grotevant (2000) distinguish three levels of deprivation: (1) deprivation of the most basic level (food, hygiene, medical care); (2) lack of an environment capable of stimulating the development of the child, and (3) lack of stable interpersonal relationships. Each level of deprivation has a different effect on the development of the child. The first level affects the physical development. The

second level influences the general and the cognitive development of the child. The third level above all affects the emotional development, and the possibilities for the child to attach to caregivers, and to build up healthy relations later in life.

The exact mechanisms through which deprivation influences the development of children are not known, but appear to be a complex interplay of different factors. Several models have been proposed. Many of these models fall into the following two categories:

1. Neurological change

Models in this category assume that early life deprivation changes the neurological functioning of children. This change is permanent. The reversal of the effects of deprivation on the child is difficult.

The model that is called 'experience expectant learning' or 'sensitive periods model' by Rutter (2004) and O'Connor (2003) is an example. In order to develop properly, the brain needs to receive certain stimuli at the appropriate time, namely the stage in life when the brain is receptive to the stimuli. If these are not received, the brain is altered, and the functioning will change. This lack of stimuli is most likely caused by deprivation of the second (cognitive) and third (emotional) level.

Recent developments in technology have made it possible to study the neurological development of children in a non-evasive way (Eluvathingal, Chugani, Behen, Juhász, Muzik et al., 2006). This has lead to more insight in the effects of deprivation on multiple biological processes. Nutritional deficits can have an adverse effect on the development of the brain (Pollit, 1996; Wachs, 1995), which indicates that deprivation of the first level can also be related to neurological changes. Eluvathingal and colleagues (2006) found that early deprivation changed the functioning of the brain of children in Eastern European children's home. Wisser-Fries and colleagues (2005) discovered that early deprivation of a bond with a caregiver (deprivation of the third level) changes the level of certain neuropeptides, which hinders the child in displaying attachment-inducing behavior at a later time.

After processes of neurological change have taken place, the possibilities for recovery and treatment are limited for these children.

2. Behavioral adaptation

The child adapts his behavior to his depriving environment. This behavior is subsequently anchored in the behavioral patterns of the child. In a new, healthy environment, the behavior is no longer well-adjusted, and most probably will be experienced as problematic by parents and others directly involved in the care for the child. When the child has been in a healthy environment for a longer period of time, a positive change in behavior is possible. Rutter and O'Connor (2003, 2004) refer to this as 'Experience adaptive learning'. Behavioral adaptation can take place after all three levels of deprivation (Gunnar et al., 2000).

For deprived adopted children the term 'survivor behavior' is sometimes employed. The children show behavioral characteristics that reflect their

struggle for survival in children's homes. They show egocentric behavior, hoard food, and try anything to get attention (Federici, 1998). It takes time for them to realize and learn that this is no longer necessary in the adoptive family, and in the new social surroundings. They can change their behavior, and learn how to share and be less egocentric. The effects of behavioral adaptation are more likely to be reversible than the effects of neurological change (Rutter et al., 2004). This provides better opportunities for recovery and treatment of the children.

The models described above show that genetic, physical and psychosocial influences may lead to an elevated level of behavioral problems in adopted children. The possibility to investigate the influence of genes and neurobiological processes on psychosocial development is a relatively recent one. This amongst others has lead to more emphasis on and insight in the role of genes in the social sciences. In a recent publication, Roisman and Fraley (2006) argue that the role of genes in behavior is overestimated, and the influence of the environment is underestimated. The influences of "nature" and "nurture" are often seen as opposing, mutually exclusive sides. In his 'Genes and behavior', however, Michael Rutter (2006) argues that nature and nurture should not be seen as opposing sides, but as processes that occur simultaneously, and can influence each other: "…the great bulk of psychological traits and mental disorders is multifactorial in origin. With these, there is good evidence of both genetic and environmental influences." (Rutter, 2006, p. 221).

An example of this is a study by Caspi and colleagues (2002), in which they found that the genotype of maltreated children had an influence on the development of violent behavior in these children once they reached adulthood. Children with a certain genotype appeared to be more sensitive to negative influences from a maltreating environment. The combination of genotype and an abusing environment leads to a higher prevalence of violent behavior (Caspi et al., 2002).

It remains difficult, however, to determine the exact mechanisms and processes that take place in the development of adopted children, since precise information is needed about genetic characteristics, fetal development, early childhood experiences, and post-adoption experiences (Brodzinsky & Schechter, 1990). Lack of information about the early experiences of the children in Romania makes it impossible to properly answer questions about possible mechanisms in this thesis.

Raising deprived adopted children

For adoptive parents, information about how to deal with the problems is of greater importance than information about how the problems came into existence. In a recent publication, Van IJzendoorn and Juffer (2006) argue that adoption can be seen as a successful intervention for children without parental

care in a depriving environment. Adopted children functioned considerably better than children in children's homes. However, their functioning was not as good as that of their non-adopted peers. Adoptive parents may be faced with extra challenges, in their wish to optimize the development of their child. Because of this, some parents will need the advice of professionals. Adoptive parents are overrepresented in professional mental health care (Peters et al., 1999). In addition to a heightened parenting burden (Judge, 2003), a lower referral threshold may also be of influence (Peters et al., 1999). A warm, structured, predictable and safe environment seems to be of great importance for a positive development of these children (Federici, 1998; Hart & Luckock, 2006).

Since the children spend a large part of their day in school, teachers are also faced with the behavioral problems adopted children may show. For these teachers, knowledge about how to deal with these problems is of great importance. Early life institutionalization and deprivation are known to have an adverse effect on cognitive functioning (O'Connor, Rutter, Beckett, Keaveney, Kreppner et al., 2000) and on the psychosocial adjustment and functioning of adopted children (Andersen, 1992; Dubowitz & Sawyer, 1994; T. M. McGuinness, MCGuinness, & Dyer, 2000; Tizard & Hodges, 1978). Little is known, however, on how teachers deal with the problems in the classroom.

Although more and more is known about the prevalence and possible causes of psychosocial problems in (severely) deprived adopted children, there is still a dearth of information on how to deal with these problems.

Outline of this thesis

In this thesis, we will try to take a step towards answering the question of how to deal with the psychosocial problems of (severely) deprived Romanian adopted children. Before doing so, we will first asses the effects of early life deprivation: the prevalence of problems, their development over time, and the degree to which they are a burden to the adoptive parents. Then we will report the experiences of parents, teachers and mental health workers in dealing with these problems.

In the first chapter, the behavioral problems of adopted children will be discussed, with an emphasis on co-morbidity, and the characteristics of children in whom co-morbidity of severe behavioral problems occurs. Chapter two describes whether the behavioral problems of their child place a burden on the adoptive parents. Their parenting stress and satisfaction will be compared to the stress and satisfaction of non-adoptive parents. The behavioral development of the Romanian adopted children after a period of approximately five years in the adoptive family will be discussed in chapter three. Chapter four is the first of three chapters in which the people directly involved with the care for deprived adopted children describe how they deal with the effects of deprivation in daily life. In chapter four, parents describe their experiences: the problems that occur most frequently, the way in which they try to cope with them, and the way in which they try to form a bond with their child. Parents of

children with severe behavioral problems are compared to parents of children with little to no behavioral problems. In the next chapter we describe the experiences of teachers of children with severe behavioral problems. Problems that occur most frequently in the classroom are discussed, as is the way the teachers handle these problems, and how they describe their contact with the adoptive parents. The experiences of professional counselors in guiding these families are described in chapter six. In our last chapter we will discuss the main conclusions and give some recommendations for future research.

An overview of the method during the three waves of our study

This study took place in different waves. The methodology of these waves is described in the separate chapters. In order to offer more clarity, we give a short overview here of the entire study. Detailed descriptions of the instruments used can be found in the different chapters.

Initially, all Dutch parents who adopted a Romanian child between 1990 and the first half of 1997 were approached to take part in this study. Of the families of this group of 96 children, 86% decided to participate. Knowledge about the reasons for which 14% decided not to participate is lacking. During this first wave, the group consisted of 74 adoptive families with 83 Romanian children (36 girls and 47 boys). The average age of the children at adoption was 2 years and 9 months (2;9, range 0;1 – 6;7). At the time of study their average age was 6;8 years (3;5 – 14;6). During this stage, the parents were interviewed.

When the group was asked to participate in the second wave of the study, 72 families with 80 Romanian children decided to do so, a response rate of 83% of the original population. The non-response group represented both problematic and non-problematic children: For one family the problems they experienced in raising their Romanian adopted child were reason not to participate again. Constant contact with mental health care, and the instruments parents had to fill out for that reason, made them decide that participation in this study would be too much of an effort for them. Another family decided not to participate because they felt the results of the first wave were too negative and did not reflect their family situation.

At the time of the second wave, the group consisted of 36 girls and 44 boys who were on average 2;10 years old (range 0;1 – 6;7) when they were adopted. Their average age was 8 years (range 4;10 – 15;6). The parents were interviewed again. During the interview, both parents were present. Participation of mothers and fathers during the interview was fairly equally divided. Mothers tended to contribute slightly more, which was to be expected given the fact that in most cases mothers stayed at home to take care of the child(ren). In addition to the interview, the parents were asked to complete several standardized instruments. Some were completed by both parents separately, others were completed mainly by the mothers, with assistance of the fathers. The combined contribution of mothers and fathers possibly gave way to dynamic group processes. We cannot assess how these processes have

influenced the results. The questionnaires were completed during the interview, often during a break about halfway through the interview. The discussion of problems during the interview may increase the risk of inflated CBCL scores. We do not believe this was the case, given the high stability of the CBCL scores that can be seen in chapter 3. During the third wave, the parents were not interviewed before filling out the CBCL, and this did not lead to lower scores.

Since seven sets of parents adopted more than one child from Romania, they filled out the standardized questionnaires for more than one child. This endangered the independence of our data. In order to correct for this, we conducted the analyses of chapter 1, 2 and 3 for three different groups. First we analyzed the total group of 80 children. Next we randomly selected one child from each family, rendering a group of 72 children. And finally we reversed this selection, now including the group that had been randomly excluded before, again a group of 72 children. Analyses of these three separate groups did not lead to differences in the results. Therefore, given the limited size of the group, we decided to include all 80 children.

For the third wave of the study, our aim was to conduct a more in-depth qualitative analysis. For this we selected two groups from the original 80 children, a clinical and a non-clinical group:

Clinical group: The clinical group consisted of 18 children from 17 families. These children scored within the clinical range on Total Problems of the Child Behavior Checklist (CBCL, Achenbach & Edelbrock, 1983), and in the clinical or borderline range of at least one other instrument used to assess the presence of symptoms of trauma, ADHD or autism, indicating complex behavioral problems. The clinical group consisted of 11 boys and 7 girls. They were on average 2;11 years (2 years, 11 months) old when they arrived into the family, and were 10;8 years old at the time of the third wave of this study. For this group, the parents were interviewed, and, upon gaining permission of the parents, the teachers of the children and the mental health workers they consulted were approached. A group of 17 teachers was interviewed, of which 13 (76%) were from schools for special education. There was no non-response. One of the children did not receive education at the time of our study, because her behavioral problems made this impossible. The parents of the clinical group were able to name 12 mental health workers they felt had counseled them in an effective way. All these mental health workers decided to participate, and were interviewed.

Non-clinical group: The non-clinical group, consisting of 15 children, was selected based on the same instruments as the clinical group: these children did not show scores in the clinical or borderline range on any of the four instruments. Furthermore, at the second wave of this study they received regular education, and parents did not report more than two behavioral problems in the interview. The non-clinical group consisted of 9 boys and 6 girls. The children in the non-clinical group were on average 2;7 years old at the time of adoption. At time of study, they were 12;5 years old (interviews of

the non-clinical group took place about 5 months later than interviews of the clinical group). For this group, the parents were interviewed.
In addition to in-depth interviews with these two groups of families, we asked the parents of all 80 children to complete the CBCL again. The parents of 72 children participated. Reasons for non-response were mainly due to an inability to locate the participants because they had moved without leaving a forwarding address. The CBCL was completed mainly by the mothers.

This study describes the results of the population of Romanian children adopted to the Netherlands between 1990 and 1997. Statistical testing will be done bearing in mind the worldwide population of Romanian adopted children adopted in the period 1990 – 1997, since there are no reasons to assume that selection took place in the decision to place children with adoptive families in a certain country.

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1 Adoption of deprived children: Co-morbidity in Dutch children adopted from Romania

Abstract
Background: Children adopted from Romania have often experienced deprivation. Aims: Examining the influence of deprivation on development of children. Method: Parents of 80 children adopted from Romania to the Netherlands were interviewed. They filled out four standardized instruments to determine behavioral problems. Results: Forty-one children (51%) scored in the clinical range of at least one of the instruments. Co-morbidity was frequently found. Compared to the children without behavioral problems, the children showing co-morbidity were older, less healthy at time of arrival, more often receiving special education, and their parents consulted mental health professionals more often. Conclusions: A small group shows co-morbidity, possibly indicating neurological damage due to deprivation. A larger group shows mild behavioral problems, maybe as an adjustment to deprivation. Another group has little to no behavioral problems, showing resilience to deprivation.
Keywords: adoption, co-morbidity, Romania, early deprivation, behavioral problems

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Introduction

Adoption from Romania started in 1989 after the fall of dictator Ceausescu. Because of his policy, thousands of children were placed in very poor orphanages. Some children were later adopted. Through research, the consequences of neglect became visible, as many of the Romanian adoptees showed developmental delays and behavioral problems. Rutter and colleagues (2001) reported symptoms of autism, ADHD and trauma amongst others. They also found that children adopted before the age of six months were largely able to overcome the effects of early life deprivation, while for children adopted at a later age the effects appeared to be more pervasive (Rutter & the English and Romanian (ERA) Study Team, 1998).

Other research among Romanian children rendered comparable results (Ames, Fraser, & Burnaby, 1997; Groze & Ileana, 1996; Johnson, 1999; Judge, 2004). Romanian children appear to experience more behavioral problems than adoptive children from other countries. A meta-study done by Bimmel and colleagues shows that a substantial number of the children function well (Bimmel, Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2003). Romanian children appear to have experienced more deprivation, which can influence a child in different ways. Recent findings suggest that severe deprivation may cause neurological damage, hindering the child's development and his abilities to attach to caregivers (Eluvathingal, Chugani, Behen, Juhász, Muzik et al., 2006; Wisser Fries, Ziegler, Kurian, Jacoris, & Pollak, 2005). This would confirm the mechanism proposed by Rutter (2004) and O'Connor (2003), in which deprivation has a permanent effect on the child, leaving little room for improvement at a later stage.

The behavioral problems can also be seen as a coping mechanism of the children. They adapt their behavior to the deprived circumstances, and the behavior that ensues is not suited in their new, caring surroundings. Rutter (2004) and O'Connor (2003) refer to this as experience adaptive learning. This mechanism leaves more room for improvement of functioning after the child is placed in a loving and caring family.

In the current study, 80 Romanian adopted children in the Netherlands were compared to other international adoptees, and to groups of non-adopted children. We wanted to study whether the behavioral problems found by Rutter and colleagues (2001) would also be present in the Romanian adoptees in the Netherlands, and whether these problems would be clustered in a small group of children showing co-morbidity, or more equally divided among the children. Lastly, we wanted to explore whether certain factors such as age and health at arrival in the adoptive family, both possible indicators of deprivation, were related to the degree of behavioral problems experienced by the child. Therefore the following research questions were posed:

1. Is there a difference in behavioral and/or emotional problems among Romanian adoptees, other adoptees and non-adopted children?
2. To what extent do the children show symptoms of Post Traumatic Stress Response (PTSR), Autism, or Attention Deficit Hyperactivity Disorder (ADHD), as found by Rutter and colleagues (2001)?
3. What are the nature and the extent of co-morbidity?
4. Are psychosocial factors and behavioral problems of the Romanian adoptees related?

Method

Participants

Dutch parents who adopted a Romanian child in the period between 1990 and 1997 were asked to participate in the first phase of the study. Seventy-four families with 83 children (of the total group of 96 children, response 86%) decided to participate. For the second phase of the study, 72 families with 80 children (36 girls and 44 boys, response 83%) decided to participate again. When the children were placed into the Dutch families they were on average 2;10 (2 years 10 months) years old (range 1 month – 6;7 years), and their adoptive mothers and fathers were on average 37 and 39 years old, respectively. At the time of the second phase of the study the children were 8;0 years old (range 4:10 – 15;6 years), and they had been in the adoptive family for 5;1 years on average. All children came from Romanian orphanages or hospitals.

Instruments

The parents were asked to complete the following five instruments:

1. A semi-structured questionnaire
   Questions about the family and the adoption, about the physical, cognitive, emotional and social development of the child, possible medical problems, and possible behavioral problems of the child.
2. Child Behavior Checklist (CBCL)
   The parents completed the Dutch translation of the CBCL (Verhulst, Van der Ende, & Koot, 1996). The CBCL consists of two parts: problem scales and competence scales. We used the problem scale part, consisting of a general problem scale, two broadband scales (internalizing and externalizing) and eight syndrome scales. We determined the internal consistency of all scales. All Cronbach's alpha's were >.70 (Hoksbergen, van Dijkum, & Stoutjesdijk, 2002).
3. Trauma questionnaire
   The items of the Trauma questionnaire, designed for this study, in combination with several CBCL items were used to determine symptoms of Post Traumatic Stress Response. The scale contained 35 items (Cronbach's alpha = .93). A score of 20 or higher is considered a

score in the clinical range (Hoksbergen, ter Laak, van Dijkum, Rijk, Rijk et al., 2003b).

4. Auti-R scale
   The Auti-R was used to determine symptoms of autism. Two versions were used, depending on the age of the child. A total score was computed. Scores were divided into three categories: "no autism", "autistic symptoms" (borderline range) and "autism" (clinical range) (Van Berckelaer-Onnes & Hoekman, 1991). For both versions Cronbach's alpha was >.90 (Hoksbergen, ter Laak, Rijk, van Dijkum, & Stoutjesdijk, 2005).
5. ADHD questionnaire (AVL)
   The ADHD questionnaire contained 18 items. A total ADHD score and scores on three subscales (attention problems, hyperactivity and impulse control) were computed (Scholte & Van der Ploeg, 1998). A score between the 80th and 90th percentile is considered a borderline score, a score above the 90th percentile is considered clinical. Cronbach's alpha's for the total score and the three subscales were >.90 (Hoksbergen, ter Laak, van Dijkum, Rijk, & Stoutjesdijk, 2003a).

Procedure

Two experienced researchers interviewed all parents at home. The parents were also asked to fill in several standardized instruments. The total time needed to complete the interview and the standardized questionnaires was approximately three hours.

Analyses

The scores on all instruments were computed, and compared with norm groups, using t-tests with Bonferroni correction for multiple comparisons. On the CBCL, the Romanian group was compared to:

- a Dutch norm group of comparable non-adopted children, to see whether the children differed from non-adopted Dutch children;
- a group of 159 Asian adopted children, all adopted before the age of 6 months and on average 7 years old at the time of study (Stams, Juffer, Rispens, & Hoksbergen, 1998), ("group < 6 months"), this enabled us to compare the Romanian children to children who were adopted at an earlier age, and had likely experienced less deprivation;
- a group of 2148 adopted children, on average 29 months old at the time of their adoption, and 10 – 15 years old at the time of study (Verhulst & Versluis-Den Bieman, 1989), ("group 2½ years"), to see whether the Romanian children differed from a group of adoptive children from different countries.

The percentages of children that scored in the clinical range were also compared to the Dutch norm group.

Symptoms of autism, trauma and ADHD are discussed in separate manuscripts, we will describe the results of these questionnaires only briefly.

Based on the scores on the instruments used, three groups were formed: a co-morbidity group, a clinical group and a non-clinical group. This enabled us to compare children showing co-morbidity to children with milder problems and children without behavioral problems. The clinical groups of the separate instruments were compared to the corresponding non-clinical group, and amongst each other using t-tests, ANOVA and Chi^2.

Results

A Behavioral and emotional problems of Romanian adopted children

Forty-one (51%) of the Romanian adoptees scored within the clinical or borderline range of the CBCL or one of the other three instruments. Table 1 shows the comparison of the scores of the Romanian group, the norm group and the group <6 months (Stams et al., 1998) on the CBCL.

Table 1 Average CBCL scores of Romanian adoptees, a norm group of non-adopted children, and a group adopted before the age of 6 months (Stams et al., 1998).

CBCL syndromes		Boys				Girls			
		Romanian adopt. (n=44)		Norm gr. (n=579) a	<6 months (n=73) b	Romanian adopt. (n=36)		Norm gr. (n=593) a	<6 months (n=86) b
Attention Problems		7.34	a***b**	3.21	4.91	6.67	a***b**	2.45	4.30
Aggressive Behavior	E	12.02	a**	6.97	10.44	9.89	a***b*	5.13	7.17
Fearful/Depressed	I	3.30		2.23	4.30	2.92		2.47	3.02
Delinquent Behavior	E	2.02		1.28	1.99	1.61	a*	0.91	1.41
Social Problems		3.48	a***b*	1.31	2.34	3.11	a***b*	1.17	2.06
Physical Complaints	I	1.00		0.74	1.35	0.56		1.00 **	1.39 ***
Cognitive Problems		1.91	a***b**	0.39	0.74	1.69	a**b*	0.46	0.64
Withdrawn	I	1.91		1.61	2.60	2.11		1.79	1.97
Internalizing	(I)	6.07		4.52	8.08*	5.44		5.16	6.25
Externalizing	(E)	13.98	a***	8.26	12.10	11.42	a**	6.04	8.57
Total Problems		37.89	a***	21.27	33.02	32.42	a**	19.18	26.80

One sample t-test: *p<.05, **p<.01, ***p<.001 (two-tailed)

Explanation: a: Romanian group versus norm group; b: Romanian group versus group < 6 months. The * in the column of the norm group and group < 6 months signifies that these groups score significantly higher than the Romanian group.

CBCL = Child Behavior Checklist.

Despite the fact that boys show higher average scores on all scales, differences between boys and girls on the CBCL were not significant (F (11, 68) = .49, p = .89, Wilks' Lambda = .93). In the group <6 months boys scored higher than girls on all syndromes, except on Physical Complaints (Stams et al., 1998).

On Total Problems and Externalizing, the Romanian group scored significantly higher than the norm group. On Internalizing, the boys of the group < 6 months scored significantly higher than the boys in the Romanian group and the norm group. The Romanian group scored significantly higher than the norm group and the group < 6 months on the following syndrome scales: Attention Problems, Aggressive Behavior, Social Problems and Cognitive Problems.

The Romanian adoptees scored more often in the clinical range for Total Problems than the group 2½ years (36% vs. 16%, Chi^2 25.53, df 1, p<.001). The scores of Romanian adoptees and the group < 6 months did not differ (36% vs. 31%, Chi^2 1.03, df 1, p=.31). The group 2½ years scored less often in the clinical range than the group < 6 months (16% vs. 31%, Chi^2 27.46, df 1, p<.001), but scored higher than the cut-off score of the Dutch norm group, 10% (16% vs. 10%, Chi^2 77.24, df 1, p<.001).

B Behavioral problems reflecting symptoms of Post Traumatic Stress Response, autism or Attention Deficit Hyperactivity Disorder

Post Traumatic Stress Response: Sixteen of the 80 Romanian adoptees (20%, 9 boys and 7 girls) scored 20 or higher (average score 30.5) on the Trauma questionnaire, indicating that symptoms of trauma were present (Hoksbergen et al., 2003b). The other 64 children, "Others-64", scored lower with an average of 6.3 (t = –11.64, df 19, p<.001).

Autistic symptoms: Autistic symptoms were found in 13 children (16%, 8 boys, 5 girls). No difference between boys and girls was found. On all seven areas of the Auti-R, the autism group scored higher than a random selection of the Others-67 (Hoksbergen et al., 2005). The prevalence of Autistic Spectrum Disorders in general population is 0.6% (Fombonne, 2003).

ADHD behavior: Twelve children (15%), 11 boys and one girl (Chi^2 7.67, df 1, p< .001), scored in the clinical or borderline range of the AVL (Hoksbergen et al., 2003a). Of the ADHD group, 67% enrolled in special education, of the Others-68 25% (Chi^2 8.24, df 1, p<.001). Prevalence of ADHD in the general population is estimated at 2-5% (Van der Ploeg & Scholte, 1999).

Due to the high co-morbidity among the PTSR, autism and ADHD group (see Table 2), and small numbers, comparisons between the three groups could not be made on socio-demographic factors.

The parents were asked to judge the development of their child compared to his peers on six developmental areas. To compare the groups, the difference between development at time of arrival and at time of study was computed. Only children that did not show co-morbidity with one of the other

syndromes were included in the comparison. The numbers are small, therefore statistical testing could not be done. However, the following trends can be seen:

- the four children in the ADHD group improved least
- the three children in the autism group improved most on all developmental areas
- the improvement of the autism group was largest on physical development, development of motor skills and language development.
- compared to the autism group, the six children in the PTSR group showed little improvement in emotional development, development of motor skills and in social development.

C Co-morbidity (table 2)

All 16 children in the PTSR group scored in the clinical range of the CBCL. Of the Others-64, 13 children (20%) did. One child of the 16 PTSR children also showed ADHD behavior, three children showed autistic behavior, and six children showed all three syndromes. Ten of the 13 children in the autism group showed co-morbidity, they scored in the clinical range of the CBCL, nine also belonged to the PTSR group and seven scored in the clinical range of the ADHD questionnaire. Six children belonged to the PTSR and ADHD group. Ten of the 12 ADHD children showed co-morbidity, they all scored in the clinical range of the CBCL. Six children belonged to the autism and the PTSR group.

Table 2 Co-morbidity in 41 children with scores in the clinical or borderline range of the CBCL (n=36), autism (13), ADHD (12) and PTSR (16).

Nature problem behavior	Number of children in clinical or borderline range (%)	
CBCL (Total Problems)	17	(41%)
Autism	3	(7%)
ADHD	2	(5%)
PTSR and CBCL	6	(15%)
PTSR, Autism and CBCL	3	(7%)
PTSR, Autism, ADHD and CBCL	6	(15%)
PTSR, ADHD and CBCL	1	(2%)
ADHD and CBCL	2	(5%)
Autism, ADHD and CBCL	1	(2%)
Total	41	(100%)

CBCL = Child Behavior Checklist
ADHD = Attention Deficit Hyperactivity Disorder
PTSR = Post Traumatic Stress Response

In summary: 19 of the 36 children that scored in the clinical or borderline range of the CBCL showed co-morbidity with one of the three problem behaviors. Eleven children scored in the clinical or borderline range of 3 or 4 instruments. Three of the 13 children in the autism group and two of the 12 ADHD children showed no co-morbidity.

D Which psychosocial factors are related to co-morbidity? Comparison of the co-morbidity group, the clinical<3 group and the non-clinical group

Six children scored in the clinical range of all instruments, and five scored in the clinical range of three instruments (Table 2). We compared the group of 11 children that scored in the clinical range of three or four instruments (co-morbidity group), the group of 30 children that scored in the clinical range of one or two instruments (clinical<3 group), and the group of 39 children without a score in the clinical or borderline range (non-clinical group) on seven psychosocial variables (Table 3).

Table 3 Comparison of the co-morbidity, clinical<3 and non-clinical group on seven demographical and psychosocial characteristics.

Variables	Co-morbidity group (N=11)	Clinical<3 group (N=30)	Non-clinical group (N=39)
Age at arrival	3;3	2;11	2;9
Age at time of study	7;7	7;7	8;5
Health at time of arrival *	Good: 3	Good: 12	Good: 24
	Moderate/bad: 8	Moderate/bad: 18	Moderate/bad: 15
Gender	8 boys 3 girls	16 boys 14 girls	20 boys 19 girls
Special education	11 (100%)	8 (22%)	6 (15%)
Number of professional caretakers*	3.18	1.67	0.67
Number of psychosocial problems (according to the interview)*	11.55	6.67	2.33

* indicates a significant difference among the groups (Kruskal Wallis Test, $p<.001$ or Chi^2 test, $p<.05$)

The clinical<3 group scored between the co-morbidity group and the non-clinical group on all variables. Compared to the non-clinical group, the children in the co-morbidity group were six months older at time of arrival, and 10 months younger at time of study. These differences were not significant. The co-morbidity group was less healthy at the time of arrival into the adoption family (73% vs. 38%, Chi^2 4.06, df 1, $p = .04$) and numerically consisted of more boys (73% vs. 51%, Chi^2 1.60, df 1, $p = .21$). All children in the co-morbidity group were enrolled in special education, in the non-clinical group 15% of the

children was (Chi^2 27.38, df 1, p<.001). The three groups differed with regard to the number of professional caretakers consulted (3.18; 1.76; 0.67, ANOVA F=17.32, df 2, p<.001) and the number of psychosocial problems (11.55; 6.67; 2.33, ANOVA F=49.29, df 2, p<.001). The co-morbidity group experienced the highest number of problems, and needed the most counselors. The non-clinical group experienced the least problems, and needed the least counselors.

Health at time of arrival into the family was not related to age at time of arrival. For all six developmental areas, and on all three times, the children in the co-morbidity group were most behind on their peer group, and the children in the non-clinical group least. The difference between the groups increased over time. The groups differed significantly in their improvement on General Development; the non-clinical group improved most, the co-morbidity group least. The same trend can be seen for all other developmental areas (Table 4).

Table 4 Difference in score between time of arrival and time of study on six developmental areas for three groups: co-morbidity, clinical<3 and non-clinical.

	Co-morbidity group (N=11)	Clinical<3 group (N=30)	Non-clinical group (N=39)
General Development*	0.18	0.77	1.00
Physical Development	1.27	0.93	1.41
Development of Motor Skills	0.64	0.87	0.87
Language Development	0.27	0.93	0.92
Emotional Development	0.36	0.80	0.97
Social Development	0.18	0.50	0.50

Explanation: A larger number indicates more improvement

* indicates a significant difference among the groups (Kruskal Wallis test, p<.05)

Discussion

Half of the eighty Romanian children adopted in the Netherlands showed behavioral problems, comparable to results found in international studies (Ames et al., 1997; Groza, Ryan, & Cash, 2003; Judge, 2003; Rutter et al., 2001). The physical and psychological deprivation, and possible stressful or traumatizing incidents these children experienced in Romanian orphanages were probably an important causal factor for their current behavioral problems. Genetic differences can also be of influence (van der Valk, 1998). It is conceivable that abandoned children in Romania more often have parents with hereditary psychosocial disorders (Peters, Atkins, & McKernan-McKay, 1999). However, too little is known about the biological background of these children to confirm this.

Compared to two other groups of adoptees and a norm group of non-adopted children, the results of the Romanian adoptees on the CBCL are striking. Compared to the norm group, the Romanian adoptees scored much higher on Total Problems, Externalizing, Attention Problems, Social Problems, and Cognitive Problems. Compared to a group of children adopted before the age of six months from Asian countries, the Romanian group scored higher on Attention Problems, Social Problems and Cognitive Problems. It is likely that the problem behavior of the Romanian children is related to their experiences in a Romanian children's home at a young age.

The Romanian boys did not score different from the norm group on Internalizing, and they scored lower than the group of children adopted before the age of 6 months. The last group showed higher scores on Internalizing than the norm group. Apparently, the Romanian children display "survivor behavior" (Federici, 1998). In the Romanian orphanages children who are aggressive and externally oriented will get more attention, care and food than internally oriented children. In these circumstances the physically and mentally strong children with an externalizing attitude will survive (Henry, 1999). The physical strength of the children in our group is displayed by the relatively low scores of the Romanian children on the Physical Complaints scale of the CBCL.

A relatively large number of children (16%, equal number of boys and girls) had symptoms of autism, much higher than the prevalence of 0.6% found in the general population (Fombonne, 2003). We believe, in accordance with Federici (1998), that these children suffer from Post Institutionalized Autistic Syndrome (PIAS), rather than classical autism (see Hoksbergen et al., 2005 for an elaboration on this). In contrast to classical autism, the prevalence among boys is not higher than among girls, and a decrease of symptoms over time can be seen (Hoksbergen et al., 2005). PIAS is comparable to Rutter's "Quasi Autistic Patterns". Rutter and colleagues (1999) studied 111 Romanian adoptees in the United Kingdom, and found that 12% of these children showed behavioral problems that belong to the autistic spectrum. As in our study, they found no differences between boys and girls. It appears that deprived children may develop symptoms of autism as a consequence of certain environmental factors, and that these symptoms are somewhat less pervasive, since they can decrease over time (Hoksbergen et al., 2005).

Based on the results of the children on the different instruments, three groups were formed, which enabled us to compare children displaying co-morbidity, children with limited behavioral problems and children who did not score in the clinical range of any of the instruments. The 11 children (14%) in the co-morbidity group showed a trend to be older at arrival into the family, less healthy at time of arrival, and were more often enrolled in special education, and in need of professional help. Compared to peers, the co-morbidity group was most behind in their development, the non-clinical group least. The difference between the co-morbidity group and the non-clinical group increased over time. Research on post-institutionalized children shows that problems cluster within children (Gunnar, Bruce, & Grotevant, 2000). The

behavioral problems and developmental delays are concentrated in a small group of children. These children, in contrast to the others, show little to no recovery. Co-morbidity often occurs when behavioral problems appear at a young age (American Psychiatric Association, 1994; Garmezy & Masten, 1994).

An older age and lesser health at arrival into the family possibly indicate that these children have experienced deprivation for a longer period of time, and possibly on a more profound level. This heightens the chance of neurological damage. Research by Kusché and colleagues (Kusché, Cook, & Greenberg, 1993) revealed that children with co-morbidity display general and severe neurological anomalies, while singular behavioral problems are characterized by a different neurological process in a specific part of the brain. Since the exact nature and extend of deprivation cannot be determined, it is difficult to determine the exact processes through which the (neurological) development and functioning of the child are influenced. Deprivation can occur on different levels: physical (e.g. lack of food), mental (lack of education and developmental stimulation) and emotional (lack of warmth and care) (Gunnar et al., 2000). These levels may occur separately, but often happen simultaneously.

The pervasiveness of the behavioral problems in this relatively small group of children (11) and the indications of neurological deficits suggest that the possibilities for recovery are limited. However, the true possibilities will not be clear until the children reach adulthood.

The severity of the behavioral problems is also reflected in the heightened need for special educational services and professional counseling in these families. All 11 children are in schools for special education, and on average the families have consulted over three counselors.

When children are adopted at a later age, and have health problems at arrival, parents should be alert about the occurrence of behavioral problems (Beckett, Castle, Groothues, O'Connor, Rutter et al., 2003). Early intervention could strengthen the possibilities of these children for a healthy development. An extensive psychiatric examination within the first year after arrival would provide the parents with more information about possible problems, and would make it easier to find professional help. This examination should take into account the heterogeneity of the responses of neglected children, as shown in this study, and found by Rutter and colleagues (Rutter et al., 2001).

A group of 30 children scored in the clinical range of 1 or 2 instruments. For these children, the behavioral problems are less pervasive, and may reflect coping behaviors the children developed during the period of deprivation they experienced. They have adapted their behavior to a situation in which little care is provided, the “survivor behavior” mentioned before (Federici, 1998), and this is now experienced as problematic by the families. The chances of permanent neurological change are smaller, and possibilities for recovery after a longer time in a healthy environment seem more likely than for the children in the co-morbidity group. Still these children need more special educational services and counseling than the non-clinical group. For the families in this

group it is of great importance that they receive care at an early stage, since these children may show a large positive development. This should be stimulated as much as possible.

Professional counselors guiding these children and families should be aware of the effects deprivation may have on a child. According to the parents, the professional caretakers they consulted did not always meet up to the expectations. Factors contributing to this are on the one hand the involvement and efforts of the parents, and their, sometimes very extensive, knowledge about the complex problems of adoptive children, and on the other hand the lack of specific knowledge about adoption and the effects of deprivation among professional caretakers (Gunnar et al., 2000). Our study shows that there is a need for specialized care, starting the moment the child arrives into the family. This was, however, not provided, even though 14% of this group of adoptive children showed severe, multiple behavioral problems.

A limitation of this study is the risk of informant bias, since all instruments were completed by the parents. They appear to base their assessment partly on their contacts and communications with counselors, however. An assessment by the children's teachers and counselors would provide multiple perspectives on the behavioral problems of the child. It would be interesting to see whether the perspectives of parents, teachers and counselors differ greatly. In the third stage of this study this will be done for a limited number of children. Another limitation is the fact that only Romanian adoptive children were studied, limiting the possibilities for generalization of the findings.

We believe that the results of the second phase of our longitudinal study could lead to a better organization of the psychological guidance and after-care offered to adoptive parents. Adoption from Romania is no longer possible, but research shows that children adopted from other Eastern European countries experience similar problems (Judge, 2003). Adoption from these countries is still taking place. The experiences of the parents of Romanian adoptees can help organize a better after-care for all children that arrive into their adoptive family after a period of deprivation.

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2 Parents who adopt deprived children have a difficult task

Abstract
A study was conducted on 72 families with 80 children adopted from Romania. The average age at adoption was 2 years,10 months, and at time of study 8 years. Adoptive parents experienced more family stress than a comparable group of non-adoptive parents. Divided into a group that did not (N=29) and that did (N=51) seek professional help, both groups showed less family stress than comparable non-adoptive groups. However, the group of 51 experienced more family stress than the groups (adoptive and non-adoptive) that did not seek help. Adoptive parents are committed to their task, and resilient to their children's problem behavior. Parental stress and adoption satisfaction are higher when the child displays behavioral problems, but the age or the health of the child at arrival in the family were not related to parenting stress or adoption satisfaction.
Keywords: adoption, parental stress, burden of upbringing, Romania, research

Based on (with slight adaptations):
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Introduction

The routes to becoming the parent of an internationally adopted child are complicated (Ceballo, Lansford, Abbey, & Stewart, 2004). Changed family roles, issues pertaining to child adjustment, and demands of these children are a challenge to the adoptive parents. Few studies have focused on the transition to adoptive parenthood, and how it may differ from biological parenthood. The transition to adoptive parenthood is characterized as difficult (Brodzinsky & Huffman, 1988; Levy-Shiff, Goldschmidt, & Har-Even, 1991). Adjustment difficulties are more profound when the adopted child is foreign, and has lived in deprived circumstances in the first years of his life (Judge, 2003).

Mohanty and Newhill (2006) suggest that adoption issues should be studied from a risk-resilience perspective. We have adapted the family adjustment and adaptation response (FAAR) model of Patterson (2002) to reflect the risks and resiliency of the adoptive family of a neglected child. In the FAAR model, the functioning of the family is a balance between the demands on the one hand, and the capabilities on the other. In a well-functioning family, the capabilities of the family system are sufficient to deal with the demands (Patterson, 2002). In time of crisis, the scale will tilt, but an adjustment of the capabilities will restore the balance.

In this study we focus on family stress in adoptive families of children with a deprived early childhood. The specific demands and capabilities of these families are shown in figure 1, our adjustment of the FAAR model (Patterson, 2002). We focus on the child and parent characteristics, and how these influence adoptive parenting stress and satisfaction. In adoptive families of deprived children, we expect child characteristics to be one of the demands of the family as an excessive burden on the parenting, even when parent characteristics and capabilities make the family more resilient to this burden. To these families, balance is a key factor.

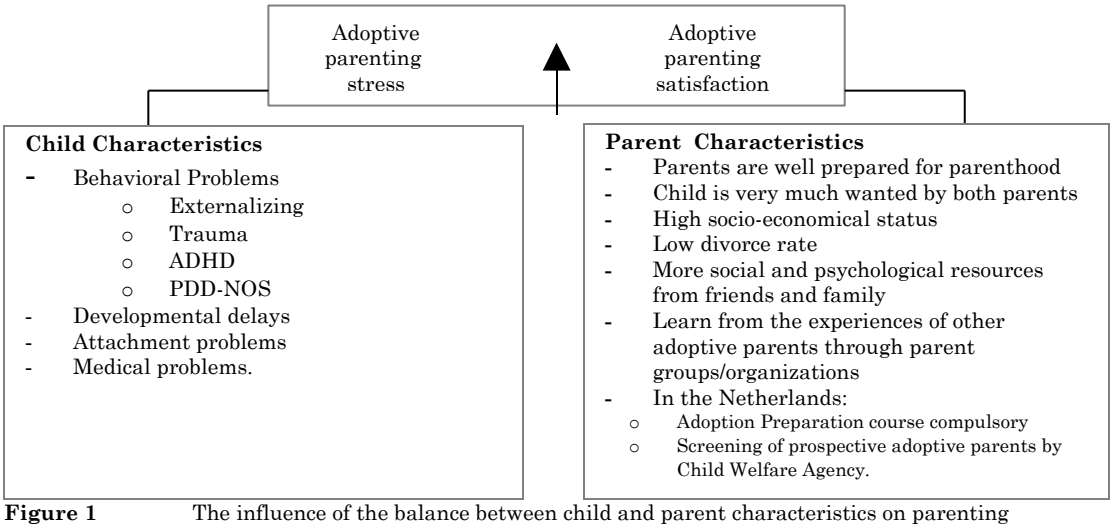

Figure 1 The influence of the balance between child and parent characteristics on parenting stress and satisfaction (adapted from Patterson, 2002), applied to the children adopted from depriving orphanages in Romania.

Below the child characteristics in figure 1 are discussed, and how they may lead to a higher parenting burden. Later the parent characteristics will be discussed in the paragraph "Parent characteristics".

Demands on families of foreign adopted children

Adoptive parents are confronted with vulnerabilities that foreign neglected and deprived adopted children bring to their families (Judge, 2003; Peters, Atkins, & McKernan-McKay, 1999). Altstein and Simon (1991) analyzed the experiences of parents raising a foreign adoptive child in the USA and six other countries. They concluded that adopting an older, neglected child from the Third World entailed risks.

Clinical experiences with adoptees prompted several professionals to name the behavioral problems they observed. Terms like "Adopted Child Syndrome" (ACS, Altstein & Simon, 1991; Kirschner, 1990), "Cumulative Adoption Trauma" (Lifton, 1994) and "Bottomless Child Syndrome" (Van Egmond, 1987) arose. The behavioral problems these syndromes encompass (like limited capacity to engage in affective relations, manipulative behavior, acting-out behavior, learning problems, aggressive behavior, and criminal tendencies) were recognized by adoptive parents and professionals. The behavioral problems resemble symptoms of Pervasive Developmental Disorder, Not Otherwise Specified, (PDD NOS), Attention Deficit /Hyperactive Disorder (ADHD), Behavioral Disorder, or Antisocial Behavior, all diagnoses in the DSM-IV (American Psychiatric Association, 1994).

Studies showed that older, foreign adopted children needed professional help more frequently than younger adoptees or non-adopted children (Hoksbergen & Bakker-Van Zeil, 1983; Miller, Fan, Grotevant, Christensen, Coyle et al., 2000; Warren, 1992). Although adoptive parents tend to seek help sooner, this does not fully account for the differences in need for professional care between adoptive and non-adoptive parents (Miller, Fan, Grotevant, & Van Dulmen, 2000).

Foreign Adoptions and Child Trauma

Children who have spent time in an orphanage run the risk of experiencing traumatizing events such as rape, assault, neglect, starvation of playmates, and abuse or even torture of other children (Carlini, 1997; Federici, 1998; Sorgedrager, 1988). If these children are subsequently adopted, they experience another life-altering change, leaving a familiar environment behind, to be transported to unknown surroundings. This may also be a traumatic experience, especially for older children. Thus, we consider the concept of trauma to be essential to a better understanding of the problem behavior seen in some adopted children (Groza, Ryan, & Cash, 2003; Scheeringa & Zeanah, 2001), and elaborated on trauma in Romanian adoptees in a former report about the subjects of this study (Hoksbergen, ter Laak, van Dijkum, Rijk, Rijk et al., 2003b).

Higher parenting burden due to child characteristics

Problems like ACS, cumulative adoption trauma, deprivation, and others, place a heavy burden on the adoptive parents, and can lead to family stress. The amount of stress a family experiences is determined by the burden of parenting, on the one hand, and the parents' resilience, on the other. Adopted children may place a heavier burden on the parents than biological children. For example, Mainemer, Gilman and Ames (1998) discovered that for parents of Romanian adoptees, parenting stress was significantly correlated with the adopted child's behavioral problems, even when controlling for the number of medical problems, developmental delays or the number of siblings. Groze (1996) identified various stressors, including significant behavioral difficulties, challenges from placing siblings together or separating them, attachment difficulties, and negative parent-child relations. Judge (2003) found that the behavioral problems of adoptive children from Eastern Europe were highly associated with parenting stress for both mothers and fathers.

Parent Characteristics

The characteristics of deprived foreign adoptive children may result in greater challenges for parents. It is surprising, however, to note that these adoptions often have a favorable outcome, as evidenced by a low adoption disruption rate, and a high parent satisfaction (Pinderhuges, 1998). Adoptive parents appear highly resilient to the stressors. The "Parent characteristics" block of Figure 1, reports reasons for this resilience: Adoptive parents have a strong desire for a child, and are often well prepared (Ceballo et al., 2004). Parents are very much involved because of the often long and complicated process that international adoption requires (Levy-Shiff, Zoran, & Shulman, 1997). Adoptive family have more social and psychological resources available from their family and friends than non-adoptive families (Cohen et al., 1993).

In the Netherlands, the capabilities of adoptive parents are further promoted by a compulsory preparation course for all adoptive parents, and careful screening of prospective parents by child welfare agencies. This matching process entails finding the best possible parents for a certain adoptee. Of course, such a screening has its limits, but international research shows that adoptive parents are often psychologically healthy during adoption, and in the years afterwards (Cohen et al., 1993; Levy-Shiff, Bar, & Har-Even, 1990). They also have more stable marriages, as is reflected in a lower divorce rate (Grotevant, McRoy, & Jenkins, 1988; Hoksbergen, Juffer, & Waardenburg, 1986; Levy-Shiff et al., 1990), and better marital adjustment and spousal communication (Levy-Shiff et al., 1997). Adoptive parents who engage in foreign adoption generally have a high level of education and are financially well off, (Fisher, 2003; Groza et al., 2003; Judge, 2003).

Foreign Adoption of Romanian children

This study focuses on Romanian foreign adoption. Some parents of the Romanian adoptees in the Netherlands approached the researchers. Their children showed behavioral and developmental problems, and they were curious to know whether more Romanian adoptees experienced the same.

A large group of Romanian adoptees was adopted to the USA and Canada. American families have adopted more than 35,000 children from Eastern Europe since 1991, mostly from Romania (U.S. Department of State, 2001). In the Netherlands, 190 children were adopted from Romania in the period from 1990 until 2001. In 2002 Romania closed its borders to international adoption as a temporary measure to prevent child trafficking. In 2004 this law became permanent, and foreign adoption of Romanian children is almost impossible now. The experience of parents with Romanian adoptees is of particular interest because the Romanian children had experienced neglect and deprivation, and were then transferred into a loving and caring environment. What would be the outcome of this big change in their lives?

Studies in the USA, Canada, and the UK showed, that many Romanian adoptees presented serious medical, developmental and psychological problems for their parents (Ames, 1990; Ames, Fraser, & Burnaby, 1997; Johnson, 1999; Johnson, Miller, Iverson, Thomas, Franchino et al., 1992; Marcovitch, Goldberg, Gold, Washington, Wasson et al., 1997; Rutter, 1996). Symptoms of attachment disorder, ADHD and PDD-NOS were found. These problems were attributed to neglect and maltreatment that occurred in Romanian orphanages (Rutter, Kreppner, & O'Connor, 2001).

A study of Romanian adopted children was conducted in the Netherlands from 1998 to 2004, and showed similar results as US data regarding the poor physical and psychological health of the Romanian adopted children. The medical and psychosocial condition of 80 Romanian adopted children was assessed. More than 50% showed health problems on their arrival into the adoptive family, 50% were physically underdeveloped, and 86% exhibited behavioral problems (Hoksbergen, van Dijkum, & Stoutjesdijk, 2002). Parents considered over one-third of the 80 Romanian adopted children to be in the clinical area of "Total Problems" of the Child Behavior Check list (CBCL) (Hoksbergen et al., 2002). Symptoms of Post-Traumatic Stress Disorder (PTSD) were observed in 16 children (Hoksbergen et al., 2003b), of autistic behavior in 13 children (Hoksbergen, ter Laak, Rijk, van Dijkum, & Stoutjesdijk, 2005), and of ADHD behavior in 12 children (Hoksbergen, ter Laak, van Dijkum, Rijk, & Stoutjesdijk, 2003a).

Purposes of this study

First, we examined to what degree the parents of Romanian adopted children perceived the raising of their children as a burden compared to non-adoptive parents, and needed help in the upbringing. Second, we compared the level of stress of the adoptive parents to the level of stress in the raising of comparable non-adoptive children. We divided the children into two groups, one that did, and one that did not receive professional help, and compared these two groups

to the corresponding non-adoptive groups. Thirdly, we assessed the adoption satisfaction of the parents, and whether this was related to the burden of upbringing. Fourthly, we investigated the relative impact of behavioral problems of the children on the experienced burden and satisfaction.

We expect that parents of Romanian adoptees experienced more stress in the raising of their children than a comparable group of non-adoptive parents, because behavioral problems that may result from the deprivation of these children in Romania, will place a burden on the family (Patterson, 2002). The balance between burden and resilience may be disturbed in these families. Secondly, we expect parents of children who receive professional care to experience more stress than parents who do not apply for such services. Thirdly, we expect perceived parental stress to be related to the adoptive parents' degree of satisfaction with the child's adoption. We expect that when parents felt a heavier burden of care, their satisfaction with the adoption would decrease. Finally, we expect that with the presence of behavioral problems, the burden of upbringing will increase, and satisfaction will decrease. In our model (see figure 1), the balance between the child and parent characteristics will be disturbed if the child shows severe behavioral problems.

Method

Participants and procedure

Between 1990 until April 1, 1997, 88 Dutch families adopted 96 children from Romania. In the first study (1999) 74 families of these families with 83 adopted Romanian children decided to participate (response rate 86%) (Hoksbergen et al., 2002). In our second study (2000), 72 of these pairs of parents, with 80 adopted Romanian children, 44 boys (55%) and 36 girls (45%), were extensively interviewed (response rate 83%). This report contains the results of the second study.

Addresses of all adoptive parents with a Romanian child in the Netherlands were obtained through personal contacts, and from adoption agencies. The parents were visited at their homes by a professional psychologist and a masters student. The interview and the completing of the questionnaires took about half a day. The parents' cooperation during the study was excellent.

The average age of the 80 Romanian children was 8 years (SD 2;3 range 4;10-15;6) and they had been living with their adoptive family for 5;1 years (SD 1;6 range 2;8-10;2). Their average age at arrival was 2;10 (SD 2;1 range 0;1-6;7). Before coming to the Netherlands, the children had lived most of their lives in orphanages in Romania. The care provided in these institutions was extremely poor. This was concluded from the health status at arrival of the children, and reports of the parents (Hoksbergen & co-workers of the Romania project, 1999). On arrival, the health of more than half was perceived as "moderate to poor" by the adoptive parents. The parents estimated that nearly

all the children from Romanian homes showed developmental delays on arrival (Hoksbergen & co-workers of the Romania project, 2002).

In order to test the hypotheses, we compared the Romanian group on the NVOS with two groups of non-adoptive parents: one group of parents requiring professional care for their children's problem behaviors (no details about the nature of these problems were asked), and a second group that did not require any professional help. These groups were assembled in an earlier study (Wels & Robbroeckx, 1996). The controls were matched for age, sex of the children and social-economic level.

The Romanian group was also compared on the Adoption Satisfaction Questionnaire to the American group of adoptive families, who adopted 53 children within the USA at age five or older (Pinderhuges, 1998).

The total group of 80 Romanian children was divided into two groups: 29 children that had not received any professional care at the time of study (non-clinical adoptive group, NCA), and a group of 51 children that did receive professional mental health care (clinical adoptive group, CA). The nature of the mental health care the families received was diverse. Sometimes the counseling was mainly for the parents, supporting them in the upbringing. In other cases the counseling was mainly for the children, but counseling with the entire family also occurred. Some care was aimed at the adoption-related problems such as attachment problems, whereas other care was aimed at behavioral problems in general, with little or no focus on adoption. Age at arrival and health at arrival did not differ significantly between the two groups (t-test), although the NCA group was 6 months younger at arrival.

Parents of the CA group reported more psychosocial problems: on average 6.84 vs. 2.48 ($t = -5.61$, $p<0.001$, Cohen's $d = 1.22$). None of the children in the NCA group received special education, whereas significantly more children (25 children, 50%) of the CA group did ($X2 = 20.68$, df 1, $p = .000$). The percentage of children receiving special education in the Netherlands is 5,2% (CBS, 2005).

The average age of the parents at time of adoption lies between 36 and 40. The socio-economic status (SES) of the parents is average to high. There were no differences in age of the parents and SES between the CA and NCA group. Two of the 72 parent couples were divorced at the time of the current study. One divorced parent-couple belonged to the CA group, and one to the NCA group. The normative divorce rate for Dutch couples with children is one in four to five (CBS, 2001).

Instruments

Parents completed a semi-structured questionnaire about the composition of the family, the development of the adopted child, and the parents' experiences with adoption. They were also asked to complete three other instruments. The burden of upbringing, and the adoption satisfaction were determined using the following two questionnaires:

1. The Nijmegen Child-Rearing Questionnaire (NVOS) to measure perceived parental stress and the upbringing situation of children up to 14

years old. The Dutch Test Committee (COTAN) judged the reliability of the NVOS as "good", referring to internal consistency reliabilities of >.90 and test-retest stability of >.70. Construct validity was judged as sufficient (Evers, Van Vliet-Mulder, & Groot, 2000). Burden of upbringing referred to the amount of effort parents have to invest in order to educate their children, and to control their behavior. Parental stress was defined as the relation between the adoptive family's perceived burden of upbringing and its capacity to cope (Wels & Robbroeckx, 1996).The NVOS consists of four parts. Part A determines the subjective parental stress and consists of 46 items (on the five-point Likert scale), which are divided into eight groups. Part B is one question that entails a global assessment of the child-rearing situation. Parents had to choose from eight descriptions, ranging from "no problems at all" to "very severe problems with upbringing, where one is desperate and needs help urgently" (Wels & Robbroeckx, 1996). Part C determines the attributions of management outcomes, and consists of 32 items (on the five-point Likert scale) divided into five groups. Part D is about the expectation of help and consists of 36 items (on the five-point Likert scale), divided into five groups. Higher scores indicate a more problematic situation, with the exception of the item "Parenting Satisfaction" (part D), where a higher score indicates a higher parental satisfaction. We computed the internal consistency for the different parts: all Cronbach's alphas were above 0.70, with the exception of "managing on one's own" for fathers (alpha = 0.53).

2. The Adoption Satisfaction Questionnaire (ASQ) was constructed by Pinderhuges (1998) and measures the adoption satisfaction of (American) adoptive parents. It contains 16 items containing statements such as: "we have much confidence in the future of our adopted child" and "I am happy with my adoptive son/daughter". The parents' opinions vary from "I strongly agree" to "I strongly disagree"(0-5). Mothers and fathers completed the ASQ separately. Internal consistency varied from 0.80 to 0.92. We translated the questionnaire into Dutch, reversing the translation to validate it. We found Cronbach's alpha's of 0.86 for mothers' and 0.92 for fathers' responses. This is the first report of this questionnaire being used on a non-American population.

Problem behaviors in the children were determined using the Child Behavior Checklist (CBCL): The adoptive parents completed the Dutch adaptation of the CBCL for children from 4-18 years (Verhulst, Van der Ende, & Koot, 1996). The "Total Problem" score consists of the sum of the scores for eight syndromes, parts of the syndromes are combined in two "wide-band dimensions": Internalizing and Externalizing. Scores in the clinical area point to a considerable level of problem behaviors (Verhulst et al., 1996). Scores are in the clinical area if they are above the 90th percentile for the wide-band dimensions, and above the 98th percentile for the clinical scales. The reliability and validity of the Dutch CBCL responses were good and satisfactory, respectively (Evers et al., 2000). The reliability of the 11 categories of the CBCL was also computed in our sample. Cronbach's alpha's were all 0.70 or higher, with the exception of "Somatic Complaints" (Cronbach's alpha = 0.32). This was due to the low

variance of this scale and non-normal distribution of the scores. Because of the low alpha, this scale was excluded from further analyses.

Data analysis
Because there were no average differences between boys and girls on the NVOS and the ASQ (NVOS Fathers F (19, 59) = 1.12, p = .37, Wilks Lambda = .63; NVOS Mothers F (19, 59) = 1.20, p = .31, Wilks Lambda = .62; ASQ Fathers t = .63, p = .53; ASQ Mothers t = .77, p = .45), analyses were conducted disregarding of sex. Moreover, there were no differences between the families with one (n=67), or more Romanian adopted children (n=5); consequently all 80 children were included. We analyzed the scores of the mothers and the fathers separately, because the mothers did most part of the upbringing. We conducted t-tests to compare two Romanian groups with the Dutch norm group. Because of multiple comparisons, the Bonferroni correction was used. We report Cohen's d, as an index of effect size (differences between averages divided by the (pooled) standard deviations). A value of >.50 was considered as a substantial effect size (Cohen, 1988). Correlations were computed to estimate the relationship between the perceived burden of upbringing and adoption satisfaction. Multiple hierarchical regression analyses were conducted to determine the contribution of the factors related to the burden of upbringing and to the adoption satisfaction.

Results

1. *The burden of upbringing: Parents of Romanian adoptees compared to non-adoptive parents*

We compared the burden of upbringing for both adoptive parents with a clinical control group of *non-adoptive* parents needing outpatient care (CC) and a non-clinical control group of representative *non-adoptive* parents who had not asked for any kind of psychosocial care (NCC) (table 1A & B). The average scores of the three groups on the different scales were compared using t-tests.

Mothers of the adopted Romanian children yielded average scores between the CC and NCC groups, except for "parenting satisfaction" (table 1). They had significantly higher scores (indicating a more negative rating) than the NCC group on five of the 19 items, seven other items showed a trend in the same direction. With respect to "share of partner", the Romanian mother scored significantly lower than the NCC group, indicating that the mothers in the Romanian group rated cooperation by the partner in upbringing more positively than the mothers in the NCC group. On two scales, including "child

Table 1A Comparison of average scores for adoptive fathers of the Romanian children: the non-clinical control (NCC) and the clinical control (CC) groups on the NVOS[1] scales

	FATHERS							
NVOS[1] scales	Romanian fathers (n=80)		CC[2] (n=39)		NCC[2] (n=166)		Effect size Romanian – CC[2]	Effect size Romanian – NCC[2]
	M	SD	M	SD	M	SD	Cohen's d	
A: Subjective parenting stress								
Acceptance	1.55	0.68	1.87*	0.75	1.34	0.42	0.45	-
Coping	1.77	0.54	2.16*	0.71	1.57	0.43	0.62	-
Experiencing problems	2.05	0.74	2.21	0.72	1.73*	0.47	-	0.52
Need for change	1.76	0.68	2.35*	0.83	1.58	0.48	0.78	-
Child as a burden	2.49	0.99	2.47	0.73	1.86*	0.55	-	0.79
Managing on one's own	2.06	0.60	2.40*	0.85	1.70*	0.56	0.46	0.62
Pleasure	1.57	0.59	2.13*	0.79	1.52	0.48	0.80	-
Relation	1.88	0.69	2.28*	0.82	1.69	0.53	0.52	-
B. Global assessment of the child rearing situation								
B score	2.74	1.38	4.07*	1.68	2.00*	0.71	0.87	0.67
C: Attributions of management outcomes								
Effort by self	2.02	0.60	2.31*	0.64	2.01	0.48	0.47	-
Ability	2.15	0.60	2.24	0.67	1.98	0.50	-	-
Share of partner	1.44	0.45	1.65*	0.51	1.45	0.45	0.44	-
Task difficulty	2.35	0.70	2.32	0.66	1.92*	0.54	-	0.69
Locus of control	1.98	0.65	2.22	0.62	2.02	0.63	-	-
D: Expectations of help								
Satisfaction	4.15	0.44	3.93*	0.52	4.13	0.42	0.46	-
Expectation of change	2.20	0.61	2.46*	0.70	1.96*	0.45	0.40	0.45
Expectation of help	2.19	0.90	2.69*	0.92	1.68*	0.50	0.55	0.70
Expectation of help: internal orientation	2.61	0.79	3.05*	0.86	2.16*	0.66	0.53	0.62
Expectation of help: external orientation	2.08	0.75	2.32	0.68	1.70*	0.57	-	0.57

[1]NVOS Nijmegen Child-Rearing Questionnaire

[2]NCC non-clinical control group; CC clinical control group

*marks a significant difference on the One sample t-test, after Bonferroni correction for multiple comparisons.

SD standard deviation

Table 1B Comparison of average scores for adoptive mothers of the Romanian children: the non-clinical control (NCC) and the clinical control (CC) groups on the NVOS[1] scales

	MOTHERS							
NVOS[1] scales	Romanian mothers (n=80)		CC[2] (n=39)		NCC[2] (n=166)		Effect size Romanian – CC[2]	Effect size Romanian – NCC[2]
	M	SD	M	SD	M	SD	Cohen's d	
A: Subjective parenting stress								
Acceptance	1.58	0.71	2.13*	0.87	1.40	0.49	0.69	-
Coping	1.91	0.62	2.50*	0.82	1.71	0.56	0.81	-
Experiencing problems	2.13	0.79	2.59*	0.84	1.94	0.60	0.56	-
Need for change	1.81	0.69	2.67*	0.86	1.71	0.60	1.10	-
Child as a burden	2.53	0.98	2.68	0.82	2.01*	0.70	-	0.61
Managing on one's own	2.18	0.74	2.55*	0.93	1.88	0.75	0.44	-
Pleasure	1.67	0.64	2.33*	0.90	1.57	0.53	0.85	-
Relation	1.97	0.79	2.46*	0.95	1.76	0.65	0.56	-
B. Global assessment of the child rearing situation								
B score	2.82	1.56	4.86*	1.68	2.38	0.94	1.26	-
C: Attributions of management outcomes								
Effort by self	2.01	0.62	2.37*	0.64	2.01	0.59	0.57	-
Ability	2.13	0.48	2.30	0.73	2.12	0.61	-	-
Share of partner	1.70	0.70	2.09*	0.78	1.99*	0.87	0.53	0.37
Task difficulty	2.40	0.75	2.64	0.88	1.92*	0.71	-	0.66
Locus of control	2.08	0.65	2.18	0.71	2.14	0.67	-	-
D: Expectations of help								
Satisfaction	3.95	0.57	3.63*	0.63	3.86	0.58	0.53	-
Expectation of change	2.34	0.70	2.70*	0.75	2.17	0.61	0.50	-
Expectation of help	2.25	0.81	3.05*	0.95	1.93*	0.67	0.90	0.43
Expectation of help: internal orientation	2.75	0.84	3.40*	1.00	2.32*	0.79	0.70	0.53
Expectation of help: external orientation	2.16	0.78	2.49	0.74	1.89*	0.61	-	0.39

[1]NVOS Nijmegen Child-Rearing Questionnaire

[2]NCC non-clinical control group; CC clinical control group

*marks a significant difference on the One sample t-test, after Bonferroni correction for multiple comparisons.

SD standard deviation

as a burden", the Romanian group scored approximately the same as the CC group. The CC group scored significantly higher on the other items and perceived the upbringing of their children as more problematic than the other two groups.

Fathers in the Romanian group (see table 1) scored significantly higher than the NCC group on 9 scales (mothers on 5), and showed the same trend on 5 other scales (mothers on 7). Like the mothers, the fathers' scores lay between the NCC and CC groups. Compared to the CC group, the adoptive fathers experienced less parental stress. For four items (mothers two), including "child as a burden", the score was approximately the same as that of the CC group.

The following significant differences between mothers and fathers were found (t-test, two tailed $p<0.05$ after Bonferroni correction): "Share of partner": mothers more often attributed problems in the upbringing to a lack of contribution by the fathers. "Parenting Satisfaction": mothers were less satisfied about the upbringing situation than fathers.

2. Burden of upbringing: Adoptive parents that do or do not receive professional care compared to non-adoptive parents

On the NVOS questionnaire, scores of both the mothers and the fathers in the Clinical Adoptive (CA) group in parts A, B, and D, and in three elements of the C scale, were significantly higher than the scores of the Non-clinical Adoptive (NCA) group, indicating a more negative ranking of the parenting situation. In table 2, we only report the mothers' results, because the scores for mothers and fathers did not differ significantly.

The NCA group was first compared with the NCC group (both groups had not received professional care). The NCA group did not differ significantly from the NCC group on any of the items. Secondly, the CA group was compared with the CC group. Parents of both groups had consulted professional caregivers because of problems with their child. The CA group scored significantly lower (indicating a more positive ranking) than the CC group on six items: acceptance, coping, need for change, pleasure, general assessment of the upbringing situation (B score) and expectation of help (t-test with Bonferroni correction for multiple comparisons, $p<0.05$). On the other items, the CA group showed no significant differences with the CC group.

Table 2 Average scores for mothers of the clinical adoptive (CA), clinical control (CC), non-clinical adoptive (NCA) and non-clinical control (NCC) groups on the NVOS[1] scales.

NVOS[1] scales	CA[2] (n=51)		CC[2] (n=47)		NCA[2] (n=29)		NCC[2] (n=166)		Effect size	
									CA – CC	NCA – NCC
	M	SD	M	SD	M	SD	M	SD	Cohen's d	
A: Subjective parenting stress										
Acceptance	1.74	0.75	2.13*	0.87	1.32	0.55	1.40	0.49	0.48	-
Coping	2.08	0.59	2.50*	0.82	1.58	0.55	1.71	0.56	0.59	-
Experiencing problems	2.37	0.77	2.59	0.84	1.71	0.65	1.94	0.60	-	-
Need for change	2.01	0.67	2.67*	0.86	1.46	0.59	1.71	0.60	0.86	-
Child as a burden	2.82	0.91	2.68	0.82	2.02	0.92	2.01	0.70	-	-
Managing on one's own	2.29	0.76	2.55	0.93	1.96	0.69	1.88	0.75	-	-
Pleasure	1.80	0.70	2.33*	0.90	1.44	0.45	1.57	0.53	0.66	-
Relation	2.14	0.82	2.46	0.95	1.68	0.66	1.76	0.65	-	-
B. Global assessment of the child rearing situation										
B score	3.31	1.50	4.86*	1.68	1.96	1.29	2.38	0.94	0.97	-
C: Attributions of management outcomes										
Effort by self	2.09	0.65	2.37	0.64	1.86	0.55	2.01	0.59	-	-
Ability	2.10	0.53	2.30	0.73	2.18	0.36	2.12	0.61	-	-
Share of partner	1.74	0.72	2.09	0.78	1.62	0.66	1.99	0.87	-	-
Task difficulty	2.65	0.72	2.64	0.88	1.96	0.60	1.92	0.71	-	-
Locus of control	2.08	0.69	2.18	0.71	2.08	0.58	2.14	0.67	-	-
D: Expectations of help										
Satisfaction	3.86	0.55	3.63	0.63	4.10	0.58	3.86	0.58	-	-
Expectation of change	2.50	0.68	2.70	0.75	2.06	0.67	2.17	0.61	-	-
Expectation of help	2.46	0.81	3.05*	0.95	1.87	0.67	1.93	0.67	0.67	-
Expectation of help: internal orientation	3.04	0.76	3.40	1.00	2.23	0.74	2.32	0.79	-	-
Expectation of help: external orientation	2.40	0.76	2.49	0.74	1.72	0.63	1.89	0.61	-	-

[1]NVOS Nijmegen Child-Rearing Questionnaire

[2]NCC non-clinical control group; CC clinical control group

*marks a significant difference on the One sample t-test, after Bonferroni correction for multiple comparisons.

SD standard deviation

3 Relationship between burden of upbringing and adoption satisfaction of parents

Adoption satisfaction did not differ between mothers and fathers. The CA and NCA group did differ on Adoption Satisfaction, the CA group scored significantly lower, indicating less adoption satisfaction (t-test, p <.001,see table 3). The Dutch parents were also compared to the American parents (Pinderhuges, 1998). Because the American study used a four-point scale instead of a five-point one, the average scores of the American parents were adapted to fit a five point scale (divided by four and then multiplied by five). The Dutch parents experienced significantly less (t-test, t = -3.2, df 79, p<.05) adoption satisfaction than the parents in the American sample, who's adoptive children were all adopted nationally after the age of five (Pinderhuges, 1998).

Table 3 Scores on the Adoption Satisfaction Questionnaire (ASQ) for mothers and fathers in the CA and NCA group, and for the USA sample (Pinderhughes, 1998)

Adoption Satisfaction	Total Romanian adoptees N = 80		Clinical Adoptive group (CA) N = 51		Non-clinical Adoptive group (NCA) N = 29		Group Pinderhuges (USA) N = 53	
	M	SD	M	SD	M	SD	M	SD
Mothers	3.84	0.72	3.62	0.73	4.23*	0.51	4.10+	0.46
Fathers	3.84	0.80	3.60	0.83	4.25*	0.55	4.13+	0.52

* indicates a significant difference between the CA and the NCA group (t-test, p<.001)

\+ indicates a significant difference between the Total Romanian group and the Pinderhuges group.

For both mothers and fathers, a higher level of family stress was associated with less adoption satisfaction. High satisfaction with the upbringing situation (NVOS scale D: Parenting Satisfaction) corresponded with high satisfaction with the adoption situation (Spearman's r: 0.61, p<.001, see table 4).

All scales of the NVOS were correlated to the adoption satisfaction, except for mothers' "Ability", i.e., the way they perceived their ability to raise their child. Fathers exhibited almost the same results, in addition to "Ability", "Share of partner" and "Effort of self" were not correlated to adoption satisfaction either.

4 Factors related to the burden of upbringing and the adoption satisfaction

Multiple hierarchical regression analysis (method Enter) was conducted to determine the relative contribution of the factors to adoption satisfaction, and to the general assessment of the upbringing situation. The following predictors were used: age at arrival, health at arrival, period in the Netherlands,

Table 4 Correlations between perceived adoption satisfaction and family stress, for mothers and fathers.

	Adoption Satisfaction	
NVOS[1] Scales	Mothers (n=80)	Fathers (n=79)
A: Subjective parenting stress	Spearman PM	Spearman PM
Acceptance	–0.70*	–0.75*
Coping	–0.66*	–0.65*
Experiencing problems	–0.71*	–0.73*
Need for change	–0.68*	–0.76*
Child as a burden	–0.70*	–0.78*
Managing on one's own	–0.50*	–0.34*
Pleasure	–0.61*	–0.55*
Relation	–0.54*	–0.66*
B. Global assessment of the child rearing situation		
B score	–0.71*	–0.60*
C: Attributions of management outcomes		
Effort of self	–0.51*	–0,41
Ability	–0.24	–0.25
Share of partner	–0.33*	–0.23
Task difficulty	–0.76*	–0.74*
Locus of control	–0.51*	–0.37*
D: Expectations of help		
Satisfaction	0.61*	0.60*
Expectation of change	–0.52*	–0.65*
Expectation of help	–0.54*	–0.62*
Expectation of help: internal orientation	–0.58*	–0.62*
Expectation of help: external orientation	–0.67*	–0.71*

*p<0.05

[1]NVOS Nijmegen Child-Rearing Questionnaire

An increasingly high score by parents (i.e. experience more problems) on items in dimensions A-D is related to a decreasing level of adoption satisfaction.

In dimension D, a positive correlation on "satisfaction" means, the higher the level of satisfaction with the upbringing situation, the higher the level of satisfaction with the adoption.

Correlations of ≥.50 are considered to represent a strong relationship (Cohen, 1988).

and Total Problems score (CBCL). Age and health at arrival were entered in the first step, the time spent in the Netherlands in the second step, and the Total Problems score (CBLC) in the third step. For both mothers and fathers, the only factor that contributed significantly to the variance in adoption satisfaction was the Total Problems score (Mothers: Adjusted R2 = 0.40, beta = -0.64; Fathers: Adjusted R2 = 0.45, beta = -0.69). As the Total Problems score increased, the parents' satisfaction decreased. The Total Problems score explained 40% of the variance in adoption satisfaction of the mothers, and 45% of the variance in adoption satisfaction of the fathers.

For the general assessment of the upbringing situation (NVOS B), the same applies. Only the Total Problems score contributed significantly to the variance in both mothers' and fathers' assessment of the upbringing (Mothers: Adjusted R2 = 0.54, beta = 0.77; Fathers: Adjusted R2 = 0.48, beta = 0.67). As the Total Problems score increased, both mothers and fathers perceived the upbringing more negative and problematic. For the mothers, 54% of the variance in assessment of the upbringing is explained by the Total Problems score, for father this is 48%.

Discussion

We investigated 72 parent couples and the 80 Romanian children they adopted. These adoptees had lived with their adoptive family for about five years. Prior to coming to the Netherlands, the children had lived most of their lives in orphanages in Romania. These orphanages have a reputation of providing poor care for the children. We used an adaptation of the FAAR model of Patterson (2002) to analyze the burden and resilience of adoptive parents of these neglected Romanian adoptees.

Adoptive mothers and fathers perceived higher parental stress, and experienced bringing up these children as a greater burden than non-adoptive parents do. This confirms our first hypothesis. In addition, the adoptive mothers reported more child-rearing problems; they needed more assistance, wanted it more strongly, and certainly expected to receive more assistance from the father and third parties than non-adoptive mothers did. The amount of stress experienced by the parents was not related to the age of the child at arrival, or the number of children in the family, contrary to the results found by Bird, Peterson and Miller (2002).

In these adoptive families, the mothers are mainly responsible for the day-to-day management of child-care and child-rearing (Hoksbergen et al., 2002), although the scores of how mothers and fathers perceived parental stress were similar. Compared with the NCC group, adoptive fathers scored slightly more towards "highly problematic" but they also assessed family stress as slightly less problematic than the adoptive mothers.

Compared with the CC group (non-adoptive parents who required professional help), the parents of Romanian adoptees experienced less family stress and assessed the child-rearing situation as less problematic. However, for "child as a burden" the adoptive parents' scores were similar to the CC group. We interpreted this as reflecting a situation in which all the adoptive parents felt that bringing up a Romanian child demanded a high degree of resilience. On the other hand, they also seemed to be able to cope more appropriately with problems.

To analyze this in more detail, we divided the group of adoptive parents into two sets: a group of 29 children that had not received professional help at the time of this study (non-clinical adoptive group, NCA), and a group of 51

children that had received professional help (clinical adoptive group, CA). These two groups differed substantially in terms of parents' perceived family stress. As is to be expected, parents in the CA group perceived their adopted children as a greater burden than those in the NCA group and the upbringing situation was also perceived as considerably more problematic. This confirmed our second hypothesis.

The division into two groups enabled us to compare the parents of these adoptive groups with non-adoptive parents. The CA group was compared to the CC (clinical control) group, since both groups had consulted professional help. The NCA group was compared to the NCC (non-clinical control) group, as both groups had not consulted professional help. The scores of adoptive parents in the NCA group did not differ significantly from those of the NCC group, but did show a trend towards a more positive perception (lower scores on almost all scales, and a higher satisfaction). This shows that despite the adverse early history of the children, these families function remarkably well. The scores of the CA group on six items were higher (indicating a more negative ranking) than those of the NCC group, but significantly more positive than the CC group. The results for "child as a burden" and "task difficulty" indicated that the problem behavior of children in the CA group did not differ from the CC group. These results agreed with those found by Judge (2003), who concluded that adopted children's individual behavioral problems were the single most powerful correlate of parental stress. However, the significantly lower scores on other items showed that parents in the CA group were more satisfied and experienced less stress in bringing up their children, thus indicating that they were more resilient. This was confirmed by the results in the non-clinical groups. Even though the children's problems were comparable, adoptive parents showed less stress and more satisfaction in the upbringing situation than non-adoptive parents. These results suggest that adopted children are highly wanted, and that adoptive parents are committed to, and capable of, making the best possible success of their child-rearing. In these families, there is a balance between the child characteristics and parent characteristics mentioned in Figure 1. The extra burden placed on the family by the adoption of a deprived child is balanced by the extra resilience of the adoptive parents.

A factor that possibly makes the adoptive parents more resilient is the unity of the parents in the care for their children. The adoptive parents of the Romanian children assessed "share of partner" more consistently and more positively than parents of non-adopted children, thereby indicating that adoptive parents were less likely to attribute family stress to their partner's (poor) contribution to raising their child than non-adoptive parents did. However, adoptive parents required more assistance, and parents in the CA group did indeed call in professional help more often.

Among adoptive mothers and fathers, higher parental stress resulted in lower adoption satisfaction, confirming our third hypothesis. This increases the chance of adoption failure (the child being placed elsewhere) (Pinderhuges, 1998). It is essential to identify those adoptive families in which the balance between resilience and perceived burden is disturbed at an early stage.

Regression analyses showed that both the variance in the assessment of the upbringing situation (NVOS B-scale) and adoption satisfaction were explained by the behavioral problems of the child, measured with the CBCL. Although causality cannot be determined, this supports our fourth hypothesis that behavioral problems of the child are related to the burden experienced by the parents, and to the adoption satisfaction. The chance of adopted children with a history of deprivation exhibiting behavioral problems is high (Hoksbergen et al., 2003b). The behavioral problems these children display, such as detachment and alienation from other people, limited expression of emotions, passive behavior, outbursts of anger, aggressive and criminal behavior, and other problem behavior, may cause serious difficulties for adoptive parents.

The extra burden that deprived adoptive children place on their parents due to the behavioral problems they show, appears to be counterbalanced by the parents extra resilience in most cases. The families appear stable, the divorce rate is low, only two of the 72 couples were divorced at the time of study. In the Netherlands, the average divorce rate is one in three in couples without children, one in four to five in couples that do have children (CBS, 2001). The parents' resilience could also be a consequence of the preparation of the adoptive parents before the adoption. All parents were screened by the Dutch Child Welfare Agency, and all parents followed the obligatory preparation course for adoptive parents. Parents express that they receive support from each other in the upbringing of their child. The child characteristics in our adaptation of the model of Patterson (2002, see figure 1) are in balance with the parent characteristics. However, in order to maintain this balance, parents do consult care in 64% of the cases. This care should be available immediately when the child arrives into the family, and it should be attuned to the special needs and capabilities of these families. Professional care for adoptive families should take into account the resilience, commitment and capability shown by these adoptive parents. Their ideas and observations on the problem behavior of their adopted child should be taken seriously if they ask for professional help. In understanding the psychosocial problems of adoptive families, the background of the adopted child seems to be of more importance than the background and abilities of the adoptive parents. In adoptive families, it is less likely that problems arise as a consequence of known genetic heritage (parents and children experiencing similar psychosocial problems), or because parents are not in a suitable situation (either physically or mentally) to bring up children.

We do, however, have some questions concerning the professional help available, since adoptive parents often need to call on such services. When children with a specific background are placed into an adoptive family, professional help should be available from the start. In many cases, this would help adoptive parents handle the problem behavior exhibited by their adopted child more effectively. Support programs that incorporate the experiences of parents who have adopted deprived and/or institutionalized children may be

effective. We also recommend that parents of deprived (adopted) children be given the opportunity to share mutual experiences.

Since we only studied parents of adopted Romanian children, our findings are necessarily limited to this group of children who were almost all neglected in their early years. We are not certain that these findings can be generalized to other foreign adoptive children (although neglect in children's homes occurs in several countries).

International adoption from Romania became virtually impossible when the new law came into effect, and the group of international Romanian adoptees will grow no more. This limits the future use of the results of this study. However adoptions from other Eastern European countries do still take place. These children generally show the same behavioral problems as the Romanian children (Judge, 2004). So the results found by us can also help in establishing better care for them. All adopted children that have spent their early years in deprived surroundings, may benefit from the experiences with the Romanian children. Parents of adopted Romanian children are not the only parents who have to deal with the consequences of neglect and abuse.

Another limitation of our study is that all the instruments we used were completed by the parents, and such data are subjective and may be susceptible to bias. The view of a professional on the child and the family would be a valuable contribution to future research. However, most parents were well informed by their contacts with professional care.

Our study shows that the adoption of a deprived child can be a burden on families. Adoptive parents try extremely hard to cope with problem behavior of their adoptive child and the resulting parental stress. Adopting a deprived and/or institutionalized child is a major challenge, but adoptive parents of Romanian children appear to be able to meet these challenges, and still feel a sense of satisfaction.

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3 Development of behavioral problems in children adopted from Romania to the Netherlands, after a period of deprivation

Abstract
A longitudinal study was conducted among 72 Romanian adoptive children (41 boys, 31 girls) in the Netherlands, who, according to the parents and medical records, had all experienced a period of some degree of deprivation before their adoption. The children were on average 2 years and 9 months old at adoption. Parents filled out the Child Behavioral Checklist at two times. On average there was little change in scores between the two measurements, and correlations were high. Some children displayed a marked improvement, others a worsening of problems. The change in CBCL scores was not related to age or health at arrival into the adoptive family. Children who received special education at the first measurement (31%) improved significantly more on Total Problems than children who did not. The same applies for professional help. The 46 children (64%) for whom professional help was engaged improved significantly more than the other 26 children. It appears to be effective to engage educational and psychological help for these (severely) deprived children at an early stage.
Keywords: adoption, Romania, behavioral problems, development, deprivation

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Introduction

Foreign adopted children have often resided in orphanages or hospitals in their country of origin. The circumstances in these institutions are far from optimal. In some countries only the most basic physical care is provided. Also, the children receive no further psychological attention. This period of neglect before adoption may negatively influence the cognitive and behavioral functioning of the child later in life (Hoksbergen & co-workers of the Romania project, 2002; Rutter & the English and Romanian (ERA) Study Team, 1998). Since children adopted from Romania are transferred from severely deprived circumstances to a caring and nurturing environment, they offer a unique opportunity to study the consequences of neglect and the development afterwards (Haugaard & Hazan, 2003; McGuinness & Dyer, 2006). In this study, we describe the development of behavioral problems in children adopted from Romania after a period of severe deprivation, and the factors that may influence their development.

Deprivation in Romanian orphanages

As a consequence of the policy of the Romanian dictator Ceauşescu (1965-1989), many Romanian children ended up in orphanages. Due to a general lack of funds, these state-run orphanages were often of very poor quality, leaving the children malnourished, and making them susceptible to diseases. Since few caretakers were available, very little attention was paid to the mental and emotional development of the children (Federici, 1998). After the fall of Ceauşescu, international media started to pay attention to the circumstances of the Romanian orphans, and many couples from the USA, Europe and Canada decided to adopt a Romanian child. In the Netherlands, 190 Romanian children were adopted from 1991 to 2000 (Hoksbergen, van Dijkum, & Stoutjesdijk, 2002).

Gunnar, Bruce and Grotevant (2000) describe three levels of deprivation:

First, deprivation of the most basic level (food, hygiene, medical care); second, lack of a stimulating environment for the development of the child, and third, lack of stable interpersonal relationships. These levels of deprivation may occur separately or in combination. In general, all three levels of deprivation can occur simultaneously, varying among and within institutions. Some children may be "favorites" of the caretakers, and receive more care (Ames, Fraser, & Burnaby, 1997), while others receive only the care necessary to keep them alive.

The European Parliament pressed Romania to close its borders to adoption in June 2001, which was done as a temporary measure to prevent child trafficking. However, the moratorium was extended to June 2004, when new legislation was finalized. This new law seems to have permanently ended international adoption from Romania. The goal of the Romanian government is to find a home for all institutionalized children with Romanian families, and to prevent child trafficking (Post, 2007). The promotion of domestic adoption and

fostering and the ban on international adoption are two of the conditions the European Parliament had set before Romania could join the EU in 2007. These conditions have not been completely met, since in 2003 an estimated 37,000 Romanian children still lived in orphanages, and from October 2001 to October 2003, only 3,513 institutionalized children had been adopted by Romanians (Joint Council in International Children's Service, 2004). Recent letters from Romanian orphans, whose adoption was halted by the moratorium, have reopened the discussion about the current Romanian adoption law. In this letter, addressed to the European Parliament, the children claimed they were abused in their Romanian orphanage, while families abroad were hoping to adopt them (Graham, 2006). As the children state: "…we are frustrated, punished, beaten and humiliated…we had the unluck [sic] to grow 12 years in the private orphanage…" (Graham, 2006). At the same time, there is evidence that child trafficking is continuing (Jones & Farhoud, 2007). Children without parental care remain a very vulnerable group in Romania.

Consequences of deprivation for Romanian adoptees

Rutter and colleagues (2001) longitudinally studied 165 children who were adopted from Romania to the United Kingdom before the age of 42 months. They found the following specific features in some of the children: attachment disturbances, inattention/over-activity, quasi-autistic patterns and cognitive impairments. These features occurred separately, and in combination. The chances of these specific features occurring increased with the age of the child at the time of adoption.

Fisher and colleagues (1997) studied 75 Romanian children who were adopted to Canada, using a variety of assessment tools, including the Child Behavior Checklist (CBCL). Twenty-nine of these children were adopted before the age of 4 months; the other children were adopted at an older age. The latter displayed more behavioral problems when compared to the younger adopted children, and when compared to a Canadian norm group. The parents reported the following problems as characteristic of children who were older at adoption: eating problems, medical problems and stereotyped behavioral problems.

Development of Romanian adoptees after adoption

Rutter and colleagues (2004) have studied a group of Romanian adoptees on multiple occasions, and they were able to assess the recovery of cognitive impairment, attachment difficulties, and quasi-autistic patterns shown by the children. They found a significant recovery of cognitive impairment after children had lived for a considerable time in the adoptive families. However, serious deficits persisted in some of the children. Institutionalized rearing seemed to permanently influence cognitive functioning only when there was a period of profound general deprivation.

For attachment, institutionalized rearing had a negative effect, even when there was no period of profound deprivation. Symptoms of autism in these children also decreased, which sets this form of autism apart from classic autism, where often no improvement is seen (Hoksbergen, ter Laak, Rijk, van

Dijkum, & Stoutjesdijk, 2005; Rutter, Anderson-Wood, Beckett, Berdenkamp, Castle et al., 1999). However, differences among the children were profound, which suggests that not all children are affected in the same way, and that the intensity of the effects also differs (Rutter et al., 2001). Comparison of Romanian children adopted before and after the age of 6 months showed that a complete recovery of the cognitive development is only seen in children adopted at a younger age (Rutter & the English and Romanian (ERA) Study Team, 1998). The recovery of the group older than 6 months at placement was limited, and the cognitive deficit remained. A follow up study (O'Connor, Rutter, Beckett, Keaveney, Kreppner et al., 2000) noted no further recovery or catch-up was noted. The authors concluded persistent deficits are probably a consequence of severe early deprivation in adopted children, and that psychological deprivation is of greater importance than nutritional deprivation.

Judge (2003, 2004) found comparable results in her study of Eastern European orphans. All children recovered to some extent, but the children who were older at adoption exhibited more developmental delays. Cognitive and language deficits recovered more rapidly and more fully than emotional, social and behavioral problems. She concluded that recovery is influenced by the developmental delay at the time of adoption, the age at adoption and the time spent in the adoptive family. Like Rutter (1998), Judge (2003) found that nutritional deprivation has little influence on the functioning of the child at a later age.

Mechanisms through which deprivation may affect functioning

A period of deprivation may affect the functioning of children in several ways (Cicchetti & Toth, 1995). Rutter and colleagues (2004) and O'Connor (2003) put forward three possible mechanisms, which in turn determine the possibilities for recovery. The "sensitive periods model" (experience expectant development), according to which the brain needs certain stimuli within the period it is sensitive to them to develop properly, leaves little room for recovery after severe deprivation. Stimuli missed cannot be made up later, when the child is in a healthier environment. The mechanism of "experience adaptive development" assumes that development takes place as an adjustment to the environment (O'Connor, 2003; Rutter et al., 2004). A deprived early childhood will leave a child maladjusted to a healthy family environment. The degree of recovery is determined mainly by the period spent in a healthy and caring environment after deprivation, and less by the experienced deprivation. The "cumulative effects" mechanism assumes that adverse early experiences have a lasting effect when they are reinforced by the experiences of the child at a later stage in his development.

However, early life deprivation will only have effect if this risk trajectory is followed. If the child is placed into a healthy environment in time, the effects of deprivation will be very limited according to this mechanism.

The way in which the period of neglect changes the child is an important determinant of the degree of recovery. Rutter and colleagues (2004) found that a large group of the Romanian children showed recovery, but that in some

children, major difficulties persisted. They suggest that in these children a form of biological developmental programming or neural damage took place. Because of large individual differences, the exact process still remains unclear.

Purpose and hypotheses

Results of international studies show that not all children respond the same to a period of deprivation (Johnson, 1999; Judge, 2003, 2004; Rutter et al., 2001). While some show (severe) problems, others appear to function normally. For a proper intervention with professional help, it is of importance to see how behavioral problems of these children develop over time.

In this, mainly exploratory, study, we used two measurements of the Child Behavior Checklist (CBCL, Achenbach & Rescorla, 2000) to quantify this development over time. Possible factors related to the development are studied, like the age and health of the child at arrival into the family, and also family-related factors like the presence of siblings. The following research questions are posed:

1. How did the behavioral problems of deprived Romanian adoptees develop after a period of approximately five years in a healthy environment?
2. Which factors influenced the development of behavioral problems over time?
3. Did the children show variety in the development of behavioral problems over time?

We expect that the behavioral problems of the children will lessen over time, although some problems will persist. Factors of which we expect an influence on the development of behavioral problems are gender of the child, age at adoption (time spent in Romania), health at arrival, time spent in the family, presence of siblings in the family, receiving special education and receiving professional care.

Method

Participants

This study is the third wave of a longitudinal study among Romanian adoptees in the Netherlands. In the first and second wave, all Romanian children, adopted between 1991 and early 1997, were asked to participate. The response in the first phase was 86%, and in the second phase 83%: a group of 80 children in 72 families. For the third phase, the families were again invited to participate, and 64 families with 72 children decided to do so. The children were still within the age range of the Child Behavior Checklist (only two children had aged out of it).

The background of the children was comparable: all stayed in Romanian orphanages and were subsequently adopted into a Dutch family. The group consisted of 41 boys (57%) and 31 girls (43%). Their average age at arrival into the family was 2 years and 9 months. At the time of the first measurement, their average age was 7 years and 11 months. At the second measurement, they were on average 13 years and one month old. The parents judged the health at arrival into the family: 37 children (51%) were in good health, whereas for 36 children (49%), the health was judged as moderate or bad.

Instruments

To monitor the development of behavioral problems over time, the Child Behavior Checklist was administered twice.

The Child Behavior Checklist (CBCL)

The Dutch translation of the CBCL (Verhulst, Van der Ende, & Koot, 1996) was completed by the parents to determine the presence of behavioral problems. The questionnaire consists of two parts, problem scales and competence scales. We only used the problem scales, which consist of 2 broadband syndromes (internalizing and externalizing) and 8 separate problem scales. The scores on these scales can be divided into non-clinical, borderline or clinical. The reliability and validity of the Dutch CBCL are judged as sufficient and good (Evers, Van Vliet-Mulder, & Groot, 2000).

Procedure

The CBCL was completed by the parents at both measurements. The time between the two measurements was approximately five years. Cooperation of the parents was excellent, the non-response during both research stages was low (17% and 10% respectively, see Participants).

Analyses

The CBCL scores of boys and girls did not differ on the first ($F(11, 60) = .63$, $p = .79$, Wilks' Lambda = .90) or second ($F(11, 60) = .51$, $p = .89$, Wilks' Lambda = .92) measurement. Therefore, we decided to analyze them together. Standardized t-scores on the CBCL were used instead of raw scores, since raw scores may have a different meaning as the children grow older (Verhulst et al., 1996). The development between the two times was analyzed using t-tests (data was checked for normal distribution) and correlations. To compensate for multiple comparisons, we applied the Bonferroni correction. To reduce the risk of type II errors, we chose to have a p-value below .10 to indicate a significant association. We analyzed ten factors which could possibly be related to a change in CBCL scores over time using t-tests and correlations.

Three groups were formed based on the differential score between the two measurements: a group showing a strong decrease in behavioral problems (N=9), a group showing little change (N=53), and a group showing a marked increase in behavioral problems (N=10). The first group showed a decrease in the score on Total Problems that was over one standard deviation of the

average, the third group showed an increase over one standard deviation. All other children were in the second group.

Results

At the first measurement, 22 (31%) children were in schools for special education. During the second measurement, five years later, 34 children (47%) were. Of the 38 children who were not in schools for special education at the second measurement, 21 (55%) had repeated a grade at some point in their educational career.

CBCL scores at two times

As can be seen in Table 1, the scores changed little between the first and the second measurement. There were no significant differences (paired t-test) between the two measurements. The scores of the second measurement did show a trend to be lower than at the first measurement, especially in the category Externalizing and the related subscales.

Table 1 CBCL scores at the first and second measurement for the total group of 72 Romanian adoptive children.

CBCL scales	Measurement 1	Measurement 2	Correlation
Total Problems	57.0	56.6	.71*
Internalizing	51.3	52.3	.52*
Externalizing	57.0	54.9	.69*
Withdrawn	55.3	55.9	.51*
Physical Complaints	53.9	54.9	.21
Anxious/depressed	55.6	55.9	.43*
Social Problems	60.7	59.3	.67*
Cognitive Problems	60.3	60.5	.71*
Attention Problems	63.8	62.5	.77*
Delinquent Behavior	56.5	57.4	.57*
Aggressive Behavior	60.2	58.3	.69*

* indicates a significant correlation between the two measurements (Pearson's correlation, $p<.05$)

CBCL = Child Behavior Checklist

Correlations between the two measurements were high, and significant for all scales except for Physical Complaints. The relation between the individual scores of the children on Total Problems at measurement one and two can be seen in figure 1.

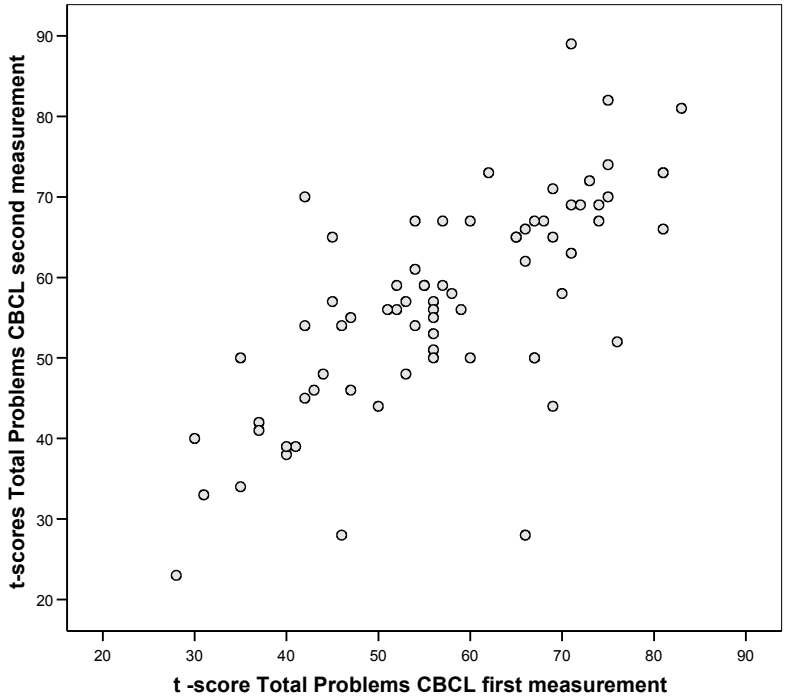

Figure 1 Scatter-plot of t-scores on CBCL – Total Problems at two measurements with a period of five years between them for the total group of 72 Romanian adoptive children.

At the first measurement, 27 children (38%) scored within the clinical range of Total Problems. At the second measurement, 25 children (35%) did. For Internalizing, 12 children (17%) scored in the clinical range at the first measurement, 11 (15%) did so at the second measurement. On Externalizing, the number of children in the clinical range decreased from 24 (33%) to 20 (28%). In the Dutch norm group of the CBCL, the percentage in the clinical range of these scales is 10. In the Romanian group, the percentage is significantly higher on Total Problems and Externalizing (Chi^2, $p<.001$).

Change in CBCL scores related to child characteristics

The difference on Total Problems between measurement one and two was used to analyze the possible role of different factors in the change in behavioral problems.

Analysis of age at adoption, age at time of study and time in the family did not render any significant correlations (–0.15, 0.08 and 0.18 respectively).

Boys (41) and girls (31) did not differ significantly in their development on the CBCL (t-test, t=0.21, df 70), the average difference between measurement one and two was .17 for the boys and .68 for the girls.

Children who were in moderate or bad health at arrival into the adoptive family tended to improve slightly on Total Problems, while children in good health at arrival showed a minor worsening of problems (average differences were –1.20 and 0.35 respectively). The difference between these groups was, however, not significant (t-test, t= 0.65, df 70).

The scores of the children with siblings (both biological and adoptive) did not differ significantly from the children without siblings (-0.80 vs. 0.83, t-test, t=0.58, df 70).

At the first measurement, 22 children were enrolled in special education. Compared with the other 50 children, this group improved significantly more on Total Problems of the CBCL (–3.95 vs. 1.18, t-test, t=2.00, df 70, p=0.05).

At the second measurement, 34 children were in special education. They did not differ significantly from the 38 other children with respect to the difference on Total Problems (-0.97 vs. 0.13, t-test, t=0.45, df 70).

The 46 children for whom professional help was sought, showed significantly more improvement on the CBCL than the 26 others (-3.00 vs. 4.23, t-test, t=3.03, df 70, p=.00).

Groups exhibiting large changes

Three groups were formed: a group with an increase in problematic behavior (further: Increase Problems Group, IP, n=10), a group showing little change (No Change Group, NC, n=53) and a group with a decrease in problematic behavior (Decrease Problems Group, DP, n=9). These groups were formed based on the difference between first and second measurement of Total Problems. The mean difference was 0.4 (SD 10). Children with a difference of more than one SD below the average were included in the DP group, children with a difference of more than one SD above the average formed the IP group. The CBCL scores for these separate groups can be found in table 2.

Table 2 CBCL scores on the three broad-band scales at two measurements for three groups: increase of problems (IP group), no change (NC group) and decrease of problems (DP group).

CBCL scale	Decrease problems N=9		No change N=53		Increase problems N=10	
	Meas. 1	Meas. 2	Meas. 1	Meas. 2	Meas. 1	Meas. 2
Total Problems	66.9	47.3	56.9	56.9	48.3	63.2
Internalizing	60.2	45.1	50.5	52.2	47.5	59.5
Externalizing	64.9	44.2	56.9	55.8	50.5	59.2

Children in the DP group all started with relatively high CBCL scores at the first measurement, while children in the IP group had low scores at the first measurement. This was reversed during the second measurement. In table 3, the factors possibly related to CBCL change are described for the three different groups.

Table 3 Age at adoption and at time of study, health at adoption, and enrolment in special education for three groups (IP, NC and DP).

	Decrease of problems N=9	No change N=53	Increase of problems N=10
Sex of the child	4 boys, 5 girls	31 boys, 22 girls	6 boys, 4 girls
Age at arrival into the family	3;2	2;8	2;8
Age at second measurement	12;10	12;11	14;3
Time in the family	9;7	10;3	11;7
Average year of adoption	1996	1995	1994
Health at arrival	5 moderate/bad 4 good	25 moderate/bad 28 good	5 moderate/bad 5 good
Special education at first measurement	4 regular education 5 special education	38 regular education 15 special education	8 regular education 2 special education
Special education at second measurement	5 regular education 4 special education	26 regular education 27 special education	7 regular education 3 special education
Use of professional help	9 professional help	33 professional help 20 no help	4 professional help 6 no help

Though differences were not significant, or could not be tested due to the small size of the groups, the following trends can be seen in table 3: Children in the DP group were older at the time of arrival into the adoptive family, and younger at the time of the second measurement. They had spent less time in the adoptive family. This seemed contradictory. Therefore we decided to analyze the date of arrival into the family, to see if there were any differences. The children in the DP group were adopted one year later than the NC group, and two years later than the IP group.

The three groups did not differ with respect to health at arrival or enrolment in special education. At the time of the first measurement, the families of children in the DP group had all consulted professional care, versus 62% in the NC group and 40 % in the IP group.

Discussion

Severe deprivation in early life can have a profound effect on children. Behavioral problems may be one of the consequences. When the deprived children are subsequently adopted into caring families, improvement is possible. In this study, our aim was to see how the behavioral problems of 72 Romanian adoptees developed over time after they were placed into Dutch adoptive families.

How did behavioral problems of deprived Romanian adoptees develop after a period of approximately five years in a healthy environment?
Two measurements with the Child Behavior Checklist (CBCL) showed no large differences for the group as a whole over a period of five years. Only externalizing problems tended towards improvement over time. An elevated presence of externalizing problems was found in an earlier wave of this study and in other international studies (Hoksbergen & co-workers of the Romania project, 2002; Judge, 2004; Rutter et al., 2001). It appears that children in severely depriving circumstances need externalizing behavior to survive. This behavior will get attention from the caretakers, and as a consequence, the children may get more food and care. It is to be expected that this behavior will decrease when children spend a longer period of time in a healthy environment, where food and care are amply provided (O'Connor, 2003).

The percentage of children in our study who scored within the clinical range of the scales on both measurements is higher than the norm group. Apparently, the consequences of deprivation are still visible, even after spending a considerable period of time in a caring adoptive family. The lack of knowledge about genetic make-up and missing detailed information about early childhood experiences of these children make it hard to discern the exact mechanism through which deprivation influences behavioral problems. The persistence of problems appears to indicate some form of lasting damage, which supports the sensitive period mechanism (O'Connor, 2003; Rutter et al., 2004). Recent developments in research suggest that neurological deficiencies in early childhood may be of importance in the development of deprived children, limiting their ability to attach to caregivers (Eluvathingal, Chugani, Behen, Juhász, Muzik et al., 2006; Wisser Fries, Ziegler, Kurian, Jacoris, & Pollak, 2005). While the behavioral problems were persistent in the group as a whole, we see great diversity in development among the children individually; the exact mechanism through which deprivation influences development remains unclear.

Which factors influenced the development of behavioral problems over time?
When analyzing the factors that may influence the development of behavioral problems over time, only placement in special education and the engagement of professional help promote a decrease in problems over time. The parents that have engaged these services perceive significantly less behavioral problems in their children after a period of five years. This appears to stress the importance of (early) intervention in families with severely deprived adoptive children. Future research could go into more detail with regards to the kind of care that is most helpful.

It is noticeable that health at arrival and age at arrival do not make any difference in the level of recovery in these children. Older children at arrival often experience more behavioral problems, and bad health at arrival may also be a predictor of later difficulties (Hoksbergen, Spaan, & Waardenburg, 1988; Rutter & the English and Romanian (ERA) Study Team, 1998).

Did the children show variety in the development of behavioral problems over time?

The differences between the measurements for children individually vary greatly. Some children show a large improvement, while for others the problems increase. The pattern seen in the group shows characteristics of regression-to-the-mean: the children scoring lowest improve most, and the children with the least problematic scores show an increase in problem scores. To see if this pattern randomly divided the group, or possibly reflected certain underlying differences between the groups of children, we analyzed three groups separately. Children were divided into three groups according to CBCL scores: decrease in problems, no change, or increase in problems. This shows again that the engagement of professional help promotes a positive development. The group that improved most had a highly problematic score at the first measurement. Over half (55%) of the children were in special education, and all nine families (100%) had consulted professional help. Results on the second measurement show that the interventions appeared to be effective for these children.

In contrast to the analysis of the group as a whole, these groups did differ on age at adoption and on age at study. The children who improved greatly were older at arrival and younger at time of study. They were adopted on average two years later than the group that showed a large increase in problems. This probably reflects a difference in the care these children received in Romania. Their health at arrival into the adoptive family did not differ, so physically, they appear to have received the same (deprived) treatment. However, the psychological and emotional deprivation may have been less in later years. Some sort of improvement seems to have taken place in these institutions. It would be interesting to see whether these differences are also found in Romanian adoptees in other countries.

The age of arrival into the family does not appear to influence the possibilities of a positive development. This is important knowledge for parents of older adoptees, and also for the teachers and counselors involved. Despite their possibly severe behavioral problems after adoption, they do have possibilities to improve greatly over time.

A limitation of this study is that it only uses the perception of the parents to determine development in behavioral problems of their adopted child. It would be of importance to compare this to the findings of professionals, and even use neurological screenings to determine possible developmental consequences of severe deprivation. Since differential scores were used, and the groups were small, reliability might be a problem in this analysis. The trends observed are worth further exploration in larger groups of (deprived) adoptive children.

To determine the complete development after adoption, a baseline measurement using the CBCL shortly after adoption would have been very useful. This would be advisable for future research, but also has practical benefits, since severe developmental delays could be detected at the earliest possible stage, and professional care could be provided right away.

Administering the CBCL shortly after adoption for all children could also shed more light on the differences and similarities in the development of children from different countries of origin. To really determine the long-term effects of early childhood deprivation, we need to follow these children into adulthood.

This study is focused on children adopted from Romania. The results may, however, also be useful for adoptive children from other countries. Although deprivation in Romania was generally severe, studies show that children from other Eastern European countries portray similar problems (Judge, 2004), and deprivation is known to happen in children's homes in other countries as well. Brown and colleagues (2006) argue that institutional care for children is still overused in Europe.

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4 Parenting of deprived children: Romanian adopted children in the Netherlands

Abstract
Deprived adopted children present parenting difficulties. In this study of deprived Romanian adoptees, parenting characteristics are analyzed and discussed. We studied possible influences of parental characteristics on child functioning. We compared families with (severely) problematic children (n=18), and non-problematic children (n=15), using interviews, and the Child Behavior Checklist. All deprived children, especially the problematic children, require a highly structured parenting approach combined with a warm, loving and accepting parenting attitude. Parents of the two groups differ little; parents in the problematic group are less able to use (verbal) communication and are more actively aware of the parenting techniques they apply.
Keywords: Adoption, parenting, deprivation, Romania

Submitted as:
Rijk, C. H. A. M., Hoksbergen, R. A. C., & ter Laak, J. (submitted). Parenting of deprived adopted children: Romanian adopted children in the Netherlands.

Introduction

Due to neglect in the country of origin, adopted children often show developmental delays and behavioral and attachment problems when they arrive into their adoptive family (Judge, 2003; Rutter, Kreppner, & O'Connor, 2001). The upbringing of these children demands strength and capability of the parents. In this study, we focus on the way parents of Romanian adoptees deal with the challenges they meet in raising these neglected children and on the effects of parenting on the adjustment of these children after their adoption.

Challenges faced by adoptive parents of Romanian adoptees

International studies and earlier phases of the current study have found that Romanian adoptees may display multiple developmental and behavioral problems as a consequence of neglect (Ames, Fraser, & Burnaby, 1997; Groza, Ryan, & Cash, 2003; Rijk, Hoksbergen, ter Laak, & van Dijkum, submitted; Rutter et al., 2001).

Adoptive children have often experienced several separations in their country of origin. They are usually not able to form a stable interpersonal relationship with their caretakers. This may result in difficulties and may eventually result in behavioral problems (Gray, 2002; O'Connor, Marvin, Rutter, Olrick & Britner, 2003; Rutter et al., 2001).

Rutter and colleagues (1999) report symptoms of Quasi Autistic Patterns in a group of Romanian adoptees. These children display autistic behavior that is somewhat different from classical autism; they show a marked improvement over time. There was no difference in the incidence between boys and girls. The head circumference of the Romanian adoptees was normal, as opposed to classical autism, where an increase in head circumference is often noted. Rutter et al. (1999) report an incidence of six percent for autistic symptoms in the Romanian adoptees they studied. We found similar results in a group of 80 Romanian adoptees (Hoksbergen, ter Laak, Rijk, van Dijkum, & Stoutjesdijk, 2005).

Other psychological problems, such as cognitive delays, ADHD-like behavior, and externalizing behavioral problems are also often reported by parents of Romanian adoptees (Ames et al., 1997; Benoit, Jocelyn, Moddeman, & Embree, 1996; Judge, 2003; Rutter et al., 2001).

When adopted children have spent some years in the family, most children show a positive development. A small group, however, does not improve, and continues to demonstrate behavioral problems (Ames et al., 1997; Groza et al., 2003; Rutter et al., 2001).

Parenting styles and relation with the child's functioning

Parenting style is related to the behavior and the development of children (O'Connor, 2002). Parenting and other relations in the environment shape the child's behavior, and the child in turn shapes the environment.

Children adopted after a period of neglect and deprivation form a separate group. These children appear less susceptible to the influence of parenting (O'Connor, 2002). Maltreated children negatively influence the parent-child relationship in the foster family (Milan & Pinderhuges, 2000). The negative experiences of children possibly limit the responsiveness to positive parenting. The developmental catch-up that adopted children from depriving backgrounds make, influences the parent-child relationship (Croft, 2001). According to Croft (2001), the effect is mainly child to parent, and not the other way around. Parenting behavior is an important aspect of forming a bond between adoptive parents and their child (Juffer, Bakermans-Kranenburg, & IJzendoorn, 2005). In their study, Juffer et al. (2005) applied two interventions to make parents more responsive to their children. Both improved the parent-child relationship significantly. For one intervention, mothers were provided with a personal book. In the other intervention, three sessions of Video Home Training were additionally provided (Juffer et al., 2005).

Deprived children seem less susceptible to the influences of parenting due to their early experiences of deprivation. Little research is conducted to find out which parenting style is best suited for children that have experienced a period of neglect. Studies of clinical settings and therapeutic programs suggest, however, that the following five aspects of parenting are beneficiary for the adoptees:

1. Structure and stability: The majority of studies stress this as most important when parenting a deprived child (De Lange, 2002; Federici, 1998; Hughes, 1997; Rosenfeld & Wasserman, 1990; Sanders, 1999). Deprived children develop best when their daily routine is predictable; this creates feelings of safety. Parents can offer this structure by creating a (visual) reminder of the daily activities, and by carefully preparing the children for changes in their routines (Federici, 1998; Rosenfeld & Wasserman, 1990). In addition, the children should be well aware of the rules of the family, and there should be no exceptions to these rules, as this creates a feeling of insecurity.
2. Making up for missed experiences: Children from depriving environments have often missed important experiences of care in their early childhood. Several treatments include compensating for this lack of warmth (De Lange, 2002; Federici, 1998; Hughes, 1997; Rosenfeld & Wasserman, 1990). By being allowed to go through the missed developmental stages, the children can learn developmental skills that are essential for a healthy development. An example of this is that older children sometimes need to be comforted and hugged more often than children of their age normally would (Federici, 1998).
3. Parent-child communication: Communication between parents and their adoptive child is of great importance (De Lange, 2002; Federici, 1998; Hughes, 1997; Rosenfeld & Wasserman, 1990), because it conveys information about the rules of the family, and

helps the child to gain insight in its own feelings and those of others. Adopted children are often transferred from a depriving environment to a caring family. Communication helps them to understand these new experiences. It remains important to (re)explain new situations, and the rules of the family. Especially conflicts must be explained. Another function of communication is to express empathy and emotions. This can help these children to make sense of their own emotions, and learn to accurately name them (Rosenfeld & Wasserman, 1990).

4. Physical proximity: Physical closeness with the parents is necessary to form parent-child attachment (De Lange, 2002; Federici, 1998). Frequent hugs are important. This may be difficult for the children, as they have not experienced much physical closeness in their early years. Often, these children do not feel comfortable being hugged. They first need to trust people, learn how to relax, and how to engage in physical closeness. Holding therapy might be a way to build up an attachment relationship (Welch, 1988).
5. Parent–child relationship central focus of attention: The child first has to be able to form an attachment relationship with the parents, before school comes into view. The child should spend the first months after adoption mainly with the parents (and siblings). The number of visitors should be limited, and even the contact with the extended family should be less frequent than normally. The children need to learn that their parents are the main caretakers. This enforces the attachment relationship, and may prevent or cure indiscriminate friendliness in the child (De Lange, 2002; Federici, 1998; Rosenfeld & Wasserman, 1990; Sanders, 1999).

These complex tasks for the adoptive parents can be supported by professional help, especially when the situation gets out of control (Federici, 1998; Sanders, 1999). Parents must keep paying attention to their own well-being and self-esteem, and not set their expectations of the functioning of the child and family too high. Prospective adoptive parents, and all others involved in adoption, can learn from the experiences of adoptive parents with deprived children.

Purpose of this study

In this study, we want to explore how the parents of Romanian adoptees, who have all experienced a period of deprivation, raised their children, and whether this had an effect on the functioning of the children. On the basis of the experiences of the parents, we will describe the problems they faced, and the parenting strategies that were effective in handling the problems and promoting a positive development of the child. Parents of children with behavioral problems will be compared to the parents of children with very few to none behavioral problems, to evaluate whether the parenting strategies of the two groups differ.

Method

Participants

This is the third wave of a longitudinal study among Romanian adoptees in the Netherlands (Rijk et al., submitted). In the first and second wave of this study, all Romanian children, adopted between 1991 and early 1997, were asked to participate. A group of 80 children from 72 families participated. In the first two waves, the parents were interviewed about the functioning and development of their children, and several standardized instruments were applied.

In the current, third wave, 33 children were selected to participate, based on their results in the earlier waves: a clinical group of 18 children and a non-clinical group of 15 children.

Clinical group

The clinical group consisted of 18 children from 17 families. These children scored within the clinical range on Total Problems of the Child Behavior Checklist (CBCL), and in the clinical or borderline range of at least one other instrument determining problem behavior (Trauma questionnaire, ADHD questionnaire and autism questionnaire, Rijk et al., submitted), indicating complex behavioral problems. The clinical group consists of 11 boys and 7 girls. They were on average 2;11 years (2 years, 11 months) old when they arrived into the family, and were 10;8 years old at time of study. Their health at arrival as judged by their parents: 6 children (33%) were in good health; of 12 children (67%), the health was judged as moderate or bad.

Non-clinical group

The non-clinical group (15 children) was selected on the basis of the same instruments; these children did not show scores in the clinical or borderline range of any of the instruments. Furthermore, at the second phase of our longitudinal study they received regular education, and parents did not report more than two behavioral problems. The non-clinical group consisted of 9 boys and 6 girls. The children in the non-clinical group were on average 2;7 years old when they were adopted. At the time of study, they were 12;5 years old (interviews of the non-clinical group took place about 5 months later than interviews of the clinical group). At arrival, as judged by the parents, 8 children (53%) were in good health, while the health of 7 children (47%) was judged as moderate or bad.

Instruments

1. Semi-structured interview

The parents were questioned using a semi-structured interview. The questions were open-ended, and discussion of the subject by the parents was promoted. The interview consisted of several subjects. First, general questions were asked about the situation of the child and the family at that moment, and whether important incidents had occurred in the period between the second and third

phase of the study. Then the current psychological, social and cognitive functioning of the child was discussed in detail. Subsequently, parents described how they dealt with adoption issues and behavioral problems, and to what degree their approach was effective. The school of the child was also discussed, as was the professional care that was consulted by some of the families. Here we will focus on the functioning of the child in the family, and on the parental approach.

2. Child Behavior Checklist (CBCL)

The Dutch translation of the CBCL (Verhulst, Van der Ende, & Koot, 1996) was completed by the parents to determine the presence of behavioral problems. The questionnaire consists of problem scales and competence scales. We only used the problem scales, which consist of two broad-band syndromes (Internalizing and Externalizing) and eight separate problem scales. The scores on these scales can be divided into non-clinical, borderline, and clinical. The reliability and validity of the Dutch CBCL are judged as sufficient and good (Evers, Van Vliet-Mulder, & Groot, 2000).

Procedure

All 32 sets of parents approached agreed to participate. A professional psychologist/behavioral scientist and a student visited them at home. Parents were interviewed, and they completed the CBCL. They had also completed the CBCL in the second phase of the study, on average three years earlier. The cooperation of the parents during the study was excellent.

Analysis

Qualitative analyses were conducted following the system of Strauss and Corbin (1990). All 33 interviews of one to two hours were recorded on tape, and subsequently transcribed. The transcriptions were divided into fragments, and the information that was not relevant for the subjects of the topic list was deleted. Two researchers then labeled the fragments of all interviews independently. All separate fragments received a label, which described what was said in the fragment. The labeling was subsequently compared within and across cases. The observers agreed in 97% of the cases. On average 38 labels were assigned per interview, and the average number of labels on which the observers disagreed was 1. The labels that were different were discussed so that an agreement could be reached. The codes were organized into different categories. Analysis and comparison of the different interviews led to a coding system that could be applied to all interviews. In table 1, an overview is given of the labeling system. Quotes from the interview will be added in italics in the results as clarification.

The results of the CBCL were compared to the norm group (non-adopted children) of this questionnaire, using t-tests with Bonferroni correction for multiple measurements.

Table 1 Schematic overview of the labeling system used to analyze the interviews

Category	Factor	Labels*
Functioning of the child	General functioning	- Better than before - Same as before - Worse than before
	Cognitive functioning	- Serious delay - Mild delay - Same as peers - Better than peers
	Psychosocial / behavioral problems	- Hyperactivity and concentration problems (ADHD symptoms) - Autistic symptoms - Aggressive behavior - Not listening/disobedience - Fears - Indiscriminate friendliness - Impaired development conscience - Others *
Parenting behavior	Limiting behavioral problems	- Structure+ - Communication+ - Time-out
	Stimulating positive behavior and self-confidence	- Rewards/privileges - Compliments - Attention - Communication: verbal acknowledgement
	Promoting the parent-child relationship	- Nothing special - Physical closeness - Attention: spending time with child - Activities together with child

* to limit the size of the table, only the labels that occurred more than once are mentioned
+ these labels were further divided into different types

Results

General functioning of the children
Parents were asked how their children were functioning in general at the moment of study, and whether this was an improvement or delay compared to the second phase of this study, three years earlier.

Clinical group

In the clinical group (n=18), five sets of parents reported that the functioning of their child worried them, and that it had not improved, or had even grown worse in the last three years. For five other children, the parents reported a clear improvement in functioning. The other eight children functioned generally the same as before.

On the Total Problems scale of the CBCL, all children scored within the clinical range in the previous phase of this study. In the current phase, 13 children scored within the clinical range, whereas the scores of five children were in the non-clinical range.

In table 2, an overview is given of the CBCL scores of the clinical and non-clinical group at the first measurement, and three years later.

Table 2 Comparison of the CBCL standardized scores of the clinical and non-clinical group at measurement 1 and 2.

	CLINICAL GROUP (n=18)		NON-CLINICAL GROUP (n=15)	
CBCL standardized scores	Measurement 1 (av. age 7;7)	Measurement 2 (av. age 10;8)	Measurement 1 (av. age 8;11)	Measurement 2 (av. age 12;5)
Total Problems	73 + *	67 +	43	38
Internalizing	64 +	60 +	41	39
Externalizing	71 + *	63 +	46	40
Withdrawn	64 +	60 +	50	50
Physical Complaints	57 +	58 +	52	51
Anxious/depressed	63 +	59 +	51	51
Social Problems	74 +	67 +	53	51
Cognitive Problems	75 +	69 +	52	52
Attention Problems	77 +	72 +	53	52
Delinquent Behavior	64 +	61 +	51	51
Aggressive Behavior	73 + *	64 +	52	50

+ indicates a significant difference between the clinical and non-clinical group at the mentioned time (t-test,
p <.10 after Bonferroni correction for multiple comparisons)

* indicates a significant difference between measurement 1 and 2 within the group (t-test, p < 0.10 after Bonferroni correction for multiple comparisons)

CBCL = Child Behavior Checklist

Non-clinical group

In the non-clinical group (n=15), all parents reported that their children functioned well at the moment of study. The parents' judgment of the functioning of their children was confirmed by the results of the children on the CBCL (Table 2). All 15 children scored in the non-clinical range of Total Problems (CBCL).

Cognitive functioning

The parents were asked how they judged the cognitive functioning of their children in comparison to peers. The school types of the children were also assessed.

Clinical group

In the clinical group, the parents of 11 children mentioned a serious cognitive delay of the child in comparison to his peers. For three children the parents mentioned a mild cognitive delay. Four children had no cognitive problems, and they were not in special education. Of the 14 other children, 13 children were in special education. One child did not receive any education at the moment of study, due to severe behavioral problems.

Non-clinical group

In the non-clinical group, two parents mentioned a slight cognitive delay. These two children were also transferred to special education in the period after the second phase of our study.

Behavioral problems

The parents were asked which behavioral problems they encountered.

Clinical group

In the clinical group, all 18 children showed signs of psychosocial and/or behavioral problems. In table 3, we list the problems that parents reported most often.

Table 3 Behavioral problems most mentioned by the parents of the clinical group (n=18)

	Number of children
Aggressive behavior	13
Autistic behavior	10
ADHD behavior	8
Disobedience	6
Fears	5

Thirteen parents mentioned aggressive behavior, both verbal and physical. The children threatened to hurt others or themselves, and destroyed the belongings of others or their own belongings. Some experienced sudden attacks of anger:

> *"and then he comes home angry and mad… (…) and he takes it out on us, and on anything in his path. Hitting, kicking, throwing things…"*

The parents of ten children were confronted with autistic behaviors, such as stereotypical behavior, fixations, problems in contacts with others and striking resistance against change:

> *"When she arrives at school and discovers she has a substitute teacher, that is a disaster."*

Eight parents mentioned ADHD-like behavior. The children had trouble concentrating, and were busy and restless. Parents also mentioned fears, such as fear of abandonment or fear of animals, disobedience, and communication difficulties.

For three children, parents reported indiscriminate friendliness. An impaired development of conscience was mentioned for two children.

Non-clinical group

In the non-clinical group (n=15), the parents of five children mentioned diverse psychosocial or behavioral problems: two children experienced fears, two children had a delay in their language development. One child displayed busy and restless behavior.

Parenting

To assess the characteristics of parenting, the parents were asked how they handled behavioral problems at the time of study and in the past, and how they had established a relationship with the child after adoption.

Clinical group

Three children no longer lived with the family, but were placed in an institution. The parents of two children were considering a placement in the future.

> *"We can see that it won't work out here. I mean, the situation in the family… I think we will not be able to keep dealing with it…"*

All families in the clinical group consulted professional help at some moment between arrival and the second wave of our study, five years later on average. In 12 cases, more than one source of professional help was consulted. At the current phase, 11 children still received a form of therapy. The parents of two children expressed that extra care was no longer needed since the school (special education) provided this.

In table 4, an overview is given of the ways in which parents dealt with the psychosocial and behavioral problems of the child.

Table 4 Methods used by parents of the clinical group (n=18) to deal with psychosocial and behavioral problems of the child

Problem	Parenting methods applied
Aggressive behavior	- time-out - ignoring - physical contact: hugging, holding, firmly gripping the child - talking to the child - bringing the child in a quiet environment
Autistic behavior	- making the child aware of his own behavior - telling the child to stop (stereotypical behavior)
ADHD behavior	- time-out - talking to the child
Disobedience	- structural approach: clear and consistent rules - talking to the child - time-out
Fears	- helping the child confronting his fears - reassuring the child (fear of abandonment)

The parents of the clinical group used the time-out as a method to deal with several problems. When children displayed anger attacks, the time-out was used to calm them. The child was placed in a quiet environment, with as little stimulation as possible. That seemed to have positive effects.

> *"No sounds, except the sounds he makes himself. Other than that… quiet."*

Parents used time-outs for the same reason when the child displayed ADHD-like behavior. For disobedient behavior, the time-out was used as a form of punishment, to allow the child to evaluate his own behavior.

Talking to the child as a means to make the child understand why certain behaviors cannot be allowed, was mentioned by 10 parent couples. However, this was not always successful; the children could be difficult to reach:

> *"He just did not get it, so I kept repeating what he could and couldn't do. What you would do with a two-year old. And just keep hoping that one day it will stick."*

Communication was also used to express feelings:

> *"…name emotions. Don't just look happy or sad, but mention it explicitly…"*

Fourteen sets of parents stressed the importance of a structured approach to deal with behavioral problems, with clear and consistent rules. This is also apparent when these parents were asked to describe their style of parenting in general. All 17 sets of parents mentioned structure, clarity, setting clear and consistent rules, and related concepts as being very important.

> *"We structure and plan everything for him. We tell him exactly what he should do. It doesn't work if he has to make a choice. It upsets him."*

One parent described how she sometimes found this difficult:

> *"We are really structured, really strict. Sometimes it feels almost uncomfortable. With the other children you can sometimes make an exception to the rules: "I've thought about it, and you know what, you can do it after all". But with her you really can't do that"*

Sometimes, parents needed to be persistent:

> *"It took hours before she gave in, and finally answered our simple question about school."*

Parents also described how they prepared children for changes in their routine, and for special events. They did this to prevent the stress experienced by the children if they were surprised by the event. They prepared the children by planning ahead:

> *"Yes, before his birthday, we make a calendar, and every evening we cross one day off …"*

Parents rewarded positive behavior. They granted the children certain rewards or privileges (8 parent couples) or complimented the child (6 parent couples). Complimenting was also used to promote the self-confidence of the children. To achieve this, parents gave the child much attention, and tried to convince the child of his own capabilities.

Parents were asked how they promoted the parent-child relationship after adoption. Ten parents named physical closeness as an important way of forming a bond. This was done in the form of hugs, playing games, holding, and massages. Seven parents stressed the importance of giving the child much attention. The parents spent much time alone with the child, and were always available to the child:

> *"During the first period after she arrived in the family, one of us was always at home."*

Another striking example of the time parents invested is that the father of one of the children, despite his busy work schedule, spent a period of time alone with his daughter every day. This time was spent doing games and talking, all activities aimed at the development of his daughter.

While closeness was often mentioned, parents also stated the need to respect the child, and to give the child his own place.

> *"You cannot expect a child that was alone almost 24 hours a day (in Romania) to suddenly enjoy having people around all day."*
>
> Non-clinical group

The parents in the non-clinical group had less behavioral problems to deal with. All children were still living in the family. At the second phase of the study, none of the families had consulted professional care. In the period between the second and third phase, professional help was consulted for four children.

The approach of the parents was comparable to that of the clinical group. To deal with the behavioral problems, the parents talked to the children. One child displayed restless behavior. This was either ignored, or the child was made aware of it.

When the parents were asked about their general parenting style, eight of the 15 parent couples mentioned structure, stability and clarity as important.

> *"Yes, we've done that from the start, so he knows what to expect… Set times for dinner and bedtime…"*

All parents mentioned the importance of communicating with the child.

> *"Conflicts are solved by talking about them."*

In contrast to the clinical group, all parents in the non-clinical group described talking as an effective way to deal with problems.

Giving compliments or rewards and privileges was applied to reward positive behavior. Complimenting was also used to promote self-confidence. Parents stimulated activities that the child was good at. They also talked to the child about it:

> *"…like when he is playing with friends. I tell him that he doesn't always need to do what the others want. He can make his own choices…"*

When these parents were asked what they did to promote the parent–child relationship, seven couples expressed that they did not do anything in particular, that it just happened:

> *"…it just happened, you shouldn't force it, it will happen inevitably."*

The other parents named physical closeness and spending much time with the child as important contributors to a good bond. Parents hugged and held their children, and used massages to form a physical bond with their child. And in the first few years after adoption, one parent was always available, and lots of activities were undertaken together.

Some parents expressed the importance of not forcing a relationship, allowing the child to get used to the new situation:

> *"… and gradually it got better, so I was able to quietly bath him and put him to bed."*

Differences between the clinical and the non-clinical group

The parenting approach of the parents in the two groups was mostly similar, and differed in only two respects.

Communication with the child

Parents in both groups used communication as a way to explain why certain behavior could not be allowed, and as a way to express emotions. In the non-clinical group, parents also used it to promote the self-confidence of the child, and to give the child insight into his own behavior and the behavior of the parents. This was less so in the clinical group. The parents in the clinical group

often did not feel that they were understood when they talked to their child, and felt they often had to repeat things.

Promoting the parent-child relationship

In the non-clinical group, seven of the 15 sets of parents stated they did not consciously promote the parent-child relationship. As several parents stated it:

"It just happened."

The parents in the clinical group were all able to specifically describe the efforts they undertook to stimulate the parent-child relationship.

Discussion

Adoption of a child who has lived in a depriving environment is a challenge. These children may have developmental and behavioral problems as a consequence of the period of neglect, and they may have difficulties in forming attachment relationships.

We studied two groups of Romanian adoptive children. All children experienced a period of neglect in Romania. One group experienced (multiple) psychosocial problems according to the results of an earlier measurement, while another group experienced much less problems. The interviews with the parents and repeated measurements with a three-year interval using CBCL confirmed this. Multiple measurements using the CBCL did, however, show a decrease in the behavioral problems, particularly in the clinical group. Parents of the children in the clinical group were nonetheless still confronted with aggressive, autistic and ADHD-like behavior. To cope with these problems, the parents applied many of the parenting strategies that were reported in the introduction:

1.Structure

Parents in both the clinical and non-clinical group named structure, or concepts related to structure, as an important factor in their parenting strategies. The families, especially in the clinical group, have incorporated structure in the daily routine of the family. This makes the situation predictable for the child, and this offers a sense of safety. A deviation from the set routine often upsets the children. Although almost all parents stressed the importance of structure and stability, the ways in which they have incorporated this in the daily routine differ. Some parents use visual reminders, while others rely more on verbal communication.

2.Making up for missed experiences

Most parents in our study do not mention this explicitly. However, hugs and physical closeness are described as ways to form a bond with the child, also for older children. For deprived children, this may be a way to make up for missed experiences. Possibly, parents may be less aware of this method, or they apply it without being aware of this.

3.Communication

Verbal communication was seen as important by 25 of the 33 sets of parents in our study. It is used to stimulate positive behavior and correct negative behavior of the child, and as a means of explanation and comfort. Some parents also mentioned non-verbal communication to modify the child's behavior, like making eye contact. The parents in the clinical group less often reported the use of communication as effective than parents in the non-clinical group (55% vs. 100%). The children in the clinical group appeared to be less receptive to communication.

4.Physical proximity

Parents of 18 children used hugging and other forms of physical closeness such as massages to form a bond with the child. They did not only do this in the period after adoption, they keep doing so to strengthen the bond between parents and child.

5.Parent–child relationship central focus of attention

Especially in the period just after adoption, most parents mentioned this as one of the means to form a bond with the child. Often, one of the parents (the mother) stays at home.

The parenting styles of the clinical and non-clinical group were very similar. The parenting styles of both groups show characteristics of the authoritative parenting style: parents give the child room to develop but at the same time set clear limits and communicate with the child about the reasons for these limits. Little or no characteristics of authoritarian, permissive or uninvolved parenting were mentioned (Baumrind, 1966). The authoritative parenting style has been found to be positively related to the socio-emotional adjustment of a child, and negatively related to maladapted behavior of the child (Baumrind, 1966; Kaufmann, Gesten, Lucia, Salcedo, Rendina-Gobioff et al., 2000).

There were some differences in the parenting styles of the two groups. One of the differences was the use of verbal communication, both as a means to express emotions and to give explanations for the actions of the parents in the raising of their children. The parents of the non-clinical group reported this approach more often than the parents of the clinical group (100% vs. 55%). However, 13 children in the clinical group had moderate to severe cognitive developmental delays, which limits the use of communication as a mean to modify behavior. The children were almost three years old at adoption, so the fact that they learned Dutch as a second language (Gindis, 2005) may also interfere with the understanding of verbal communication. The parents in the clinical group who did report improvement in their children often attributed this to the improvement in communication and interaction with the child over time.

A recent study (Wisser Fries, Ziegler, Kurian, Jacoris, & Pollak, 2005) found that early childhood neglect can alter the vasopressin and oxytocin neuropeptide level in the brain. These neuropeptides are of great importance for the forming of social bonds, and disturbances limit the child's ability to undertake attachment behavior and to interact with the environment in a way that promotes the development of a parent-child bond. A hindered parent-child

communication may be a consequence of this. If the results of Wisser Fries et al. can be replicated, this is an important development in the understanding of the problems of deprived children. This biological effect may explain the fact that in most studies (Ames et al., 1997; Rijk et al., submitted; Rutter, 1996) a small group of the neglected children will continue to show behavioral and attachment problems.

The possibility to communicate with your child is of great importance in the functioning of the parents and the family. In communication both the sender and the receiver are important for a good transmission. It would be interesting to analyze, from the moment of adoption on, how parent-child communication is established and maintained.

A second difference between the clinical and non-clinical group is the degree to which the parents were aware of the parenting skills they applied. The parents in the clinical group were able to more specifically describe the skills they had applied than the parents in the non-clinical group. Being more aware of your parenting style is probably a logical consequence of experiencing more problems; parents often tried different ways to deal with their problems. It may also be a consequence of the contact with professional caretakers that most parents had had. When help is sought, the family situation and parenting style are likely analyzed by the caretaker and by the family, so a higher awareness of parenting style is to be expected. Parenting becomes less intuitive for these parents.

The fact that behavioral problems of most children decreased between the second and third phase of this longitudinal study, shows that they are going through a positive development. Parents have formed a bond with the children, and are better able to communicate with them. The parenting skills applied by the parents appear to have a positive result.

However, a group of five children is clearly not developing in a positive way. Three children were placed outside their homes, because parents were no longer able to cope with the problem behavior of the children. Two other parent couples were considering this for the future. This emphasizes the severity of the behavioral problems of some children. The parenting style of the parents of these children did not differ from the parenting style of the other parents. It is conceivable that these children have suffered a form of biological damage as a consequence of their deprived early childhood (Wisser Fries et al., 2005).

Practical implications

All children had to overcome the disadvantages of a bad start in life. Some were better able to recover than others. Since parenting styles differed little, it is unlikely that parenting has a large influence on the differences in development of behavioral problems after neglect. However, almost all children developed positively after spending some time in the family, so parenting most probably has some positive influence on the child. But as O'Connor (2002) stated, severely neglected children seem to be less receptive than other children to the positive effects that parenting may have. This may be very taxing for parents, and stresses the importance of good after-care for adoptive families, which

should be available immediately after adoption. The parenting of a neglected child demands a lot of strength and capability of the parents, and they should be assisted in this. The experiences of the parents in the current study can help professionals to support adoptive parents more effectively.

Limitations

The relatively small number of participants, and the fact that parents themselves were our informants on parenting behavior, are limitations of this study. In the future, it would be interesting to use an observation of the family in its daily functioning to assess parenting behavior. This would give a more neutral view on the parenting skills applied. This was, however, beyond the scope of our study. Studying a larger group of adoptive children from different countries would heighten the possibilities to generalize the results. In this study of the effects of deprivation and the influence of the parenting style, however, we have chosen for a relatively small group of Romanian adoptees, most of whom experienced severe deprivation. This allowed for more in-depth analysis of the interviews within the set timeframe. Since adoption from Romania is no longer possible, the group of Romanian adoptees will grow no more. Neglect and deprivation are, however, not limited to Romanian adoptees, but are seen in adoptees from other countries as well. These children and their parents may benefit from the results of this study.

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5 Education after early-life deprivation: Teachers' experiences with Romanian adopted children

Abstract
Little is known about the experiences of teachers working with deprived adopted children. In this qualitative study, teachers and parents of seventeen deprived Romanian adopted children (10;8 years old at time of study, 2;11 years old at adoption) were interviewed. Most children (76%) visited schools for special education. Behavioral problems reported by the teachers were hyperactive behavior, social problems, aggression and a high sensitivity to the influence of others. Teachers attributed these problems mainly to the period of deprivation before adoption. Teachers applied a highly structured, warm and accepting approach. In general, parents were satisfied with the teachers. Almost all teachers needed the advice of colleagues or other experts about the children.
Keywords: adoption, Romania, behavioral problems, school

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Introduction

Adopted children who experienced deprivation in their country of origin, frequently have developmental and behavioral problems. These problems are a burden on the parents (Hoksbergen, Rijk, van Dijkum, & ter Laak, 2004; Judge, 2003). Little is known, however, about the consequences of these problems for the teachers of these children, and the way the teachers handle these problems. Adopted children sometimes go to school fairly soon after their adoption, especially children who are adopted at a later age. They face issues concerning adjustment to their new family, environment, language, and culture, which will be of importance in their functioning in the classroom. In this study, we focus on the experiences of teachers of deprived adopted children in the classroom, and on the way they handle problems that arise.

Adopted children's cognitive and school functioning

A meta-analytic study was done by Van IJzendoorn and colleagues (2005) to assess the cognitive development and school functioning of adopted children. They analyzed studies in which adopted children were compared with non-adopted children, children who had stayed in the biological family or in the institution from which the adopted children had been adopted. In general, they concluded that adopted children do not differ from their non-adopted peers in cognitive functioning, and do better than their peers who have stayed behind in a children's home in the country of origin. Adopted children did differ from non-adopted children with respect to their school functioning and language development, adopted children functioned less well on both accounts.

The meta-analysis of Van IJzendoorn (2005) and colleagues represents children from many different countries, and levels of deprivation may differ greatly between these countries. We studied children from Romania, who have almost all experienced (severe) deprivation prior to their adoption, and this may impact their functioning more strongly.

Cognitive functioning

A significant group of Romanian adoptees have experience cognitive delays after their adoption (Ames, Fraser, & Burnaby, 1997; O'Connor, Rutter, Beckett, Keaveney, Kreppner et al., 2000; Rutter & the English and Romanian (ERA) Study Team, 1998). After spending a longer period of time in the adoptive family, these children show a significant catch-up (Ames et al., 1997; Rutter, Kreppner, & O'Connor, 2001). Despite this catch-up, some deficiencies remain (Rutter et al., 2001). An online-survey done by the Eastern European Adoption Coalition (EEAC) confirms this. According to the results of their inventory of the cognitive development and emotional disorders of Eastern European adoptees, and of their need for special educational services, a substantial proportion (45%) of the children needed special educational services at some time (McCarthy, 2005).

Language development

One of the factors that may hinder cognitive and behavioral development of internationally adopted children is the acquiring of the language of the new country (de Vries & Bunjes, 1988). Although in general adopted children quickly learn how to communicate fluently in the new language (approximately 6-12 months, usually losing their native language at the same time), it is unknown how long it takes to get to the same language level as a native speaker of the same age. In immigrant children of school age, this takes five to seven years in general (Gindis, 2005). This period may however be shorter for international adopted children, because their adoptive parents are native speakers and mostly well educated (Verhulst & Versluis-Den Bieman, 1989). However, the children will still need some time to shift from competent speech to a full understanding of the language.

Gindis (2005) speaks of a cumulative cognitive deficit (CCD) for international adopted children. In their malnourished and deprived early childhood, the children accumulate adverse factors for their cognitive development, such as too little guidance and stimulation in the process of learning. This results in cognitive, and possibly also in behavioral problems. This applies particularly for older adopted children. According to Gindis (2005), the period that the child loses its original language, and has not yet acquired the new language sufficiently for good communication, is related to the degree of CCD. Most children adopted at a later age have known such a period. Regular remedial services appear less effective for children with CCD. Treatment of CCD at school requires a broad approach, where the child learns how to learn (Gindis, 2005).

Monica Dalen (2001) found that problems in language skills were an important factor in the lower school performance of internationally adopted Korean and Colombian children in Norway.

School functioning

Despite the small differences in cognitive functioning, adopted children in general showed more problems in school functioning (van IJzendoorn et al., 2005; Verhulst & Versluis-Den Bieman, 1989) than non-adopted children. Romanian adopted children are no exception to this (Ames et al., 1997; Morison & Ellwood, 2000; O'Connor et al., 2000). Despite cognitive catch-up, these problems persist, and in addition to difficulties in language acquisition, several psychosocial problems specific to deprived adopted children may be of influence.

All adopted children have experienced one or more separations from a caretaker in their country of origin. This frequently leads to attachment difficulties in the new family. Children who experience difficulties in attachment after adoption may show attachment problems both at home and at school. Some of the behavioral characteristics of these children are difficulties in concentrating, and hyper-vigilance, which might hinder their school performance. The symptoms of attachment problems show similarities with ADHD, which is diagnosed more often in adopted children than in non-adopted

children (Gindis, 2005; Hoksbergen, ter Laak, van Dijkum, Rijk, & Stoutjesdijk, 2003). Monica Dalen reports that a higher prevalence of hyperactivity in adopted children contributes to their lower school functioning (Dalen, 2001).

Attachment problems are often classified in the subtypes: secure, anxious-resistant, anxious-avoidant, and disorganized (Sroufe, Carlson, Levy, & England, 2000). Granot and Mayseless (2001) found that children who show avoidant and disorganized attachment patterns, most frequently experience adjustment problems at school.

Zirkie (2001) advised school counselors to create a special environment for children with attachment problems. The child should feel safe, and has need of one person he or she can trust completely. It is also of great importance that teachers understand the (attachment) issues that surround adoption (Kaplan, 1989).

Earlier waves of our study showed that a substantial part of the Romanian adoptees in the Netherlands have behavioral problems such as symptoms of autism, ADHD and trauma (Rijk, Hoksbergen, ter Laak, & van Dijkum, submitted). International studies in the USA and UK found similar results (Judge, 2004; Rutter et al., 2001). These behavioral problems hinder the cognitive development of children. Symptoms of trauma and ADHD both negatively influence the ability of the child to concentrate on schoolwork (Peters, Atkins, & McKernan-McKay, 1999; Yule, 1999) These complex behavioral problems keep the child from living up to his cognitive potential.

Aims of this study

International studies (Gindis, 2005; O'Connor et al., 2000; Rosenthal & Groze, 1991; van IJzendoorn et al., 2005) show that adopted children function less well in school than their non-adopted peers, and more often need special education services than non-adopted children. Little is known about the way teachers deal with the adjustment difficulties of adopted children. This qualitative study was designed to gain more insight into the difficulties experienced by the teachers, and the way in which they coped with having a deprived adopted child in the classroom.

The aims of this study were to explore:

- whether there are problems with these deprived children in daily school life, and what the nature of these problems is
- whether teachers think that the deprived background of the child is of influence on the current functioning in school
- how teachers handle the problems they encounter with these children.

Method

Participants and procedure

This is the third phase of a quantitative and qualitative longitudinal study among Romanian adoptees in the Netherlands. In the first and second phase of this study, all Romanian children, adopted between 1991 and early 1997 were asked to participate. The response in the first phase was 86%, and in the second phase 83%: a group of 80 children in 72 families. For the third, mainly qualitative phase, 18 children were selected based on the results of the second phase: the children (18 children from 17 families) scored within the clinical range on Total Problems of the CBCL, and in the clinical or borderline range of at least one other instrument determining problem behavior (Trauma-questionnaire, ADHD-questionnaire and autism-questionnaire), indicating complex behavioral problems. The group consisted of 11 boys and seven girls, who were on average 2;11 (2 years, 11 months) old when they arrived into the family, and 10;8 years old at time of study. An earlier stage of this study (Hoksbergen & co-workers of the Romania project, 2002) showed that differences in behavioral and developmental problems between boys and girls were minimal. We therefore decided to analyze the group as a whole. Five children (28%) were an only child. In all other families, other children were present (biological or adopted). Again, these two groups show little to no difference in behavioral problems, so we decided to analyze them as one group. The health of the children at arrival into the family was judged by the parents; 6 children (33%) were in good health, of 12 children (67%), the health was judged as moderate or bad.

All 17 parents agreed to participate. They were visited at home and interviewed by a psychologist. During the interview, which took approximately two hours to complete, all parents gave permission to interview the child's teacher. One child was not receiving education at the moment of study due to serious behavioral problems. Subsequently, the 17 teachers who all had one Romanian adopted child in their class were asked to participate. They all decided to do so. One teacher could only give a written response to the questions. This possibly lead to different responses than an interview would have lead to. Despite this risk, we decided to include the elaborate answers of this teacher, to prevent the already limited group of participants becoming even smaller. All other teachers were interviewed at their school. These interviews took about 1-1½ hours. Thirteen children (76%) were in special education, and four (22%) were in regular education.

Instruments

The parents and the teachers were interviewed using a semi-structured questionnaire. An open atmosphere was stimulated in order to encourage parents and teachers to express themselves freely, and both parents and teachers were asked to illustrate their stories with details and examples. Table 1 contains the topics discussed with the parents and with the teachers. The

interview with the parents contained various topics about the development of the child, and the way the parents dealt with the problems. For the current study, we will only focus on the topics that were related to the school situation.

Table 1 Interview topics discussed with parents and teachers

Interview topics Teachers	**Interview topics Parents (school related)***
General characteristics of the school	General characteristics of the school
- nature of the education	- nature of the education
- number of children in the classroom	Functioning of the child
- function(s) of the teacher	- cognitive functioning
Functioning of the child	- social functioning
- cognitive functioning	- strengths and weaknesses
- social functioning	- contact with classmates
- scholastic attitude	- happiness of child at school
- contact with and attitude towards classmates	Approach teacher
- strengths and weaknesses of the child in school	- educational approach by school/teacher
- happiness of child at school	- contact with teacher
- impact of deprivation/adoption	- effectiveness of approach teacher
Approach teacher	
- educational approach by school/teacher	
- methodology	
- effectiveness of teacher's approach	
- support by third party (e.g. remedial teacher)	
- contact with parents	

* the interviews with the parents contained discussion of various topics, of which the experiences with the school and teacher was only one. For this report, however, we will only focus on that part of the interview.

Analysis

The qualitative analyses were conducted using the method of Strauss and Corbin (1990). All interviews were recorded on tape, and then transcribed. Two researchers coded the fragments of all interviews independently, and the coding was subsequently compared within and across cases. All fragments received a label, a short description of the content of the fragment. The observers agreed in 96% of the cases; on average 54 labels were assigned per interview, with disagreement in on average 2 cases. The discrepancies were discussed, and an agreement was reached for all cases.

The labels were organized into different categories, which reflected the different themes discussed during the interviews. Analysis and comparison of the different interviews led to a coding system of themes that could be applied to all interviews (table 2). This coding system was also used to describe the results in this report. Quotes from the interview will be added (in italics) in the results as clarification.

Table 2 Labeling system applied to analyze the interviews with the teachers

Category	Factor	Label
Functioning of the child	Behavioral problems	- ADHD-behavior - Social problems / symptoms of autism - Aggressive behavior (verbal/physical) - Other
	Cognitive functioning	- level compared to peers (higher, lower, same) - deficits (in which area) - scholastic attitude (focused, easily distracted, eager to learn)
	Contacts with others	- with peers/classmates (good, bad, little contact) - with teacher (good, bad, little contact) - with other adults (good, bad, little contact)
Approach by teacher	Positive effect on child	- structure - positive attention for the child - good contact with/awareness of the child - time out
	Negative effect on child	- getting angry - too much positive attention
School	School characteristics	- school type (regular education, special education → which type of special education) - No. of children in classroom - No. of teachers per class
	Teacher guidance	- guidance available (remedial teacher, school psychologists, colleagues, other) - guidance consulted
Teacher – parent contact		- quality of contact (good, bad) - how is contact made/kept (parent meetings, notebooks, telephone) - Conflicts

Results

The teachers were asked to describe the functioning of the child, and the nature of the problems they encountered in the classroom.

Cognitive functioning according to the teachers
The 13 children (9 boys, 4 girls) who were in special education, functioned below the average cognitive level of children of the same age according to the teachers. The types of special education differed: some children received the material from regular education at a slower pace, while others received education at a more basic level. All teachers, except one, indicated that the children had more problems with mathematics than with reading or grammar.

The four children (2 boys, 2 girls) who were in regular education, functioned on the same cognitive level as their peers. One boy never had educational problems, and one girl had been in special education in the past, but functioned well now in regular education. One girl repeated a grade, and functioned well now, and one boy needed special treatment by the current teacher because of problems with concentration and focusing. He was tested individually, instead of with the rest of the class, because he functioned poorly when tested with the rest of the group present.

Eleven children (65%) had difficulties with their scholastic attitude according to their teachers. Some children had problems concentrating on their work, while others worked too fast, which lead to a lower quality of their work.

> *"Once he starts working, he is very fast. And he makes mistakes because of that. We need to slow him down, otherwise his work is sloppy, and contains more mistakes than necessary."*

These problems required much (individual) guidance of the child by the teacher.

Behavioral problems
The teacher of one child mentioned no behavioral problems. Of the other 16 children, five teachers (29%) mentioned that behavioral problems of the children limit their educational development.

> *"He could in my opinion have handled a higher level of education. But when you look at his behavior in class… no, it would not be possible for him to be in a regular school"*

The behavioral problems that teachers encountered most in the classroom were:

1. Hyperactive behavior
Teachers of eleven children (65%, 8 boys, 3 girls) stated that the child was often hyperactive in the classroom. These children typically talked loudly and had problems staying in their seat.

"She is constantly moving, very hyperactive… very present in the classroom"

Because of this, they have problems concentrating on their schoolwork.

"He is very curious, always wants to know what is going on around him in the classroom. External stimuli constantly keep him from his work"

One boy was officially diagnosed with ADHD. The teacher of another boy mentioned that the boy was being evaluated for possible ADHD, and that there was a strong suspicion of ADHD. He was receiving medication (methylphenidate) for this, as was another girl, who had not been diagnosed with ADHD, but did show hyperactive behavior.

2. Social problems

The teachers of 14 children (82%, 10 boys, 4 girls) reported that the child had difficulties in social contacts, both in making contacts, and in maintaining friendships. Some were too dominant towards others, causing the other children to avoid contact with them. Others were living too much "in their own world", with little focus on the other children, and lacked the social skills to form meaningful bonds with classmates.

"He really craves attention, and he tries many ways to get it. But he goes about it all wrong, and only causes a feeling of aversion from the other students. They avoid him…"

Four children (18%, 3 girls, 1 boy) have officially been diagnosed with autism, or disorders related to autism. One boy was not diagnosed, but showed symptoms of autism. His teacher did mention that the diagnose Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS) had often crossed his mind. These children experience problems in contact with others, and are rigid in their daily routine. They could not accept changes, especially if these changes were unexpected.

"If there is a substitute teacher, he does not function at all in class"

3. Easily influenced by their environment/classmates

All teachers mentioned that the children showed a heightened awareness of and sensitivity to their environment. As a consequence, the intensity of the behavioral problems of most children was not constant, but fluctuated over time.

"When the holiday season is approaching, the whole class is excited and more active, and he is very sensitive to this. In the weeks before Christmas, he is not able to function on his normal level…"

Changes in the situation in the classroom were noticed instantly by the children, and this was reflected in their behavior. The children were not only sensitive to the circumstances in the classroom, but also to the behavior of other children. Teachers mentioned that the classmates and peers had a large influence on the behavior of the child. Three (18%, 2 boys, 1 girl) teachers said explicitly that the classmates made the child do things together with them that were not allowed, and then let the child take the blame for it.

"And then they would make him do things together with them, and if a teacher discovered it, all other children made sure they were gone, leaving him alone to take the blame. He lacks the insight to see that they are setting him up"

4. Aggressive behavior
Eleven children (65%, 7 boys, 4 girls) showed aggressive behavior. They directed this aggression towards the teacher, other children in the classroom or school, and towards their own belongings or those of others. Both verbal and physical aggression occurred.

"He sometimes gets enormous fits of anger. He screams, shouts, hits and bites… he completely loses control…"

When the teachers were asked to name the causes of the developmental and behavioral problems of the children, twelve (71%) of them named the adoption and the period of neglect in Romania. Other teachers named other causes for the behavioral problems. They stated that the child has a certain disorder (ADHD, autism) and that this would have occurred in any situation. Another group of teachers doubts the exact cause of the problems:

"Sometimes I doubt about the cause of the problems. I wonder if it is mainly the attachment problem, or if there are elements of ADHD in it too. I find it hard to really say something about the cause of the problem. I think that would require a long time of observation of the child…"

Teacher's approach
Teachers mentioned approaches that had a positive effect on the child, and approaches that did not. The following approaches were successful:

1. Providing structure
All 17 teachers named "giving structure" as an effective approach. They offered structure in different ways. The behavior and attitude of the teacher was structured and constant, so that it was predictable for the children. They made an effort to be consistent in their approach of the children.

"No fluctuations, your behavior and mood should be constant"

The situation in the classroom was also structured as far as possible. Many teachers had clearly defined rules and daily routines in the classroom. Activities were planned consistently on the same day or time of day. Teachers used verbal and visual reminders to point out the rules and plans: throughout the day, they stated what was next on the agenda; they had the agenda written on the blackboard, or on a stencil on the child's desk; they used images or pictures to make an overview of the activities for that day. The teachers stressed that this should be done consistently.

"What works best is a clear and structured approach, where borders are set, and agreements kept. I try to be as consistent as possible. A loving, warm but consistent approach works best, I think…"

The educational material was offered in small quantities, and the same educational methods were applied as far as possible, enabling the child to oversee the task.
Structure was incorporated in the teaching system of most special schools, but all teachers still mentioned it explicitly for the children in our study.

> *"This child requires his own structure within the already strict structure of the group" (from written response)*

2. Positive attention
Many children appeared to be highly sensitive to positive attention by the teacher. This was given by complimenting the child if he was functioning well in the classroom, by giving actual rewards or privileges, or by giving personal attention to the child (e.g. a hug, or a pat on the head, or taking a little moment to talk to the child personally).

> *"Letting her know you like having her around. Giving compliments, and letting her know it is OK to make mistakes. That you can learn from mistakes, and maybe do better next time. Accepting her the way she is. A positive approach…"*

All teachers mentioned in some way that it was of great importance to know the child, and to have a good individual contact with the child. This enabled the teachers to prevent problems in the classroom by noticing and resolving them at an early stage.
The teachers took time to get to know the child individually, and made regular (eye)contact. Thirteen teachers (76%) mentioned that they felt that they had a good relation with the adopted child. They were constantly alert on first signs of problems, so they could avert an escalation. They did so by talking to the child (some mentioned voicing the emotions of the child), by giving the child another activity to distract the attention from the difficult situation, and by taking the child out of the situation completely.

> *"If I see that things get out of control, I go up to him and ask him to talk about what is going on"*

Teachers described how some children can get lost in their emotions, and that this is best averted at an early stage.

> *"I try to avert a crisis immediately, and sometimes he can go back to work right away. But once his anger gets out of control, it takes a long time for him to return to normal functioning"*

3. Time out
The time out was mentioned by 13 (76%) teachers. Teachers placed the child in a quiet corner of the classroom, in the hallway or in a separate room designed especially for this purpose. Time out was used as a punishment in some cases, but in most cases it was used as a mean to bring calm in a situation that was distressing to the child. As mentioned above, teachers tried to avoid the anger and distress of the children getting out of control, since recovery takes a long time. Time out was often used for this. The children were highly sensitive to

disquiet in their environment, and needed a period of calm, with little stimuli, to control their behavior and emotions.

> *"…and explain to her that it is not a punishment, but only meant to calm her down. Just to cool down for a moment…"*

Some children were very aware of their need for this, and were even able to ask for it themselves.

> *"… and then he came up to me and said: "Miss, the other kids are too noisy, I am going to sit on the quiet-chair in the hallway for a while"*

When asked for teaching styles that did not have a positive effect, eleven (65%) teachers mentioned getting angry at the child. When the teachers screamed at the children, they responded by getting into a rage themselves, or by getting very frightened or sad. One boy did not appear to respond to anger at all. Getting angry did not induce a positive behavior-change in the child.

> *"Sometimes I would try to correct him by shouting at him to stop. This always resulted in him screaming back at me. It kept getting worse, so at one point it was very clear that this didn't work at all for him"*

Teachers of three (18%) children indicated that too much positive attention for the child was not effective either. The children became very enthusiastic, and got distracted from their work:

> *"If I tell him that he is doing a good job, he often starts to laugh, or shout, or he starts bouncing on his chair. He even fell off once. The compliment at that point only distracts him from his work"*

Teacher's resources

Fifteen teachers (88%) indicated that they were satisfied with the guidance-system at their school, and that they got sufficient support from their colleagues, and from remedial teachers and psychologists available to them. They felt that they could approach their colleagues and ask them advice both officially in staff meetings, and more casually between classes.

> *"If there are issues you can't resolve, there is always the possibility of consulting a child psychologist. But for small issues, you can contact your fellow teachers, and the principal of the school. Sometimes their attention and understanding is enough…"*

Two teachers (both from special education) were not satisfied. They had the feeling that they did not receive enough support from the school in handling the children in their classroom, and that they needed to find out much on their own.

> *"The school is starting up a system to track the development of students this year. But up till now, I had to figure it all out myself"*

Thirteen (76%) teachers indicated that they consulted their colleagues or other experts at one time about how to handle certain problems presented by the child. The problems for which they asked assistance varied. Some concerned scholastic tasks, such as asking special assistance for mathematics, others concerned behavioral or emotional problems of the child, and five (29%, 4

special education, 1 regular education) teachers consulted experts about possible adoption-issues, because they did not feel that they knew enough about this matter themselves. Two teachers expressed the wish to have more information about the consequences of adoption and neglect during their training, but recognized that this is very specific information, and that there is little room for this in the full curriculum.
All teachers indicated that these children need much personal attention and guidance.

Contact with the adoptive parents
Eleven (65%) teachers felt they had a good contact with the parents. They experienced these contacts as open and warm, and agreed about the way to deal with problems. One teacher got advice from the parents about the best way to handle the behavioral problems of the child, and found this very helpful. The teachers were also able to advise the parents on occasion. Teachers and parents contacted each other on parent-meetings, by phone, or by using a notebook that the child took home, and back to school.

Six teachers (35%) had a difference of opinion with the parents at the time of study, or in the past, hindering a good parent-teacher contact. Three of these teachers thought that the parents found it difficult to accept the limitations of their child, expecting too much, and putting too much pressure on the child. In one case, the situation had escalated to a point where parents and teacher only contacted each other through a mediator.

Three children no longer lived with their parents, but in an institution for child care. In these cases, the teachers were also in contact with the caretakers of the child in the institution. These contacts were all good.

Parents' opinion of the school and teacher
Twelve parents (71%) expressed that they felt that the teacher had a positive effect on the development of the child.

> *"Yes, you can clearly see that her structured approach is effective. A calmer child at home and more positive results at school…"*

In three cases (18%, 1 regular, 2 special education), the parents were not satisfied with the teacher and the school. The parents of these children felt that the school underestimated the possibilities of their children, not doing enough to stimulate the cognitive development.

> *"They do not see his potential. I myself have taught him things that the school said he would never be able to learn"*

In two other cases parents had felt this way in the past, but remarked an improvement now.

Discussion

In this study, the teachers and parents of 17 Romanian adoptees were interviewed. The children had all known deprivation in the orphanages in Romania. In a previous stage of this study, all children showed behavioral problems. At the time of study, 13 children (76%) were in schools for special education.

Cognitive functioning
Most children in this study functioned below the average cognitive level of their peers, possibly a consequence of the period of deprivation they experienced in Romania (O'Connor et al., 2000; Rutter & the English and Romanian (ERA) Study Team, 1998). The exact cause of these cognitive delays remains unknown. Genetic, pre- and perinatal factors and early-life deprivation are possible contributors. The fact that almost all children had more trouble with abstract tasks like mathematics possibly indicates that they were going through their development at a slower pace. It is important that teachers of children adopted at a later age make a distinction between cognitive deficits and cognitive delays.

The fact that these children are still delayed in their cognitive functioning, after spending an average period of almost eight years in the adoptive family, indicates that the significant improvement that many children show after adoption (O'Connor et al., 2000) did not fully normalize the cognitive function of these children.

Language development
It is interesting to note that none of the teachers mentioned language difficulties as a main problem in the classroom or as a possible cause for the lower school functioning of these children. Problems in mathematics were more profound than language problems. A possible explanation might be that the children have all been in the adoptive family for a longer period of time (eight years on average) and most have acquired the Dutch language well. Problems in language may have disappeared, or they may have become more difficult to recognize for teachers (de Vries & Bunjes, 1988; Gardell, 1980).

Behavioral problems hindering school functioning
Eleven teachers mentioned the hyperactive behavior of the children as the most noticeable problem in the classroom. One child was officially diagnosed with ADHD, and for other children teachers suspected the presence of it. Some children were given ADHD medication to counter their hyperactivity and lack of concentration. Two teachers questioned whether the correct diagnosis would be ADHD or attachment disorder. The same symptoms can occur for both diagnoses. It is important that teachers are aware of the similarities between these two disorders, since a proper diagnosis may lead to a different treatment. Medication may be less effective in case of attachment difficulties. Teachers

should also be aware of the higher incidence of Fetal Alcohol Syndrome in adopted children of eastern European origin, which may also lead to comparable symptoms (Stromland, 1996).

The same applies for autism, and related disorders. Adopted children with symptoms of autism may suffer from what we call Post Institutionalized Autistic Syndrome (PIAS, Hoksbergen, ter Laak, Rijk, van Dijkum, & Stoutjesdijk, 2005), symptoms of autism related to a history of early-life deprivation and institutionalization. Children with PIAS have symptoms similar to autism, but unlike autistic children, these children show a lessening of the problems over time. PIAS is seen equally often in boys and girls, where classic autism is seen more often in boys (Fombonne, 1999).

Teachers should be aware of the specific difficulties of adopted children, and the possible similarities of these problems with ADHD and autism. They should also be especially aware of the children's possibilities for recovery after spending a longer period of time in a healthy environment (Groothues, 2001). Sometimes a diagnosis can become a permanent label, which limits people in the direct environment of the child in stimulating development.

Underlying issues with attachment and abandonment may also be reflected in the fact that the children can be easily influenced by their social environment, and by their peers. Children with attachment disorder are often very aware of their environment (Brodzinsky & Schechter, 1990), afraid that they may lose control over the situation otherwise. This hypervigilance may result in a higher sensitivity to changes, and a lessened ability to concentrate on their school work (Schwartz & Davis, 2006). Children with abandonment issues can be both indiscriminately friendly and overly suspicious in their contact with others, and this will have a profound effect on the relation of the child with the teacher and with peers. It may cause them to be too sensitive to the influence of classmates and peers (Schwartz & Davis, 2006).

Effective approaches according to teachers

When asked for the most effective approach of these children, all teachers mentioned "giving structure". They made an effort to structure their own behavior towards the children, the situation in the classroom and the educational material as much as possible. Many teachers of schools for special education stated that structure is beneficial to all children in special education. Some mentioned that the children in this study appear to need even more structure than the other children at school. The need for a structured environment was also mentioned by the parents of these children (Rijk, Hoksbergen, & ter Laak, in press). A structured environment offers a sense of safety and predictability to children who have experienced a period of deprivation. Their negative response to (unexpected) changes seems to confirm this. The fact that "time-out" is used by a large group of the teachers indicates that too many stimuli confuse the child, and that these children fare best in a calm, structured environment.

Most teachers applied a warm and positive approach towards the child. They gave the children a lot of attention and contact time which, in their

opinion, had a positive influence on their relation with the child. This approach makes the child feel safe, and induces self-confidence in the child.

Teachers spent much time and effort in guiding these children. Even in special schools, where all children require special attention, teachers felt that they spent extra time on the adopted children, both in the classroom and in finding information about the specific problems of deprived adopted children. It is of great importance that teachers are enabled to spend this much time and effort on the child, something that is unlikely to happen in a regular school with often 30 or more children in one classroom. Especially during the early years in which they are overcoming cognitive delays, special education is the best solution for these children. However, teachers should be careful that the child is not stigmatized, since the positive development of the cognitive functioning shown by many adopted children may enable them to transfer to regular education at a later stage.

Two earlier stages of our study show that the total group of 80 Romanian adopted children in our study is overrepresented in special education, and that the number of children in special education is growing (31% at first stage, 47% at second stage). Especially for the children that had to transfer from regular to special education, an earlier placement in special education may have been more useful for their (cognitive) development.

External support for teachers

If questions arise on how to deal with certain problems in the classroom, most teachers were able to consult their colleagues and other professionals linked to the school. This was done for many of the children. The unique problems of adopted children with a history of deprivation prompted teachers to seek information and advice about this matter.

Teachers should have information at their disposal about adoption-related issues, and developmental and behavioral problems of deprived children. Parents may play an important part in this, and independent information should also be available. Parents and teachers can help each other in dealing with the problems that arise, as was done in most cases in our study. However, conflicts between parents and teachers may also occur. In this study, disagreements between parents and teachers occurred for six families. All problems concerned a different view on the potential of the child. Parents felt the school underestimated the children, while teachers felt that the parents had troubles accepting their child's limitations. An independent expert on the cognitive development of deprived adopted children could help to resolve these issues. As stated before, the unique situation of children adopted after a period of deprivation, requires a well-informed teacher, with knowledge about possible problems, and the best way to care for these children. A good relation between the teacher and the parents of the child is of great importance.

Limitations of this study

This study was aimed to be a first qualitative exploration of the way in which teachers deal with the specific problems of deprived adopted children, an area

of study that has been largely neglected so far. The small sample size is one of the limitations of this study, as is the existence of a number of confounds (sex of the child, presence of siblings in the adoptive family). There is also a lack of non-adopted and non-clinical control groups. Future research should include control groups to enable comparison. In this way, the uniqueness to adopted children of both the problems and the teachers' approach can be determined. To analyze the approach of the teachers more objectively, observation in addition to interviews would be a useful instrument. A next step in future research could be an empirical approach of a much larger group. Comparison with a non-adopted and a non-clinical group will then be possible.

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6 Parents' and mental health workers' perceptions of therapeutic needs, and experiences of services for Dutch children adopted from Romania

Abstract
While it is established that International adoptive families are overrepresented in mental health care, little is known about their experiences with mental health services. Experiences of 11 adoptive families and 12 mental health workers of severely deprived Romanian children adopted from institutions are described. Parents and mental health workers were interviewed. Reasons for applying for help, diagnoses, treatment method and evaluation are discussed. Most parents reported difficulties in finding appropriate care and had consulted several other therapists before they arrived at the current mental health service. Diagnoses often included cognitive delays, autistic symptoms and attachment difficulties. Different treatment methods were applied, in both outpatient and residential settings. Parents were more positive about the treatment-outcome than were the mental health workers, the latter often having to consult colleagues about appropriate treatment. While the workers agreed that adoption-specific knowledge and knowledge about the effects of deprivation are essential for proper treatment, most of them felt that they lacked expertise for such work.
Keywords: adoption, Romania, deprivation, mental health services, qualitative research

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Introduction

Some parents of internationally adopted children who have been deprived in their country of origin, experience parenting as more of a burden than do non-adoptive parents (Rijk, Hoksbergen, ter Laak, van Dijkum, & Robbroeckx, 2006) due to the behavioral problems of their children (Judge, 2003; Rutter, Kreppner, & O'Connor, 2001). External help is often required in parenting, and many families receive this from general mental health services. However, some require mental health services that are specifically aimed at adopted children and their families. In the Netherlands, adoption agencies do not provide standard aftercare for adoptive parents, so those requiring help have to initiate it themselves. With only 54 domestic adoptions versus 1185 international adoptions in 2005, internationally adopted children form the largest group of adopted children in the Netherlands (Ministerie van Justitie, 2005).

Here we describe the experiences of eleven families receiving professional help with their severely deprived adopted child from Romania.

The need for help

Several international studies report an over-representation of families with internationally adopted children in the use of mental health services (Castle, Rutter, Beckett, Colvert, Groothues et al., 2006; Johnson, 1999; Judge, 2004; Ryan, 2003), a pattern that prevails after correcting for differences in experienced problems between adopted and non-adopted children (Miller, Fan, Grotevant, Christensen, Coyle et al., 2000; Warren, 1992). This is especially the case when children have experienced long periods of deprivation in their early childhood. Possible consequences of early-life deprivation include cognitive delays, behavioral problems such as quasi-autistic symptoms and symptoms of trauma and of Attention Deficit Hyperactivity Disorder (ADHD) (Hoksbergen & co-workers of the Romania project, 2002; Rutter et al., 2001). In their recent study of Romanian adopted children in the UK, Castle and colleagues conclude that approximately one-third of the children adopted after the age of six months need special education services and mental health services for a long period of time and that early deprivation and its consequences are the most important reason for this (Castle et al., 2006).

However, other reasons for the overrepresentation of adoptive families in general in mental health services have been suggested. For example, a higher socioeconomic status of adoptive parents could lead to more requests and better service responses (Brand & Brinich, 1999; Ingersoll, 1997). There is likely to be greater parenting insecurity among adoptive parents (Ingersoll, 1997) and access to services might be easier given the pre-adoption preparation period when parents are in regular contact with professionals (Miller et al., 2000). Whatever the reason, the fact remains that adoptive families in general, and families of deprived adopted children in particular feel a higher need for mental health services.

Available care

In addition to regular mental health services for children and adolescents, some adoption-specific services are available, amongst others in countries where substantial numbers of Romanian children were adopted, such as the USA, UK, and the Netherlands.

Adoption-specific care is often directed at the parent-child attachment, taking the form of parent-support groups, individual therapy for the child and/or parent, family therapy, and residential care (Frank & Hochman, 1991). In the Netherlands, several types of services are available for adoptive families of internationally adopted children, although, with the exception of specific adoption courses and adoptive parent groups, these are rarely exclusively to them. Video Home Training, a therapeutic technique incorporating video-recordings of daily life, is often used for adoptive families (Polderman, 2004). However, appropriate care for adoptive families immediately after placement of a severely deprived child from a less economically developed country is not available and the effects of early-life deprivation produce a challenge in addition to the attachment and identity formation problems common to all adoptions (Hoksbergen & co-workers of the Romania project, 2002).

Despite the challenges for adoptive families posed by adopting severely deprived children, little is known about their experiences, especially in relation to mental health services. This study explores these experiences, gathering the opinions of participants about the process, the help available, the results, and the need for information on specific issues raised by adoption.

A qualitative design was used as it allows more in depth discussion of these topics. Using the case descriptions of eleven Romanian children, we charted the problems with which the parents sought help, the services they used and how they identified sources of support (e.g. referred by others or through a search of their own). The process of therapy is also described, along with diagnoses and treatment methods. We also discuss perceptions of parents and mental health workers on the effectiveness of the services provided, including aspects that parents and mental health workers view as essential for effectiveness.

Method

Participants and procedure

This research is part of a longitudinal study of a group of 80 Romanian adoptees, as described by Hoksbergen et al. (2004). For the current third stage of the study, children with multiple and severe behavioral problems were selected for scrutiny, based on their test scores in earlier stages. Twenty-nine children had a clinical score on the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1983) indicating that professional support was advised. Eighteen children additionally scored in the clinical range of at least one of three other instruments designed to identify the presence of symptoms of

autism, ADHD or Post Traumatic Stress Disorder (PTSD). This group of 18 children showing multiple behavioral problems was selected for participation in the third stage. The parents all 18 children were interviewed, but for the analysis of experiences with mental health care, the group was narrowed down to 11. This was because only 11 were receiving professional help at the time of study although all 18 children had received it in the past. Of the seven children not selected, three no longer needed extra support; the parents of the other four children felt that the support they received from the school for special education was sufficient.

The 11 children selected did not differ significantly from the other 69 children in the longitudinal study with regard to age at arrival in their adoptive family, or the length of time they had been there. During the interviews with parents, permission was requested to contact the professionals they had consulted; where several professionals had been involved parents were asked to select the person they felt had worked with the child most, and had been most effective in dealing with the problems. Except for the parents of one child, who felt that caretakers at two institutions had played an important role in the treatment of their child, and that both should be interviewed, all parents were able to name at least one mental health worker. Thus, 12 mental health workers were approached, all of whom agreed to participate in the study. Interviews with parents and mental health workers lasted about an hour.

The nature of the services provided differed, but all mental health workers interviewed had worked with the child and/or the family on multiple occasions. Three children were in residential care, the other eight children lived with their parents. Ten of the mental health workers were part of the regular mental health care system in the Netherlands and the costs of any therapy were covered by health insurance. Two therapists were independent, but were officially registered mental health workers. Parents were able to apply for a special personal budget for services for their children, through which independent care was partially funded.

Interviews

Parents and mental health workers were interviewed using a list of topics to be discussed. Questions were open-ended and elaboration, discussion and the use of examples were encouraged. In the interview with the parents, many subjects concerning the functioning of the child were examined but this article focuses on questions regarding service use. Table 1 provides an overview of the topics discussed with parents and mental health workers.

Table 1 An overview of the topics discussed with parents and mental health workers

Interview topics mental health workers	Interview topics Parents (treatment related)
- General data about mental health worker and institution - Reason why the family applied for help - Diagnosis - Role of adoption and deprivation in current problems - Treatment plan and method - Status treatment process - Effectiveness of treatment - Need for information about adoption and deprivation & need for consulting colleagues - Expectations for the future	- Reason for seeking professional help - Pathway to current services - Earlier experiences with professional help - Treatment method - Effectiveness of treatment - Contact with mental health worker

Analyses
All interviews were recorded, transcribed and analyzed, using the method described by Strauss and Corbin (1990). The text of the interview was divided into fragments, each contained information about one subject. These fragments were labeled using one or two words by two independent observers, who showed a high level of agreement (96%; mean number of labels = 36, mean number of disagreements = 1). Discrepancies were then discussed and adjusted. The labels formed a classification system that could be applied to all interviews and used to answer the research questions.

Results

An overview of the interviews about the 11 children is given in Table 2, at the end of this chapter. First, general information about the children is presented: their age at time of study and at time of adoption, and whether they were receiving special education. The average age of the children was 11 years; their average age at adoption was three years and three months. Ten children attended a school for children with special education needs and one was in a school for regular education. As mentioned, these children were selected because they showed multiple behavioral problems at an earlier stage of this study. All scored within the clinical range of the Child Behavior Checklist (Achenbach & Edelbrock, 1983).

Finding appropriate care

As can be seen in Table 2 (at the end of this chapter), all parents consulted other services before they arrived at the current one. On average, the parents consulted several (mean = 3,6) mental health workers before they came into contact with the person they were now seeing. For various reasons, all parents had trouble finding appropriate care for their child, often due to a lack of what was available:

> *"If we had known about these options back then, we would have been able to engage them much sooner. But you have to discover everything on your own."*

When asked to explain previous failed treatments, parents often mentioned a lack of knowledge of the mental health workers about adoption-specific problems and, in particular, the effects of deprivation. They did not feel understood, and were disappointed in the services provided. In some cases, the lack of knowledge about the effects of early-life deprivation led to the families being passed around mental health workers without successful treatment. Indeed, some parents expressed reluctance to engage new services, because they thought that the effort involved in starting a new treatment process was often not rewarded with effective therapy.

> *"I have to admit, that lately we don't really feel like contacting new counselors. It is so exhausting to have to explain the whole story again every time, and have all the tests done again, when it doesn't really result in anything effective for our family."*

Most parents (7) indicated that they had been referred to the current services by former mental health workers. Two parents had found current services on advice from their child's school (both schools for special education) and two parents had found their current services on their own.

Reasons for finding professional help

When we asked parents why they sought counseling, the following difficulties were mentioned most frequently: problems in social interaction, aggression and symptoms of conduct disorder. When the mental health workers were asked the same question, as can be seen in table 2, the problems they identified were similar: aggression, difficulties in interaction and communication and conduct disorder. There were no large discrepancies between the perceptions of the two groups. Exceptions were self-harm and inappropriate sexual behavior. Initially, these were not mentioned by the parents as reasons for finding professional care, but they emerged when parents were asked to list all behavior problems that their child displayed.

The mental health workers of four children clearly stated that they felt that the burden on the family was too high.

> *"The burden of bringing up this child is really becoming too much for these parents. But they find this really hard to accept. I try to help them with that as well, not just with their care for the child"*

Three of them wondered whether the child would be able to continue living at home, or would be better placed in residential care.

Mental health workers' thoughts on diagnosis
Some mental health workers had access to an official diagnosis of the child made in the institution where they worked. Others formed their own opinions by making an inventory of the different behavioral problems that the child displayed. Nine children were diagnosed with Reactive Attachment Disorder (RAD), four children with Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS), an additional two children showed symptoms of PDD-NOS, and five children were diagnosed as 'mentally retarded', and one other child was diagnosed with cognitive delays. As can be seen in table 2, some children received multiple diagnoses. A combination of severe cognitive delays, (symptoms of) PDD-NOS and attachment difficulties occurred frequently. Some mental health workers mentioned difficulties in properly diagnosing the child owing to lack of knowledge about the child's genetic background and early-life experiences:

> *"And we thought about Fetal Alcohol Syndrome, because he shows some of the signs of that. But without any information about his background, it is really hard to say something about that. You can't be sure."*

Perceived causes of problems
All mental health workers agreed that the period of deprivation that the children had experienced in their country of origin before they were adopted was of great importance. Both physical and affective deprivation were seen as factors that contributed to current problems. Physical neglect was regarded as a possible cause of developmental delays, while affective neglect might well be the source of attachment difficulties and problems in social interaction:

> *"And I heard from her parents about the circumstances there. They must have been very damaging to her, even physically, in the development of her brain. Not to mention the forming of conscience and the possibilities for attachment."*

Aggression and a delayed development of conscience were (partially) blamed on the 'survivor' behavior that may result from severe deprivation. In order to survive, the child had learned to take as much as she or he could, and not to care about others:

> *"He was almost six when he was adopted. That clearly shows in his behavior (…) He is a fighter, a survivor."*

Hereditary problems and alcohol and drugs abuse by the mother during pregnancy were also mentioned as suspected causes, but not enough background information about the children was available to confirm this.

Treatment methods
Different treatment methods were applied. Three children were in a residential setting, receiving guidance in small living-groups. When asked about the

nature of the guidance, mental health workers cited that the children needed a structured approach in which the daily routine was clearly set. The children required considerable individual attention, and time had to be invested in explaining things and making visual aids. The professionals also stressed the importance of an affectively neutral approach to the children. Emotions like anger or sadness shown by the mental health worker confused the children, and hindered the development of positive behavior.

For six families, one of the mental health worker's tasks was to guide the parents. This often included advice on how to deal with parenting difficulties. The workers also emphasized the importance of a structured, consequent approach to the child and, occasionally, helping parents accept the current situation and the fact that their child might not be able to continue living with them. Practical help was also offered, for instance with school placement and in co-coordinating the efforts of those involved in helping the child.

The mental health workers who guided the parents usually had limited contact with the child. The exception was in two families where professionals worked directly with the whole family, using Video Home Training, or Holding Therapy, an intensive physical method applied to form a bond between child and parents. Two other mental health workers worked mainly with the child, using play-therapy and social skills training. Play therapy was used to make the children aware of their emotions and their behaviors, and to enhance control of these. In three cases, the mental health worker was also (partially) responsible for the child's medication, in most cases a neuroleptic drug.

Perceived effectiveness of treatment

Both parents and mental health workers indicated whether they thought the help had been successful. In general, parents were more positive about the achievements made than were the professionals. Ten of the eleven children's parents saw a positive development:

> *"They work really hard to change that behavior, and we do see a positive change… one step at a time…"*
>
> *"It is really nice that we finally found someone who listens to us. Who is cooperative in finding solutions to improve the daily functioning of our family."*

In contrast to the positive opinion of the parents, only one of the mental health workers felt that the treatment had been fully successful:

> *"It is amazing how much some children change through therapy. They are finally able to realize that these parents are going to stay, and take care of them, even when they behave badly. They can become child again, and lose the feeling of having to care for themselves all the time."*

Six others saw some improvement, but not all the therapy goals were achieved. Four others saw little or no change in the behavioral problems. One mental health worker explicitly said that he was not satisfied with what he had achieved:

> *"Although I know the parents are satisfied with the care they are receiving here, I am actually not. I wish I could do much more for them. They have*

had such a long and ineffective history of professional care before they came here. I would really wish a good and effective adoption aftercare for them, and for all parents struggling with these problems."

Future

For the three children in residential settings, the mental health workers expected that they will stay there until adulthood, and probably need some form of help for the rest of their lives. For three children currently living in families, the mental health workers doubted whether this was sustainable because the pressure on the family was so high and some form of residential care might well prove necessary in the future.

"The family is able to take the burden right now, but puberty may change this. I doubt whether they will be able to maintain the current situation, or whether residential care may prove to be unavoidable."

For three children, mental health workers indicated that help was likely to be necessary for a long time because treatment goals had not been achieved and serious issues remained:

"We see a clear positive change, but we still have a long road ahead of us, and new issues are surfacing. "

For two boys (see table 2, nr. 5 & 11), the mental health workers expected to complete the therapy soon. For one boy (see table 2, nr.9), therapy was concluded without referral to other care although professionals remained available if needed. The mental health worker expected no further need for care, but she remained available for advice.

Knowledge about adoption-specific problems

All mental health workers agreed that knowledge about the specific problems of adopted children, especially deprived adopted children, was a necessary condition for effective therapy. Adopted children in general may face issues in the development of their identity and in coping with abandonment (Brodzinsky & Schechter, 1990). Early life deprivation may in addition cause developmental delays and behavioral problems (Judge, 2004; Rutter et al., 2001).

"The unique situation of these children, and of these families, requires knowledge about adoption, and about the effects that prolonged deprivation may have on a child."

Three of the mental health workers interviewed indicated that they had considerable experience in working with adopted children, whereas the other nine had little or no relevant experience. Most of them felt that, at the start of the treatment, they had insufficient knowledge about the specific problems presented by adopted children from severely deprived backgrounds. They had to search for information about adopted children and the effects of deprivation on treatment, whereupon the majority found that consultation with colleagues was the most fruitful source.

Knowledge about the consequences of deprivation was seen as important for both parents and mental health workers and the need for adoption

information to be available in all children's agencies was expressed. The mental health workers also indicated that they should be able to contact adoption experts during therapy as specific questions arose.

Discussion

A qualitative design was chosen to study the experiences of 11 families with severely deprived Romanian adopted children (mean age 11; at adoption 3;3; 2 females, 9 males) and twelve mental health workers. All parents needed professional help. The design enabled us to explore both the experiences and opinions of the parents and mental health workers.

The parents cited different reasons for requesting professional support, but aggression, symptoms of autism (problems in social interaction, amongst others) and symptoms of conduct disorder were most frequently cited. Previous reports indicate that these problems often occur among deprived internationally adopted children and place a great burden on the parents (Rijk et al., 2006). The high need for help with these difficulties reflects this burden. Hence, professionals should be alert when parents of internationally adopted children report such problems and parents should receive assistance immediately to prevent deterioration.

There was a strong agreement between parents and mental health workers about the reason for treatment, indicating that the former were able to communicate successfully the problems they were experiencing. Parents and mental health worker also tended to speak the same language because they discussed the problems together during treatment. In addition to the difficulties named by parents, mental health workers also identified self-harm and inappropriate sexual behavior, problems that parents did not raise initially although they did acknowledge them in the general part of the interview but not as reasons why they sought help. Parents may be more prone to mention the problems they experience on a daily basis.

The most frequently occurring diagnoses were attachment difficulties, PDD-NOS and cognitive delays. This was to be expected, based on earlier research on deprived Romanian adopted children, as it is known that a period of severe deprivation may lead to cognitive delays, attachment difficulties and quasi-autistic symptoms (Fisher, Ames, Chisholm, & Savoie, 1997; O'Connor, 1999; Rutter, Anderson-Wood, Beckett, Berdenkamp, Castle et al., 1999; Rutter et al., 2001). It is also notable that attachment difficulties were often not mentioned by the parents as a reason for seeking help. Possibly, they focused more on problematic behavior, and so did think of attachment difficulties as an underlying cause. The high frequency of attachment problems may also be due to the fact that this term is often applied as a general diagnosis encompassing diverse difficulties. It tends to be one of the first things mentioned when adopted children display challenging behavior.

When mental health workers were asked about the cause of the children's difficulties, the adverse effects of deprivation were clearly stated. All felt that the period of deprivation in Romania had played a significant part in the current problems. Other possible causes they named were hereditary factors, and drugs and alcohol misuse by the mother during pregnancy, the latter possibly leading to Fetal Alcohol Syndrome (Stromland, 1996). Often, little is known about the children's genetic background and early life experiences, which makes a proper diagnosis and anamnesis more difficult. It is important for institutions and adoption agencies in the country of origin to collect as much information as possible about the child as a means of helping later treatment.

For most families, the road to finding appropriate support services was a long one. Almost all had already seen two or more other mental health workers before, and parents reported finding it difficult to access services that suited their child and family, a delay that harms the development of the child. Adoptive parents need easy access to available and appropriate services, so that therapeutic care can be started as soon as possible.

The eleven children received different kinds of treatment. Three were in residential care and mental health workers suspected that this would be necessary for three others in the future. Such care relieved the burden on the family, and offered the child a very structured, predictable environment.

The advice of ensuring structure and predictability was also given to those parents seeking help with parenting. In order to function optimally, these children require a safe environment with structured daily activities and few unexpected changes. The same conditions were also found to be important in studies among the parents and teachers of these children (Rijk, Hoksbergen, & ter Laak submitted).

Therapy with the whole family was used to improve the parent-child relationship and promote attachment. Through this, mental health workers hoped to achieve behavioral modification. For one child, Video Home Training (Polderman, 2004) was used; for another, Holding therapy (Welch, 1988). In both cases, parents learned to interpret the behavior of their child from an attachment perspective and how they could best respond to this.

Individual play therapy was applied to make the child aware of their own behavior and emotions, and to help him control and modify them. Early-life deprivation may lead to (symptoms of) Post Traumatic Stress Disorder (Hoksbergen, ter Laak, van Dijkum, Rijk, Rijk et al., 2003). Play therapy may be useful to reduce these problems.

In general, parents are more positive than mental health workers about the effectiveness of therapy. Parents appeared to value any positive development, even if treatment goals were not reached. It may be that earlier experiences with (ineffective) services have lowered their expectations. An earlier part of this study indicated that adoptive parents have a more positive approach towards their children's difficulties than non-adoptive parents (Rijk et al., 2006).The mental health workers seemed more aware of the fact that the treatment did not have the effect it was supposed to have, and that the goals

established after intake were not reached. The nature and severity of the children's behavioral problems lead to low expectations of future improvement.

For only one child was the therapy concluded successfully. The method used was Holding therapy, an intensive approach, in which explicit physical proximity is promoted to form a bond between parents and child. This is a controversial form of therapy that requires extensive knowledge and sensitivity on the part of the professional, and can be harmful and dangerous when applied wrongly (Myeroff, Mertlich, & Gross, 1999). The therapy was aimed at one specific goal (parent-child attachment) and the desired result was reached in a relatively short time. A clear and singular aim, and the lack of additional (severe) problems may explain this success. For the other ten children, therapy was still in progress, or the child had been referred to another agency.

Most mental health workers expected that long-term treatment would be necessary and for some children help is likely be necessary throughout their lives. Although in a few cases treatment goals were partially achieved, other issues remain. The complex and extensive nature of these children's difficulties form a challenge for both parents and mental health workers and long-term investment is necessary (Rushton, 2003). It is important for interventions with deprived internationally adopted children to undertake longitudinal follow-up studies charting their development to adulthood.

Limitations, and recommendations for future research

The aim of this study was to explore the experiences of families with deprived internationally adopted children receiving professional help. Diverse treatment possibilities (residential care, guidance of parents, therapy for families and children) were used. The study provides a general picture on which future studies may be based. It would be interesting, for example, to compare the effectiveness of different therapies, and to assess which therapy is best suited for which child.

A limitation common to qualitative studies is the lack of a non-adopted group with comparable behavioral problems, and a comparison group of adopted children from countries other than Romania. Since no previous research has been done on this subject, comparison was not possible.

Implications and recommendations for practice

The mental health workers agree that adoption-specific knowledge was important for people working with adoptive families as most of them felt they lacked this at the onset of treatment. Ideally, all mental health workers should have this knowledge, but since adopted children form a relatively small group – and deprived internationally adopted children are an even smaller group – it is not reasonable to expect it. However, it is possible for mental health workers to have easy access to relevant information. Several of the workers and parents we interviewed suggested that adoption experts should be available for consultation. Adoptive families benefit from an approach that is adapted to their specific situation (Hart & Luckock, 2006).

It is remarkable in a country as sophisticated as the Netherlands that these, obviously severely deprived, children are placed in their adoptive families without any structured aftercare. The severe behavioral problems of the children, and the difficulties of the parents in finding suitable help identified in the chapter demand radical change in the system, with standard aftercare available to all adoptive families.

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Table 2 Overview of the diagnosis, treatment method and effectiveness according to parents and mental health workers for the 11 children.

Characteristics child	Reasons for consulting professional	Diagnoses	Treatment method	Effectiveness of care according to: Parent	Mental health worker	Treatment finished?	Future
1. Female Age: 10;9 Age adoption: 2;4 Special education: Yes	- aggression - self-harm - compulsions - problems in contact with other children	- Severe cognitive delays - Reactive Attachment Disorder	Daily treatment in group setting based on anthroposophical principles [1]	+	–	Yes →	Referred to other institution
	- communication problems - aggression - self-harm - extreme need for attention - lack of conscience	- PDD-NOS - Reactive Attachment Disorder - Severe cognitive delays	Residential care in small group form	+/–	+/–	No	Will likely stay in institution until adulthood
2. Female Age: 9;10 Age adoption: 2;8 Special education: Yes	- aggression - communication problems - cognitive problems - self-harm - testing boundaries	- Severe cognitive delays - PDD-NOS - Attachment difficulties	Residential care in small group form - structure - much attention - explaining and visualizing	+	+/– (partially effective)	No	Will likely stay in institution until adulthood
3. Male Age: 12;9 Age adoption: 6;7 Special education: Yes	- aggression - lack of conscience - autistic behavior - testing boundaries - inappropriate sexual behavior	- ADHD - PDD-NOS	Residential care in small group form - structure - neutral affective attitude - explaining and visualizing	+	+/– (partially effective)	No	Will likely stay in institution until adulthood
4. Male Age: 10;3 Age adoption: 3;1 Special education: Yes	- aggression - tics	- Reactive Attachment Disorder - Severe cognitive delays	- Medication (several neuroleptic drugs) - Guidance parents - Referral to additional help	+	–	No	Referred to institution. Still responsible for guidance and medication.

Characteristics child	Reasons for consulting professional	Diagnoses	Treatment method	Effectiveness of care according to: Parent	Mental health worker	Treatment finished?	Future
5. Male Age: 8;6 Age adoption: 2;3 Special education: No	- problems in social behavior - fears (abandonment, new situations)	- ADHD - Attachment difficulties	- Video Home Training[2] - Guidance parents - Medication (Dipiperon®, in cooperation with general practitioner)	+	+/– Set goals were mostly reached, some issues remain	No	Treatment will be concluded in the near future.
6. Male Age: 13;1 Age adoption:2;5 Special education: Yes	- ADHD-behavior - aggression - testing boundaries - low frustration-tolerance - difficulties in social interaction	- Attachment difficulties - Symptoms of PDD-NOS	- Play Therapy - Social Skills Training - Reward system	+	+/– (Positive development, but problems remain)	No	Mental health worker foresees worsening of problems due to puberty.
7. Male Age: 12;9 Age adoption: 0;7 Special education: Yes	- problems in social contacts - aggression - inappropriate sexual behavior	- PDD-NOS - Severe cognitive delays	- Guiding parents - Coordination approach child at home and at school → consequent	–	–	No	(Very) slow positive development, but serious issues remain.
8. Male Age: 10;11 Age adoption: 3;2 Special education: Yes	- aggression - testing boundaries in classroom - needs to be in control - demands much attention - difficulties in social interaction	- Attachment difficulties - Fears - Severe attention problems	Play Therapy (learning awareness of own emotions and behaviors, and how to control them)	+	– (progress during therapy, but no change in other situations)	No	Therapy will not be concluded in the foreseeable future.
9. Male Age: 11;1 Age adoption: 4;3 Special education: Yes	- problems in contact and communication	- Attachment difficulties - Cognitive delays	Holding Therapy (Working with family and guiding parents)	+	+	Yes →	(but option to contact mental health worker when problems arise)

Characteristics child	Reasons for consulting professional	Diagnoses	Treatment method	Effectiveness of care according to: Parent	Mental health worker	Treatment finished?	Future
10. Male Age: 13;0 Age adoption: 6;5 Special education: Yes	- low cognitive level - delay in emotional development - problems in social interaction - inappropriate sexual behavior	- Severe cognitive delays - Attachment difficulties	Guiding parents Both practical guidance (e.g. school placement) and advice (helping parents accept the situation)	+/–	–	No	Mental health worker foresees placement in residential setting in near future and wishes for parents to acknowledge the pressure they experience.
11. Male Age: 8;2 Age adoption: 1;8 Special education: Yes	- aggression - fits of anger - self-harm - problems in social interaction - stereotypical behavior	- Attachment Problems - Symptoms of PDD-NOS	Guidance of parents: Advice about parental approach Alternative therapy: Homeopathic medication (relaxing)	+	+ (set goals were partially reached)	No	Therapy will gradually be concluded.

ADHD = Attention Deficit Hyperactivity Disorder

PDD-NOS = Pervasive Developmental Disorder – Not Otherwise Specified

1 Based on the teachings of Rudolph Steiner. Much emphasis is placed on the creative development of the child, and specific therapy forms such as eutony are used.

2 Video Home Training is a therapeutic technique for which video-recordings of daily life are used. Parents review the recorded material with their therapist, and receive advice about how to handle the problems that occur.

General Discussion and Conclusions

In December 1989, the 24-year old regime of Nicolae Ceauşescu came to an end. Romania was abruptly opened to Western communication channels, and with it its children's homes. Many press officials from several countries visited the large number of state-run orphanages. It soon became obvious that the circumstances of 120.000 to 150.000 abandoned children living in those children's homes were dreadful (Ames, 1990; Battiata, 1990). Almost immediately after the collapse of Ceauşescu's dictatorship international adoption started, as did studies of the circumstances of these internationally adopted children in the receiving countries (Ames, Fraser, & Burnaby, 1997; Groze & Ileana, 1996; Johnson, 1999; Marcovitch, Goldberg, Gold, Washington, Wasson et al., 1997; Rutter, Kreppner, & O'Connor, 2001; Rutter & the English and Romanian (ERA) Study Team, 1998).

The dreadful conditions of Romanian orphans after the reign of Ceauşescu made many Western parents decide to adopt, but also made their parenting task an extra challenge. Most children that have resided in a Romanian orphanage have experienced both physical and psycho-emotional neglect and deprivation (Ames, 1990). Their complex background makes the upbringing of these children a challenge for all involved. First of all the parents, but also the teachers and mental health workers are confronted with this challenge.

The central theme of this thesis is how parents, teachers and mental health workers deal with the psychosocial problems of (severely) deprived adoptive children. Before these three perspectives were assessed, the behavioral development of the children and parental burden of the adoptive parents were determined.

This study is part of a longitudinal study among Romanian adoptive children in the Netherlands. These 80 children (44 boys, 36 girls) were on average 2;10 (2 years and 10 months) old when they were adopted. The behavioral functioning and development of these 80 children was evaluated when they were on average 8;0 years old and for 72 of them again when they were on average 10;1 years old. At the first measurement, 31% of the children was in special education; at the second measurement this was 47%. At both times this was an over-representation in comparison to non-adoptive children. For a selection of 18 children (11 boys, 7 girls) with severe behavioral problems and 15 children (9 boys, 6 girls) with little to no behavioral problems, further qualitative analysis was conducted. Parents of these 33 children were interviewed, as were the teachers (n=17) and mental health workers (n=12) of the group of 18 children with severe behavioral problems.

Nature, severity and pervasiveness of behavioral problems

Forty-one (51%) of the 80 children that participated in our study showed symptoms of behavioral problems to an extent that they scored within the clinical range of different standardized instruments like the Child Behavior Checklist (CBCL, Achenbach & Edelbrock, 1983). Symptoms of trauma (20%), (post-institutionalized) autism (16%), and ADHD (15%) were found, comparable to the results of the study of Romanian adoptive children done in the UK by Michael Rutter and colleagues (Rutter, O'Connor, & the ERA study team, 2004). Based on the results, the total group can be divided into three subgroups: a group that showed severe, multiple behavioral problems with a high rate of co-morbidity (14%), a group that showed moderate behavioral problems (37%), and a group that showed little to no behavioral problems (39%).

This division may reflect the processes through which the experienced deprivation has affected the functioning of the children. Thirty-nine percent of the children showed little to no behavioral problems after they have spent several years in their adoptive family. An earlier stage of the current study showed that most children (87%) did show some behavioral problems shortly after arrival into the adoptive family (Hoksbergen & co-workers of the Romania project, 1999, 2002). For the children who showed little to no behavioral problems after spending on average five years in the adoptive family, the deprivation they experienced does not seem to have had a permanent effect. This could indicate that they were mostly resilient to the adverse experiences, or had only adapted their behavior in the depriving situation, and were able to successfully adjust to their new environment, the adoptive family (O'Connor, 2003; Peters, Atkins, & McKernan-McKay, 1999; Rutter et al., 2004).

A considerable group (37%) of the children in our study showed moderate behavioral problems. For these children, deprivation appeared to have a more lasting effect. However, the permanency of these effects cannot be determined until the children have reached adulthood. This makes it hard to discern the processes that lead to these behavioral problems. A heightened vulnerability to behavioral and developmental problems is likely, and the individual circumstances of the children may influence how this affects their functioning (O'Connor, 2003; Peters et al., 1999; Rutter et al., 2004).

A small group of children (14%) showed severe developmental and behavioral difficulties, often combined with cognitive delays. For these children, neurological damage as a consequence of deprivation is more likely (Eluvathingal, Chugani, Behen, Juhász, Muzik et al., 2006). Genetic and prenatal factors may also have been of influence. More detailed information about their history could shed more light on this. For these children, the effects appear permanent and pervasive (O'Connor, 2003; Rutter et al., 2004).

This diversity in responses makes it likely that the effects of early life deprivation reflect a complex interplay of genetic and environmental influences on the child, which may create both vulnerability and resilience. Some children appear affected on a neurological level, while others have likely only experienced behavioral adaptation (Rutter, 2006). The length of stay in a

children's home, the severity of deprivation, prenatal drug or alcohol abuse by the mother, and the traumatic events experienced are likely factors that create vulnerability for behavioral and developmental problems, whereas personal (foster) care for the child, consistency in care, a strong genetic make-up, and an outgoing character may create resilience.

The second measurement using the CBCL took place five years later, when the children had been in the family for approximately 10 years on average. On average, scores changed little over time, with a high correlation between the first and second measurement (.71 on Total Problems), indicating that the behavioral problems of the children remained stable, and that the parents were consistent in filling out the CBCL. The behavioral problems appeared to be pervasive. When looked at the individual development of the children, it becomes clear that some children did show a marked improvement, and others an increase in behavioral problems according to the results of the CBCL. Certain trends can be seen when looked at three different groups (decrease in problems, no change, and increase in problems). The "decrease in problems" group was the oldest at adoption, and the youngest at time of study, while the "increase in problems" group was the youngest at arrival and the oldest at time of study. The year of adoption also differed, the "decrease in problems" group was adopted on average two years later than the "increase in problems" group (1996 vs.1994). This may reflect a change in the care children received in the children's homes, and in the nature of deprivation they experienced. Both groups had comparable levels of health problems at arrival, indicating that both had experienced the same degree of physical deprivation. Improvements in care in the children's homes possibly lead to a lessening in cognitive and affective deprivation, however, which could have improved the resilience to long-term behavioral problems in children adopted at a later time. The lack of change in CBCL scores of the group in general clearly indicates that the burden on the family does not lessen much over time. The fact that all children in the "decrease in problems" group had received professional help in the period between the two measurements, and half of them were in special education, reflects the possibilities for improvement if external help is engaged at an early stage.

Parenting burden

The parents of Romanian adoptees in general experienced more parenting stress than non-adoptive parents. Divided into two groups, a group that did and a group that did not receive professional help, the adoptive parents could be compared to their non-adoptive counterparts. The group that did not receive professional care did not differ from the comparable non-adoptive parents in their perception of the upbringing situation. The Romanian adoptive families who received professional care did differ from the comparable non-adoptive families on some aspects of the NVOS. Their assessment of the problems was comparable, but the parenting situation and satisfaction were judged more positively by the adoptive parents. Though their actual burden appeared to be

comparable to non-adoptive families receiving mental health services, the perceived burden was less for adoptive parents. The adoptive families in our study appeared to be stable (low divorce rate) and to some degree resilient to the stress of a child with behavioral problems. Mothers and fathers differed very little in their assessment of the parenting burden, which may reflect a strong unity of the parents in the raising of their children. Regression analysis shows that the parenting burden increased and adoption satisfaction (1998) decreased as the behavioral problems increased. Predictably, the parents who had sought professional help experienced less adoption satisfaction than the parents who had not sought help.

The heightened parenting burden, also found by Judge (2003a), reflects the high demands that the upbringing of a deprived adoptive child places on the adoptive parents. It is a burden that they mostly appear to be able to bear. Pre-adoptive screening of the parents and guidance in both the pre-adoptive and post-adoptive period can be important tools in minimizing and alleviating the parenting burden.

Parents' experiences in dealing with the effects of deprivation

A selection of 18 children with multiple, severe behavioral problems was studied, as was a selection of 15 children that showed little to no problematic behavior. The parents differed very little in their approach of developmental and adoption issues and behavioral problems. The most important themes mentioned during the interview reflected a structured, warm and loving approach with much attention for and communication with the child. A highly structured daily life provides predictability for the child, which creates a feeling of safety. It prevents the stress that is often seen in deprived adoptive children when they are confronted with (unexpected) changes. This need for structure may reflect traumatic experiences in the past, where the child had no control over his environment (Allen & Vostanis, 2005; Hoksbergen, ter Laak, van Dijkum, Rijk, Rijk et al., 2003). Even years after their adoption, these children still require a safe and predictable environment to prevent stressful responses which might severely hinder their functioning (Federici, 1998). The need for a warm, loving and accepting approach by the parents indicates that the children had suffered deprivation of the third level (Gunnar, Bruce, & Grotevant, 2000), a lack of warmth and care giving in the Romanian children's homes. A warm and accepting approach promotes self-confidence, which these children often lack (Hart & Luckock, 2006). Acceptance of the difficulties and possibilities of the children prevents stress in both the children and the parents. Communication was important on different levels, as a way to explain rules and situations, as a way to bond, and as a way to give the child insight into his and others emotions. By communicating to help the child understand himself and the environment, parents can resolve deprivation of the second level (Gunnar et al., 2000), the lack of stimulation of the child's development.

Communication was one of the two things in which the group with severe behavioral problems differed from the non-problematic group. Parents mentioned it less in the first group. It is likely that the developmental and

behavioral difficulties of the children hindered communication. Another difference between the two groups was the awareness of their parenting methods. As was to be expected, parents in the problematic group were more aware of the parenting skills they applied, and needed to apply. Their contacts with mental health workers may have been of influence on this awareness. Parents in both groups invested much time and effort into the raising of their child, with one parent at home permanently in most of the cases.

Teachers' experiences in dealing with the effects of deprivation

The children in our study are over-represented in special education, and this has only grown over time. The percentage of children in special education increased from 31% to 47% in a period of five years. Seventeen teachers of the children with multiple, severe behavioral problems were approached. Most of them (n=13, 76%) were from schools for special education. The main problems the teachers reported in the classroom were hyperactivity, aggression, social problems and a heightened sensitivity to the influence of other children. Despite the known cognitive delays due to early life deprivation (O'Connor & Rutter, 1999), teachers in our study often reported that behavioral problems of the children limited the development of their cognitive abilities. Their hyper-vigilance in the classroom kept the children from focusing on their scholastic tasks. This is important knowledge for all teachers of (deprived) adoptive children. Creating a safe environment in the classroom may have a strong positive effect on the cognitive development of these children (McCarthy, 2005).

The approach adopted by the teachers to counter these problems was comparable to that of the parents. A strongly structured approach, with much positive attention for the child, was deemed most helpful by the teachers. Even within the systems of schools for special education, these children required their own approach according to the teachers. Hyperactivity and aggression were reported to peak when the children were faced with unexpected or overcrowded situations. So teachers made the environment of the children as predictable and as quiet as possible. A time-out into a quiet place, designed for this, was often used to prevent the child from going into a negative spiral of aggression. Like the parents, teachers invested much of their time and effort in helping the child to function properly in the classroom. The teachers' experiences reflect effects of deprivation comparable to those experienced by the parents when caring for their children: traumatic experiences combined with a lack of control over the environment have likely created a fear of unknown events in the children, which is expressed through their hyper-vigilance in the classroom and their stress-response when faced with unexpected changes.

In general, parents were satisfied about the methods of the teachers, although in some cases there were disagreements about the abilities of the children. Parents did not always feel that the potential of their children was fully explored in school. Frequently teachers indicated that they felt a lack of knowledge about the influence of early life deprivation and adoption on the

school functioning of the children, and that they had consulted colleagues or advisors about how to deal with certain problems of these children.

Experiences of mental health workers in dealing with the effects of deprivation
Twelve mental health workers of the group of 18 children that experienced severe behavioral problems were interviewed. First, parents were asked to describe their experiences with professional mental health care. All parents reported some degree of difficulty in finding appropriate care, some to a point at which they considered no longer actively seeking help due to past disappointments with professional help. All parents had consulted multiple mental health workers, a time-consuming and expensive process. Parents were, however, generally satisfied with the mental health workers they were consulting at the time of study. As a reason for this they reported that the current mental health worker understood the specific problems they were confronted with.

Most notably, the mental health workers, who had diverse backgrounds and methodologies, were generally not satisfied with the care they provided, stating it was not effectively reducing the problems experienced by the adoptive families. With one exception in which therapy was concluded positively, all other mental health workers indicated that set therapy goals were not (yet) met, and that they had not (yet) achieved the results they had set out to achieve. The discrepancy in satisfaction between parents and mental health workers indicates that there is much need for the development of effective treatment methods for the specific problems of these children (Federici, 1998). Nine out of the twelve mental health workers reported a lack of knowledge about adoption, and more specifically about the effects of adverse early childhood experiences. They had all consulted colleagues or other counseling, but most did not feel that they had found the appropriate methods. The interviews with the mental health workers reveal a lack of knowledge about and resources for deprived adoptive children.

The characteristics of care that the mental health workers feel is effective, show great similarities with the approach of the parents. Again, a structured, warm and accepting approach is promoted.

Their adoption into Dutch families has enabled these children to receive much care and attention from their parents, teachers and mental health workers. For some children, this has resulted in them functioning normally. For others, (severe) problems remain. For these children, proper and extensive care remains of great importance. The results of chapter 4, 5 and 6 demonstrate that these children respond best to approaches that are beneficial to all (problematic) children. A structured and warm approach is the basic attitude one would hope all parents, teachers and mental health workers have. What is special about these children is that they need a more strongly and consistently applied version of this approach, in some cases even more than a non-adoptive problematic group of children, such as children in a school for special education for children with behavioral problems (see chapter 5). As is demonstrated in chapter 4, the extreme need for structure these children

display can go against the grain of the parents, who at first feel they are being much too strict. Finding a balance in this is a process that will require some time.

To this day, the international adoption of Romanian children remains a subject of discussion. In the process of becoming a member of the European Union (which became official in January 2007), Romania was required to change their child care system. A moratorium, later changed into a law, made international adoption of Romanian children impossible (U.S. Department of State, 2004). Despite this, supporters and opponents of Romanian adoption continue to discuss the benefits and disadvantages of international adoption for children without parental care in Romania. A recent publication by Roelie Post (2007) describes how this discussion unfolded over the years, revealing a lack of proper regulations in Romania and evidence of child trafficking. This amongst others has lead to the law preventing international adoption from Romania. Other sources describe how the abuse and lack of proper care in Romania made orphans express the wish to have been adopted internationally, instead of staying in a Romanian institution (Graham, 2006). Given the developmental and educational challenges of these children demonstrated in this study, and the difficulties in finding help, appropriate care for them should be the first focus of all parties involved. Although the number of domestic adoptions has been steady at around 1.300 children each year between 2000 and 2005 (Romanian Office for Adoptions, 2006), the number of children still residing in institutions (approximately 30.000) remains a reason for concern (Joint Council in International Children's Service, 2004).

Limitations and suggestions for future research

This study describes the development and functioning of a specific group of children that are faced with the challenge of being adopted (Brodzinsky & Palacios, 2005), and the consequences this may have, and additionally, with the effects of (severe) early life deprivation. Since the borders of Romania will likely remain closed for international adoption, it is not to be expected that this group will grow in the future. Adoption from other Eastern European countries still takes place, however, and research suggests that these children show comparable behavioral and developmental problems (Judge, 2003b). With an average of 1200 international adoptions into the Netherlands each year (Ministerie van Justitie, 2006), some children from countries where care for orphans is poor, it is likely that most of these adoptive children have experienced some degree of deprivation or neglect. The experiences of the children in this study may shed light on the situation and best approach of all internationally adopted deprived children. The difficulties of parents, teachers and mental health workers in finding proper knowledge about the effects of deprivation, and about effective treatment to limit these effects, indicate that

more insight is needed. In order to promote prevention, the factors that make these children vulnerable or resilient to the effects of deprivation should be assessed.

The exact processes through which deprivation affects the functioning of the children cannot be determined due to a lack of knowledge about their precise history in Romania. Indirect indicators such as the time spent in a children's home or the health at arrival do indicate that the severity of the deprivation is directly related to the degree of developmental and behavioral problems, but we remain in the dark about the genetic and prenatal background of the children. More information about this may help in creating more effective treatment methods.

Recent developments in neurological research can give insight into the way the neurological functioning is altered by early life deprivation. An example of this is the recent study of Eluvathingal and colleagues (2006). The mechanisms described in this study should be explored further. In addition, the development of deprived children should be followed into their adulthood to fully asses their ability to recover from deprivation.

A qualitative design was chosen to answer some of the questions in this study, since they were largely unknown terrain, and we wanted to gain insight into the important themes according to the people involved. These qualitative aspects of the study provide us with an indication of the benefits and difficulties of parental and professional care for deprived children, but cannot be applied to evaluate the effectiveness of different parenting styles or treatment methods. This could be done by using observations and clinical trials. Development and evaluation of effective treatment to counter the effects of physical, developmental and emotional early life deprivation should be the focus of future research. These projects should by no means be limited to adopted children, but should be aimed at early intervention and prevention of problems, both in the country of origin of children and, if they are adopted, in the adoptive family. A recent example of an initiative for early intervention is the Orphanage DVD Education project of clinical psychologist Niels Peter Rygaard (www.attachment-disorder.net). The group of children that appears to experience little to no long-term effects of deprivation, shows the remarkable resilience of some children when faced with adversity. Further research could help us to better understand this strong resilience, and lead to better care and support for those children who are obviously less resilient to adverse experiences.

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SAMENVATTING

Omgaan met verwaarloosde adoptiekinderen

De ontwikkeling en begeleiding van Roemeense adoptiekinderen in Nederland

Verschillende vormen van vroegkinderlijke verwaarlozing (fysiek, mentaal en emotioneel) kunnen effect hebben op de latere ontwikkeling van kinderen. Gedragsproblemen kunnen het resultaat zijn. Wanneer kinderen die (ernstige) vroegkinderlijke verwaarlozing hebben meegemaakt worden geadopteerd, biedt deze situatie de mogelijkheid om te bestuderen welke effecten verwaarlozing op kinderen heeft, in hoeverre het mogelijk is hiervan te herstellen als het kind in een gezonde omgeving wordt geplaatst, en op welke manier de omgeving een positieve ontwikkeling het beste kan stimuleren.

Deze studie is een onderdeel van een longitudinal researchproject onder Nederlandse gezinnen met Roemeense adoptiekinderen. Doel van de studie is om te achterhalen hoe de kinderen, die allen (ernstige) verwaarlozing hebben gekend in Roemenië, zich ontwikkelen in de jaren na hun adoptie, en te bestuderen welke benadering ouders, leerkrachten en hulpverleners hanteren om een positieve ontwikkeling te bevorderen. De 80 onderzochte kinderen, 44 jongens en 36 meisjes, werden in de periode 1990 -1997 geadopteerd en waren bij aankomst in het adoptiegezin gemiddeld 2 jaar en 10 maanden oud (2;10, range 0;1 – 6;7). Hun functioneren en mogelijke gedragsproblemen werden vastgesteld toen ze gemiddeld 8;0 jaar oud waren. Vijf jaar later werden 72 van deze kinderen (41 jongens, 31 meisjes) opnieuw onderzocht om ontwikkelingen in hun situatie te kunnen vaststellen. Ten tijde van de eerste meting bezocht 31% van de kinderen een school voor speciaal onderwijs, bij de tweede meting was dit gestegen naar 47%, zeer veel hoger dan het landelijke gemiddelde, dat rond de 3 % ligt.

Om naast inzicht in de problemen ook te kunnen bestuderen hoe met deze problemen werd omgegaan, is een deel van de groep van 72 kinderen op basis van eerdere onderzoeksresultaten geselecteerd om deel te nemen aan uitgebreider onderzoek. Voor een groep van 18 kinderen (11 jongens, 7 meisjes) met ernstige gedragsproblemen en een groep van 15 kinderen (9 jongens, 6 meisjes) met weinig tot geen gedragsproblemen werd verdere kwalitatieve analyse uitgevoerd. Hiertoe werden de ouders van al deze 33 kinderen geïnterviewd, alsook de leerkrachten (n=17) en de hulpverleners (n=12) van de groep kinderen met ernstige gedragsproblemen.

Hoofdstuk 1

In dit hoofdstuk worden de gedragsproblemen beschreven, die de kinderen ten tijde van het eerste onderzoek lieten zien, toen zij gemiddeld vijf jaar in het adoptiegezin waren. Van de 80 kinderen krijgen er 36 (45%) een klinische of grensscore op de gestandaardiseerde vragenlijst, de Child Behavior Checklist (CBCL). Dit wijst op het bestaan van ernstige gedragsproblemen. Symptomen wijzend op trauma (20%), autisme (16%) en ADHD (15%) komen eveneens voor. Tussen jongens en meisjes bestaan geen significante verschillen. De totale groep van 80 kinderen is onder te verdelen in een groep van 11 kinderen (14%) met ernstige gedragsproblemen, bij wie co-morbiditeit vaak voorkomt, een groep van 30 kinderen (37%) met milde gedragsproblemen en een groep van 39 kinderen (49%) met weinig tot geen gedragsproblemen. Hoewel deze kinderen allemaal een periode in een Roemeens kindertehuis hebben doorgebracht, waar zij naar alle waarschijnlijkheid verwaarlozing hebben meegemaakt, is hun reactie hierop verschillend. Mogelijk spelen hierbij verschillen in de mate van genetische kwetsbaarheid en verschillen in omgevingsfactoren een rol. Hierover kan op basis van deze studie echter geen conclusie getrokken worden. Het frequent (voor 51 van de 80 kinderen) consulteren door de ouders van professionele hulpverlening geeft aan dat zij assistentie nodig hebben bij de opvoeding van hun kind.

Hoofdstuk 2

De ouderlijke belasting ten gevolge van de gedragsproblemen van de kinderen is onderwerp van hoofdstuk 2. Met behulp van de Nijmeegse Vragenlijst voor de Opvoedingssituatie (NVOS) werd bepaald in hoeverre de 72 ouderparen van de 80 Roemeense kinderen de opvoeding als belastend ervaren. De ouders van de Roemeense kinderen ervoeren meer opvoedingsbelasting dan ouders van een niet-geadopteerde normgroep. De ouders van 51 van de 80 kinderen hadden professionele hulp voor hun kind(eren) ingeschakeld, de overige 29 kinderen ontvingen geen professionele hulp. Vergeleken met een normgroep van niet-adoptieouders die geen professionele ondersteuning voor hun kind ingeschakeld hadden, bleken de ouders van die 29 kinderen niet te verschillen in hun perceptie van de opvoedingsbelasting. Vergelijking van de adoptieouders en niet-adoptieouders die wel hulpverlening hadden ingeschakeld liet wel enkele verschillen tussen deze twee groepen zien. De perceptie van de ernst van de problemen was even groot, maar de adoptieouders ervoeren minder stress en meer voldoening in de opvoeding. De gezinnen in onze studie lijken stabiel (o.a. slechts 2 echtscheidingen) en tot op bepaalde hoogte bestand tegen de stress die de opvoeding van een verwaarloosd kind met zich mee kan brengen. Moeders en vaders verschilden nauwelijks in hun perceptie van de zwaarte van de opvoeding. Dit zou kunnen wijzen op een grote overeenstemming in het gezin over de benadering van het kind. Regressieanalyse bij de groep adoptieouders laat, zoals voorspelbaar, zien dat

met het toenemen van de ernst van de gedragsproblemen ook de opvoedingsbelasting toeneemt, en de tevredenheid met de adoptiesituatie afneemt.

Hoofdstuk 3

De ontwikkeling van de gedragsproblemen van de kinderen, in de periode van vijf jaar na het eerste onderzoek wordt beschreven in hoofdstuk drie. Voor een groep van 72 kinderen werd de CBCL twee keer ingevuld, met een periode van gemiddeld vijf jaar tussen de twee metingen. De gemiddelde leeftijd bij de eerste meting was 8 jaar, bij de tweede meting 13 jaar. De gemiddelde score van de groep blijft stabiel, en er bestaat een hoge correlatie tussen de twee metingen. De zwaarte van de gedragsproblematiek is weinig veranderd in vijf jaar, de groep als geheel laat geen toename of afname van de gedragsproblemen zien. In vergelijking met de Nederlandse normgroep scoren zij nog steeds significant hoger. Wanneer gekeken wordt naar de individuele ontwikkeling van de kinderen, is te zien dat bij sommige kinderen wel een duidelijke toename en bij anderen een afname van de gedragsproblematiek geconstateerd kan worden. Verdeling in drie groepen (toename, geen verschil, afname gedragsproblemen) maakt enkele trends zichtbaar. De kinderen in de groep waarin de gedragsproblemen duidelijk afnamen hadden gemiddeld de hoogste leeftijd toen zij geadopteerd werden, en waren het kortste in het adoptiegezin. Terwijl de groep in welke de problemen toenamen het jongste was ten tijde van adoptie, en reeds langer in het Nederlandse gezin. Ook het jaar van aankomst in Nederland verschilde: de kinderen in de groep waar de problemen toenamen waren gemiddeld twee jaar eerder naar Nederland gekomen dan de kinderen in de groep die een afname van problemen vertoonde. Dit geeft mogelijk aan dat de zorg in de Roemeense kindertehuizen in de periode tussen 1994 en 1996 is veranderd. De groep die later naar Nederland kwam ervoer mogelijk meer gevolgen van verwaarlozing op de korte termijn, maar de problemen lijken minder pervasief te zijn. De kinderen in de groep bij wie de problemen afgenomen zijn hebben allen professionele hulpverlening gehad. Mogelijk heeft het tijdig inschakelen van deze hulp bijgedragen aan de positieve ontwikkeling die de kinderen laten zien.

Hoofdstuk 4

In dit hoofdstuk wordt beschreven welke benadering de adoptieouders kozen om gedragsproblemen te verminderen en een positieve ontwikkeling te stimuleren. Gestructureerde diepte-interviews met 18 ouderparen van kinderen met ernstige problemen en 15 ouderparen van kinderen met weinig tot geen gedragsproblemen werden op kwalitatieve wijze geanalyseerd. De groepen ouders verschilden weinig in hun benadering van de opvoeding, van de gedragsproblemen en van adoptiespecifieke aspecten. De belangrijkste thema's

die volgens de ouders een positieve uitwerking hadden waren een sterk gestructureerde aanpak, een warme, liefdevolle en vooral accepterende houding naar het kind toe, en veel aandacht voor en communicatie met het kind. De (sterk) gestructureerde benadering van het dagelijks functioneren maakt voor het kind gebeurtenissen voorspelbaar en dit geeft de kinderen kennelijk een gevoel van veiligheid. Dit voorkomt de sterke stressreactie bij veranderingen (zoals bijvoorbeeld het verzetten van een afspraak, een vervanger in plaats van de vaste leerkracht op school, het op vakantie gaan) die sommige kinderen vertonen. Goede communicatie werd van groot belang geacht. Dan kunnen veranderingen worden besproken en blijft er voor het kind zekerheid bestaan. De band met het kind wordt bevorderd en het kind kan inzicht krijgen in de eigen emoties en die van anderen. Alle ouders hebben veel aandacht voor het kind en besteden veel tijd aan de opvoeding. In de meeste gevallen is er te allen tijde ten minste één ouder thuis bij het kind. Ouders van de kinderen met ernstige gedragsproblemen verschilden in twee opzichten van de ouders van de kinderen met weinig tot geen gedragsproblemen. De eerste groep ouders gaf aan dat zij minder communiceerden met hun kinderen dan ouders van kinderen met weinig tot geen gedragsproblemen. Dit heeft mogelijk te maken met de soms ernstige cognitieve problemen van de kinderen in de eerste groep, waardoor bij hen het begrip kan ontbreken van wat er gecommuniceerd wordt. Ten tweede lieten de ouders in de problematische groep zien dat zij zich sterker bewust waren van hun opvoedingshandelen. Er was minder sprake van vanzelfsprekendheid en de ouders waren beter in staat hun opvoedingsbenadering precies te benoemen. Contact met hulpverleners zou dit mogelijk bewerkstelligd kunnen hebben. Voor alle kinderen in de problematische groep was ooit professionele hulpverlening ingeschakeld, voor de kinderen in de niet-problematische groep was dit slechts voor twee kinderen het geval.

Hoofdstuk 5

Dit hoofdstuk beschrijft de ervaringen van 17 leerkrachten van de kinderen in de problematische groep die in hoofdstuk 4 beschreven werd (één kind ging niet naar school vanwege de ernst van haar gedragsproblemen). Bij 13 kinderen (76%) gaat het om leerkrachten uit het speciaal onderwijs. De belangrijkste problemen van de Roemeense adoptiekinderen op school waren volgens de leerkrachten: hyperactiviteit, agressie, sociale problemen en een te grote beïnvloedbaarheid door andere kinderen. Voor vijf kinderen had de leerkracht het gevoel dat de gedragsproblemen van het kind diens leerproces en cognitieve ontwikkeling negatief beïnvloedden. Om deze problemen te verminderen hanteerden de leerkrachten een benadering die dezelfde kenmerken vertoonde als de benadering van de ouders. Een gestructureerde aanpak, met veel positieve aandacht voor het kind, werd van groot belang geacht. Deze kinderen hadden volgens de leerkrachten nog meer structuur nodig dan de gemiddelde leerling in het speciaal onderwijs. Hyperactiviteit en agressie waren het sterkst

wanneer het kind geconfronteerd werd met onverwachte of erg drukke situaties. Leerkrachten poogden zoveel mogelijk te voorkomen dat deze situaties zich zouden voordoen. Een "time-out" in een rustige omgeving bleek een werkzaam middel om te voorkomen dat het agressieve gedrag uit de hand liep. De leerkrachten besteedden over het algemeen veel tijd aan het kind en hanteerden een sterk persoonlijke benadering. Het merendeel van de 17 ouderparen was tevreden over de aanpak van de leerkracht. In enkele gevallen was dit overigens niet zo. Het ging dan vaak om een meningsverschil over het cognitieve potentieel van het kind: ouders hadden niet altijd het gevoel dat dit geheel benut werd. Dertien leerkrachten (76%) gaven aan dat ze een gebrek aan kennis ervoeren over de effecten van vroegkinderlijke verwaarlozing en adoptie, en dat zij collega's of andere adviseurs geconsulteerd hadden om advies te vragen over de beste benadering van bepaalde problemen.

Hoofdstuk 6

De ervaringen van de hulpverleners worden beschreven in dit hoofdstuk. Elf van de 18 kinderen in de problematische groep ontvingen op moment van onderzoek nog professionele hulpverlening, of hadden deze recentelijk afgerond. In totaal werden 12 hulpverleners (voor één kind twee hulpverleners) alsmede de ouders over hun hulpverleningservaringen geïnterviewd. Alle ouders hadden moeilijkheden ervaren bij het vinden van geschikte hulpverlening voor hun kind. In twee gevallen waren deze moeilijkheden zo groot dat de ouders overwogen hadden niet langer actief verder te zoeken naar geschikte hulp.

Over de huidige hulpverlening die zij ontvingen waren de ouders over het algemeen tevreden. Als belangrijkste reden hiervoor noemden de ouders dat ze zich door de huidige hulpverleners begrepen voelden. De achtergrond en methodiek van de geconsulteerde hulpverleners waren zeer divers. In drie gevallen was er sprake van residentiële zorg voor het kind, in alle andere gevallen werden het kind en/of de ouders ambulant begeleid. Het belang van een gestructureerde benadering van het kind werd ook door de hulpverleners opnieuw benadrukt. In tegenstelling tot de ouders waren de hulpverleners weinig tevreden over de resultaten die zij met de Roemeense adoptiekinderen behaalden. Op één uitzondering na, waar de therapie met positief resultaat was afgerond, waren de hulpverleningsdoelen (nog) niet compleet of geheel niet gehaald. Een gebrek aan kennis over adoptie en meer specifiek over de effecten van verwaarlozing in de vroege kindertijd werd vaak genoemd. Alle hulpverleners consulteerden collega's of begeleiders, maar de meesten hadden nog niet het gevoel de juiste methode gevonden te hebben.

De interviews met de leerkrachten laten zien dat er een gebrek aan kennis is over de effecten van verwaarlozing, en over de beschikbare hulpverlening voor geadopteerde kinderen die met verwaarlozing te maken hebben gehad.

Tijdens de opvoeding van verwaarloosde geadopteerde kinderen kunnen ouders, leerkrachten en hulpverleners te maken krijgen met specifieke gedragsproblemen die het gevolg kunnen zijn van deze verwaarlozing. Het is van groot belang dat zij over kennis beschikken inzake deze specifieke problemen, en over de manier waarop deze probleemkinderen het beste kunnen worden benaderd. Tevens zouden ouders op een eenvoudige manier toegang moeten krijgen tot hulpverleners die gespecialiseerd zijn in de behandeling van deze ooit verwaarloosde kinderen.

DANKWOORD

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Curriculum Vitae

Kathinka Rijk werd geboren op 13 april 1978 te Eindhoven. In 1996 behaalde ze haar Atheneum diploma aan het Sondervick College in Veldhoven. Daarna studeerde zij Gezondheidswetenschappen aan de Universiteit Maastricht. Tijdens haar studie was ze ook werkzaam als tutor en trainer van onderwijsgroepen. In 2002 rondde zij haar studie af, met als specialisatie Geestelijke Gezondheidskunde. Al tijdens haar afstudeeronderzoek was zij als onderzoeksassistente werkzaam op de afdeling Adoptie van de Universiteit Utrecht. Ook na haar afstuderen bleef zij hier werkzaam. Haar bijdrage aan het longitudinale onderzoek dat vanuit deze afdeling plaatsvindt, heeft geresulteerd in het proefschrift dat u nu voor zich heeft. Inmiddels is zij werkzaam als docent aan de Faculteit Sociale Wetenschappen, Universiteit van Tilburg.

Kathinka Rijk was born on April 13th, 1978 in Eindhoven, the Netherlands. In 1996 she graduated from the Sondervick College in Veldhoven. After her graduation she studied Health Sciences at the Maastricht University. During her study, she worked as tutor and trainer for first- and second-year students. In 2002 she completed her master's degree in Mental Health Sciences. During the completion of her master's thesis, she started working at the Adoption department of Utrecht University. She continued working there after her graduation. The results of her contribution to the longitudinal study initiated by the Adoption department can be found in the dissertation you are currently holding. Currently she is working as a lecturer at the Faculty of Social and Behavioral Sciences, Tilburg University.