

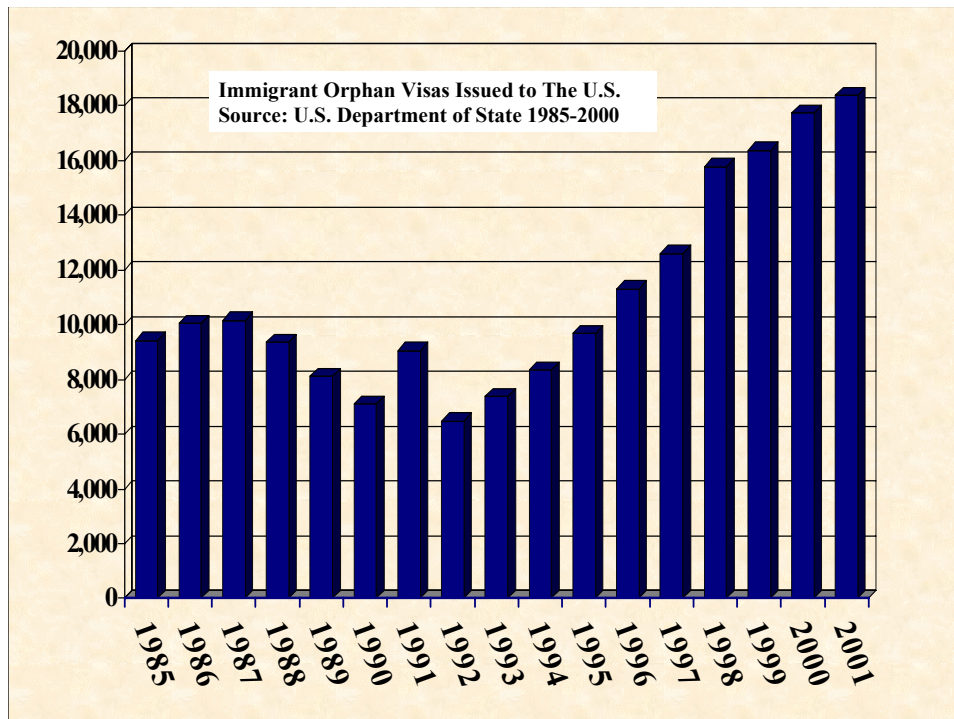


International Adoption Research Findings

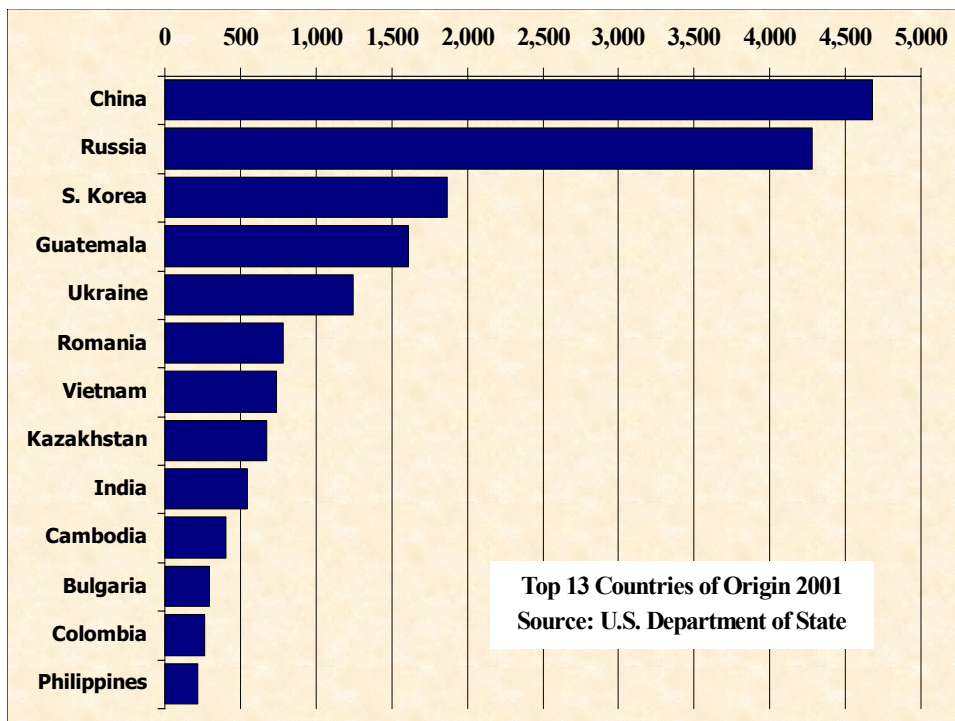
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Brief Background

International adoption began when children from Germany, Greece, and the Baltic States, orphaned by WWII, were adopted by American and European families. The Korean and Vietnam wars produced more child victims of war and rapid industrialization. Korea was the primary source of adoptable children until the early 1980's when Romania and other Eastern European countries came to the forefront. Currently, adoptions from China and Russia combined consist of approximately half of all intercountry adoptions. Over 187,000 children have joined American families through international adoption in the last 15 years.



This recent decade has brought about a change in the countries of origin creating a demand for research on these relatively new populations. According to Dana Johnson, M.D., Ph.D. from the International Adoption Clinic in Minnesota, institutionalized infants and young children are considered to be more at risk now than they were 10 years ago due to declining economic, environmental (e.g., lead exposure), and medical conditions, such as drug resistant tuberculosis and Hepatitis C.



The majority of identified medical problems among intercountry adoptees tend to be transient and treatable conditions. It should be considered that infants and children eligible for adoption likely represent those with unique strengths -- they are survivors of multiple threats including lack of prenatal and poor perinatal care, exposure to elements if abandoned, inadequate institutional care and personal attention, malnourishment, acute and chronic exposure to infection and other health conditions. Markedly high infant mortality rates for those under 1-year age in institutional care attest to the adverse living conditions they must survive.



It has been difficult for researchers to reconcile the wide variability in functioning among children with early institutional rearing. For example, some children show gains in I.Q. while others do not make any forward progress or seem to lose abilities despite being cared for in the same institution under the same condition. Similarly, when placed in an enriched environment following institutionalization, some children thrive while others remained delayed or show slowed developmental progress. Part of the problem has to do with the nature of research, which tends to investigate groups in order to have statistical merit. Why one child thrives and another

does not under similar conditions can partly be explained by individual differences--an area that has been discussed much. Despite that many questions remained unanswered, the body of existing research has provided useful information regarding the predictable sequelae of institutional care.

Physical Growth

Failure of institutionalized children to reach their growth potential has been noted for nearly a century. Due to nutritional deficiency institutionalized infants and children have compromised immune systems increasing vulnerability to infectious and recurrent illnesses. In turn, infectious illnesses prevent adequate absorption of food and subsequent normal growth. Even without the threat of infectious illnesses, nutritional deficiency results in atrophy of the glands and suppression of hormones responsible for growth (e.g., hypopituitarism) and maturation. Short stature and delayed pubertal onset can result.



Even when nutritional intake is adequate, many institutionalized infants failed to gain appropriate weight and vigor (A failure to thrive \equiv) due to a lack of human contact during feeding. Impersonal feeding experiences (bottle propping), which are experienced as unrewarding to a child, inhibit production of the body's ability to absorb adequate nutrition from ingested foods. In turn, nutritional deficiencies impede normal neurodevelopment and can compromise learning. When combined with other social and economic deprivations, malnutrition in early life hinders appropriate brain growth and negatively impacting long-term mental development. The longer a child has been institutionalized the more physical growth is delayed. Older children with prolonged orphanage rearing may never attain their growth potential.

Motor Functioning

Although motor delays in institutionalized infants have been acknowledged for some time, compared with the literature on intellectual or cognitive functioning, fewer empirical studies have been conducted examining the motor status of institutionalized infants and children. General motor development is dependent upon locomotor opportunities. These opportunities are dependent upon caretaker handling, which in turn is dependent upon caretaker-child ratios. Low caretaker-child ratios and training caretakers to touch and handle children more often has been shown to significantly decrease motor delays among institutionalized infants.



Additionally, motor development is notably delayed in infants and children from poorer quality institutions. More favorable motor performance has been found among children from institutions providing increased opportunities for physical handling and exercise. Once in a nurturing home, motor gain tends to be rapid. Many adoptive parents have noted observing their child making tremendous motor gains within the first several weeks of their care, again attesting to the benefits of individualized care.

Cognitive Functioning

In general, cognitive or intellectual functioning as measured by IQ (intelligence quotient) has been found to be influenced by the environment, family background and socioeconomic status. Cognitive functioning of ex-institutionalized children has been found to vary according to length of time spent in an institution, type of post-institutional placement (e.g., adoption, restored to birth family) and age at the time of adoption or restoration. Consistent findings indicate length of institutionalization is related to severity of delays. Specifically, cognitive performance declines the longer a child remains in an institution. In a study conducted by myself and Dr. Karen Budd from DePaul University involving 54 newly adopted female Chinese infants aged 6 to 21 months of age, factors that contribute to more favorable cognitive performance included being adopted at a younger age, shorter periods of institutional care, foster care experience, and more robust growth measurements (height, weight, head circumference). These factors continued to be significant six months postadoption.



The older a child is at the time of adoption, assuming an early history of orphanage care, the more potential for learning and academic difficulties exist. However, exceptions do occur. Sometimes a child with a prolonged institutional history will show little evidence of institutional care. Other times, a child with a relatively nurturing life before adoption can show persisting delays. This is why it is important to understand your individual child's capabilities and establish realistic expectations.

Speech & Language

Just as environment has been found to impact performance on IQ tests, environment also influences the development of speech and language skills. Such problems have been consistently identified among institutionalized infants and children with the incidence of such problems differing widely. Infants as young as 2-months of age reared in institutions demonstrate differences in the frequency and quality of their vocalizations compared to same-aged home-reared infants.



Language development and related abilities in children who have been institutionalized appear dependent on several variables including the child-caretaker ratio, verbal responsiveness

by caretakers, and age of adoption or duration of institutionalization. Studies with private, home-reared infants have shown that acquisition of receptive and expressive language is related to verbal stimulation provided by the caretaker. Defined and frequent verbal stimulation resulted in increased infant vocalization and general language ability.



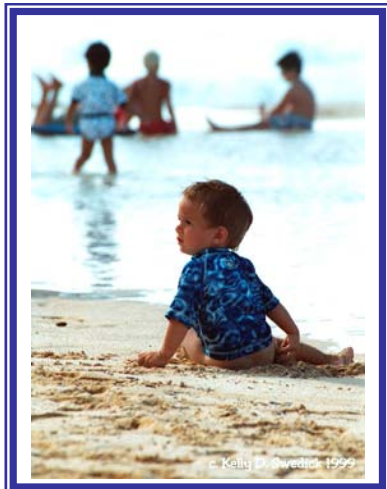
Specific areas of weakness regarding speech and language abilities found among institutionalized children or those with institutional histories include the quality of expressive language, vocabulary, comprehension, rote verbal memory (e.g., sentence memory), reading skill and written output or expression. Again, some studies have found that later adopted children show more speech and language problems and than children adopted at younger ages. For example, Ames (1997) found that Romanian adoptees who had been adopted after 8 months of institutional care performed in the borderline range on a language measure eleven months post-adoption. Three years later, these children continued to perform more poorly on the vocabulary, comprehension, and sentence memory than those adopted before 4 months of age and a home-reared control group.



In institutions, where individual attention is severely limited, opportunity for verbal stimulation and reinforcement (e.g., imitation) is lacking. Structural and tonal complexity of spoken language in the institutional milieu is also lacking, given caretakers in institutions tend to be uneducated and verbally impoverished. Some evidence suggests that speech and language deficits associated with institutionalization persist post-adoption and into later childhood and adulthood, and particularly when institutionalized children are adopted at older ages.

Attachment

When I was conducting a study with infants who were adopted from abroad, I asked adoptive parents about their initial concerns. Many parents expressed concern about whether their child would attach to them. Six months later postadoption virtually none of the parents indicated attachment to be an area of concern. Despite reassuring findings from other studies, attachment continues to be an area of concern for those considering adoption.



What is attachment? Attachment is defined as instinctual drive to seek proximity to a caretaker. The behavior that we observe when a child is seeking closeness with a caretaker is called attachment behavior. In addition to being an innate drive, attachment is influenced by the quality and organization of child-

caretaker interaction or the relationship over time. Upon birth, the newborn infant is capable of receiving input from all five senses (sight, smell, hearing, taste, and touch) and is wired to respond to the human face. The newborn most readily responds to the mother's voice and can synchronize bodily movements with the mother's voice. Infants can distinguish their mother's odor from other women, are readily responsive to soothing and stimulating touch, and are capable of imitating adult facial movements. All of these biologically based abilities gradually strengthen and mature over time allowing infants to learn about their caretaker and how to exercise their role in the reciprocal child-parent relationship.



By 2 to 3 months of age infants demonstrate social skills, such as smiling, turn taking, and synchronized gazing. At 4 to 6 months of age infants are capable of object permanence (knowing objects out of sight still exist) and begin to form stable mental representations of others and their relationships with others. It is from experience that infants learn whether or not and how their caretaker will respond. It is from experience that infants learn to how to gain attention, which represents a set of beliefs about him/herself and the caretaker. This is called an "*internal working model*." Based on repeated experiences infants create an internal working model of themselves and others that is continually being modified. Responsive and sensitive caretaking communicates self-value and importance and teaches the infant that his or her behaviors influence the environment. Attachment behavior in younger infants may take the form of crying, cooing--whatever it takes to be close to a caretaker, especially in times of distress. Older infants because of their greater language and motor capabilities exhibit more sophisticated attachment behaviors, such as laughing and pointing or hugging a caretaker. A healthy attachment means an infant trusts a caretaker to take care of him or her responsively, sensitively, and consistently.



Infants reared in institutions have repeatedly been described as passive and quiet. Understanding the institutional environment helps provides us with information about why this is. In most cases, children in orphanages are cared for by multiple caregivers who may be virtual strangers to the children. Caretaking by multiple people in itself is not considered harmful as children can attach to more than one caretaking figure. It is the quality of caretaking that matters. In orphanages children may not know their caretakers, who are like strangers to them, and cannot predict who will care for them. Caretakers, who are often well-meaning, tend to be overworked, underpaid, and understaffed severely limiting the ability and motivation to provided children with individual attention. Interpersonal investment and reward, such as eye contact, verbalization, and face-to-face communication is minimal. Institutional caretakers tend to lack any formal training in childcare, and in some cases, caretakers may be older institutionalized children. Institutional staff are paid for their services and, despite good intentions, likely have incentive not to become personally involved with those for whom they care. Interest and time spent on any particular child would hinder completion of duties and caring for the other charges. In a study of a relatively high quality English orphanage, researchers, Barbara Tizard and Jill Hodges found that staff purposefully avoided personal attachments with the children to prevent undesirable behaviors (e.g., crying and protesting) that made it more difficult for the staff to

complete their duties. The staff also considered it cruel to allow child-staff attachments to develop given the temporary nature of the relationship.



Additionally, institutional care is highly regimented with little flexibility to meet individual needs. Children wake, eat, toilet, bathe, and sleep at designated times according to the convenience of the larger system. In this sort of environment a child's attempts to elicit attention are repeatedly and consistently ignored. As a result, a child learns that little can be done to influence the environment and the child becomes passive and withdrawn.



Unfortunately, because of the multiple, variable, and casual caretaking environment in institutions, children are vulnerable to exploitation. Incidences of neglect and abuse have been consistently reported in child institutions. Underreporting is likely given children probably do not have access to trusted persons inside or outside the institution, may risk further abuse from telling, or may not know they are being abused. Institutional staff only have penalties to gain (e.g., loss of staff, monetary fines) in revealing abusive behavior by others. Up to 15 percent of children in one low resourced Romanian orphanage showed evidence of physical or sexual abuse when examined by a team of American physicians. Such a history can make it difficult for a child to others, thus impeding the attachment process.

Young infants, though also at risk in an institutional setting, tend to be the least affected given their needs are primarily physical. In an adequately staffed and resourced institution, young infants are likely to have their basic needs met. As infants become increasingly more cognizant, physically mobile, and capable of interaction, their psychological and emotional needs increase as well. It is the progressively complex needs of older infants and children that institutions cannot adequately meet. This is why the longer a child has been exposed to institutional care, the longer it will likely take for the child to secure his or her place within the new family, especially if a child has conscious memories of institutional life.



As mentioned earlier, caretakers in the institutions cited in Tizard and Hodges (1978) and Hodges and Tizard (1989) longitudinal study were actively discouraged from forming attachments to the children because of high staff turnover and the difficult to manage subsequent behavior exhibited by the child who became attached (e.g., protesting, crying disrupted daily routines). At 2 years of age, a child had experienced an average of 24 caretakers and by 4 2 years of age, 50 caretakers. Although unfortunate for the children, the vast number of caretakers a children had experience meant an intimate, one-to-one caretaker-child relationship never had the opportunity to develop making for an ideal natural experiment investigating these children's ability to attach to their adoptive and restored parents. Additionally, the children had been institutionalized before the age of 4 months indicating the lack of pre-institution caretaker-child bonds. Essentially, these children had never had the opportunity to attach to a caregiver until they were adopted or restored. As adopted children and adolescents they tended to seek adult attention and approval more than their home-reared counterparts. This suggests that, despite inexperience, they were willing and actively attempting to form attachments. At age 8, adoptees

were more likely to exhibit expressions of affections than home-reared children but by age 16, adoptees did not differ compared with home-reared adolescents. However, if an adoptee did not form an attachment bond by age 8, then it was unlikely to improve by age 16.



Attachment is a relationship in process. Most parents who have adopted a child find the attachment process to naturally evolve and strengthen over time. For infants this process can be rapid--a matter of weeks. For toddlers and children the process may not be as smooth as initially expected, especially for children with memories of life before adoption. Children adopted at older ages (≥ 2 years) do develop positive attachments to their adoptive parents and age at adoption has not been found to be related to security of attachment. Consult with a professional if you feel the quality of your relationship with your child is not where it should be given the time you have spent together or feel that it can be improved.

Indiscriminate Friendliness

Though the phenomena of indiscriminate friendliness has been documented for half-a-century, good research in the area is limited. Well-conducted empirical studies have focused primarily on children adopted from Eastern Europe. To date, studies examining indiscriminate friendliness have not been published with children from Asian countries.



Indiscriminate friendliness is a term used to describe a set of social behaviors including overly friendly gestures and verbalizations toward strangers and known adults alike without discrimination as to the relationship or context. The usual initial cautiousness or fear when interacting with strangers is absent. Temperament likely plays a role in indiscriminate friendliness, as children who are naturally outgoing and gregarious are probably more prone to display indiscriminate friendly behavior. However, temperament cannot account for the lack of social judgement when engaging in interpersonal interactions, which is specific to indiscriminate friendly behavior. While more studies are needed, consistent findings indicate indiscriminate friendliness can be an enduring characteristic of institutional rearing. Longitudinal studies are, again limited, but results indicate children can exhibit indiscriminately friendly behavior for years, sometimes even into adolescence.



If your child is indiscriminately friendly, it does not mean s/he is not attached to you. A child who is overly friendly with strangers can be strongly attached to parents. However, a child who is indiscriminately friendly requires vigilant supervision. Here's why: From an interpersonal perspective indiscriminate friendliness is adaptive in an institution. Children who are "overly friendly" have learned how to get people to respond to them in a typically very nonresponsive environment. These children may have been more likely to have been favorites of caretakers in

institutions and subsequently received more attention than other children. Behaviors that helped the child survive in an institution can be dramatically inappropriate in an adoptive home and community. For example, a child who spontaneously hugs an unknown caretaker in an institution might yield verbal affirmation, a pat on the head or a reward of some sort. In regular family life, a child who indiscriminately hugs a stranger in a public setting or follows a stranger about not only makes for an awkward interaction but is potentially placing him or herself in danger. Children who do not discriminate in their interpersonal interactions are at greater risk of being prey to child predators.



Sometimes indiscriminately friendly behavior can be unknowingly encouraged. When a child arrives to their new home it is a joyful time. Extended family and friends may gather around the child or in the home to celebrate and the child may be passed from one person to another. While family and friends are close, caring new relatives, the message to be friendly is imparted--though to the child, these family and friends are strangers. Other times, if the child is of another race than his or her adoptive parents, the family will be more conspicuous in public. People may know a child is adopted and with good intentions may come up to the child and make friendly conversation, again encouraging your child to be friendly with strangers. Introducing your child to people outside the immediate family upon arrival to his or her new home should be done thoughtfully so as not to overwhelm a child or encourage indiscriminate socialization. Additionally, there is no need to flood a child with material possessions, such as toys. In the early months postadoption, a child can become easily overstimulated and disorganized while also absorbing the message to value objects over people or relationships.



Parents should be concerned if they observe their child wanders away from them without apparent distress, is willing to follow or go home with strangers, or if the child often tells strangers or acquaintance private or personal matters. With such children it is extremely important to firmly and consistently establish familial boundaries. This includes actively teaching the child about “stranger danger,” distinctions between public versus private behaviors and language, and constant vigilant supervision of the child.

Socialization

In some studies parents of adopted children noted their children got along well with older and younger peers but had difficulty socially relating with same-aged peers. Dantas et al., (1985) found most of infants in an orphanage to interact with older infants and children than same-aged peers. As adolescents, there is evidence that adoptees continue to exhibit difficulty relating to peers. Fewer and less close peer relationships were demonstrated by adoptees compared to home-reared adolescents. Specifically, adoptees were significantly less likely to report having a definite special same-sexed friend and were less likely to confide in and/or receive support when feeling worried and unhappy. Adoptees reported belonging to a crowd of peers less often than their home-reared comparisons. Hodges (1990) and Hodges and Tizard (1989) suggest that

disturbance peer relationships is a long-term effect of earlier institutional experiences. Classroom and other peer or group settings may be similar to institutional environments, in which children may feel they have to compete for adult attention. This perception of rivalry may be associated with less intimate peer relationships and persistent attention seeking behavior toward adults. Hodges and Tizard labeled this phenomena the *Aex-institutional syndrome*.≡

In some situations, orphaned children can develop close peer relationships within adverse circumstances. For these children, their peer relationships become the primary source of emotional and social support in the absence of nurturing adult caretakers. More information about the socialization process among orphaned children in an institutionalized setting is needed.



General & Psychological Adjustment

The large majority of institutionalized infants and children subsequently placed into enriched adoptive homes show good life adjustment and overall functioning as measured by parent and self-report, rating scales, and psychological measures. Several studies have examined the socioemotional adjustment of Korean American adoptees in American homes. The earlier studies lacked standardized measures and techniques, comparison groups, or used small sample sizes, and/or did not report systematic data or analyses. With methodological limitations in mind,



these studies suggest overall good adjustment and functioning. Early behavior problems were temporary manifestations of adjustment to their new homes and environments. Learning difficulties in those adopted after the age of 3 were attributed to learning a new language and culture while shyness and withdrawn behavior were described as depressive reactions, first culture acquired temperaments, and responses to depriving early environments. A more recent four-year study by the Search Institute, an agency specializing in the study of adolescent development, examined the mental health status of 406 adopted Korean adolescents who were found to be psychologically healthy and without evidence of serious

adjustment problems. These findings are consistent with that of another setting investigating the mental health of adolescent adoptees from India, Thailand, and Chile and found their mental health status to be similar to that of the general population.

A number of studies have cited that adoptees are more at risk for behavior problems than nonadoptees or that adoptees are disproportionately represented in clinical settings (e.g., therapy). It is important that the reader understand some basics of research in order to be able to interpret an author's study within the appropriate context. For example, some studies use only clinic groups (children referred for emotional or behavioral problems), which limits generalization as most children do not compose of clinical history. One reason why we might be seeing a higher incidence of adopted children among clinic referred groups is that adoptive parents, who are familiar with social service agencies, may be more inclined to seek professional

assistance than nonadoptive parents. Additionally, adoptive parents may be predisposed to anticipate or interpret behaviors as being problematic and may attribute behaviors to being related to adoption issues and seek assistance accordingly. Teachers tend to rate adoptees to have more classroom behavior problems than nonadoptees and this may represent a perception bias about adoption. On the other hand, other studies have shown that adoptees to be closer to their adoptive parents, demonstrate higher IQs and general functioning. Clearly, children who have experienced adverse preadoptive experiences (e.g, neglect, abuse, multiple placements, severe malnutrition...etc.) are more vulnerable than children without these negative life influences, whether they are adopted or not.

What is missing from adoption research includes current and in-depth, qualitative studies regarding the process of cultural (trans and bicultural), social, and psychological adjustment of intercountry adoptees as adolescents and adults though some initial academic work in this area is currently being plowed, albeit by a few transracial adoptees (K. Bergquist from SIU, J. Palmer from Colgate, and A. Baden from St. John's University).



While outcome studies often present conflicting results regarding the well-being and adjustment of adoptees, it is generally agreed that the multifaceted issues inherent in adoption pose unique emotional and psychological challenges. Adjustment to adoption is a process that is influenced by children's perceptions of themselves and their families. Self and familial perceptions are also affected by societal messages as well as preadoptive history, experiences, and developmental maturity. Incorporating past ambiguous relationships and histories, coming to terms with adoption related losses, reconciling fantasies with facts, and securing a sense of familial belonging are just a few of the complex issues adopted children encounter.



Families who talk about adoption openly and nondefensively support positive adjustment in their children. Yet, talking about adoption may not come easily. Feeling unskilled in facilitating adoption related conversation can hinder parents from engaging in important and meaningful dialogue with their children. Additionally, parents may be unaware of how developmental maturity influences children's knowledge about adoption and perceptions of themselves as adoptees. Open and sensitive communication among family members is the key to providing a safe atmosphere to talk about adoption related issues.



Adoptive parents may wonder when the most appropriate time is to have meaningful communication about adoption. In a transracial adoption, it is usually obvious that the child is not a biological relative and "adoption" may be a familiar term in familial dialogue. However, prior to the neurodevelopmental growth spurt, also known as school readiness, that typically occurs around the age of 5 to 7, most children will not have the cognitive capacity to understand the meaning of adoption. But once a child's capacity for understanding has increased, the complexity of adoption begins to be illuminated.

“Middle childhood is often the period when being adopted is first seen as a problem...realize[s] there’s a flip side to his beloved adoption story - that in order to be “chosen,” he first had to be given away.” (Brodzinsky, 1992)

At what age can a child most benefit from exploration of their adoption status and related adoption issues? Clinically and empirically based information strongly suggests middle childhood (≥ 6 years) is an appropriate time given greater cognitive capacity, more mature verbal expression, increased self-awareness, and the emerging ability to think abstractly about relationships and ideas. Children in middle childhood use emerging abstract thinking and reasoning skills to try to logically make sense of their world. Newly acquired problem solving



skills are actively applied to all facets of life, including the interpersonal. Middle childhood is also a time when ambivalent or negative perceptions, feelings, and realities related to loss through adoption may surface and may conflict with the joyful adoption story relayed by parents.

Prior, children may have easily accepted information about their adoption told to them by parents. In many cases information may be little or fragmented given ambiguous or complex pre-adoptive histories. During latency, children can feel a strong desire to make sense of this preliminary information surrounding their origins and subsequent adoption. They may experience themselves as a mystery. Uncovering, understanding, and sharing one’s unique adoption story are important passages for children attempting to come to terms with the meaning of being adopted. Putting together the pieces of one’s adoption story is a challenging developmental task.

Within the family, qualitative changes in the parent-child relationship also occur during middle childhood as well. Increased independence, full-day school schedules and greater investment in social relationships and activities can result in less familial communication, especially related to adoption matters. Thus, the need for supportive adoption dialogue during middle childhood is critical. Sensitively addressing children’s emerging thoughts, feelings, and experiences related to adoption can assist in providing a firm foundation for further healthy identity development and a more secure adoptive family.



“How do we contemplate a past in which we played no part and a future which will proceed with out us?” (Nickman, 1985).

With even greater abstraction capabilities and command of language, pre-adolescents are entering the world of metacognition -- the ability to think about thinking. With emerging reflection skills, pre-adolescents may begin the process of pondering the complexity of themselves and their personal history related to adoption. Here begins the developmental task of identity formation with an intensity not previously possible. Thoughts, questions, and uncertainties may contain an existential quality, *“Why am I adopted?”* or *“What does it mean?”*

Searching historical information is one way to help preadolescents get in touch with their past and define their current self in order to move forward.

Pre-adolescence may also be a time when realization of the involuntary nature of a child's transition to a family may stir feelings of confusion regarding a birthfamily, or an "intended" family. The unknown can stir the imagination producing fantasies reflecting powerful wishes and desires. Exploring and understanding feelings related to one's perceptions of a birthfamily or history can assist in facilitating a realistic and adaptive perspective. In turn, such reflection within a supportive milieu can further the development of healthy identity formation as a pre-adolescent comes to terms with increased self-responsibility and who they desire to become.



**For those who would like academic references, below is a selected
research reference list of outcome studies and essays specific to infants and children
with institutional histories:**



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