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**THE STRENGTHS AND DIFFICULTIES OF ADOPTED CHILDREN – A PILOT
STUDY**

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MRFTAR002

A dissertation submitted in partial fulfilment of the requirements for the award of the degree
of Master of Arts (Clinical Psychology)

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Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature:

Date:

University of Cape Town

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Abstract

Background and Aims: International research has led to the conclusion that adopted children are at a greater risk of behavioural and emotional difficulties than non-adopted children. However, these findings have been inconsistent and inconclusive, and therefore cannot necessarily be generalised to a country such as South Africa with its diverse populations. This study explored the strengths of adopted children and the difficulties they face, in comparison with children who are raised by their biological parents, with a focus on the Cape Town area. Furthermore, this study sought to establish whether there was an association between demographic variables and adopted children's total difficulties scores.

Method: The study employed a mixed methods concurrent triangulation design. The quantitative data was collected from a survey with the parents ($n=61$) and teachers ($n=43$) of adopted and non-adopted children ($n=61$) using the Strengths and Difficulties Questionnaire (SDQ). The qualitative data was gathered from interviews with the adoptive parents ($n=7$) of eleven adopted children.

Results: The t -test results of the parent-rated SDQ scores suggested that adopted children displayed significantly more ($p = .03$) conduct-related behavioural difficulties than non-adopted children. The self-rated SDQ scores suggested that adopted children exhibited significantly more ($p = .04$) behaviours associated with hyperactivity than non-adoptees. However, these group differences were not consistent across informants. On all the other scales and total difficulties scores, there were no differences between the two groups. Multiple linear regression analyses suggested that the teenage adoptees (14-17 years) and those who had consulted with a mental health professional had more total difficulties than the younger children and those who had not been referred to a mental health professional. The thematic analysis suggested that while the adopted children were exposed to risk and had difficulties their common strength was social competence.

Conclusion: Overall, the adopted children were coping well with adoption and they and their non-adopted peers had comparable strengths and difficulties.

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People are much greater and much stronger than we imagine, and when unexpected tragedy comes...we see them so often grow to stature that is far beyond anything we imagined. We must remember that people are capable of greatness, of courage, but not in isolation...They need the conditions of a solidly linked human unit in which everyone is prepared to bear the burden of others.

Archbishop Anthony Bloom - The David Kiseen memorial lecture (1969).

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CHAPTER ONE: INTRODUCTION

Van Ijzendoorn and Juffer (2006, p. 1228) define adoption as “...the permanent, legal placement of an abandoned, relinquished or orphaned child within a family of relatives (kinship adoption) or within an unrelated family (non-kinship adoption)”. The practice of adoption has a long history and can even be traced back to biblical times, with the legendary story of Moses who was left in a basket by his mother to float on a river, until he was found and adopted by Pharaoh’s daughter who raised him as her own. However, most biblical stories of adoption were about infertile wives who raised children borne by their handmaids (Pivnik, 2010).

Today, adoption is practiced within the confines of the law and international policies like the Geneva Convention, which outlines the protocol for the adoption of children. However, the practice of informal adoptions is still rampant across the world and especially in Africa, where children represent the most vulnerable members of society. It has become popular practice for desperate couples and celebrities from the first world to adopt children from Africa and Asia, because it is easier than adopting children within their own countries; often, there is an exchange of money for the child (Selman, 2009). These ‘adoptions’ differ from legal adoptions, which usually occur through recognised government structures and registered independent organisations. However, these legal processes are lengthy and fraught with red tape, while the informal routes are quicker and have fewer pre-requisites for parents to adopt a child.

In South Africa, the practice of adoption also has deep historical roots. In most of the indigenous cultures, adoption was practiced to continue a family name, for instance, where a patriarch failed to produce an heir (Kadushin, 1970). Most often, the adoption of an heir occurred within the same family as a way of preserving the bloodline. For instance, the wife would conceive a child with the brother or other relative of her husband (or vice-versa), and he would ‘adopt’ the child, by raising the child as his own.

This old practice of adoption has not changed much, with most African children being ‘adopted’ by relatives, especially those orphaned because of HIV/AIDS. However, many children no longer have the benefit of extended family, and these are finding their way into the legal adoption system. These adoptions are conducted under South African law, which also recently legalised transracial adoption, which had previously been prohibited under apartheid law. This has resulted in an increase of Black children being adopted by White families.

As adoption laws and child welfare concerns increased, the interest of clinicians and researchers in adoption and in its practices, experiences and outcomes began to grow. Researchers began to explore adoption, albeit without formal theory to ascertain whether adopted children experienced unique psychological difficulties (Palacios & Brodzinsky, 2010).

In psychology, the difficulties of children are generally grouped under emotional and behavioural problems. However, the definition of emotional and behavioural problems is problematic, with several definitions being offered by various scholars but no general acceptance of a particular definition (Cross, 2011; Merrell, 2003). Nevertheless, scholars do agree that emotional and behavioural difficulties are best understood in terms of internalising and externalising difficulties, which typically emerge at various developmental phases (Carr, 2006; Merrell, 2003).

In middle childhood the most common difficulties are conduct and attention deficit hyperactivity (ADHD) problems, which include externalising behaviours, such as aggression, defiance and truancy. Conversely, the internalising difficulties in middle childhood are mostly indicated by somatic complaints and anxiety. In adolescence, the externalising behaviour most commonly exhibited is drug abuse, while the internalising problems include depression and eating disorders (Carr, 2006).

In the general population, it has been found that children have more conduct than emotional difficulties. Boys generally have more difficulties than girls, with boys experiencing more externalising difficulties, while girls have more emotional or internalising difficulties than boys (Carr, 2006; Cross, 2011).

The emotional and behavioural difficulties of children are influenced by several factors, such as family problems, disruption of attachment (e.g. the unexpected loss of particular caregivers), neglect or abuse. However, these risk factors can be moderated by protective factors, such as parental support, good parent-child relations and a safe, nurturing environment that fosters wellbeing (Hutchison, 2011).

The concern for adopted children emanates from the fact that most of them are exposed to risk factors, which make them vulnerable to behavioural and emotional problems. Such risk factors include institutionalisation, cognitive and nutritional deprivation as well as physical and emotional abuse. Furthermore, adoption itself has been a controversial issue, with two opposing perspectives regarding adoption. There are those who insist that adoption is good and that it is in the best interests of a child. Opponents argue that adoption is

damaging to a child and that it may actually cause more behavioural and emotional difficulties for children.

In the last decade, researchers in various parts of the world have begun to explore adoption in more detail, specifically to ascertain whether it is indeed a risk or protective factor for children. Brodzinsky, Smith & Brodzinsky (1998) suggest that one of the ways of exploring this contentious area of study is through adoption outcome studies.

1.1 Rationale

According to the National Department of Social Development (personal communication, February 18, 2011), there were 10, 814 adoptions between 2005 and 2010 in South Africa, which is a relatively small group in a general population of approximately 50 million. Nevertheless, it is crucial to explore what happens to these children because more and more children are being orphaned as a result of the high prevalence of HIV/AIDS in South Africa. In Cape Town, a notable increase in abandoned babies has also become a concern for authorities, leading to an increase in the number of adoptions each year (Cape Town Child Welfare, personal communication, March 11, 2011).

Furthermore, the new Children's Act No. 38 (2005) emphasises the preservation of a child's cultural heritage by matching children and parents based on culture and religion, without any psychological research to support this recommendation. In addition, little is known about what happens to adopted children beyond the first two years post-adoption, after which there are generally no follow-ups by social workers.

Although adoption has received considerable attention in the popular media, there is a paucity of empirical evidence with regard to adopted children in South Africa and the long-term effects of their adoption. Furthermore, the findings of international research are inconclusive and cannot necessarily be generalised to South Africa, which is a different psychosocial, cultural and political environment. This study therefore intends to contribute towards filling this gap in knowledge.

Thus far, international research has focused on the problems experienced by adopted children, in relation to the negotiation of 'normal' developmental tasks, but it has not focused on their strengths. This additional gap in knowledge is a limitation of most of the existing research, and one that this study will make an effort to address.

As an exploratory study in an area lacking in empirical research, the significance of this study lies in its contribution to psychological knowledge, and in its objective of understanding the strengths of adopted children in Cape Town and the difficulties they face.

The findings of this study are relevant to clinicians working with adopted children, because they can inform therapeutic interventions, which will help adopted children to adjust to their circumstances. It is hoped that this study will stimulate further academic discourse and psychological research on adoption in South Africa.

1.2 Research Aims

This study explored *quantitatively* the strengths and difficulties of adopted children, compared to children being raised by their biological parents in Cape Town. In addition, this study investigated whether there was an association between demographic characteristics and the adopted children's total difficulties scores.

This study also explored *qualitatively* the strengths and difficulties of adopted children within their contexts, by gaining insight into adoptive parents' experiences of the adoption process, and investigating their opinions of their adopted children's strengths and difficulties.

On a secondary level, the study sought to substantiate *qualitatively* the findings of the *quantitative* survey, and to explain any disparity between these findings.

1.3 Structure of the Dissertation

This dissertation is divided into five chapters. In Chapter One, the topic under research is introduced and the rationale and aims of the dissertation were outlined. Chapter Two reviews the existing literature on adoption and the research that has been conducted with regard to adopted children. Chapter Three describes the research design, sample and the methods employed in this particular study to collect and analyse the data. In this chapter, too, the ethical considerations and issues of reflexivity are discussed. Chapter Four reveals the results of the statistical and thematic analysis of the data and presents the main findings. Chapter Five summarises and integrates these findings. It also makes recommendations for future research and discusses the clinical implications of the findings.

CHAPTER TWO: LITERATURE REVIEW

In this chapter, a brief history of adoption research is outlined to contextualise the current study. Some theoretical frameworks within which adoption outcomes can be understood are discussed. Thereafter, research comparing the strengths and difficulties of adopted children and non-adopted children is described. Following this, the risk and protective factors that may account for specific outcomes relating to adopted children and the empirical evidence supporting those findings are presented. Finally, the limitations of the existing research and conclusions are presented.

2.1 Adoption Research

In America and Europe, research into adoption has been conducted since the mid 20th century. It has been observed that adoption research tends to follow trends, reflecting the contemporary issues of interest to academics of the time (Palacios & Brodzinsky, 2010). Some topics that have been of interest to researchers are: the adoptees' and their adoptive parents' experiences of adoption, effects of the adoption process, post-adoption adjustment after early exposure to deprivation, and adoption outcomes.

Adoption outcome studies first captured the attention of researchers after a landmark report by Schechter (1960). As a psychiatrist, he was the first to identify an over-representation of adoptees in his clinic. He reported that, over a five year period, more than 13,3% of his patients were adopted children, in a general population where adopted children represented 0.134% of the population. This indicated that adoptees were 6 times more likely to be referred to his practice than non-adoptees. He proposed that these significant figures of adoptee referrals were indicative of the psychopathological vulnerability of adopted children (Schechter, 1960; Schechter, Carlson, & Simmons, 1964).

This report paved the way for early outcome studies, which are now more than a decade old (Brodzinsky, 1993; Brodzinsky, Radice, Huffman, & Merkler, 1987; Sharma, McGue, & Benson, 1996). However, as is characteristic of adoption research, an interest has recently been rekindled in adoption outcomes (Juffer & van Ijzendoorn, 2005; Keyes, Sharma, Elkins, Lacombe, & McGue, 2008; Rosnati, Montirosso, & Barni, 2008).

Adoption outcomes research has yielded two contradictory sets of findings. Firstly, it has revealed that adopted children have a higher risk of behavioural difficulties (specifically externalising behaviours) compared to their non-adopted peers. The second set of findings

has led to the conclusion that most adopted children are well adjusted. This is taking cognisance of the early adversity they may have been exposed to before adoption, and the challenges of adjusting to life after adoption. Furthermore, these researchers assert that the adoptees' ability to adapt and develop in spite of the early adversity is evidence of the adopted children's resilience. Both sets of findings are grounded in, and supported by, psychological theory.

2.2 Theoretical Frameworks

The psychological theories that have been used by adoption researchers to anchor their findings can be grouped under two broad, but contrasting, perspectives. First there is the risk and resilience perspective (Luthar, Cicchetti & Becker, 2000). According to this perspective, adopted children are vulnerable to pre- and post-adoption risks. The danger or at-risk conditions may range from a single stressful life experience to exposure to war (Luthar et al., 2000). For instance, most of the children adopted from the public system have been exposed to adversity both before and after birth. These children are usually born to mothers from deprived socio-economic backgrounds, and they thus received little or no pre-natal care (McGinn, 2007). These impoverished backgrounds expose both mother and child to malnourishment and negative lifestyle habits, like smoking, drinking and substance abuse. In South Africa, the high prevalence of HIV/AIDS means that there is the added risk of mother to child transmission of HIV. Furthermore, the mother's psychological stress and anxiety around having an unwanted child all have negative ramifications for the developing foetus (Juffer & van Ijzendoorn, 2005; McGinn, 2007). These sub-optimal pre-natal conditions, combined with postnatal emotional, nutritional and cognitive deprivation and abuse, associated with life in an institution, places adopted children at a greater risk of negative outcomes (Goldman & Ryan, 2011).

Subsumed under this broad 'risk and resilience' perspective are theories that suggest specific explanations of why adoption might place children at risk. Some of these theories are the Biosocial Model (McGinn, 2007), the Stress and Coping model of adoption adjustment (Brodzinsky, Smith & Brodzinsky, 1998) and Attachment theory (Bowlby, 1973). Although each of these theories provides a different theoretical argument for why adopted children might be at risk of negative outcomes, they all share the idea that adopted children are exposed to early adversity, which increases their risk of negative outcomes.

The biosocial model (McGinn, 2007) subscribes to the view that adoptees' genetics and environment influence their outcomes. This theory proposes that some genetic or

biological factors increase the risk of negative outcomes, as some psychological disorders are hereditary. For instance, it has been found that there is a genetic component to ADHD, conduct disorder, schizophrenia and anti-social behaviours as well as alcohol and substance abuse (Brodzinsky & Schechter, 1993; Mash & Barkley, 2003). Adopted children whose biological parents have these pathologies are at increased risk of developing them as well. Therefore it would be folly to discount the 'nature' aspect in adoptee outcomes. While positive environmental factors may lessen the severity of these outcomes, some environmental factors may actually trigger or cause children to have difficulties. For example, when children who have alcoholic biological parents are placed with an adoptive parent with an alcohol addiction, it further increases the child's risk. Adopted children who experience parental divorce or domestic violence may become vulnerable to emotional difficulties, such as depression (Brodzinsky & Schechter, 1993). Based on the biosocial model, both biological (nature) and environmental factors (nurture) are crucial in considering adopted children's outcomes.

A different explanation of why adopted children might be at risk of negative outcomes is offered by the stress and coping model of adoption adjustment (Brodzinsky et al., 1998). Within this paradigm, adoption is considered a stressful experience inherently associated with loss for which adoptees learn coping strategies that help them to cope with being adopted. According to Brodzinsky (2011), when a child is adopted, emphasis is placed on what the child gains, namely, a permanent home with nurturing parents, and not on what the child loses or has already lost, in the case of children who are abandoned. Such loss causes stress for the child, which increases the risk of behavioural and emotional difficulties (Brodzinsky et al., 1998; Brodzinsky & Schechter, 1993).

Adoption-related loss often goes unacknowledged by society, and yet adoption involves substantial loss for the adoptive triad – the child, the adoptive parents and the birth parents (Brodzinsky, 2011; Lifton, 2010). Some of the losses in adoption are the birth parents who lose their child (McGinn, 2000), adoptive parents who have failed to procreate and who thus lose the hope of having their own 'golden child' (Lifton, 2010) and the adoptees, who lose their birth family, genealogy and the history that contextualises their identity (McGinn, 2000). Although this theory assumes that those losses are felt by all adoptees, it acknowledges that each child's experience is unique. The intensity of the feelings lies on a continuum, from intermittent mild feelings of confusion and sadness to persistent and deeply felt grief. Those feelings are then expressed through emotional and behavioural symptoms like anxiety, sadness and anger, crying or acting out (Brodzinsky, 2011).

Early and late placed adoptees also differ in their experience of loss. According to (Brodzinsky, 1987), for early placed children the sense of loss is "...subtle, and emerges slowly with time and in conjunction with the child's growing awareness..." and understanding of the meaning of adoption (as cited in Brodzinsky & Schechter, 1993, p. 7). In addition, this loss is less traumatic and unlikely to lead to psychopathology but instead increases a child's vulnerability to emotional and behavioural difficulties. For the late placed child, the losses are more apparent and perhaps more traumatic, as they are separated from attachment figures. According to the present theory, this makes late adoptees more vulnerable to adjustment difficulties than their early placed peers (Brodzinsky & Schechter, 1993).

According to the stress and coping theory, the outcomes of adopted children are determined by how the grieving process is facilitated and to what extent the feelings of grief and loss are resolved. However, there are some obstacles to adoptees mourning or grieving for their losses. Firstly, mourning requires remembering, but children who are adopted as infants never knew their birth parents or families (Pivnik, 2010). Secondly, children have a limited ability to mourn and they tend to perceive a lost object as being both alive and dead simultaneously. In addition, the knowledge of a 'lost' birth parent that is still alive further complicates the process of grieving (Brodzinsky, 2011; Lifton, 2010; Pivnik, 2010).

When grief goes unresolved, it is played out in the child's emotional and behavioural expression. Of particular interest in school-age children is the role of the fantasies through which they try to reconstruct the lost birth mother. However, the birth father poses an even greater challenge because there is no mental image, and there is no connection, unlike the birth mother, with whom the child may sense the in-utero bond (Pivnik, 2010).

Lifton (2010) describes these lost objects as 'ghosts of the adoptive kingdom', which forever follow the lives of the adoption triad, for instance, the ghost of the birth mother, a comforting, loving and supportive presence to the adoptee, but also the adoptive mother's rival for the adoptee's affection. The unresolved grief and losses experienced by adoptees result in anger and rage, and often this rage is split off. In other words, the adoptees begin to perceive the adoptive parents as all bad and the birth parents as all good, which lead to them thereby expressing their anger toward their adoptive parents (Lifton, 2010). This is complicated by the fact that they cannot express their anger towards the birth parents, because they cannot interact with them.

Furthermore, these theorists have suggested that most of what have been described as difficult or pathological behaviours in adopted children are actually their unrecognised, yet obvious, expressions of a normal grieving process (Brodzinsky & Schechter, 1993). Some

may argue that this is a rather simplistic view of the difficulties faced by adoptees, but the response of the proponents of theory is that this is because society finds it difficult to acknowledge that the 'solution' of adoption is actually a story of loss (Brodzinsky et al., 1998).

The theme of loss in adoption is carried further in attachment theory (Bowlby, 1973). Attachment theory is based on the premise that the mother-child relationship is the first and most important relationship anyone will develop. Bowlby (1973) emphasises that, although the biological mother is usually the primary attachment figure, the attachment relationship is between a child and the caregiver to whom the child directs attachment behaviours. He uses the terms 'mother figure' and 'substitute mother' to refer to the alternative attachment figure.

Furthermore, attachment theory proposes that the development of the mother-child relationship begins at birth. This suggests that a similar trajectory of attachment development will follow with an adoptive mother if the child is placed at birth. According to Bowlby's phases of attachment development, the attachment behaviours of an infant from birth to about 12 weeks are indiscriminately directed to the child's caregivers. Gradually the preference for one mother-figure develops and this attachment is consolidated from 5 months until about 3 years of age.

If the attachment figure is a consistent, responsive caregiver, the child develops a secure attachment. However, when that attachment is broken due to adversity, such as separation, death or neglect, that attachment is compromised. These early experiences of adversity may lead to an inability to form attachments with others. In turn, this may increase the risk of behaviour problems in children (Bretherton, 1992).

Psychoanalysts Winnicott (1965) and Clothier (1943) proposed a different perspective to Bowlby's view of the time frame within which attachment develops. Their primary contention was that the relationship between mother and infant starts during pregnancy. Winnicott (1965) suggested that a mother becomes intimately attuned to her child during the last trimester of her pregnancy. Not only does this attunement let her instinctively know what the child needs, but this continues into the first few weeks after birth. He called this a period of primary maternal preoccupation.

Based on these views, Verrier's (1987) theory of the 'primal wound' emerged. This theory applied Winnicott's theories of attachment formation to adoption. According to Verrier (1987), relinquishing a child for adoption after birth disrupts the primary attachment relationship with the biological mother that was initiated in the womb. This early maternal separation causes the child to suffer from the primal wound or "profound trauma" (Lifton,

2010, p. 73). This may result in adopted children experiencing feelings of grief, loss, anger and abandonment toward the biological parents. These feelings may hinder the formation of an attachment relationship with the adoptive parents (McGinn, 2007).

While the 'primal wound' theory is compelling, it has not been widely accepted. This is mainly because empirical evidence has shown that children who are placed within the first year are able to form secure attachments. However, it is the late placed adoptees who have not had the opportunity to form attachments in the early years who are associated with poor adoption outcomes. This ushers in the fundamental issue of the idiosyncratic outcomes of adopted children.

Although most adopted children share similar adverse pre-adoption histories, their outcomes are unique. The risk and resilience perspective offers a useful approach to understanding this heterogeneity in adoption outcomes (Luthar et al., 2000). Within this framework, the term 'resilient' is used to describe children and adolescents who have adjusted well, despite having been exposed to serious dangers to their physical, emotional and cognitive well-being. Therefore, when these children's outcomes are 'normal' or better than expected, they are described as resilient (Luthar et al., 2000). This raises a controversial issue in the study of risk and resilience, namely, whether resilience is an inherent quality or whether it is a quality developed through interactions within one's context (Greene et al., 2008; Luthar et al., 2000). However one chooses to view the concept of resilience, the lack of homogeneity in adoption outcomes can be accounted for, as can the better than expected outcomes. Van Ijzendoorn and Juffer (2006) found evidence for both sides, and assert that significant change or growth can be achieved when children possess some internal capacity to engage with their immediate environment (family) and the wider social context.

The stress and coping theory also subscribes to this notion of resilience, although within this theory, it is referred to as 'coping'. The stress and coping theory suggests that adoptees develop a repertoire of problem- and emotion-focused coping strategies, which alleviate the stress of adoption. Some of these strategies are: the adoptees seeking for information regarding adoption and their biological parents. Emotion-focused strategies include splitting, minimisation and self-blame (Easterbrook, 2008). Although the emotion-focused strategies are often perceived as negative and less effective than problem-focused strategies, they offer short term relief from stress.

The second broad perspective focuses on why adoption is beneficial, offering explanations why adoption may account for the positive outcomes of adopted children. Within this perspective is the Catch-Up Model of adoption (van Ijzendoorn & Juffer, 2006).

This model postulates that adoption is an effective, curative intervention in the lives of adopted children who have experienced early deprivation or adversity (van Ijzendoorn & Juffer, 2006). Hindle and Shulman (2008, p. 28) similarly describe adoption as a “radical intervention” on two levels. Firstly, adoption is a therapeutic intervention for children from previously institutionalised or deprived backgrounds. Secondly, adoption is a socially acceptable solution to the historical stigma of having a baby out of wedlock, and to problems of unwanted pregnancies (Hindle & Shulman, 2008)

The catch-up model also views adoption as a protective factor against any challenges that the child’s post-adoption environment may present. The model proposes that adopted children catch up to their non-adopted peers in physical growth, psychological adjustment and cognitive development after placement with their adoptive parents. Furthermore, children who are adopted before one year of age completely catch up to their non-adopted peers in all developmental spheres (van Ijzendoorn & Juffer, 2006). However, although the children who are adopted later (i.e. after one year) make up much of the growth after placement, they still slightly lag behind their non-adopted and early placed peers. Nevertheless, adoption alleviates the effects of pre-adoption adversity and deprivation.

Within this paradigm, adoption has also been acclaimed for offering children a remarkably transformed environment, which promotes positive behavioural and emotional outcomes. This is largely because adoption is a conscious decision and because most adoptive parents have persevered through the lengthy adoption process because they are ready to be parents (Juffer & van Ijzendoorn, 2005). In addition, adoptive parents are screened (including for financial stability), and receive pre-adoption counselling and parenting instruction. This generally explains why most adoptive parents belong to working middle class families. This socio-economic status facilitates access to resources, services and strong support systems (Rojewski et al., 2000). The benefits from these professional services are early identification and intervention to correct any post-adoption problems. Furthermore, the strong support system helps to counter any negative external challenges the adoptee may experience post-adoption.

Conversely, scholars within the risk perspective have criticised this one-sided perception of adoption as the ultimate cure for children in need of families. They argue that there are aspects of adoption that may negatively affect adoptees’ adjustment. For instance, they refer to adoption-related loss experienced by both adoptees and adoptive parents and poor parent-child relations (Hindle & Shulman, 2008; Whitten & Weaver, 2010). Adoption theorists (Brodzinsky et al., 1998) point out further challenges associated with adoption by

outlining the adoptive family's developmental life cycle. These are extra tasks that adoptive families need to negotiate, over and above the normal developmental tasks experienced by families. This clearly shows that, while adoption may have curative capabilities, it is certainly not an easy or risk-free intervention.

In summation, unlike the 'risk and resilience' theories, which focus on the risks of adoption that contribute to negative outcomes, the 'catch-up' perspective views adoption in a more optimistic light and focuses on strengths that enhance positive outcomes. In addition, the catch-up model of adoption emphasises that adoption offers children a transformed environment that fosters enhanced development. Nevertheless, all the theories discussed above allow for the possibility of resilience; in other words, despite the initial challenges experienced by adopted children before adoption, they still have the potential for 'normal' (age-appropriate) and positive outcomes.

2.3 Research Comparing Adopted and Non-adopted Children

In early outcome studies, researchers compared the incidence of the adopted population in clinical settings with that of non-adoptees (Brodzinsky, 1987; Kim, Devenport, Joseph, Zrull and Woolford, 1988; Schechter et al., 1964). Consistent results indicated that adoptees were over-represented in clinical settings. These studies led to the conclusion that adopted children were more susceptible to emotional and behavioural problems than their non-adopted peers living in intact homes with both biological parents (Brodzinsky, 1993).

Conversely, the over-representation of adoptees in clinical settings has been attributed to adoptive parents' higher propensity to refer even minor behaviour problems to clinicians (Ingersoll, 1997; Warren 1992). In a review of the literature, Peters, Atkins and McKay (1999) found that adoptive parents frequently consult mental health services for less severe problems than biological parents do when raising their own children. This may be attributed to adoptive parents being more comfortable with seeking help, having been exposed to these services during the adoption process. Therefore, the over-representation of adoptees in clinical settings tends to be exaggerated and misinterpreted to suggest that adoptees have more behavioural problems than non-adoptees (Warren, 1992).

Contemporary researchers (Keyes et al., 2008; Rosnati et al., 2008) have employed an empirical approach to outcome studies. Most studies now use longitudinal designs and a wide array of behavioural assessment tools to assess and compare adopted children and non-adopted children, on several different behavioural and emotional scales. Two broad

assessment categories have been identified: externalising behaviours and internalising behaviour.

Externalising behaviours are an outward expression of internal processes. Externalising behaviour problems include aggression, defiance, drug abuse, breaking rules and delinquency (Carr, 2006). Research findings indicate a general consensus that adoptees are at increased risk of externalising behaviour problems compared to non-adoptees (Greene et al., 2007; Hawk & McCall, 2010; Hjern, Lindbland & Vinnerljung, 2002; Keyes et al., 2008; Rosnati et al., 2008).

In a meta-analysis (Wierzbicki, 1993) of 66 published studies, adoptees were found to be significantly more psychologically maladjusted than their non-adopted counterparts, which manifested in the exhibition of aggressive behaviour, hyperactivity, delinquency, conduct problems, peer problems and running away. In addition, substance abuse, truancy and school troubles were highly correlated with being adopted (Miller, Fan, Christensen, Grovtevant & Dulmen, 2000). Similar findings were reported in the USA, Ireland, Italy, India and Sweden, using different measures. These studies indicated that adopted children had more difficulties associated with attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct disorder than non-adoptees (Dhavale, Vinaya & Poornima, 2005; Greene et al, 2007; Hjern et al., 2002; Keyes et al., 2008; Rosnati et al., 2008; Simmel et al., 2000). Of note, adopted Swedish adolescents were four times more likely to be admitted for a psychiatric disorder or substance abuse, and two to three times more likely to commit a crime than non-adopted Swedish adolescents (Hjern et al., 2002). Although some studies (Rojewski, Shapiro & Shapiro, 2000) have reported only slight differences, the general conclusion is still that adopted children have more externalising difficulties than non-adopted children.

Internalising behaviour problems are emotional difficulties. Internalising problems encompass behaviours such as excessive worrying, crying, withdrawal and somatic complaints (Carr, 2006). Adoption outcome research uses measures of depression, anxiety, and self-esteem to assess internalising difficulties. It has been found that adopted children have a low risk of presenting with internalising behaviours. In addition, the magnitude of difference between adoptees and non-adopted children on internalising difficulties is small (Juffer & van Ijzendoorn, 2005; Rosnati et al., 2008). In fact, a few studies have indicated that there is no difference between adoptees and non-adoptees on prevalence of depression, and levels of psychological wellbeing and self-esteem (Borders, Black & Pasley, 1998; Decker & Omori, 2009; Juffer & van Ijzendoorn, 2007). Nevertheless, the majority of

adoptees in research studies were found to have more psychological problems and higher rates of suicide, and to be more anxious than non-adoptees (Brodzinsky et al., 1987; Hjern et al., 2006; Keyes et al., 2008; Miller et al., 2000; Rosnati et al., 2008). As a result of these inconsistent findings, it is difficult to draw definitive conclusions regarding internalising difficulties among adopted children. This may suggest that there are other variables within the different populations that influenced the different findings in each study.

Adoption outcome research has mostly focused on difficulties rather than strengths of adopted children. Consequently, there is limited empirical evidence with regard to the strengths of adopted children. The study most cited in this regard was done over two decades ago by Marquis and Detweiler (1985). More recent studies refer to better-than-expected outcomes and resilience in adopted children (Gleitman & Savaya, 2011; Greene et al., 2007; Juffer & van Ijzendoorn, 2007; Tan & Marfo, 2006).

In their controversial study, Marquis and Detweiler (1985) used a sample of 46 adopted children and 121 non-adopted children. The adopted children were drawn from one private adoption agency and 95% of them had been placed within the first five weeks to one year of age. They found that adopted children were more confident than non-adoptees. They viewed others more positively and had stronger bonds with their adoptive parents. This study was heavily criticised by Brodzinsky (1987) for generalising these results and having used a small, non-representative sample. Furthermore, research has shown that, the earlier a child is placed, the better the outcomes; all the children in this study were placed within the first year. Consequently, it was argued that Marquis and Detweiler (1985) were looking at adoption through “rose-coloured glasses” (Brodzinsky, 1987, p. 398).

Despite these criticisms, recent studies have revealed findings of adoptee outcomes that are similar to population norms, which can be interpreted as strengths. The findings of studies in the USA (with Chinese adoptees) and Israel indicated that adoptees fell within the ‘normal’ (age appropriate) range of functioning when compared to national norms (Gleitman & Savaya, 2011; Tan & Marfo, 2006). Adopted children were found to exhibit more pro-social behaviours than non-adoptees (Miller et al., 2000; Sharma et al., 1996). Furthermore, there was no difference in self-concept and self-esteem between adoptees and non-adoptees (Greene et al., 2007; Juffer & van Ijzendoorn, 2007).

Finally, the findings from studies of Romanian adoptees (Pearlmutter et al., 2008; Rutter et al., 2010) provide valuable insight into the remarkable levels of resilience of adopted children. The results of these studies indicated that adoptees were in the average range of functioning when compared to population normative data, although adoptees were

found to be more involved with their families, and to possess more intra-personal and affective strengths than the normative sample (Pearlmutter et al., 2008). The researchers contend that Romanian adoptees have remarkable resilience because these results are not characteristic of children who have been exposed to severe adversity.

The reviewed research seems to support the risk and resilience perspective, which suggests that being adopted does place children at risk for some difficulties, particularly with regard to externalising behaviour problems. However, there is also evidence of the adoptees' resilience and ability to cope, which increases their positive outcomes. Furthermore, the catch-up perspective is also supported by the research, which suggests that, despite their initial setbacks, adopted children can and do catch up to their non-adopted peers and even surpass them in some areas. As the theoretical perspectives suggest, the behavioural and emotional outcomes of adoptees vary significantly however, the adoption status does not determine those outcomes (Brodzinsky, 2011). Instead, such outcomes are determined by several pre- and post-adoption risk and protective factors.

2.4 Risk Factors

The risk factors include the child's pre-natal and pre-adoption history, age at adoption and adoption across race (Greene et al., 2007; Juffer, 2006; Logan, Morrall & Chambers, 1998; Simmel, Barth & Brooks, 2007; van IJzendoorn & Juffer, 2006; Voirra et al., 2006; Whitten & Weaver, 2010).

2.4.1 Pre-adoption History.

The pre-placement or pre-adoption experiences adoptees are exposed to vary depending on how, when and where they are relinquished for adoption. Most children go through the public system before they are adopted. The public system refers to government funded agencies and systems, which have different profiles in the different countries where research was carried out. Children who are adopted through the public system experience similar, albeit varying, degrees of adversity from neglect to emotional, physical and psychological abuse (Goldman & Ryan, 2011; Palacios & Brodzinsky, 2010).

There exist sub-groups within the group of children adopted from the public system whose pre-placement histories have a significant influence on their outcomes. Some of these children are adopted immediately after birth; usually the parents have made adoption plans for them before birth. Then there are children who are abandoned or orphaned. These children are placed into foster care or public institutions of care while awaiting adoption. A

recent increasing trend in Cape Town is of children who are 'dumped' in unsafe places like rubbish bins, bushes and public spaces, who are then found and brought into the public system (CTCW, personal communication, March 11, 2011). Clearly, the experiences of these sub-groups of children will not be the same, and neither will the difficulties they experience.

While the private adoption system, which refers to adoptions arranged outside the government system by non-governmental organisations and individuals, are widely thought to have much less risk for adoptees, privately placed children are often also vulnerable to pre-natal risks. Some of those risks include birth mothers' substance use and abuse, which have lifelong developmental consequences for the unborn child (Whitten & Weaver, 2010).

There is consensus in adoption research that the adoptees' pre-placement history is a key determinant of their developmental, emotional, cognitive and behavioural outcomes. Children who have experienced abuse and neglect before adoption consistently score higher on measures of mental health difficulties than non-abused adoptees. Furthermore, the effects of institutional deprivation are visible even after a significant time in the adoptive family (Greene et al., 2007; Logan et al., 1998; Simmel et al., 2007; Voirra et al., 2006). For example, the children at Metera Babies Centre in Athens (Voirra et al., 2006) were assessed with regard to attachment at 12 months of age, with institutional caregivers, and then again at 4 years, with their adoptive mothers. The results revealed that, at 12 months, the children showed disorganised attachment relationships with the institutional caregivers. Furthermore, at age four, the former Metera children showed much less attachment security to their adoptive mothers than non-adoptees did with their biological mothers. This was despite having been in placement for at least 2 years. In addition, there has been empirical research into the effects of early experience of being inconsistently cared for by several, different caregivers in an institution. These studies revealed that these children develop specific behavioural problems, like indiscriminate friendliness or uninhibited social behaviour (Bruce, Tarullo & Gunnar, 2009; Greene et al., 2007; van Ijzendoorn & Juffer, 2006; Voirra et al., 2006).

However, it is important to note that negative pre-adoption experiences are not experienced by all adoptees. The quality of child institutional care is largely influenced by political, geographical and cultural differences in each country (Selman, 2005). Studies of children who had received a good quality of institutional care before adoption reported positive post-adoption adjustment of the children (Gleitman & Savaya, 2011; Tan & Marfo, 2006). This further reinforces that the child's pre-adoptive history has a significant influence on the child's overall outcomes. In addition, these studies support the risk perspective that the

adverse experiences of adopted children influence their outcomes. Furthermore, even after the intervention of adoption, the effects remain evident, as seen by the persistent difficulties they experience long after adoption.

2.4.2 Age at adoption.

Early outcome studies, assessing the effects of age at adoption, indicated that children adopted at birth had similar outcomes as non-adoptees when matched on socio-economic status. However, there was a slight risk for socio-behavioural problems evidenced by poor peer relations, parent-reported difficulties at home and higher referrals to mental health professionals (Howe, 2001).

Children placed after 12 months were found to be at greater risk for poor attachment security, poor parent-child relations and overacting than their early placed peers were (Gleitman & Savaya, 2011; Rushton & Dance, 2006; van IJzendoorn & Juffer, 2006). The consensus in adoption research is that the later a child is placed, the poorer the emotional and behavioural outcomes are for the child (Howe, Shemmings & Feast, 2001; Rushton & Dance, 2006; Sharma et al., 1996; Voirra et al., 2006). Reports from adoptive parents of late-placed adoptees have consistently revealed that these children exhibited significant behavioural problems by the end of the first year of placement, thus increasing the risk of placement disruption. In fact, research has revealed that children in disrupted placements are significantly older at adoption than are those in continuing placements (Coakley & Berrick, 2008; Rushton & Dance, 2006).

However, extensive research has led to the conclusion that age at adoption is only an important factor, insofar as it reflects the length of time that a child was exposed to pre-adoption adversity (Grotevant et al., 2006; Howe, 2001; Odenstad, Hjern, Rasmussen Vinneljung & Dalen, 2008; Simmel, Brooks, Barth & Hinshaw, 2001). An example of this is the longitudinal study, which compared the children of the Metera Babies Center (Voirra et al., 2006) who had spent their first two years of life at Metera, with non-adopted children raised in intact homes. The results of this study were that the former Metera children had improved significantly from their developmental delays by age four. In addition, there was also no difference with non-adoptees in terms of behavioural problems and relationships with their teachers. The researchers (Voirra et al., 2006) concluded that the age at adoption and length of time with adoptive family did not have a significant impact on the adoptees' development. Instead, the determining factor on their developmental outcomes was that they had spent their first two years of life in an institution.

2.4.3 Transracial adoption.

Transracial adoption is commonly understood as the adoption of Black children by White parents. However, it also encompasses most international adoptions, such as Asian and Eastern European children being adopted by European or American Caucasian families (Griffith & Bergeron, 2006).

Transracial adoption has been a controversial issue in adoption studies, particularly with regard to the ability of transracially adopted children to identify with their actual races. In addition, the outcomes of transracial adoptees have produced diverse results, depending on the individual study focus used, which makes it difficult to generalise the results (Brodzinsky, 2011).

Juffer and van Ijzendoorn (2005) conducted a meta-analysis of 47 studies focusing on behaviour outcomes of transracial adoptees, compared to non-adoptees. The studies assessed children from Asia and South America. The results revealed that international adoptees experienced more total difficulties, and that they showed more internalising and externalising difficulties than non-adoptees. However, international adoptees had less mental health referrals and behavioural difficulties than domestic adoptees. Nevertheless, the researchers advised caution in interpreting these results, as the sample of international studies for mental health referrals was small. Furthermore, the children's pre-placement histories affected the outcomes because children from Romania and Russia, who had adverse pre-placement histories, had more behaviour problems than those who had no adverse histories.

In addition, transracial adoptees have been found to be at increased risk of delinquency, thus leading to school problems, ADHD and identity confusion (Juffer, 2006; Lindbald, Weitoft & Hjern, 2010; Weinberg, Waldman, van Dulmen & Scarr, 2004). These researchers agreed that children's awareness of differences between themselves and their adoptive families predicted their total and externalising difficulties. This was particularly relevant to transracial adoptees whose obvious physical features like skin colour and the resultant desire to look the same was significant (Juffer, 2006). It was found, for instance, that Black adoptees in White families were more likely to have behaviour problems than Caucasian adoptees (Weinberg et al., 2004). Furthermore, a Swedish study's findings suggested that international adoptees from Eastern Europe, Middle East/Africa and Latin America (with the most noticeably different physical appearance), had more difficulties associated with ADHD than same-race adoptees (Lindbald et al., 2010).

Contrary to these findings, there is an argument from other researchers that it is not the status of being transracially adopted that predicts problem behaviour outcomes. Instead there are external factors, like the quality of the parent-child relationship, that are significantly associated with problem behaviour outcomes (Whitten and Weaver, 2010).

Both perspectives make compelling arguments. However, it is difficult to prove beyond doubt that either perspective is better than the other. But when taken together, they form a more coherent depiction of transracial adoption. It is generally accepted in psychology that awareness of difference is problematic for children. There is also acceptance in the field that external factors do influence children's outcomes to varying extents. Therefore, it would be logical to conclude that the problems associated with adoption may be further complicated by transracial adoption and other contextual factors.

In summation, the theoretical arguments and research evidence seem to support the idea that the adopted children's pre-adoption experience is the key determinant of their outcomes. Furthermore, the earlier a child is placed, the better the outcomes are likely to be, as this limits the duration and possible extent of risk factors the child experiences.

2.5 Protective Factors

In as much as the difficulties of adoptees are influenced by risk factors, some protective factors may account for the strengths of adopted children. Researchers have identified some of these protective factors as: adoption itself, as an intervention, adoptive parent-child relations and early adoption which was discussed above under age at adoption (see 2.4.2) (Gleitman & Savaya, 2011; Hindle & Shulman, 2008; Whitten & Weaver, 2010).

2.5.1 Adoption

Adoption is most often a mutually beneficial relationship between the adopted child and the adoptive parent. Parents experience the joys and rewards of raising a child, and the adoptee gains a nurturing home (Brodzinsky, 2011). The catch-up model of adoption goes beyond this simplistic view of adoption. This model acknowledges the corrective and reparative qualities of adoption that enhance positive outcomes, increase catch-up growth and foster resilience in adoptees (van IJzendoorn & Juffer, 2006).

Numerous studies (Rushton & Dance, 2006; Simmel et al, 2007; Voirra et al, 2006) have supported the concept of adoption as a valuable intervention. The findings from these studies suggested that the psychosocial adjustment of children who had previously been institutionalised, significantly improved after adoption. The outcomes of previously

institutionalised adopted children have also been found to be significantly better than children who remain in childcare institutions (van IJzendoorn & Juffer, 2006). Researchers (van IJzendoorn & Juffer, 2006; Voirra et al., 2006) concluded that the move to an adoptive home environment improved physical growth, social development, behavioural outcomes and assertiveness in the children.

Despite these positive outcomes, adoption alone cannot completely erase the effects of pre-adoption deprivation. Studies of Romanian adoptees (Pearlmutter, Ryan, Johnson & Groza, 2008; Rutter & Sonuga-Barke, 2010) suggest that institutional deprivation has life-long consequences. Other studies also found evidence in support of adoption, in that the problems that had been identified by adoptive parents at the time of adoption were resolved after some time in placement (Greene et al., 2007; Whitten & Weaver, 2010). Nevertheless, in a minority of the children, the problems persisted, even after they have spent a significant amount of time with the adopted family. These findings support the risk and resilience perspective, but also highlight the heterogeneity in adoption outcomes. Follow-up studies of previously institutionalised Romanian adoptees, who had been adopted by families in the United Kingdom (UK) (Rutter, Sonuga-Barke & Castle, 2010; Van der Vegt et al., 2009), presented strong evidence that the adoptees' development had caught up to UK norms by 6 years of age. The children who were significantly impaired at 6 years made further, but small, improvements between 6 and 11 years of age. The authors conceded that, despite the adoptees' catch-up growth, the effects of institutionalisation and deprivation, experienced prior to adoption, had far more profound effects on the adoptees than adoption alone could counter.

The catch-up model of adoption and supporting research shows or illustrates the plasticity of human development. It also highlights the fact that pre-adoption experiences have lifelong consequences for the adoptees' behavioural and emotional adjustment (van IJzendoorn & Juffer, 2006) even after the intervention of adoption.

2.5.2 Parent-Child Relations.

Most people who become adoptive parents initially tried to become parents naturally, but failed, after which they often endured several stressful and traumatic fertility treatments. They then choose the next best option, which is adopting an infant and raising it as their own. However, the decision to adopt is difficult and filled with disappointment, as couples have to let go of their identity as biological parents and learn to accept a new one of being adoptive parents (Brodzinsky et al., 1998). It is in this context, that an adopted child is placed. The

ensuing parent-child relationship is largely determined by how well the child fits into the adoptive family system. It is also influenced by how well the adoptive parents negotiate the transition to adoptive parenthood. The importance of this parent-child relationship has not been a matter of academic debate, as it is generally accepted that a warm, nurturing, consistent and open relationship between parents and children enhances child development, regardless of whether it is between biological parents and children, or adoptive parents and their adopted children.

Adoption research supports this concept, as research findings indicate that adoptees with close relations and open communication with their parents have high self-esteem. They exhibit low levels of externalising and internalising difficulties compared to adoptees with strained parent-child relations (Gleitman & Savaya, 2011; Pearlmutter et al., 2008; Rutter & Sonunga-Barke, 2010). Adoptees with good parent-child relations are also less likely to cut school, to be suspended from school, to abuse substances or to have trouble with the law compared to their peers (Whitten & Weaver, 2010). These findings have led to the conclusion that good parent-child relations buffer the adoptee against post-adoption challenges.

2.6 Conclusion and Limitations

The theory and research reviewed in this chapter underscores the complexities of adoption. Psychological theory sets up a largely optimistic view of adoption outcomes for children adopted at birth. According to the theories reviewed, these children have the potential for normal outcomes. Conversely, late adoptees, who have endured more adversity, tend to be more vulnerable and at risk of negative outcomes. However, their resilience is evidenced when their outcomes are normal or better-than-expected.

The research studies revealed empirical evidence that supported the theories. Their findings reflect a consensus that adopted children have more externalising difficulties than do non-adopted children. However, the magnitude of difference between the groups is small to medium. Researchers concur that a child adopted at birth or before the first birthday will have similar outcomes as non-adopted children. Late adoptees in contrast tend to have poorer outcomes than do their early placed or non-adopted peers. Furthermore, the pre-adoption history of an adoptee is the key determinant of the child's outcomes. However, the literature reviewed does have some limitations.

The inconsistent findings of adoption outcome studies have left these studies vulnerable to heavy criticism. Operationally, the term 'adopted' has been problematic because it is ambiguous and can refer to different relationships, like kinship adoption, step-

parent adoption, foster parenting, abandoned children being left with relatives or friends and orphaned children being relinquished to next-of-kin. All these children may refer to themselves as adoptees, but the interplay of the underlying dynamics will affect the outcomes and thereby render the results less reliable (Miller et al., 2000).

Methodological flaws in sample selection have also drawn the disapproval of academics. Most of these studies recruited participants from clinical settings. Consequently, researchers overstated the prevalence of behaviour problems by generalising the results to the whole adoptee population (Simmel et al., 2007). However, the studies drawing participants from communities revealed inconsistent results (Palacios & Brodzinsky, 2010).

Research samples have also been criticised for being small and non-representative. Contemporary studies in the USA and Sweden have attempted to rectify this by using large samples drawn from national survey data (Miller et al., 2000; Feigelman, 2001).

Another methodological flaw is over-reliance on a single source, either parent or teacher reports. The voice of the adoptee is largely non-existent in adoption research (Brodzinsky et al., 1998).

Furthermore, adoption research relies heavily on the use of measures of mental health like the popular Achenbach Child Behaviour Checklist (CBC). However, these measures are often used with populations on which they have not been standardised. This compromises the validity of these studies (Keyes et al., 2008). Therefore, psychological enquiries on the outcomes of adoption remain largely unanswered (Miller et al., 2000).

The lack of psychological research on the outcomes of adopted children in South Africa represents the biggest limitation of the studies reviewed and the largest gap in knowledge. The findings from the available literature cannot be generalised to South Africa without conducting relevant research in South Africa in support of international findings, because South Africa is a unique and different political, social and environmental setting. Consequently, the current study was designed to contribute to the field of knowledge regarding adoptee outcomes, by exploring the strengths and difficulties of adopted children in Cape Town, South Africa.

2.7 Research Aims

This study explored *quantitatively* the strengths and difficulties of adopted children, compared to children being raised by their biological parents in Cape Town. In addition, this study investigated whether there was an association between demographic characteristics and the adopted children's total difficulties scores.

This study also explored *qualitatively* the strengths and difficulties of adopted children within their contexts, by gaining insight into adoptive parents' experiences of the adoption process, and investigating their opinions of their adopted children's strengths and difficulties.

On a secondary level, the study sought to substantiate *qualitatively* the findings of the *quantitative* survey, and to explain any disparity between these findings.

University of Cape Town

CHAPTER 3: METHOD

In this chapter, the study design is outlined and the rationale for the design is discussed. Thereafter the samples, instruments and procedures followed in data collection are described. The strategies used to analyse the data are then described. Finally, the ethical considerations that were adhered to are explained and issues of reflexivity are considered.

3.1 Research Design

This was a correlational study that explored the relationship between adoption and adopted children's strengths and the difficulties they face. The study employed a mixed methods concurrent triangulation design. In this design both quantitative and qualitative data are collected at the same phase of the research and analysed separately. Combining qualitative and quantitative research strategies broadens the scope of the study. It gives researchers a more detailed and complete picture of the human behaviour or experience under research (Tashakkori & Teddlie, 2003).

The quantitative data for this study was collected through a cross sectional survey. The Strengths and Difficulties Questionnaire (SDQ) developed by Goodman (1997) was given to a sample of parents and teachers of adopted children and children raised by their biological parents. In addition, the self – rated version for children was given to participants between 11 and 17 years of age. This method was the most suitable for the research because it is "...possible with cross sectional surveys to identify differences between sub-groups of a sample in terms of prevalence of various psychological phenomena and the correlative relationships among those various psychological phenomena" (Nicholas, 2008, p. 25). This design was also economical in time and cost because questionnaires were posted or emailed to the participants.

Concurrently, semi-structured interviews using open-ended questions were conducted in order to gather qualitative data from a sub-sample of adoptive parents. The interviews yielded data which would not otherwise be obtainable using the survey method alone (Tashakkori & Teddlie, 2003). For instance, it was possible to gather data about the participants' personal experience of adopting a child, their opinions of the child's adjustment and their observations of the child's behaviour.

The data collected from the interviews and survey was then integrated at the interpretation and discussion phase of the research. Furthermore, the qualitative data was used to corroborate the findings of the survey and to explain results that were not consistent between the methods (Tashakkori & Teddlie, 2003).

3.2 Participants

The survey sample comprised 61 children. Of these 56 were between 11-17 years of age and completed the self-rated SDQ. In addition, 61 parents and 43 teachers completed the parent and teacher-rated questionnaires.

This sample was divided into two sub-groups, adopted and non-adopted. The adopted sample consisted of 30 children, their adoptive parents and 18 teachers. The non-adopted sample consisted of 31 children, their biological parents and 25 teachers.

The inclusion criterion for the study group was: school age children adopted by a non-related person. The control group comprised school age children being raised by their biological parents.

The interview sample comprising 7 parents of 11 adopted children was purposefully selected from the survey sample to reflect diverse experiences of adoption, for instance transracial adoption and multiple adoptions. The sample was intended to be small based on the fact that larger samples do not increase the quality of the data or the findings (Streiner & Souraya, 2010). Instead a small sample makes it easier for the researcher to explore in-depth, pertinent themes and gain more insight through a thorough analysis of less data. Further demographic characteristics of the survey and interview samples are detailed in Chapter Four.

3.3 Measures

3.3.1 Strengths and Difficulties Questionnaire.

The Strengths and Difficulties Questionnaire (SDQ) developed by Goodman (1997) was used in the survey. It is a brief behavioural screening tool that can be completed by parents and teachers of children aged 3-16. There is also a self rated version for children aged 11-16. It is used as a measure of mental health status. It enquires about 25 attributes both positive and negative. The 25 items are divided into 5 scales: emotional problems, conduct problems, hyperactivity/inattention problems, peer problems and pro-social behaviour. Each scale provides a separate score that indicates a child's strengths or difficulty in that area. However, when added, the scores of four of the scales, excluding pro-social behaviour, provide a total difficulties score (Goodman, 1997). The total difficulties score ranges from 0-40 and the higher the score the more emotional and behavioural difficulties the child experiences.

The SDQ is brief, economic and easily accessible in over 40 languages online (at <http://www.sdqinfo.com>). Its reliability and validity are well established in the USA and Europe. However, its cross cultural validity is particularly relevant to this study because the SDQ has not been standardised for South Africa.

In a cross cultural collaboration to determine the validity of the SDQ outside Europe, several studies in Brazil, Canada, Pakistan, Middle East and Australia were analysed. The results across culture and language indicated that the scale maintained the same test-retest reliability and clinical relevance as in Europe (Woerner et al., 2004).

The validity of the SDQ compared to other behavioural assessment measures was found to be just as good. Total scores generated by the Rutter questionnaires (1970) and the SDQ were highly correlated. The Achenbach Child Behaviour Checklist (1991) was highly correlated with the SDQ. Furthermore, both measures were equally strong in identifying both internalising and externalising behaviour. Furthermore, the SDQ was significantly better at detecting inattention and hyperactivity (Goodman & Scott, 1999). The CBCL and Rutter questionnaires are lengthy and focus on undesirable traits. The CBCL has 118 items on psychopathology alone while the SDQ's 25 items offer a balanced view of child behaviour by measuring both strengths and difficulties. All these factors made the SDQ the optimal measure to achieve the goals of this study.

In South Africa and Congo, the SDQ has been used as a clinical screening measure as well as for research (Cluver & Gardner, 2006; Kashala, Elgen, Sommerfelt & Tylleskar, 2005). In Congo, the SDQ was found to be useful in describing mental health problems. However, the cut-off scores were significantly higher than in other published scores of similar ages (Kashala et al., 2005).

Therefore, the SDQ was used in this study to compare the adjustment of adopted children to non-adopted children. However, not much emphasis was placed in interpretation of the scores as markers of clinical caseness because this measure has not been standardised for this study's population. As a result the clinical caseness scores may not have accurately reflected the prevalence of psychopathology among these children.

3.3.2 Demographic Questionnaire.

To collect demographic information, I designed a questionnaire which was completed by all the parents. This form asked about the child's adoption status, age, gender, child's age at adoption, parents' marital status, parent's highest educational qualification as well as any history of contact with mental health professionals. The parent's highest qualification

reported was not necessarily that of the parent who completed the form, but that of either the mother or father with the highest educational qualification.

3.3.3 Interview Schedule.

The interview protocol was designed to elicit participants' personal experience of adopting a child, opinions of the child's adjustment as well as the observed strengths and difficulties that the child faced. Some of the questions asked were: "What are the most difficult behaviours you have noticed?" and "How do you think being adopted has impacted on your child?" For the full interview schedule see Appendix Four.

3.4 Procedure

3.4.1 Adopted Sample.

The sample of adopted parents was recruited through Cape Town Child Welfare (CTCW). This organisation facilitates the adoption of children for the Department of Social Development in Cape Town. A random sample of parents of adopted children, whose current chronological age met the school age criterion for this study, was drawn from the CTCW adoption register. They were then telephoned by an adoption social worker from CTCW and invited to participate in the study. This was done in order to uphold the organisation's strict confidentiality policy regarding adoption files. The contact details of those who accepted the invitation were then released to me.

Thereafter, I made telephonic contact with the parents and gave further details about the study, and asked for their permission to contact their children's teachers. Consent forms and questionnaires were then sent out by post or electronic mail according to the parent's preference. The posted mail included a stamped, self addressed envelope to return the questionnaire. While over 200 calls were made by CTCW, and I made over 80 calls and emails, only 30 parent-rated and 25 self-rated completed questionnaires had been received at the end of the data collection phase which lasted four months.

The children were provided with an instruction sheet and two stickers to seal their envelopes before giving to the parent to send to the researcher. The seals were intended to be a deterrent to anyone tampering with the envelope. It was also hoped that they would provide some reassurance to the child that confidentiality would be upheld. However, the same could not be done for children whose parents opted for the electronic mail option.

The majority of parents opted to take the questionnaire personally to the teacher. In these cases the teacher was also provided with a stamped, addressed envelope in which to return their completed questionnaire. Twelve parents opted to exclude the teacher from the study as they had not disclosed the child's adoptive status and wished to keep this information confidential. A total of 18 signed consent forms and completed questionnaires were returned by the teachers.

3.4.2 Non-adopted sample.

The control group was recruited through a co-educational, former model C, primary school. This school was selected because it was the best match with the adopted sample based on age, gender and socio-economic status. Permission to recruit from the school was obtained from the Western Cape Education Department, thereafter the principal and teachers from the school then assisted with the process.

Fifty-five randomly selected children in grades 6 and 7 (11-13 years old) were sent home with letters inviting their parents to participate in the study. The letters contained an information sheet about the study, consent form and the SDQ. The consent form also asked the parent's permission for their child and the child's teacher to participate in the study. The parents who accepted the invitation sent back their signed consent forms and completed questionnaires in sealed envelopes to the teacher.

Once parental consent was obtained, the children signed assent forms indicating their willingness to participate in the study. Arrangements were made with the teacher who gave the children special time to complete their questionnaires. The children's teachers also completed questionnaires. The questionnaires in sealed envelopes were collected from the teacher. Twenty-five teachers and thirty-one children and their parents returned completed questionnaires.

3.4.3 Interview Sample.

Interviewees gave their informed consent to be interviewed and for the interviews to be recorded. The interviews were conducted in the participants' preferred location to ensure they would be comfortable. A Dictaphone was used to record the interviews.

3.5 Ethical Considerations

The main purpose of ethical research is to ensure the participant's rights and welfare are protected (Sommer & Sommer, 2002). There were two American Psychiatric Association

(APA) principals of ethical research that were pertinent to in this study. Respect for people's rights and dignity (rights to privacy, confidentiality, self determination and anonymity) and non-maleficence (APA, 2001). Both principals were upheld.

The confidentiality of the data and personal details of the participants was upheld. Firstly, the surveys, recorded interviews and interview transcripts were securely stored and only I had access to them. Furthermore, I did not have access to CTCW adoption files in order to protect the identities and confidentiality agreement between CTCW and their clients. The identities of all the participants were not disclosed to anyone and their names and identifying data were excluded from the study. All the names used in this paper are pseudonyms and in no way resemble the names of the actual participants.

The right to self determination or autonomy was also upheld. All participants were informed that they were free to accept or refuse to participate at any point in the study without penalty. In addition they were given my supervisor's contact details if they needed further information regarding the study. Informed consent was obtained from all parents and teachers willing to take part in this study and assent was obtained from all the children completing the self-rated SDQ. Due to the sensitive nature of the adoption disclosure, the teachers and children were only invited to participate in the study after the parents had given their consent. Furthermore, to ensure participants fully understood what they were consenting to; all participants received an information sheet detailing the research purpose and procedures.

Non-maleficence is a concept that researchers must take care not to harm individuals or communities within which they are doing their research. Specifically for this study, I was aware that talking about adoption and the difficulties most of the parents had endured during the process of adoption was potentially hurtful. In order to ensure that participants were supported, they were offered a referral to a psychologist. In addition, at the end of each interview, participants were given some time to talk about how they were feeling and to ask questions regarding the study.

3.6 Data Analysis

Analysis of the survey data aimed to explore the strengths and difficulties of adopted children compared to non-adopted children. In addition, the analysis explored the relationship between demographic variables and the SDQ total difficulties scores for the adopted children.

The analysis of the qualitative data aimed to discover themes related to the strengths and difficulties of the adopted children. Furthermore, the analysis aimed to substantiate the

findings of the quantitative survey, and to explain any disparity between the quantitative and qualitative findings.

3.6.1 Survey Data.

For the adopted sample, completed questionnaires were obtained from 30 parents, 25 children and 18 teachers. For the non-adopted sample, completed questionnaires were obtained from 31 parents, 31 children and 25 teachers.

Five children in the adopted sample aged 7-10 were too young to complete questionnaires. In the non-adopted sample, 10 teacher-rated questionnaires had a substantial amount of missing data. Therefore these cases were excluded from the analyses of the SDQ scores.

The questionnaires completed by the three sets of participants (parents, teachers and children) were scored manually and the data generated was entered into the Statistical Package for Social Sciences version 19 (SPSS) for analysis. All 25 questions of the SDQ and their corresponding response categories were coded as set out by the SDQ scoring guide (not true =0, somewhat true=1, certainly true=2 except for questions 7,14,15, 17 and 18 which were coded as not true =2, somewhat true =1 and certainly true=0). This data was then recoded to generate the 6 scales of the SDQ for each set of respondents: emotional symptoms, conduct problems, hyperactivity/inattention problems, peer problems, pro-social behaviour and the total difficulties score.

It was important to ensure that the adopted and non-adopted samples were comparable in terms of the demographic characteristics. Therefore the demographic data (age, age at adoption, gender, mental health consult (mental health consult referred to whether the child had been referred to a mental health professional or had never had contact), type of adoption (referring to whether the child was adopted transracially or within the same-race) as well as the adoptive parent's marital status and highest qualification were entered into SPSS for analysis. Because of limited variability within the samples, parent's marital status was re-coded for analysis into 2 categories: married and other (comprising single, divorced and widowed) and parent's highest qualification was re-coded into 2 categories: tertiary and Grade 12 or less, for analysis.

Age was a continuous variable therefore a *t*-test was conducted to compare the mean ages between the two groups. In addition a series of Chi-Square tests were conducted to compare the adopted and non-adopted children on the demographic categorical variables

(gender, parent's highest qualification, parent's marital status and mental health consultation).

Following this, preliminary descriptive analyses of the continuously scored psychological outcomes (emotional symptoms, conduct problems, hyperactivity/inattention problems, peer problems, pro-social behaviour and the total difficulties score) were undertaken in order to ascertain their distributional characteristics. Thereafter a series of independent two samples *t*-tests were performed to evaluate the difference between the adoptees' and non-adoptees' mean scores on each of the SDQ scales.

In order to measure the magnitude of the difference between the scores for adoptees and non adoptees, effect sizes were calculated. The interpretation of the effect size was based on Cohen's (1988) conventions which indicated that when $d = .20$ the effect size is small, $d = .50$ indicates a medium effect size and $d = .80$ indicates a large effect size.

This study also investigated whether there was an association between the *adopted* children's total difficulties scores and the demographic variables. To achieve this, a series of multiple linear regression analysis were conducted to test the association between the selected demographic variables (age, type of adoption, gender and mental health consult) and the *adopted* children's total difficulties scores from all informants. The continuous variable age was re-coded into a categorical variable with two categories: older adoptees (14-17 years old) and younger adoptees (7-13 years old). However, the following demographic variables: parent's marital status, highest qualification and age at adoption were excluded from the analysis because of limited variability within the sample.

The significance level for the analyses was set $p < .05$.

3.6.2 Transcribed Interviews.

After listening to the recorded interviews several times I transcribed them. Through the process of transcribing and reading the transcripts I became familiar with the data and this is an integral part of thematic analysis (Braun & Clarke, 2006).

The transcribed interviews were then analysed using a deductive thematic approach. This is a method of identifying themes in a data set based on the theoretical framework of the study (Braun & Clarke, 2006). Therefore, the significance of a theme was determined by its relevance to the strengths and difficulties faced by adopted children.

Furthermore, the analysis was conducted from an essentialist paradigm where themes are identified at a semantic level. Within this paradigm, the focus is not on finding the

underlying meanings of what one says, instead, it is about accepting that through language, one is able to express meaning and experience (Braun & Clarke, 2006).

After reading through the transcripts, topics which were relevant to the study were coded. The codes that were recurrent across the data set were then grouped into categories representing similar ideas. These categories “represent the beginning of a theme - a kind of proto-theme, which will develop and change as the analysis proceeds” (Hayes, 2004, p. 176).

Thereafter, the categories were named and analysed further for prevalence and significance to the study. The prevalence of a theme was determined by the number of children which the theme applied to. This process facilitated the narrowing down of the categories into themes. Following this, the final themes were labelled; defined and illustrative quotes from the data were selected to support the themes.

The validity and reliability of data generated from this thematic analysis was considered. Firstly all the interviews were audio recorded, this method of capturing data has an advantage of accuracy as the interviews can be listened to repeatedly. However, there are some threats to the reliability of this method. For instance, there is some valuable information lost in the non-verbal communication which cannot be captured by the audio device and verbatim transcripts. In addition, there is no way of recovering the material at points where the recording was inaudible (Perakylal, 2008).

The interview schedule used for the interviews added to the validity of the qualitative data. All the questions in the interview schedule were related to the strengths and difficulties of adopted children. The same interview schedule was also used for all the interviews, thereby framing all the questions and direction of all the interviews in the same way (Hayes, 2004).

3.7 Reflexivity.

In qualitative research:

“...it is recognised that the researcher is the crucial measurement device, and that the researcher’s self (his or her social background, values, identity, and beliefs) will have a significant bearing on the nature of data collected and the interpretations of that data” (Denscombe, 2001 p. 176).

Therefore I as the researcher need to be open and honest about my motivations, worldview, and any other factors which may have influenced my collection, analysis and interpretation of the data. These issues are explored and discussed through reflexivity. Finlay

and Gough (2003) define reflexivity as "...the thoughtful, self-aware analysis of the intersubjective dynamics between researcher and the researched (p. ix). They add that research is co-instituted by the researcher, the researched and their relationship. The qualitative interviews in this study and the resulting data collected were indeed influenced by my background, approach as well as the participants' response to those.

In this study, it was interesting that all my interviewees asked me if I was a mother at some point during the interviews. This question was followed by: adopted or biological? I answered them all truthfully and revealed that I was a mother of two children of my own. As I reflected on the interviews, I wondered why this had been a common question. I listened to the interviews repeatedly and it was as if the interviewees were saying to me 'do you understand?', and I think to some extent, 'these are things only a parent can understand'. I think my being a mother helped in some way for the participants to be more open about their experiences as parents. Although my children are not adopted, it did not seem to be that important to them as long as I was a parent.

I also found that during the interviews, I had to juggle two hats. Firstly I was a researcher but my interviewees (and I) were aware that I am a clinical psychologist in-training. This conflictual dual role of researcher-therapist has been described as complex and to some extent a boundary crossing (Gabriel, 2009). There were moments when my responses towards the interviewee were more like a therapist, supportive and holding, and then at times I was a researcher, questioning and directive. These shifts were unconscious reactions sometimes employing counselling skills. These interchanging roles may have encouraged certain information while suppressing the expression of other information (Finlay & Gough, 2003). This was particularly evident when some of the interviewees wanted to engage with me as a therapist after the interviews by divulging personal information, asking for advice and my opinions on personal matters. These parents were offered referrals to another psychologist, but it confirmed that they too had experienced my inter-changing roles.

Lastly, during my interviews with transracial adoptive parents, the participants and I were aware that this was a difficult topic especially when the researcher and interviewee were also different races. I am a Black woman and three of my interviewees were White women with Black and Coloured children. In post-apartheid South Africa, race is still a contentious issue and political correctness is a fine line to tread. Added to this, transracial adoption is a hugely controversial issue and the interviewees did not know my standpoint regarding transracial adoption, and neither did they ask. However, I was acutely aware of the fact that I chose my words carefully during these interviews, perhaps because I did not want to sound

condescending, judgemental or say something that may be hurtful. In retrospect, I am certain that they were just as cautious as I was, and this is the nature of interactions across different races when you meet someone for the first time. I am also certain that this influenced the information that was revealed and how I interpreted it.

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CHAPTER 4: RESULTS

This chapter will present the findings of this study. Statistical results of the survey data will be presented first. Thereafter, the results of the thematic analysis will be outlined. The null hypotheses being tested in the statistical analysis were:

1. There will be no differences between the adopted and non-adopted children's mean scores on the scales of the SDQ.
2. There will be no association between selected demographic variables and the *adopted* children's total difficulties scores.

4.1.1 Demographic Characteristics

The mean age of the adopted children was 12.83 years ($SD = 2.48$) and the mean age of the non-adopted children was 12.58 years ($SD = .81$). An independent samples t -test was conducted to explore whether there was any difference in the mean ages of the adopted children and the non-adopted children. The results indicated that there was no significant difference ($t(59) = .54, p = .59$).

The remaining socio-demographic characteristics of the sample are outlined in Table 1. In summary, the majority of children in both the adopted and non-adopted samples came from intact, 2-parent families, most of the parents had a university or college education, and nearly 40% of the total sample had previously consulted a mental health professional. Results of all the t -test analysis for age and the Chi-square analysis for the other demographic variables indicated no significant associations between adoptive status and any of the demographic variables. Therefore, the adopted and non-adopted samples were appropriately matched and any group differences on the SDQ scores may be attributed to the children's adoptive status and not other variables which may be confounded with adoptive status (Smith & Davis, 2003).

Table 1

Demographic Characteristics of the Survey Participants

	Adopted (n=30)		Non-adopted (n=31)		Total (N=61)		Pearson Chi-square	p
	Frequency	%	Frequency	%	Frequency	%		
Gender							1.38	.24
Male	19	63.3	15	48.4	34	55.7		
Female	11	36.7	16	51.6	27	44.3		
Type of adoption								
In-racial	19	63.3	n/a	n/a	19	31.1		
Transracial	11	36.7	n/a	n/a	11	18		
Age at adoption								
0-12 months	29	96.7	n/a	n/a	29	47.5		
12-24 months	1	3.3	n/a	n/a	1	1.6		
Mental Health Consult							.39	.53
Yes	13	43.3	11	35.5	24	39.3		
No	17	56.7	20	64.5	37	60.7		
Parent's marital status							3.07	.08
Married	28	93.3	24	77.4	52	85.2		
Widowed	1	3.3	1	3.2	2	3.3		
Single	1	3.3	3	9.7	4	6.6		
Divorced	0	0	3	9.7	3	4.9		
Parent's highest qualification							.34	.56
Tertiary	25	83.5	24	77.4	49	80.3		
Grade 12	5	16.6	5	16.1	10	16.4		
Grade 10/less	0	0	2	6.5	2	3.3		

Note. Mental Health Consult refers to whether or not a child had contact with a mental health professional.

4.1.2 Preliminary Analysis

The results of the preliminary analysis of the continuously scored data suggested mild violations of the assumptions of normality and equality of variances. Based on the visual inspection of the Q.Q plots and the Shapiro-Wilk tests of normality (see Appendix 9), it was evident that most of the data was slightly non-normal in distribution. Furthermore, Levene's

test was conducted to check whether the variances between the groups were equal. The results of Levene's test in Appendix 10 indicated that groups had equal variances on all the scales except parent-rated hyperactivity problems scale.

This mildly violated the basic assumptions underlying the use of the *t*-test which requires data to be normally distributed and variances to be equal. However, the violations were mild and Pagano (2008) states that "The *t*-test is robust regarding violation of normality in the population..." (p. 451). Moreover, the same results were obtained using the non-parametric alternative, the Mann Whitney test.

Following the multiple linear regression analyses the residuals were analysed to see if the assumptions underlying linear regression had been met. Visual inspection of the histograms and P-P plots of the regression standardised residuals suggested that the normality assumption was reasonably satisfied and the standardised residuals indicated no evidence of outliers. The residual scatter plots of the dependent variables and each of the independent variables showed random patterns which indicated that linear relationships existed. Furthermore, based on accepted thresholds, the tolerance and variance inflation factors (VIF) statistics were all below ten, while the condition indices were lower than 15, indicating that there was no evidence of collinearity (Cohen, 2003). Therefore the basic assumptions for conducting multiple linear regression analyses were upheld.

4.1.3 Descriptive Statistics and Results of the Independent Samples *T*-Tests

The mean scores obtained from the parents, teachers and the children's questionnaires were compared using a series of *t*-tests. Higher mean scores on the all SDQ sub-scales except the pro-social behaviour scale indicate more internalising or externalising difficulties than lower scores. On the other hand children who score higher on the pro-social scale exhibit more pro-social behaviours than those with lower scores.

Overall, the mean scores revealed a trend for the adopted children to score higher on most of the subscales assessing difficulties. Although these differences were noted, the adopted and non-adopted children were significantly different on only two scales assessing externalising difficulties (conduct problems and hyperactivity problems). There were no other significant differences between the groups on any of the other subscales or on the total difficulties scores.

Table 2 displays the results of the parent rated scales. The results indicate that adopted children had higher scores on three of the four subscales assessing difficulties as well as on total difficulties. They scored lower on the pro-social scale than non-adoptees,

suggesting less pro-social behaviours than non-adopted children. Furthermore, the *t*-test results suggested that there was a significant difference between the two groups on the conduct problems scale, with adopted children having more behaviours associated with conduct disorder than their non-adopted peers. The magnitude of the differences was medium ($d = .57$).

Table 3 shows how the children rated their own behaviour and emotional well being. Results of the self-rated scales suggest that adopted children scored higher on all scales assessing difficulties including total difficulties. Adopted children also scored higher on the pro-social scale indicating that although they do report more difficulties, they have more pro-social behaviours than non-adoptees. A statistically significant difference on the *t*-test results reveals that adopted children reported more behaviour associated with hyperactivity and inattention difficulties than non-adoptees. The effect size was medium ($d = .56$).

The results of the teacher-rated SDQ are presented in Table 4. The results suggest that adoptees scored lower than non-adoptees on the conduct and emotional symptoms scales. The adoptees' scores were higher for two of the scales assessing difficulties (hyperactivity and peer problems scales) and the total difficulties scale. However their pro-social scores were higher than non-adoptees indicating that adopted children exhibited more pro-social behaviours than non-adoptees. The *t*-test results reveal a marginally significant difference ($p = .053$) between the two groups on the hyperactivity scale. That is, adopted children scored higher than non-adoptees at a level that fell just short of statistical significance. The effect size was also medium ($d = .52$).

Table 2

T-test Results of Parent-Rated SDQ Scores

SDQ Scales	Adopted <i>M (SD)</i>	Non- Adopted <i>M (SD)</i>	<i>t</i>	df	<i>p</i>
Emotional symptoms	1.77 (2.16)	2.13 (1.95)	.69	59	.49
Conduct problems	2.77 (1.38)	2.10 (0.94)	2.22	59	.03
Hyperactivity problems	4.50 (1.55)	3.97 (1.11)	1.55	59	.13
Peer problems	4.93 (1.68)	4.65 (1.33)	.74	59	.46
Pro-social behaviour	8.30 (1.88)	8.61 (1.75)	-.67	59	.50
Total Difficulties	14.37 (4.97)	12.84 (3.54)	1.39	59	.17

Table 3

T-test Results of Self-Rated SDQ Scores

SDQ Scales	Adopted <i>M (SD)</i>	Non- Adopted <i>M (SD)</i>	<i>t</i>	df	<i>p</i>
Emotional symptoms	3.00 (2.80)	2.74 (2.19)	.38	54	.70
Conduct problems	2.96 (1.46)	2.39 (1.28)	1.56	54	.12
Hyperactivity problems	5.12 (1.67)	4.26 (1.40)	2.08	54	.04
Peer problems	5.04 (1.74)	4.81 (1.42)	.55	54	.58
Pro-social behaviour	8.36 (1.55)	7.94 (2.34)	.78	54	.44
Total Difficulties	16.12 (5.52)	14.19 (4.00)	1.51	54	.14

Table 4

T-test Results of Teacher-Rated SDQ Scores

SDQ Scales	Adopted <i>M (SD)</i>	Non-Adopted <i>M (SD)</i>	<i>t</i>	df	<i>p</i>
Emotional symptoms	1.61 (1.85)	1.67 (1.72)	-1.29	41	.20
Conduct problems	2.61 (1.24)	2.80 (1.32)	-.95	40	.35
Hyperactivity problems	4.50 (1.43)	3.80 (1.27)	2.00	41	.05
Peer problems	4.33 (1.50)	3.40 (1.30)	1.36	32	.18
Pro-social behaviour	7.83 (2.31)	7.20 (3.32)	.04	41	.97
Total Difficulties	13.06 (2.04)	11.67 (2.61)	1.72	31	.10

4.1.4 Results of the Multiple Linear Regression Analyses

Table 5 displays the regression statistics for the parent-rated SDQ total difficulties scores. The combined impact of the independent variables accounted for 12.2% of the variance in parent-rated total difficulties scores. The overall model was not significant ($F(4) = .87, p = .50$). An inspection of the individual independent variables revealed that there were no significant associations with the parent-rated total difficulties scores.

Table 5

Summary of regression statistics for demographic explanatory variables to parent-rated SDQ total difficulties score

Demographic Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
Age	3.37	1.95	.34	1.73	.10
Gender	.47	1.90	.05	.25	.81
Mental Health Consult	-.34	1.93	-.04	-.18	.86
Type of adoption	-1.54	1.98	-.15	-.78	.44

Notes: $R^2 = .12$. Mental Health Consult refers to whether or not a child had contact with a mental health professional.

Table 6 displays the regression statistics for the self-rated total difficulties scores. The combined impact of the independent variables explains 29.7% of the variance in self-rated total difficulties scores. The overall model was not significant ($F(4) = 2.11, p = .12$). Looking at each independent variable separately, it is observed that mental health consult had a significant relationship with the total difficulties scores when controlling for age, gender, and type of adoption. Therefore, adoptees who had not had any contact with a mental health professional scored lower on the total difficulties than those who had consulted with a mental health professional.

Table 6

Summary of regression statistics for demographic explanatory variables to self-rated SDQ total difficulties score

Demographic Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
Age	-2.63	2.34	-.24	-1.13	.27
Gender	-.21	2.10	-.02	-.10	.92
Mental Health Consult	-5.20	2.18	-.48	-2.38	.03
Type of adoption	3.11	2.44	.27	1.28	.22

Notes: $R^2 = .30$

Results of the multiple regression for teacher-rated total difficulties and the independent variables are presented in Table 7. The model accounted for 45.4% of the variance in teacher rated total difficulties scores. However, the overall model was not significant ($F(4) = 2.71, p = .08$). Looking at the independent variables separately, the adoptees' age was significantly associated with total difficulties scores when all the other independent variables were held constant. Therefore, the older adoptees (14 to 17) years of age had higher total difficulties scores than the younger adoptees (7-13 years old).

Table 7

Summary of regression statistics for demographic explanatory variables to teacher-rated SDQ total difficulties scores

Demographic Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
Age	2.11	.91	.50	2.33	.04
Gender	-.15	.90	-.03	-.16	.88
Mental Health Consult	-1.22	.85	-.30	-1.44	.18
Type of adoption	-1.39	.91	-.31	-1.52	.15

Notes: $R^2 = .45$

4.1.5 Summary of Findings

In summary, the parent-rated scores on the SDQ suggested that adopted children had more behavioural difficulties associated with conduct disorder than non-adoptees. Furthermore, the teacher and self-rated SDQ scores revealed that adopted children had more difficulties associated with hyperactivity and inattention than non-adoptees. Nevertheless, there were no significant differences between the groups on any of the other subscales or on the total difficulties scores.

The regression analyses yielded non-significant models. However the variables mental health consult and age were individually significantly associated with the self-rated and teacher-rated total difficulties scores respectively.

4.2 Thematic Analysis

4.2.1 Demographic Characteristics of the Interview Sample.

Of the ten parents invited for interviews, seven (comprising six adoptive mothers and one adoptive father) accepted and were interviewed. All the parents were married and had either a college or university qualification. Four parents had two adopted children each bringing the total number of adopted children in this sample to 11. The mean age of their children was 13.5 years ($SD= 3.05$). Further demographic descriptions of the adopted children are presented in Table 8.

Table 8

Demographic characteristics of the adopted children whose parents were interviewed

	Adopted Children (N=11)	
	Frequency	Percent
Gender		
Male	7	63.6
Female	4	36.4
Type of adoption		
In-racial	7	63.6
Transracial	4	36.4
Age at adoption		
0-12 months	10	91
12-24 months	1	9
Mental Health Consult		
Yes	8	72.7
No	3	27.3
Remedial Support/Special school		
Yes	5	45.5
No	6	54.5

4.2.2 Results of the Thematic Analysis.

The thematic analysis resulted in 17 categories that could be grouped under five broad themes related to the strengths and difficulties of adopted children. These five themes were: difficulties, strengths, adoption-related loss, pre-adoption risks and identity. The categories

and themes are defined and outlined in Table 9, with supporting illustrative quotes followed by a detailed discussion of the five themes.

Table 9

Themes and illustrative quotes

Categories	Definition	Illustrative Quotes
<u>Theme 1 - Difficulties</u>		
1. Psychological diagnosis by professional/Mental health referrals	A DSM diagnosis given by a mental health professional	Mrs A: They say she is ADD, you know attention deficit, and she does battles, she battles with maths. Mrs C: First of all he is hyperactive...
2. Difficult behaviours	Behaviours which the parent feels are difficult to cope with.	Mrs C: He has elements of obsessive compulsive and I feel as a teacher with my experience that he is borderline Aspergers.
3. Learning difficulties	Cognitive or psychological barriers to learning.	Mrs B: Later on about grade 3 or 4 he went for more remedial help and eventually we took him to a psychologist and had him assessed...he doesn't focus and concentrate, he really struggles so they put him on Ritalin.
4. Emotional difficulties	Psychological problems related to anxiety or depression.	Mrs B: Sometimes she gets herself into such a state and she takes herself into a pit and she wants to die and she really does and one time I was really worried and she was talking about killing herself.
<u>Theme 2 – Strengths</u>		
5. Positive attributes	Normal or positive outcomes and positive coping skills.	Mrs A: She is very outgoing. Mrs C: ...greatest strengths are his people skills, he is unbelievably forgiving, and he understands people. Mrs G: He is very sociable, he has got a lot of friends, people like him they invite him to parties... Mr F: They are very sociable, they are very sociable.
<u>Theme 3 – Pre-adoption Risks</u>		

- | | | |
|-----------------------------------|---|--|
| 6. Relinquishment/
abandonment | Termination of
parental rights by
giving the child for
legal adoption or
illegally abandoning
the child. | Mrs A: She was actually found on a
rubbish dump...probably because of her
deformities at birth, because she had very
puffy feet, very puffy hands and that's
signs of Turners syndrome. |
| 7. Institutional Risks | Risks associated with
living in a public child
care institution and
effects thereof. | Mrs G: I mean as it turned out he was in
the 34 th percentile he was below his he was
under weight and he was under size, he
wasn't super, you know healthy and he had
a horrible, horrible, horrible diarrhoea for
long time. |
| 8. Pre-natal risks | Risky behaviours and
challenges experienced
by a pregnant woman
which impact on the
unborn child. | Mrs C: ...she was in denial for about 7 and
half months and eventually he said I think
you might be pregnant. You need to go
and check with the doctor and he said ya
you are. And she was horrified and she
went to the adoption agency and she did
the whole thing and she chose us and she
didn't want anybody to know that she was
pregnant. |

Theme 4 – Adoption-related loss

- | | | |
|---|---|---|
| 9. Adoptee's feelings of
anger | Adoptee's anger or
hostility toward birth
parents for giving them
away. | Mrs C:...he went through a stage when he
would say well; you can't tell me what to
do cause you are not my real mother and
father.

Mrs B:...she was shouting at me...you are
such a terrible mother and I hate you! At
the top of her voice... |
| 10. Adoptee's feelings of
grief/loss | Adoptee's longing for
their birth parent and
grieving for the loss of
their birth parents. | Mrs C: ...she is like 7 or so and then she
said I am feeling sad because my mother
didn't want me and I don't understand.

Mrs B: ...there have been questions...like
why did my mother leave me?

Mrs G: And then this morning walking to
school and he said to me I can see the
moon...he said when I see the moon I think
of my tummy mommy. |
| 11. Fantasies about
birthparents | Adoptee's fantasies
about their birth
parents. | Mr F: ...she has illusions that her birth
mother could possibly be some superstar.

Mrs E: Then there were stories, there by
our house we have this car and that car, but
it was just a phase he went through. |

12. Adoptive parents grief and loss	Adoptive parents feelings of loss for the child they never had.	Mrs B: So we went to see her and I looked at her and I thought – I know you – you know it’s like there was something, I had never had that and it was unexpected and such a lovely thing.
13. The emotional pain of infertility	Psycho-social and physical effects of infertility.	Mrs A: You’ve already gone through that you can’t have children, now you got one, now you not good enough...

Theme 5 – Identity

14. Confusion about racial identity	Identity based on racial categories i.e. Black, White etc.	Mrs C: ...they all say I am the only White one, I am the coconut you know the opposite of the coconut but she thinks of herself as White.
15. Feelings of being different	Feeling like one does not belong in a group because of overt or covert difference with the group.	Mrs E: ...other kids are nasty and being different with hair and everything. Mrs C: ...although I think that one often searches for things like they often say oh my aunt was like that or your grandfather was like that, actually, I think it’s just searching for a reason why.
16. Cultural identity	Identity based on cultural groupings.	Mrs A: ...and she says and what about her culture? And I said what culture? You know, I mean what culture do you get when you are in a home? What culture? You know. I mean, she’s gonna be brought up in a culture of being our family culture...I know what people mean because she hasn’t got a black culture.
17. Adoptee’s desire to meet birth parents	The adoptee’s desire to find their heritage and know where they come from.	Mr F: ...my daughter has made no bones about the fact that she would like to meet her birth mother...

4.2.2.1 Theme 1 – Difficulties.

All 7 parents expressed that they had experienced some behavioural or emotional difficulties with their children, albeit with varying intensity. Of the adopted children 45% had been to a mental health practitioner as a result of these difficulties. In describing her son’s difficult behaviour, one parent expressed that her son had been “...a very difficult child. No, he literally was very difficult”. At more than one point she “...couldn’t manage him any

longer” and “a year and a half after he had given up the psychologist, I felt that I couldn’t cope any longer...” Another adoptive mother described her daughter as “...a difficult gift...” and said “...she is really struggling with life.”

However, most of the parents attributed these difficulties to maturational challenges or other external factors such as peer pressure and family dynamics:

A bit of a tough time now at school because I think teenagers also the hair and figure and things like that she is going through that...she had her period at age 11 and I know it can be that also... (Mrs E)

It’s hard to know, how much is her personality; how much is her environment; how much is just with what it is being a teenager today or blimmming dirty mindedness or being my own person there is all sorts of things but I wouldn’t know where to put the emphasis really. (Mrs B)

We have a mother-daughter issue but that’s a teenage issue right... (Mr F)

...it was actually when I was pregnant that we really worried about him. His behaviour at that time seemed really, really out of control and very difficult for us to manage it...so we were highly anxious about his safety...and also naughty so he struggled many times always with discipline...so we went to a psychologist about this and she contracted with us 12 sessions to do parenting sessions...she felt and it’s true that that we were struggling with boundaries... (Mrs G)

According to the participants, all 11 children displayed externalising behaviour problems.

Mrs B said of her 16 year old daughter “...she can be very aggressive...” She also reported instances of stealing and verbal aggression:

We said we know money is gone missing...she was mad and she can swear like you won’t believe...So (dad) searched the room and found the money.

Mrs B also reported aggressive behaviour in her 13 year old adopted son:

He gets quite moody and gets aggressive, when he is cross everything goes and he just doesn’t think...so he sometimes attacks (adoptive sister) when he really gets cross and she does him as well.

There were also reports of defiance:

...you would ask him to do something and he just wouldn't, he just wouldn't. If he didn't want to he just wouldn't. (Mrs C)

...he is being treated for a listening like an instruction following difficulty...maybe it is something more than just the naughtiness. So he is not that good at following instructions. (Mrs G)

“He is extremely stubborn and he likes to back chat...and I hate it and I can't take it!”
(Mrs D)

The parents of 4 children (36.4%) reported difficulties associated with hyperactivity. Three of the children had been given a diagnosis of ADHD by a psychologist and were on medication.

But now she is, they say she is ADD, you know attention deficit and she does battle...she was on Ritalin...then she was on Stratera from grade 2 until October last year. (Mrs A's 13 year old daughter)

Later on about grade 3 or 4 he went for more remedial help and eventually we took him to a psychologist and had him assessed. And she said he is very bright but he doesn't focus and concentrate, he really struggles so they put him on Ritalin...he is a bit all over the place, he doesn't complete things. He takes ages, he plays with the cat and gets up and you know he is just restless and very easily distracted.” (Mrs B)

Firstly he is hyperactive...as he got older he was in everything, he'd be in everything and taking stuff out. He was just hugely active...he was just busy, incredibly busy.
(Mrs C)

Eight out of the eleven children (72.7%) displayed behaviours associated with internalising difficulties. Mrs B said of her 16 year old daughter:

She gets herself into a state and sometimes she gets herself into such a state and she takes herself into a pit and she wants to die and she really does. And one time I was really worried and she was talking about killing herself.

She goes on further to say:

She is quite a vulnerable child inside...she can come close to being emotionally available and then she can be just cut off. It's like she cuts off things in her life that are difficult...

Mrs C recounted the following about her 17 year old son,

...he used to cry and he would wake up and he would cry and cry and cry and it was usually at night and he would just cry and cry and cry and cry for like an hour, and hour and a half...even when he was older he used to wake up crying and completely stiff...

She then consulted a psychologist who referred them to an occupational therapist. The OT said he was sensory defensive and tactile defensive and thought that:

...maybe there was a lot of stuff going on around that he wasn't managing and she thought maybe that was why he was waking up and cried.

The preschool also asked us to please take him to see a psychologist. They felt that he was depressed and that the move from preschool to junior school would be a big step for him and that he would need someone outside of the family and the school to help him with the transition.

After seeing the psychologist, Mrs C reported that:

...he said Noah socially and emotionally hadn't progressed in the year since he had seen him and assessed for the first time and thought perhaps the school was right.

On further assessment the psychologist's description of her son's emotional difficulties was:

...he was like somebody who couldn't feel, he couldn't internalise. He said Noah was like somebody who had no skin on the outside of him and that everything that happened around him affected him deeply and that he like felt he had no control over what was happening in the world around him

She also reported some behaviour associated with anxiety:

...all the time he would hang onto things...he would wrap up all the wrapping sweet papers so for years we had been gathering all this stuff and tying it up and throwing it away in bits.....he had little things that he had to do before he could do something

else. It was one of those things we raised with the psychologist and he said he needs those things to make himself feel more comfortable and safe.

Mrs E described her 15 year old daughter as “vulnerable...she becomes tearful quite easily” and “It’s always somebody trying to pick on her.” She also said she was concerned about her daughter because:

...her self esteem is a little bit down...she will come home and you say Somaya go and change and she will go in her room and she just lays there.

Her 12 year old adopted brother also had symptoms of emotional difficulties from preschool “...they said that emotionally he was not ready for grade 1...”

She said the previous year:

He started crying and he didn’t want to go to school and they wanted him to go to the school psychologist...then he was sick...it was actually dermatitis...then he had a sore on his head. I don’t know, I think his body was just releasing the stress that I am going away.

4.2.2.2 Theme 2 – Strengths.

There was one common area in which the children were said to be performing particularly well. That area was social competence. Eight of the 11 children (72.7%) were described as socially competent.

She is very outgoing. When she was little she was very spontaneous, very enthusiastic...all the teachers said she is so enthusiastic; she is so keen...she’s always been a person that can speak her mind. She’s never had a problem with speaking to anybody. (Mrs A)

...he is socially completely comfortable in his own skin and he has incredible people skills...everybody likes him, he fits in with every age group; he is very funny, very perceptive. (Mrs B)

...Alex’s greatest strength is his people skills, he is unbelievably forgiving, and he understands people. (Mrs C 10 year old son)

...he is very loyal, he is concerned...he is friends with everybody. (Mrs D)

Mrs E described her daughter as “She is a lovable child, she makes friends easily.” And her son as “he is very confident, he speaks his mind...he just keeps the party alive.” While Mr F said of his son and daughter “They are sociable, they are very sociable.” And Mrs G described her son as “He is very sociable, he has got a lot of friends, people like him they invite him to parties...”

However, three children were described as being the opposite of their adopted siblings and lacking in social skills.

...he found it difficult to play with other children...and it was to do with wanting to be part of a group and not being able to be part of a group and also not being able to not be part of the group. (Mrs C 17 year old son)

Mr F transferred his daughter from one school to another because she was having difficulty relating to the other girls: “...she didn’t fit into that clique” However he reported that since she moved school: “...it’s been 6 months now and I hear the same story with the girls in the class.” Mrs B described her 16 year old daughter as “...she can be very unkind and cruel.”

4.2.2.3 Pre-adoption Risks.

Pre-adoption risks can be broadly grouped into pre-natal and post-natal risks. The pre-natal histories of adoptees are difficult to know because the information is usually unavailable. It is only the effects of pre-natal adversity that are seen in the child’s development. In this sample, two aspects of pre-natal risks were reported: maternal stress and maternal health.

Ten children (91%) were exposed to pre-natal risks. Four children (36.4%) were specifically affected by poor maternal health:

...mother probably did have AIDS because when she was born she had the antibodies for AIDS virus and at 3 months they were no more. (Mrs A)

...he did test positive on the Eliza and then negative on the PCR. I think that confirms that his mother is or was HIV positive. (Mrs G)

He was a very sick baby, very tiny 2, 5 kilos...it was very scary sometimes at night he would stop breathing. We were at Red Cross most of the time. Before he was 2 we

took out his tonsils...they said it was from the mother, I think they said she was hypertensive. (Mrs E)

When we got him, he was 19 days old because there are tests that they have to do before they can release the child. There was this one test that they were waiting for and it took 3 weeks to get the results. (Mrs D)

The pre-natal histories for five children (45.5%) suggest that the birth mother may have been stressed during the pregnancy. The histories also suggest that the mothers may not have had access to adequate prenatal care and support.

...she was in denial for about 7 and half months and eventually he said I think you might be pregnant. You need to go and check with the doctor and he said ya you are. And she was horrified and she went to the adoption agency and she did the whole thing and she chose us and she didn't want anybody to know that she was pregnant. (Mrs C 10 year old son)

...it was incredibly stressful for (birth mother) because she had actually not told her family that she was pregnant. She had come away before they picked it up...it was stressful for her. (Mrs C 17 year old son)

...her birth mother concocted a story because she didn't want Elizabeth to have that birth father...the truth is that it was someone she knew and she had had a relationship with but he was drinking and she didn't think he was a good father... Mrs B

Mr F said that the birth mother for his son was a "student" and his daughter's birth mother "...was a little bit younger..."

The postnatal risks experienced by nine children (81.8%) who were placed between three to 19 days old are unknown because no information is available on the time they spent in the hospital. However, the parents of the two children placed a five months and 23 months had more information regarding their post-natal experiences from the institutions of care.

Firstly both children were abandoned then found and brought to a child care institution.

...he had been there from birth, they said he had arrived there at the time he arrived there he must have been within 3 days...because his umbilical cord was still attached.

They say it falls off about 7 days or so after birth so he was literally a newborn...no history about his background or anything. (Mrs G: child placed at 5 months)

She was actually found on a rubbish dump...probably because of her deformities at birth, because she had very puffy feet, very puffy hands and that's signs of Turners syndrome. (Mrs A: child placed at 23 months)

The conditions in the child care institutions were reported to be sub-optimal.

...when I walked into the babies section, the smell of sour milk that diarrhoea smell it's still there and I thought this is just the constant state of care... (Mrs G)

And the effects thereof on her son

...he had this terrible terrible terrible diarrhoea and this nappy rash when I got him...the nappy rash was so bad it actually had oozing sores. It wasn't just redness or rash it was actually sores that had holes ...the horrible diarrhoea that he had was really explosive it wasn't even poo it was just like water, it was very hectic.

Now 7 years old she wondered if his "...struggle to know his body needs..." was because he "...might have dissociated from his body in order to survive the horrible diarrhoea."

The lack of stimulation, inadequate care and the effects of that were also noted when Mrs G recounted her experience at the children's home.

There were two adoptable children and the other one was way skinny and seemed way apathetic...he had his head turned to the wall and was just looking at the wall.

She also reported the poor state of health her son was in

...he was in the 34th percentile, he was below his, he was under weight and he was undersize. He wasn't super you know, healthy

Conversely, the other child adopted at 23 months had a better experience in a Catholic children's home "...she was so loved this child..." (Mrs A)

However Mrs A had an older adopted son who had been institutionalised and she said when she adopted him:

...you'd give him toys to play with, now he was 18 months he could walk, he could get around. You could leave him there for half an hour; he might pick something up; look at it and put it down.

A common marker of the effects of institutional deprivation is indiscriminate friendliness. This behaviour was reported by one parent who said her son needed people around him and to care for him. She also said he formed relationships with anyone he encountered in his life. As a baby "...he was willing to be passed to other people; he was willing to be soothed by anybody who was willing to do it" (Mrs G).

4.2.2.4 Adoption-related Loss.

Adoption-related loss affects both adoptive parents and adopted children. However the experience and expression of that loss is idiosyncratic. According to Brodzinsky (2011), expression of grief lies on a continuum from intermittent mild feelings of confusion and sadness to persistent and deeply felt grief expressed through emotional and behavioural symptoms like anxiety, sadness and anger, crying or acting out.

The parents interviewed described feelings of sadness and longing for the birth parent in 10 of the 11 children (91%).

There have been questions...like why did my mother leave me? (Mrs B)

...she is like 7 and then she said I am feeling sad because my mother didn't want me and I don't understand. (Mrs B)

...she said to me when she was 11 'it's not very nice to give away your baby, is it?' I mean just straight out of the blue like that... (Mrs A)

...I was pregnant ...he would have been about four at the time...he was like oh I didn't grow in your tummy, where did I grow? And I said in your birth mother's tummy. He asked me who is she...what is her name? (Mrs G)

And then this morning walking to school and he said to me I can see the moon...he said when I see the moon I think of my tummy mommy...also this morning he says to me I miss her you know he says I wish I could still be with her... (Mrs G)

...he asked about why, why did she give him up, we had long conversations at a really early age...he talked, asked incessantly... (Mrs C)

The anger that adoptees feel is described by Lifton (2010) in “the baby feels not only longing, but rage at the abandoning mother. This rage must be split off...as a way of holding on to ...the all loving ghost mother.” This rage was described by the parents.

...that whole year and for a little bit afterwards she kept saying to me well ‘you not my real mother, you not my real mother’ my son did that to me as well. And it did upset me in the beginning... (Mrs A)

He started crying and he didn’t want to go to school...it turned out that it was not about his teacher, he was angry with us going away, at me actually...he went back to his mother rejecting him and now I left that time and now I was leaving him again. He even thought God gave up on him...he spoke to her and said that’s how he feels. (Mrs E)

My daughter said to her mother once in a while ‘mom I don’t think my birth mother would treat me like this’ ... (Mr F)

...he went through a stage when he would say well; you can’t tell me what to do cause you are not my real mother and father... (Mrs C)

...she was shouting at me...you are such a terrible mother and I hate you! At the top of her voice... (Mrs B)

Mrs B explained her daughter’s anger as “it’s related to stress and hitting out...it’s about anger management” She goes on to recount another outburst from her daughter:

...she was cross with me and she said ‘I wish I had never been adopted, I wish I had gone to other parents!

The adoptive parent’s feelings of loss and longing for a biological child were described by the five parents who adopted because of infertility. Their loss and grief aggravated in those moments where the adoptee rejected them in anger. One example is:

...he said you are not my real mother so you can’t tell me what to do! And I said to him what does that make you then? Not my real son? And I turned and I walked out of the room. (Mrs A)

Although the loss and grief is apparent in both the adopted children and adoptive parents, it seems that those feelings are expressed because they feel secure enough in their relationships. The parents' spoke of having special bonds with their children:

So we went to see her and I looked at her and I thought – I know you – you know it's like there was something, I had never had that and it was unexpected and such a lovely thing. (Mrs B)

Somaya was laying in the crib...she was laying on her stomach, a thick bunch of curly hair and lekker chubby, I picked Somaya up and put her on my shoulder, immediately we bonded...(Mrs E)

...it was her father more than me, he absolutely loves her and she loves him, I mean we all love each other, but you know they have a special close bond between them. (Mrs A)

4.2.2.5 Theme 5 – Identity.

The identity development of adopted children is most often discussed in transracial adoption but it is a maturational task all children must negotiate. However, in adoptees this developmental task is complicated because they "...have been cut off from their origins and prevented from gaining information about their birth heritage." (Brodzinsky et al, 1998, p.31)

Their search for identity is reflected in the desire to find their birth parents and increased awareness of being different from the adoptive family. The latter is especially relevant to transracial adoptees because of the obvious physical differences.

Seven of the children (63.3%) expressed the desire to find their birth parents.

...my daughter keeps on wanting to say she wants to meet her birth mother...my daughter has made no bones about the fact that she would like to meet her birth mother... (Mr F)

...he wants to meet them and we keep telling him we are trying to find them... (Mrs C)

She will definitely find her birth mother...she wants to know about her birth mother... and then she actually wanted to know about her birth father. (Mrs B)

The reports of difference:

...I wouldn't say she feels insecure but she becomes tearful quite easily...I don't know, you wouldn't say she doesn't fit in but you can also say she is different, you know.

(Mrs E)

Mrs E goes on to say the adoption social worker:

“...wanted a perfect match for us and now I see where she was coming from because children grow up, they see their difference and it causes a bit of a hindrance. Like people that value looks and hair...but if they don't match completely then your child won't fit in and it causes a bit of an emotional problem for the child...and sometimes it's hard when people say is that your baby? I say ya it's my baby. Who does she look like? She looks like herself. Is it you; is it her daddy? No, she looks like herself.” (Mrs E)

Furthermore, because people generally expect family members to resemble each other, they look for similarities even in adoptive families:

Ironically people think my daughter looks like me and my son looks like my wife...

(Mr F)

...she looks like me so the kids at school say no, Catherine can't be adopted; she looks just like you... (Mrs B)

Interestingly one parent had this to say about people looking for similarities in children and their parents:

...I think that one often searches for things like they often say oh my aunt was like that or your grandfather was like that, actually, I think it's just searching for a reason why.

(Mrs C)

The transracial adoptees experienced more difficulties regarding their racial identity.

Mrs B who is in a transracial marriage (she is White and her husband is Coloured) adopted two Coloured children. She describes an incident with her daughter:

...there was a day...she was talking about being White and I said...you actually need to know this ...that is both your parents are Coloured...she has to know because one day she goes to find her mom, her mom is Coloured and she finds her dad and her dad is

Coloured. Then it's not only that I am adopted but I always thought I was White and I am not White...

I asked her which racial category her daughter places herself in and she said:

...sometimes she will say I am the only White one, I am the coconut you know the opposite of the coconut but she thinks of herself as White...

The term coconut is derogatory jargon implying that someone is like a coconut, brown on the outside and white on the inside. As a racial term it is used to describe someone who thinks of themselves as being a White person but they are of a different racial category.

A White mother of a Black boy said:

Like I don't think he sees himself a Black, I don't think, he never uses the term Black. He always refers to himself as Brown. And initially he used to refer to us as orange so he used to say you are orange and I am brown so it was a visual thing not a category thing. Now he refers to us as White but he still refers to himself as brown. (Mrs G)

The parents reported that being different affected their children.

I think because high school now and other kids are nasty and being different with hair and everything. (Mrs E)

...The thing is people still look at us...she notices it and I think it's affected her in the fact that she used to be very outgoing and now she is much more reserved... (Mrs A)

...you get the different reactions of people you know and yes it's hard for Anna Maria as well in certain ways and we have her at a psychologist at the moment. (Mrs A)

4.2.3 Summary of Findings

In conclusion, the thematic analysis yielded five broad themes, these were, difficulties, strengths, pre-adoption history, adoption-related loss and identity. Further analyses of these themes suggest that the adopted children exhibited more externalising than internalising difficulties.

The adoptive parents reported that all eleven children displayed externalising behavioural difficulties. Furthermore, 36.4% of the children displayed behavioural difficulties associated with hyperactivity. Whereas the reports suggest 72.7% of the children displayed internalising behavioural difficulties.

The findings further revealed that the adopted children had a common strength: social competence. Eight of the eleven children (72.7%) were described as being socially competent. The results also indicated that 91% of the children had adverse pre-adoption histories, and showed behaviours associated with grieving for adoption related losses. Finally, the results revealed that seven children had difficulties related to feeling different, identity confusion and in particular difficulties with their racial identity.

CHAPTER FIVE – DISCUSSION AND CONCLUSION

In this final chapter, the quantitative and qualitative results are summarised and integrated. Thereafter, the main findings are discussed in relation to the existing psychological theory and outcomes research. Finally, the limitations of the study, recommendations for future research, and implications for clinical work are considered.

This study explored the strengths of adopted children and the difficulties they faced in comparison with children being raised by their biological parents. Furthermore, this study aimed to establish whether there was an association between selected demographic variables and adopted children's total difficulties scores.

This study also aimed to explore *qualitatively* the strengths and difficulties of adopted children within their contexts, by gaining insight into adoptive parents' experiences of adoption and investigating their opinions of their adopted children's strengths and difficulties.

On a secondary level, the study sought to substantiate *qualitatively* the findings of the *quantitative* survey, and to explain any disparity between the quantitative and qualitative findings.

The study was conducted with school-age children in Cape Town, South Africa, as well as parents and teachers. The research utilised a mixed methods design, integrating quantitative data from a survey and qualitative data from semi-structured interviews.

5.1 Summary and Integration of Main Findings

The quantitative results suggested that the parents reported significantly more externalising behavioural difficulties, associated with conduct disorder, in adoptees than non-adoptees; the effect size was medium. These results were similar to the qualitative results, where the adoptive parents who were interviewed reported that all eleven children presented with externalising behavioural difficulties. However, these group differences were not consistent across informants, as the results of the teacher-rated SDQ scores and the self-rated SDQ scores, suggested that there were no significant differences between the two groups of children on the conduct problems scale.

The self-rated SDQ scores further revealed that the adopted children rated themselves as exhibiting significantly more behaviours associated with hyperactivity and inattention problems than the non-adopted children did. In addition, the teacher-rated scores also indicated that adopted children had more difficulties associated with hyperactivity than non-adoptees, although the difference between the groups was only marginally significant.

Although the parent-rated mean scores for the hyperactivity scale were higher for adopted children than for non-adoptees, the difference between the groups was not significant. Furthermore, the thematic analysis revealed that the parents reported hyperactivity difficulties in only 4 of the eleven (36.4%) children.

The results from all the informants further revealed that there were no significant differences between the groups on the emotional symptoms and peer problems scales, which measured internalising difficulties. The results of the two methods seem to diverge here, as the results of the thematic analysis suggested that eight (72.7%) of the adoptees displayed internalising behavioural difficulties.

According to all the informants in the SDQ survey, there were no significant differences between the groups on the pro-social behaviour scales. These results suggest normal social development. In the qualitative findings, social competence was clearly identified as a strength in eight of the eleven adoptees.

Most importantly, there were no significant differences between adoptees and non-adoptees on the total difficulties scores. Similarly, the interviewees reported that, although their children had difficulties, they were generally well adjusted. This suggests that, although the adoptees were found to have more conduct and hyperactivity difficulties than the non-adopted children did, the majority of adoptees are coping well.

In line with the risk and resilience perspectives which suggest risk factors that increase adoptees' vulnerability to behavioural difficulties, the thematic analysis yielded similar themes. For instance, ten of the eleven children had adverse pre-adoption histories, and they showed behaviours associated with grieving for adoption-related losses.

Finally, the multiple linear regression analyses yielded non-significant models, which suggest that the combined effect of the demographic variables was not significantly associated with the adopted children's total difficulties scores as rated by the three sets of informants. However, the variable 'mental health consult' was individually significantly associated with the self-rated total difficulties scores, suggesting that adopted children who had some contact with a mental health professional had more total difficulties than those who had not. In addition, the variable 'age' was significantly associated with the teacher-rated total difficulties scores, suggesting that older adoptees had more total difficulties than the younger adoptees. Perhaps this is a reflection of the increasing intensity of emotional challenges faced by adoptees as they move deeper into adolescence, thereby necessitating additional help at this stage. Age in this instance referred to the children's age at the time of

the survey and not the age at adoption or the length of time in placement because all but two of the adopted children were adopted at birth.

5.2 Discussion and possible explanations of the main findings

The results of this exploratory study of the strengths and difficulties of adopted children in Cape Town, South Africa, seems to suggest that much of the psychological theory and international research regarding adoptee outcomes may be applicable to the context of this particular study too.

As in other populations, this study indicated that adopted children had more externalising behaviours associated with conduct and hyperactivity disorders than non-adoptees (Greene et al., 2007; Hawk & McCall, 2010; Hjern, Lindbland & Vinnerljung, 2002; Keyes et al., 2008; Rosnati et al., 2008).

South Africa is a vastly different socio-political and economic context compared to Europe and the USA. Therefore, while these similarities in the findings between the present study and international findings validate these findings, it is necessary to scrutinise these outcomes further (Smith & Davis, 2003). The similarities in research findings seem to suggest that adopted children in varying socio-cultural contexts have common adoption-specific experiences, which lead to similar externalising outcomes.

Both the risk and resilience and the 'catch-up' perspectives imply that the outcomes of adoptees are influenced by many factors, but the key determinant of the outcome is the child's pre-adoption history (Bowlby, 1973; Ijzendoorn & Juffer, 2006; Luthar, Cicchetti & Becker, 2000). These perspectives would explain the similarity in behavioural outcomes if the experience of pre-adoption challenges were the same for all adopted children. However, these experiences are idiosyncratic and furthermore, even where two children have the same experience, the impact on each child is different (Selman, 2005).

In this study, only two of the children in the qualitative sample had experienced institutional care. However, the results suggest that 91% of the adopted children in that sample had been exposed to pre-natal risks, which is more common for children being adopted within the public system than it is among private adoptions and children being raised by their biological parents. Moreover, previous research has established that there are long-term negative consequences of pre-natal risks on children and adoptee behavioural outcomes (McGinn, 2007).

Some researchers argue that missing information on pre-adoption history, and an overreliance on the accounts of adoptive parents, who often have limited and sometimes

incorrect information themselves, make it difficult to attribute the difficulties to unverifiable and incomplete information (Palacios, 2009). Looking at the present study, this is a valid argument. In the qualitative sample, the adopted children's pre-adoption information provided by the parents was very limited and mostly based on hearsay. Furthermore, some of the pre-natal risks were merely deduced from information rather than verified by facts; for instance, if the birth mother was a student, it was assumed that the pregnancy may have been stressful and that she may not have had adequate pre-natal care.

While there may be some merit to these deductions, they remain unconfirmed and unverifiable. Nevertheless, it is widely accepted in adoption research that adopted children are vulnerable and at-risk of adverse experiences, both before and after birth, and it is this exposure that influences their behavioural outcomes (Brodzinsky et al., 1998; Brodzinsky & Schechter, 1993). Therefore the theoretical assertions that pre-adoption experiences account for increased externalising difficulties among adopted children may also be applicable to this study's context.

The qualitative findings of this present study point toward another adoption-specific experience, which might explain the adoptees' externalising difficulties, as well as the similarity in outcomes between this and other studies, namely: adoption-related loss. The interviewed parents described their children's feelings of anger, sadness and longing for their birth parent in 91% of the children. Some of the parents recognised that the children's anger and aggression might be related to their earlier experience of being rejected by the birth parents. However, some of these behaviours were just described as difficult behaviours. Based on the stress and coping model of adoption and adoption research, adoption-related losses are felt by all members of the adoptive family (Brodzinsky, 2011; Lifton, 2010). It may thus be that adoptive parents who are dealing with their own feelings of loss and grief related to infertility were over-inclined to take this behaviour personally. Furthermore, it may be that the adoptive parents' reports of difficult externalising behaviours were in fact just a reflection of the children's expressions of grief. Brodzinsky and Schechter (1990) go further to point out that even clinicians often pathologise behaviours that are part of a normal grieving process in adoptees. For example, Mrs G said of her adopted son:

“...it was actually when I was pregnant that we really worried about him. His behaviour at that time seemed really, really out of control and very difficult for us to manage it...so we were highly anxious about his safety...and also naughty so he struggled many times always with discipline...so we went to a

psychologist about this and she contracted with us 12 sessions to do parenting sessions...she felt and it's true that that we were struggling with boundaries..."

Based on the theorists' contention above, one may argue that this is a classic example of that to which Brodzinsky and Schechter (1990) refer. In this case, the clinician went on to do ten of the twelve sessions with the adoptive parents on boundaries. While I concede that the clinician may have had good reason for this decision, within the adoption paradigm, I would suggest that the clinician may have overlooked something in the adopted child, in light of the fact that there was a clear association between the adoptive mother's pregnancy and the child's behaviour. The mother's ability to make this association may imply that she was aware that the child was experiencing the loss of having missed something by not knowing where he came from. In addition, the child might also have been trying to express his fear of being displaced in his adoptive parents' affections by their biological child. Therefore, if all adopted children experience these types of losses, albeit differently, these experiences could be important in understanding their difficulties and in explaining why they have been found to have more externalising difficulties than their non-adopted peers.

The divergence of results regarding internalising behavioural difficulties between the methods in this study is reflected in the inconsistent international findings. As in the quantitative results of this study, some international research revealed no significant difference between the adopted and non-adopted children on internalising difficulties (Borders, Black & Pasley, 1998; Decker & Omori, 2009; Juffer & van Ijzendoorn, 2007). Nevertheless, the results of the qualitative analysis, which suggested that 72.7% of the adoptees displayed internalising difficulties, are also in keeping with international literature (Brodzinsky et al., 1987; Hjern et al., 2006; Keyes et al., 2008; Miller et al., 2000; Rosnati et al., 2008).

There seem to be at least two possible explanations for the apparent discrepancy between the quantitative and qualitative results in this particular study. Firstly, the average age of the participants is about 13 years, which is early adolescence, the onset of puberty and also the time of a major transition from junior to high school. This period is described as 'emotionally downward', and a time when it is normal for children to feel less competent, more self-conscious and more prone to depression (Weiten, Llyod, Dunn & Hammer, 2009). The evidence of this is indicated in the parental interviews where changes related to puberty, peer pressure and low self-esteem were cited as possible reasons why their children were experiencing difficulties. Such difficulties are common at this age, and are not exclusive

to adopted children hence the quantitative results which indicated that there was no difference between the groups on internalising difficulties. Furthermore, the multiple regression results of this study suggest that the teenagers (14-17 years) in the adopted sample had more total difficulties than the younger children (7-13 years), as rated by the teachers. The average age of the children in the qualitative sample was a little older than the quantitative sample thus the age of the children in this study may have had a significant influence on the results.

Secondly, the discrepancy in findings between the methods may be explained by the fact that the SDQ assesses very recent behaviours (going back 6 months). In the interviews for this study, in contrast, parents often described difficulties that their children had experienced at a younger age and recounted events over a much longer time period.

Furthermore, the SDQ simply measures observed or reported behaviours and cannot by its nature uncover the underlying reasons for those behaviours. The findings of the qualitative interviews therefore become valuable to this study by offering data covering longer time frames and allowing exploration of possible reasons underlying reported behaviours. For instance, the parents in the interviews reported that six of the children in the adopted sample had recently experienced negative life events such as death in the family, parental marital discord and other significant losses. It may be that the internalising symptoms reported in the interviewed sample reflected these other life events.

Within the resilience paradigm, the fact that adopted and non-adopted children's scores were not significantly different on emotional symptoms, peer problems, pro-social behaviour and total difficulties on the SDQ, is interpreted as evidence of resilience. These results were not unexpected, as international research had indicated that adopted children are socially competent, possess intrapersonal strengths and generally function in the normal range with no differences compared to non-adoptees (Tan & Marfo, 2006; Pearlmuter et al, 2008; Sharma et al., 1996; Tan & Marfo, 2006). Furthermore, the theory suggested that adoptees' improved post-adoption environment and access to resources enhanced their positive outcomes (Hindle & Shulman, 2008; van IJzendoorn & Juffer, 2006). In addition, adoptees developed emotion- and problem-focused coping strategies that help them to deal with the stress and challenges of being adopted (Brodzinsky et al., 1998).

Once more, the findings of this study are in line with international research and it appears that the same theoretical frameworks apply to the study's context. The demographic survey revealed that 43.3% of adopted children had been referred to a mental health practitioner. Although not significantly different to their non-adopted peers, it shows the help-seeking behaviour of parents in this sample and their ability to access services for their

children. This leads to early interventions and treatment where necessary. Furthermore, the demographics indicate that, like the parents of non-adopted children, the adoptive parents were middle class professionals with intact homes, which points to the fact that their children had a certain degree of stability and support, which improved their odds for positive outcomes.

The reports from the adoptive parents indicated that their children used problem-focused coping strategies, such as seeking information about their birth parents, and emotion-focused strategies like splitting to cope with adoption. Seven of the eleven children expressed the desire to know and find their birth parents. They asked for their birth parents' names and any information that the adoptive parents might have had. This shows a desire to understand and cope with the difficulties of grasping the concept of adoption. Although the splitting defence may become pathological when over-used, this is the strategy that the children most used to cope with the feelings of grief and loss. These theoretical ideas are visible in this study and depict a picture of resourceful and resilient adoptees, who are not just passive victims of their status but active agents influencing their own outcomes (Herman, 2008).

5.3 Limitations and Recommendations for Future Research

In making recommendations for future research, it is important to consider the possible limitations of the current study. The sample size and sampling strategies were potentially major limitations to this study.

Generally, small scale surveys need 200-300 participants in their sample to attain acceptable statistical power. However, this is an ideal and each study must be guided by the available resources (Gavin, 2008). The small sample size in this study meant that the generalisability of the study was limited. However, this weakness was countered by the triangulation design, which gathered supporting data from multiple sources using different methods. Triangulation validates and improves the clarity of the research findings (Ritchie & Lewis, 2003). In addition, triangulation increases the generalisability of the study. Furthermore, the sample size in this study was a reflection of the scope, time limitation and recruitment challenges of this study. Although I spent four months concurrently recruiting participants and collecting data, there were obstacles in accessing the adopted sample.

Firstly, CTCW has a strict confidentiality policy on adoption. Adoption files are sealed documents to protect the identities of all involved. Therefore, I could not make any contact with adopted participants without their permission, and the first contact had to be made by CTCW. Secondly, a number of parents refused to participate because they had not

disclosed the child's adoptive status to either the child or the teacher and wished this information to remain confidential. As a result, much time and effort was spent making contact with potential participants but not successfully recruiting them to participate in the study. CTCW had two adoption social workers make over 200 calls to potential participants, yet they only managed to receive consent from approximately 80. I then contacted those who had given consent, and at the end of four months, I had obtained data from 30. This type of sampling is called convenience sampling and international outcome studies have been accused of having the "...inherent problem of using relatively small, convenience samples..." (Palcios & Brodzinsky, 2010, p. 272) The present study was not immune to this limitation and as a result, the sample is not a true representation of the target population, in this case, families who adopted children through CTCW (Smith & Davis, 2003).

In addition, the adopted sample was recruited from a single agency, which increases the risk of sampling bias (Brodzinsky et al., 1998). In this study, all the adopted participants were recruited through CTCW. Participants drawn from the same agency are likely to be similar to one another, because of the nature of the work conducted by CTCW and similarity of issues affecting the communities they serve, therefore not truly representative of the entire population (Hayes, 2000). Although I attempted to recruit participants from adoption support groups, the very private and closed nature of these groups made it impossible to contact the potential participants. The group conveners made it very clear that their group members trusted them to keep their information confidential and that bringing in a researcher would breach that trust.

These sampling limitations lessen the extent to which this study's findings can be generalised to the population of those South Africans who have been adopted. For future outcome studies in South Africa, I would recommend the use of much larger and more representative samples. Perhaps they could include participants from all the provinces in South Africa, recruited from the national register of adoptions. This would be a truly representative sample and not subject to selection bias.

Another limitation inherent in this study was the lack of variability within the adopted sample. All but two of the adopted children had been adopted at birth or before their first birthday, and as explained earlier, these early adoptees are generally well adjusted. Therefore, the findings are a reflection of this. The transracial adoptees were also a small sub-sample, thereby limiting my ability to explore areas of possible importance in the adoption equation. Perhaps more variation within the samples would have yielded different outcomes. I urge future researchers in this area to consider this issue in future research. In particular, I think

that further exploration of transracial adoption could yield some interesting findings because of the South African historical and socio-political context. Perhaps a study focused on the strengths and difficulties of transracial adoptees compared to same-race and non-adopted children would be best.

In addition, the sample of adopted children in this study was recruited from the public adoption system, in much the same way as in other international studies (Rushton & Dance, 2006; Simmel et al., 2007; Voirra et al., 2006). This may be considered different from studies that recruited participants from clinical settings (Brodzinsky et al., 1998; Lindbald et al., 2010). However, the strategy is still flawed, as earlier research indicated that children adopted from the public system have more externalising difficulties than at-birth adoptees.

Lastly, international research indicated that pre-adoption history was a significant predictor of adoptee outcomes. However, the research methods of this study did not allow for adequate exploration of this factor. The survey was used to screen the participants for mental health difficulties but not for causal factors. Furthermore, the interviewees were adoptive parents with very limited information about their children's pre-adoption histories. Therefore, this study could not fully investigate the children's pre-adoption history as a determinant of adoption outcomes. I would recommend that future research revisit this issue. I think a sample of children whose pre-adoption histories are known and similar would allow for an interesting comparison with children adopted at birth. This may yield more true and fair findings of whether pre-adoption history is as relevant to the adoptees' outcomes in South Africa as it is in other populations.

As can be seen from the limitations of this study, they had mostly to do with the sampling strategies employed. However, as a pilot study, some pertinent issues have been raised and highlighted that can inform future research and improve the quality of future findings.

Despite the abovementioned limitations to this study, some aspects of this study were particularly strong and these may even have countered some of the limitations. This study employed a mixed method design, which meant that the weaknesses of the survey were offset by the strengths of the qualitative interviews (Tashakkori & Teddlie, 1998). For instance, the survey could not provide insight into the risk and protective factors associated with adoption outcomes. On its own, this method generated data about the strengths and difficulties of adoptees in a vacuum. However, the qualitative interviews filled in the information gaps in the survey data, by getting in-depth accounts of the adoptees' adjustment from their parents.

Therefore, the mixed method design allowed this study to gain a more complete picture of the strengths and difficulties of adopted children.

Although the sampling strategy was flawed, the adopted and non-adopted children sub-groups in this study were well matched in age, gender and socio-economic backgrounds. Statistical analysis confirmed that there were no significant differences between the groups. According to Asher (2004, p.348) "...control groups for comparison purposes are valuable, almost necessary, in most of psychology in order to have context in which to interpret meaningful research findings." Therefore, the well matched control group in this study allowed this study's findings to be interpreted in relation to the non-adopted population. This gave further meaning and context to the findings.

5.4 Conclusions and Clinical Implications

Principally, this study introduces a new body of knowledge on the outcomes of adoption in the South African context. Furthermore, it adds to an extensive body of international research on adoption outcomes by providing insight into the adoption outcomes in a different socio-economic and political setting.

The findings of this study suggest that the common strength among adopted children in this study was social competence. However, adopted children had more externalising difficulties than non-adopted children did. Several factors may have increased the adoptees' vulnerability to difficulties, and the qualitative findings suggest that pre-adoption history and adoption-related grief and loss were crucial factors.

Nevertheless, there were no significant differences between the adopted and non-adopted children with regard to internalising difficulties, total difficulties and all the other sub-scales of the SDQ according to all the informants. This suggests that, overall, the adopted children in this study are relatively well adjusted and that their strengths and difficulties are comparable to those of non-adopted children.

These conclusions have two important implications for clinicians working with adopted children. Firstly, clinicians need to be careful of labelling adopted children with a particular clinical diagnosis, without considering the effects of adoption-related loss and other adoption-related factors that influence adoptee behaviour and emotional adjustment (Groza & Rosenberg, 2001). Secondly, clinicians need to be careful when working with adoptive families, not to identify the adoptee as the 'problem'. Clinicians need to be aware that the difficulties of the adoptee are related to losses and responses to those losses within the family system. Furthermore, all the adoptive family members experience adoption-related loss in

one form or another. Therefore, grief work with adoptive families as a system needs to be considered as a fundamental part of their therapeutic interventions (Brodzinsky, 2011). Furthermore, adoptive parents would benefit from psycho-education to help them understand the ways in which children express grief, as these ways may be misinterpreted as merely being 'difficult'.

This study's findings seem to support the notion that adoption is mostly an effective and positive intervention in the lives of adopted children. This was evident from the fact that, overall, the adopted children in this study are coping as well as non-adopted children and that they have comparable strengths and difficulties. Therefore, adoption in any context seems to be a far better alternative for children in need of families than institutional care. This is especially the case in a developing nation such as South Africa, where competition for very limited resources is intense, the foster-care system is in a crisis, and the number of children living on the streets is increasing.

In conclusion, although this and other studies have identified adoption-specific experiences, it is pertinent to note that the outcomes of adopted children are idiosyncratic and that they reflect a complex interaction of internal and external processes. These children's adoptive status does not pre-determine their outcomes, and adoptive parents need to know that, just like parents who are raising their biological children, they play a crucial role in their children's lives and that they thus influence their emotional and behavioural adjustment.

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Appendix 1

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Parent/Teacher/Other (please specify:)

Thank you very much for your help

Appendix 2

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your Name

Male/Female

Date of Birth

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your signature

Today's date

Thank you very much for your help

Appendix 3

Demographic Questionnaire

Please complete this information sheet by ticking the appropriate box.

Name of child:

Age:

Gender:

RELATIONSHIP WITH CHILD

- Biological Child
 Adopted Child
 Foster Child

TYPE OF ADOPTION (if adopted)

- Same-Race
 Transracial

AGE AT ADOPTION (if adopted)

- 0 - 12 months
 12 – 24 months
 + 2 years

PARENT'S MARITAL STATUS

- Married
 Single parent
 Divorced
 Widowed

PARENT'S HIGHEST QUALIFICATION

- Degree/Diploma
 Grade 12
 Grade 10 or less

Has your child ever received professional counselling or
 been referred to a mental health professional?

- Yes
 No

Thank you for participating in this survey.

.....
 Signature

Appendix 4**STRENGTHS AND DIFFICULTIES OF ADOPTED CHILDREN – A PIOLT STUDY****INTERVIEW SCHEDULE****Name:****Time:****Date:****Questions:**

Q1. How did you come to adopt a child?

Q2. How would you describe your child at the time of adoption?

Q3. Describe your child's development (developmental milestones) for example, at what age did he/she walk and talk?

Q4. What is he/she like when she/he is happy, sad and angry? Give examples.

Q4. What would you say are his/her strongest attributes?

Q5. What would you say are his/her weakest attributes?

Q6. What are the most difficult behaviours you have noticed?

Q7. Why do you think your child exhibits these behaviours?

Q8. How do you think being adopted has impacted on your child?

Q9a. Have you ever sought professional medical or psychological help for your child?

Q9b. If yes, have you found this help useful?

Q9c. If no, are there any types of help that you may find useful?

Thank you for taking part in this interview.

Ending

Appendix 5

Parent Consent Form

STRENGTHS AND DIFFICULTIES OF ADOPTED CHILDREN

1. Invitation and Purpose

You are invited to take part in a research study about the strengths and difficulties of adopted children in Cape Town. My name is Tariro Marufu. I am a M.A Clinical Psychology student at the University of Cape Town and I will be conducting a survey to gather data which I will use to write a dissertation exploring the adjustment of adopted children in comparison with children being raised by their biological parents. This data will help psychologists better understand children and their strengths and difficulties.

2. Procedures

If you decide to take part in this study, we will ask you to take the Strengths and Difficulties questionnaire (SDQ). The questionnaire will ask you 25 questions which include both positive and negative attributes you have observed in your child. It will take about 5 – 10 minutes to complete.

3. Risks, Discomforts & Inconveniences

This study does not pose more than low risk to you. The main risk is that someone other than the researchers might see your private information, but this risk is still very small because of the safety measures we will take to keep your information safe.

4. Benefits

The knowledge gained from this study will be used to help improve psychological assessment and intervention with children who have been adopted.

5. Privacy and Confidentiality

We will take strict precautions to safeguard your personal information throughout the study. Your information will be kept in a locked office at the Child Guidance Clinic which can only be accessed through the researcher. Those responses sent by email will only be accessible to the researcher using a password.

6. Money Matters

You will not pay or be paid for taking part in this survey.

7. Questions

If you have questions, concerns, or complaints about the study please contact the researcher or supervisor on details below.

Researcher: Tariro Marufu

UCT Child Guidance Clinic

Chapel Road

Tel: 0711120810

E-mail – sdq.survey@gmail.com

Supervisor: Dr Lauren Wild

UCT Psychology Department

Upper Campus

Tel: 021-6504703

8. Signatures

{Participant's name} _____ has been informed of the nature and purpose of the procedures described above including any risks involved in its performance. He or she has been given time to ask any questions and these questions have been answered to the best of the researcher's ability.

Researcher's Signature

Date

I have been informed about this research study and understand its purpose, possible benefits, risks, and discomforts. I agree to take part in this research as a participant. I know that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to enjoy.

Participant's Signature

Date

My child is 11-16 years old and he/she may complete a self-rated SDQ.

Parent's Signature

Date

My child's teacher may complete a teacher rated SDQ about my child.

Contact details:

Parent's Signature

Date

Appendix 6

Teachers Consent Form

STRENGTHS AND DIFFICULTIES OF ADOPTED CHILDREN

1. **Invitation and Purpose**

You are invited to take part in a research study about the strengths and difficulties of adopted children in Cape Town. My name is Tariro Marufu. I am a M.A Clinical Psychology student at the University of Cape Town and I will be conducting a survey to gather data which I will use to write a dissertation exploring the adjustment of adopted children in comparison with children being raised by their biological parents. This data will help psychologists better understand children and their strengths and difficulties.

2. **Procedures**

If you decide to take part in this study, we will ask you to take the Strengths and Difficulties questionnaire (SDQ). The questionnaire will ask you 25 questions which include both positive and negative attributes you have observed in your student. It will take about 5 – 10 minutes to complete.

3. **Risks, Discomforts & Inconveniences**

This study does not pose any risk to you.

4. **Benefits**

This study is not designed to directly benefit you. The knowledge we will gain from it, however, will be used to help improve psychological assessment and intervention with children who have been adopted.

5. **Privacy and Confidentiality**

We will take strict precautions to safeguard your personal information throughout the study. Your information will be kept in a locked office at the Child Guidance Clinic which can only be accessed through the researcher. Those responses sent by email will only be accessible to the researcher using a password.

6. **Money Matters**

You will not pay or be paid for taking part in this survey.

7. **Questions**

If you have questions, concerns, or complaints about the study please contact the researcher or supervisor on details below.

Researcher: Tariro Marufu

UCT Child Guidance Clinic

Chapel Road, Rosebank, 7700

Tel: 0711120810 E-mail – sdq.survey@gmail.com

Supervisor: Dr Lauren Wild

UCT Psychology Department

Upper Campus

Tel: 021-6504703

8. **Preferred Contact**

Please indicate your preferred method to receive the questionnaire by circling one:

Post/ E-mail

Contact details:

.....

.....

9. **Signatures**

{Participant's name} _____ has been informed of the nature and purpose of the procedures described above including any risks involved in its performance. He or she has been given time to ask any questions and these questions have been answered to the best of the investigator's ability. A signed copy of this consent form will be made available to the participant.

Researcher's Signature

Date

I have been informed about this research study and understand its purpose, possible benefits, risks, and discomforts. I agree to take part in this research. I know that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to enjoy.

Participant's Signature

Date

Appendix 7

Assent Form for Children

Introduction

Hello! My name is Tariro Marufu. I'm doing a study on behalf of the University of Cape Town.

Purpose

I want to tell you about a research study we are doing. A research study is a way to learn more about something. We would like to find out more about the strengths and difficulties of children who are raised in different kinds of families. For example, some children are adopted, some live with a parent and stepparent and some live with both their biological parents. You are being asked to join the study because you are between 11-16 years old and we would like to know what your individual strengths and difficulties are.

Procedure

If you agree to join this study, you will be asked to answer 25 questions about yourself by ticking the box that describes you the most from Not True, Somewhat True or Certainly true. This exercise may take you about 5 to 10 minutes however; you may take as much time as you need to answer the questions and you will not be timed. I would really appreciate it if you would answer all the questions honestly and openly, so that we can find out what your strengths and difficulties may be.

Risks

Some of these questions may ask about things that some people find quite personal, or may be difficult to answer. If any of the questions upset you, please let me know and I, or another responsible adult, will be happy to take that time with you.

Benefits

There are no direct benefits for you to participate in this study, however, your participation may help us better understand children your age or learn something that will help us find better ways of working with children.

Right to Say No

You do not have to join this study. It is up to you. You can say okay now and change your mind later. All you have to do is tell us you want to stop. No one will be angry at you if you don't want to be in the study or if you join the study and change your mind later and stop.

Confidentiality

If you agree to take part in this survey, your answers to the questionnaire will be confidential. That means they will be private between you and me. I want to let you know, though, that it

is my responsibility to make sure that you are safe. That means that all your answers to the questionnaire will only be used for this study and no one else may look at them unless you ask me to share your answers with someone or I feel that it is important to share them with a responsible adult who may be able to help you.

Before you say **yes or no** to being in this study, I will answer any questions you have. If you join the study, you can ask questions at any time. Just tell the researcher that you have a question. Please feel free to contact me on 0711120810 or e-mail me at sdq.survey@gmail.com

If you sign your name below, it means that you agree to take part in this research study.

Date: _____

Child's Name/Agreement: _____

Researcher's Signature: _____

University of Cape Town

Appendix 8
Interview Consent Form

STRENGTHS AND DIFFICULTIES OF ADOPTED CHILDREN

1. **Invitation and Purpose**

You are invited to take part in a research study about the strengths and difficulties of adopted children in Cape Town. My name is Tariro Marufu. I am a M.A Clinical Psychology student at the University of Cape Town and I will be conducting an interview to gather data which I will use to write a dissertation exploring the adjustment of adopted children in comparison with children being raised by their biological parents. This data will help psychologists better understand children and their strengths and difficulties.

2. **Procedures**

If you agree to take part in this study, we will ask you to take part in an interview. The interview will be about 50-60 minutes long and ask you questions about your adoptive child. We would like to explore both positive and negative attributes you have observed in your child and find out why you think your child has developed those characteristics. The interviews will be audio recorded and transcribed for purposes of the study.

3. **Risks, Discomforts & Inconveniences**

This study does not pose more than low risk to you. The main risk is that someone other than the researchers might see your private information, but this risk is still very small because of the safety measures we will take to keep your information safe.

4. **Benefits**

The knowledge gained from this study will be used to help improve psychological assessment and intervention with children who have been adopted.

5. **Privacy and Confidentiality**

We will take strict precautions to safeguard your personal information throughout the study. Your information will be kept in a locked office at the Child Guidance Clinic which can only be accessed through the researcher. Recordings and transcripts of the interviews will be accessible only to the researcher and used only for this study.

6. **Money Matters**

You will not pay or be paid for taking part in this interview.

7. Questions

If you have questions, concerns, or complaints about the study please contact the researcher or supervisor on details below.

Researcher: Tariro Marufu
UCT Child Guidance Clinic
Chapel Road

Tel: 0711120810

E-mail – sdq.survey@gmail.com

Supervisor: Dr Lauren Wild
UCT Psychology Department
Upper Campus

Tel: 021-6504607

8. Signatures

{Participant's name} _____ has been informed of the nature and purpose of the procedures described above including any risks involved in its performance. He or she has been given time to ask any questions and these questions have been answered to the best of the researcher's ability.

Researcher's Signature Date

I have been informed about this research study and understand its purpose, possible benefits, risks, and discomforts. I agree to take part in this research as a participant. I know that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to enjoy.

Participant's Signature Date

Appendix 9
Tests of Normality

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Parent-Rated Scores						
Emotional Symptoms	.245	28	.000	.805	28	.000
Conduct Problems	.177	28	.024	.915	28	.027
Hyperactivity Problems	.214	28	.002	.927	28	.052
Peer Problems	.259	28	.000	.817	28	.000
Pro-social Behaviour	.179	28	.023	.883	28	.005
Total Difficulties	.211	28	.002	.849	28	.001
Self-Rated Scores						
Emotional Symptoms	.232	28	.000	.830	28	.000
Conduct Problems	.152	28	.095	.941	28	.119
Hyperactivity Problems	.171	28	.036	.930	28	.063
Peer Problems	.209	28	.003	.887	28	.006
Pro-social Behaviour	.247	28	.000	.796	28	.000
Total Difficulties						
Teacher-Rated Scores						
Emotional Symptoms	.222	28	.001	.840	28	.001
Conduct Problems	.267	28	.000	.865	28	.002
Hyperactivity Problems	.175	28	.027	.949	28	.187
Peer Problems	.216	28	.002	.916	28	.028
Pro-social Behaviour	.188	28	.012	.848	28	.001
Total Difficulties	.147	28	.125	.961	28	.369

a. Lilliefors Significance Correction

Appendix 10

Independent Samples *T*-Test

		Levene's Test for Equality of Variances	
		F	Sig.
Parent –Rated Scores			
Emotional Symptoms	Equal variances assumed	.029	.865
Conduct Problems	Equal variances assumed	3.074	.085
Hyperactivity Problems	Equal variances assumed	5.850	.019
Peer Problems	Equal variances assumed	.183	.671
Pro-social Behaviour	Equal variances assumed	.020	.887
Total Difficulties	Equal variances assumed	1.033	.314
Self-Rated Scores			
Emotional Scale	Equal variances assumed	2.471	.122
Conduct Problems	Equal variances assumed	.120	.731
Hyperactivity	Equal variances assumed	.142	.708
Peer Problems	Equal variances assumed	.442	.509
Pro-social Behaviour	Equal variances assumed	3.654	.061
Total Difficulties	Equal variances assumed	2.684	.107
Teacher-Rated Scores			
Emotional Symptoms	Equal variances assumed	.573	.454
Conduct Problems	Equal variances assumed	1.192	.281
Hyperactivity	Equal variances assumed	2.785	.103
Peer Problems	Equal variances assumed	.034	.855
Pro-social	Equal variances assumed	.743	.394
Total Difficulties	Equal variances assumed	.644	.428