Emotional Experience of Mothers After International Adoption: A Qualitative Study

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EMOTIONAL EXPERIENCE OF MOTHERS AFTER INTERNATIONAL ADOPTION: A QUALITATIVE STUDY

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Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology
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PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by Lindsay Foster

on the 23rd day of May, 2012, in partial fulfillment of the requirements for the degree of

Doctor of Psychology, has been examined and is acceptable in both scholarship and

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Abstract

The purpose of the study was to use a naturalistic approach to better understand phenomena in the area of mothers’ emotional functioning after adopting a child internationally. A qualitative research design was used to help identify variables, that would be appropriate for later study by quantitative design. A sample of 10 mothers who adopted a child internationally, selected by convenience and snowball sampling, was used in this study. Each subject participated in a clinical interview consisting of 10 core questions and supporting questions. Themes were derived from the participants’ answers.
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Chapter One: Introduction

Statement of the Problem

Individuals who are unable or unwilling to have birth children sometimes choose to adopt internationally. Often these individuals have tried unsuccessfully to have children. Some were told they are unable to bear children. Others were unsuccessful at becoming pregnant even with medical assistance. Perhaps the worst-case scenario is the loss of a baby. Some individuals have had miscarriages, had stillborn babies, or lost children to death. By the time some potential adoptive parents are ready to begin the lengthy international adoption process, they already may have been through numerous stressful situations and experienced a great deal of grief and loss. They may have endured upsetting news, unsuccessful attempts to become pregnant, in vitro fertilization, and possibly many more procedures and experiences. At this point, many years of unsuccessful attempts to become loving parents may have passed. The realization of loss, whether by finding out they are unable to bear children or by having lost a child, understandably may result in the development of prolonged grief, depression, or anxiety (Boelen & Prigerson, 2007).

There are other options to raising birth children, one option being domestic adoption and another being international adoption. International adoption is a very lengthy and thorough process that will likely add to already existing stress. Individuals may feel pressure to present themselves as perfect, loving parents, as many countries have very stringent requirements for adopting children internationally. Restrictions often are placed on potential parents’ age, length of marriage, previous marriages, physical and
mental-health, sexual orientation, and even use of psychiatric medication and body mass index. Some countries are more restrictive than others. As part of the home-study process, a social worker screens potential adoptive parents and also prepares them for the international adoption. An important topic during this home-study process is past and present mental-health functioning. At this point, adoptive parents most likely have done their research and know that admitting to having mental-health problems may compromise the international adoption process. Consequently, they may attempt to minimize any type of mental-health problem they have had or currently are experiencing.

Another problem that is overlooked during the home-study process is the desperation that individuals may feel to become parents. Training given during the home-study process suggests that adopting a child internationally comes with many postadoption struggles. Because of their desperation to become parents, they may not be receptive to the training given (Gunnar, Bruce, & Grotevant, 2000).

Once the adoptive parents have completed the international adoption process successfully, they are likely to experience an array of issues that may add to their overall stress level and ability to function. Unreported health problems of the child, stunted physical growth, developmental delays, attachment issues, and the stress of being a parent are likely to weigh on the new parents (Gunnar et al., 2000, Hostetter, Iverson, Thomas, McKenzie, Dole, & Johnson, 1991; Johnson et al., 1992). In order to help the child adjust to his or her new environment and family, adoptive parents need healthy attitudes and resiliency. Negative attitudes and decreased resilience may be related to postadoption depression. These individuals must demonstrate healthy daily functioning
because postadoption experiences and emotional resources of adoptive parents may affect developmental outcomes of children (Gunnar et al., 2000).

**Purpose of the Study**

The purpose of the present study is to use a naturalistic approach to better understand phenomena in the area of parental functioning after international adoption. Using a qualitative research design will help identify variables that would be appropriate for later study by a quantitative research design. The study also aims to examine the emotional experience of mothers after adopting a child from a foreign country.
Chapter Two: Literature Review

Adoption

In America, tens of millions of individuals are connected to adoption, whether they have been adopted themselves, have a family member or close friend who was adopted, made an adoption plan, or have adopted. There is a strong occurrence of personal connection to adoption (Miller, 2005). Partially because of the high prevalence of adoption in America, the look of the typical American family is changing. Adoption is adding noticeable differences and increasing the number of multiracial families in the country. Adoption is adding variety to families not only racially, but also culturally, religiously, and socioeconomically. Typically, children who are adopted come from backgrounds that are less privileged than those of the adopting parents (Miller, 2005). Perhaps the most important benefit of adoption is removing children from institutionalized care into loving homes and families. Along with the many wonderful benefits and diversity that come along with adoption, individuals involved with adoption also are faced with risks and ethical concerns (Miller, 2005).

History of adoption in the United States. Adoption, defined as “the process by which a child legally joins a family” (Miller, 2005, p. 3), dates back to Moses in the Bible (Meiser & Velen, 1995). Although the adoption process has changed dramatically, it is not new to this era. Adoption was mentioned in the Babylonian Code of Hammurabi in 2285 BC and the Hindu Laws of Manu in 200 BC. Adoption was also a phenomenon practiced by Greeks, Romans, Egyptians, Assyrians, Chinese, and Japanese (Miller, 2005). Each culture had its own system, as adoption over the years has served various
purposes, such as to protect family inheritances, preserve family names, or provide homes for abandoned relatives.

During the 1600s and 1700s, orphaned children lived on the streets and in foundling hospitals, or worked as apprentices (Miller, 2005). From 1700-1800, colonial times, children were raised and adopted unofficially by replacement parents. Not until the 1850s was adoption was officially recognized in the United States. Because of the relaxed society at that time, informal adoption was possible. The need for children to contribute to a family’s workload was one reason informal adoption was desired (Meiser & Velen, 1995). Also the number of children born to single women during this time increased and was one contributor to the rising number of children needing adoptive families. Single women were pressured into placing their children for adoption because a stigma was placed on single women bearing children (Miller, 2005). Perhaps the main contributor to the legalization of adoption in the United States, though, was industrialization (Miller, 2005; Meiser & Velen, 1995). Families who needed to move to major cities became unable to care for their large number of children and had to resort to placing their children in institutions, such as The Children’s Aid Society and The New York Foundling Hospital. These two organizations were responsible for the beginning of the distribution of children to new homes. This process was accomplished through the use of the orphan train (Meiser & Velen, 1995). Children were placed on trains and sent throughout the United States to be placed successfully with adoptive families. This operation previously had been attempted in Boston in the 1840s, but failed (DiPasquale, 1996). The operation began again in 1854 and continued until 1929 (Meiser & Velen, 1995).
Meanwhile, the need for a more formal adoption process in the United States increased as the number of children placed informally in adoptive homes increased. Massachusetts passed the first adoption law, which required the court to approve all adoptions (Miller, 2005). This enactment attempted to standardize the formal adoption process by setting requirements, including the judge’s approval, consent of the birth parent to place the child, and an assessment of the adoptive family’s ability to raise the child being considered for adoption, a process that would later be called the home-study (Meiser & Velen, 1995; Miller, 2005). Other states followed the lead of Massachusetts and passed similar laws (Miller, 2005).

Although standards were set and procedures were in place, the process of legalized adoption in the United States was still not secure. The connection between the child and birth parents was unclear. No law about confidentiality was established at this time, and therefore, the right to birth records was unclear. The availability of birth records continues to be a problem in adoption today (Meiser & Velen, 1995).

Historically, adoptions took place in order to fulfill the needs of a family or society, but by the late 19th century, the shift was being made toward meeting the needs of the child. Adoption now served two purposes: to fulfill an opportunity for couples and individuals without children to become parents and to find homes for children in need (Meiser & Velen, 1995). To help in this process, potential adoptive parents now were being investigated to determine whether were appropriate to adopt a child. In 1891, Michigan set out to investigate all adoptive parents. Beginning in 1912, many organizations were established with the purpose of enhancing the adoption process. The
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U.S. Children’s Bureau and The Child Welfare League of America, two of these organizations, have grown tremendously over the years (Miller, 2005).

From the 1930s to the 1950s, social work became a profession, and social workers became involved with the adoption process. Adoption agencies were opened and charged fees for adoption placements. The role of social workers was to help the courts with the process of sealing birth and adoption records. Their role also included helping to protect birth families, adoptive families, and children from the stigma surrounding adoption (Miller, 2005). During this time, many babies were available for adoption. Most records were kept anonymous, meaning that little information was shared with the adoptive family about the birth family and vice versa. Adoption was treated as a legal event and nothing more, and birth parents, as well as adoptive parents, were expected to complete the procedure and move on with their lives, almost as though nothing had happened. The lack of thorough records, as well as the anonymity and denial, created a problem for adopted children as they grew older and more curious about their past. As the adoption process evolved, adoptive parents began demanding more information about their adopted children. Denial of the adoption was no longer an adaptive action to take (Meiser & Velen, 1995; Miller, 2005). Although social workers and agencies attempted to reduce the shame associated with the adoption process, a negative societal stigma remained. As a result, social workers and agencies attempted to match children’s physical and religious characteristics to those of adoptive families (Miller, 2005).

Currently, a home-study is required in almost every state in the United States. A home-study is performed to assess the ability of the adoptive home to raise a child safely
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and adequately. The home-study also entails a written report by the individual, usually a social worker, conducting the home-study (Meiser & Velen, 1995). Aside from the home-study process, potential adoptive parents also need to meet multiple other requirements, depending on the state, such as a criminal background check, child abuse clearance, specified training, home licensing, and a physical examination completed by a medical doctor.

**Types of adoptions.** In today’s society, a number of different types of adoption processes are available, including domestic adoption, intercountry adoption, and international adoption. Domestic adoption occurs when an individual or parents adopt a child of the same nationality and country of residence (Miller, 2005). In an intercountry adoption, the child changes country of residence regardless of the nationality of the individual or couple adopting the child. For example, a Brazilian child adopted by a Brazilian couple who lives in Italy, would be considered adopted through intercountry adoption (Miller, 2005). In an international adoption, the child and adoptive parent are of different nationalities. An example of an international adoption would be when a Brazilian child is adopted by an Italian parent who lives in Brazil (Miller, 2005, p. 3). The term international adoption usually is used to refer to an adoption that is both intercountry and international. A common example of an international adoption would be when a Chinese child is adopted by an American individual or parent from New Jersey (Miller, 2005). For the purpose of this dissertation, international adoption will be used when referring to both intercountry and international adoption.

In addition to understanding the types of possible adoptions, one also must
understand the various options available for completing the adoption process. Individuals who decide to adopt children can choose to adopt through a private child-welfare agency, a public child-welfare agency, a private attorney, or another private adoption professional (Miller, 2005).

Each adoption situation is slightly different from the next. Once the child is adopted, birth parents may choose to maintain or not maintain their relationship with the child. After the adoption is completed, the adoption may be referred to as an open adoption, a semiopen adoption, or a traditional or closed adoption. In an open adoption, adoptive parents and birth parents may exchange identifying information. Adoptive and birth parents typically meet face-to-face and maintain ongoing contact. Parties involved can maintain contact through letters, photos, phone calls, and visits. In a semiopen adoption, adoptive parents and birth parents may share information through an intermediary. Adoptive parents and birth parents meet one time at the beginning of the adoption. Sometimes letters and photos are shared, but no agreement is made for a continued or ongoing relationship. Usually birth and adoptive parents acknowledge that the child will search for the birth parent when he or she grows older. Another option is a traditional or closed adoption, which is the way adoptions in the United States initially operated. In a closed adoption, information about birth and adoptive parents is kept confidential and birth parents and adoptive parents do not communicate (Miller, 2005). In this type of adoption, the adoptee has no access to his or her birth identity.

In a perfect world, efforts to maintain the relationship between the birth family and the child would be successful. Sometimes, however, parental rights need to be terminated
for various reasons such as abandonment, neglect, abuse, mental illness, mental
deficiency, chronic substance abuse, felony conviction, consent and relinquishment, or
the length of time the child spends in foster care (Meiser & Velen, 1995).

**Private or attorney adoptions.** Although agencies today still hold high standards,
adoption agencies previously held very rigid standards for potential adoptive parents.
These agencies were willing to consider only adoptive parents of a specific age who had
been married for a set number of years and had only a certain number of children
currently living in the home. These restrictions placed upon potential adoptive parents
sometimes made an agency adoption difficult or impossible. Some individuals who did
not qualify for the stringent standards that were imposed chose to complete a private or
attorney adoption. Birth parents sometimes chose a private or attorney adoption because
it allowed them more options and decision making during the adoption process (Meiser &
Velen, 1995).

**International adoption.** Currently, some individuals choose to adopt children
domestically through child protective services, agencies, or private adoption. Others
choose to adopt children through international adoption. Adopting a child through
international adoption involves an additional set of standards and dilemmas. Before these
are discussed, the history of international adoption will be reviewed.

**History of international adoption.** The United States receives more children
through international adoption than any other country. Trends in international adoption
are associated with the countries that are most open to international adoption. The
stronger a country’s economy, the less likely that country will participate in international
adoptions. As national political and economic circumstances change, so does the availability of children for international adoption. A country’s need for foreigners to adopt its children, indicates that something is wrong with the economy of that country (Miller, 2005). Some examples of this concept include civil strife in Central America and Africa, the devaluation of girls in China, and overpopulation in India (Miller, 2005).

Some foreign countries view international adoption negatively. Rather than regarding Westerners as helpful, these countries view them as outsiders intruding with the intent to steal their children and take away their resources (Miller, 2005).

Military families abroad were the first to adopt orphaned children, and the news quickly spread to Americans. In 1950, proxy adoptions were taking place, and citizens from the United States were able to adopt from foreign countries without traveling to the country itself. A proxy agent was designated thereby allowing the U.S. citizen’s absence. This form of adoption was popular in countries such as Japan, Greece, and Korea. This process, however, did not meet ethical standards for the following reasons: children were being declared legal children of individuals whom they had never met, state laws were disregarded in this process, and child welfare clearly was not being considered (The Adoption History Project, 2007).

After World War II, between the years 1948 and 1953, Americans adopted approximately 5,814 children from Germany and Greece, and 2,418 children from Asia (mostly Japan). This time was considered the first wave in the history of international adoption. According to Alstein and Simon (1991), the second wave of children adopted internationally occurred after the Korean War (as cited in Hollingsworth, 2003).
In the mid 1950s, shortly after the Korean War, Harry and Bertha Holt, significant contributors and pioneers in the field of international adoption, became aware of American-Asian children in Korean orphanages. Initially, the Holts decided to help these children by sending clothes and money to the orphanage, but they realized quickly that more needed to be done to help. They then decided to open their own home to children from the orphanage, but not before much planning and strategy. Before they could adopt the children from Korea, they needed both houses of Congress to pass a law allowing international adoption of Korean children into the United States. Their effort was a marker for constructing new adoption laws in the United States (Erichsen, 2007). In 1955, Bertha and Harry Holt successfully adopted eight Korean War orphans in Oregon. From 1953 to 1962, Americans adopted 15,000 children through international adoption.

Harry and Bertha Holt eventually founded Holt International Children’s Services with the goal of placing children in need of homes in the child’s birth country. After an unsuccessful attempt to place Korean children with families within their native country, thousands of children were left still needing families (Erichsen, 2007). Holt International Children’s Services continued to grow from a small organization to a very large and successful international adoption agency. Not only was it successful in helping Korean children find permanent families in the United States, but by the 1970s it also was helping children in Vietnam who were left in orphanages after the Vietnam War (Erichsen, 2007). More work needed to be accomplished, however, in order to make the Holt’s dream of finding all orphaned children a home a reality. Chief Katherine Oettinger of the United States Children’s Bureau felt that children adopted internationally would be
at high risk for being abused, neglected, and disrupted because initially the standards required to adopt internationally were only minimal. Additional standards needed to be established.

Other advances were being made slowly in the 1970s. Not until 1972 were legal rights of birth fathers recognized in the United States (Miller, 2005). A few years later, in 1975, adopted individuals were allowed access to birth-parent records through the Children’s Act. Research showed support for better outcomes in children when parents were honest and open about adoption. Although access to birth-parent records is allowed in some states, access presently depends upon the state in which the adoptee lives.

During this time, already existing forms of treatment for individuals experiencing grief and loss were opened to the adoption community. Treatment was carried over into the adoption community to help adopted children, as well as birth parents and adoptive parents, deal with grief and loss associated with adoption and infertility (Miller, 2005).

Alstein and Simon (1991) and the U.S. Immigration and Naturalization Service (1998) reported that the number of children adopted from Central and South America increased significantly from 1973 to 1993, quadrupling in number from 8 to 32% thus creating the third wave of international adoption (as cited in Hollingsworth, 2003). Alstein and Simon (1991) attributed the fourth wave, beginning in 1989, to the fall of the communist government in Romania (as cited in Hollingsworth, 2003). Children were primarily adopted from Central and Eastern Europe at this time. During this fourth wave, Americans commonly traveled in large numbers to adopt available children. The next wave, the fifth wave of international adoption, began around the year of 1993. Children
adopted during this wave were from China (Hollingsworth, 2003). More children were adopted from China by 1996 than from any other country, perhaps due to China’s population policy of having only one child per family. Also, the process of adopting a child from China was relatively easy, meaning that the process was better defined, shorter, safer, and cheaper than adoption processes in other countries. Chinese babies were known at this time to be healthier than babies from other countries as well. These reasons likely contributed to the large number of parents adopting from China at this time. According to Brodzinsky (1998), another phenomenon that was present in the fifth wave was the adoption of primarily female children, which related to the low status of female children in China (as cited in Hollingsworth, 2003).

Since the beginning of international adoption into the United States, the number of infants and children adopted internationally each year has increased steadily. International adoptions have reached approximately 20,000 infants and children each year. As a result, professionals and researchers in the field naturally have become interested in the long-term effects of early adverse experiences, such as institutionalization or more simply put, being raised in an orphanage (Ames, 1990). One area that has been researched commonly is the development of attachment (Smyke, Dumitrescu, & Zeanah, 2002).

Many other serious issues, including cultural differences, also face individuals who adopt internationally. Most international adoptions completed in the United States are transracial adoptions. Both in international and domestic adoptions, the issue of transracial adoption has become recognized as a source of concern for children and
families. Originally, many thought that love would overshadow the differences in race. Pearl S. Buck believed that love, not race, made a family, perhaps minimizing the need to recognize difference and struggles that may arise. Some individuals may fail to recognize race as an important variable that may impact the growing child’s ability to flourish. In addition to dealing with differences in race, cultural differences are also important. The need for sensitivity to culture, language, and national heritage may have been ignored originally. As a result of a greater number of outcome studies with international adoption, however, a more recent shift toward recognition of the importance of culture and race has occurred.

**Varying cultural views of adoption.** Individuals in the United States view international adoption both positively and negatively. Most children in the United States who are adopted feel as though they are the second choice. In the United States, the norm is that couples get married and have their own children. Couples who adopt in the United States, typically do so because they are unable to have a birth child. Thus, some children who are adopted may realize at some point in their lives that they were their parents’ second choice, not the child they had initially planned.

Americans have cultural biases about adoption that are not found in other parts of the world. For example, individuals from the Pacific Islands have great respect for the process of adoption. In other countries, such as Tahiti, more than one quarter of the children are adopted. Tahitian parents strive to create relationships with adopted children that are as natural as those parents have with their biological children (Bartholet, 1993). Leon (2002) found that whereas in the United States some individuals view adoption as
shameful, individuals in other cultures view adoption as a generous and positive gesture (as cited in Miller, 2005). Donner (1999) noted that approximately half of the children in Sikaiana live in foster care, which is regarded as an expression of love rather than as a misfortune or a consequence of pathology. Similarly, in African countries, parents raise nonbiological children without stigma or shame. Western societies typically are the societies that view “normal” parenting as comprising one couple raising biological children, although interestingly, the majority of these children are receiving care from other individuals in day care (as cited in Miller, 2005).

Even though international adoption has its benefits, some people believe that the process of international adoption in any circumstance is unacceptable. Mason (2001) stated that these individuals believe that the process of international adoption undermines a country’s ability to develop its own resources (as cited in Miller, 2005). Others would argue that allowing children to be adopted abroad is not fair to less privileged individuals who are interested in adopting and are residing within the country. Masson (2001) also states that another argument is that children who are adopted internationally will be victims of ethnic discrimination in their adoptive country (as cited in Miller, 2005). Thus, numerous ethical and cultural issues must be considered in the field of international adoption, and several steps have been taken to ensure best practice.

**The Hague Convention on International Adoption.** The Hague Convention is an agreement, recognized internationally among countries that participate in international adoption to ensure that best adoption procedures are followed (Daugherty, 2009). Many legal problems were resolved after the year 2000 when President Clinton signed The
Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption (Miller, 2005). Procedures were set to keep the best interest of the child adoptees in mind and to consider each adoption case. The three main goals included the best interest of the child, consideration of international adoption only when a family cannot be found in the child’s native country, and elimination of abuse. Also, each adoptive country was to designate a central authority that would oversee all international adoption documentation kept on children waiting to be adopted, birth parents, and adoptive parents (Erichsen, 2007). The Intercountry Adoption Act was created for this reason and also to help prevent abduction, exploitation, sale, and trafficking of children. The treaty helps protect birth parents and adoptive parents (Daugherty, 2009).

Each country involved in the Hague Convention has a designated authority for intercountry adoption. The Department of State is the central authority in the United States. In 2006, the rules were published, and on April 1, 2008, the Hague Convention on Intercountry Adoption went into effect in the United States. The Hague Convention specifies uniform conditions and terms, that are to be followed strictly and nationally by agencies and professionals working with potential adoptive parents (Daugherty, 2009).

Another goal of the treaty is to ensure that all countries have national adoption laws. The treaty also ensures that adoption agencies that complete international adoptions are accredited. The treaty mandates that parents who adopt internationally must complete training (Erichsen, 2007).

**Country restrictions.** In the past, the United States did not have a national adoption law or central authority overseeing international adoptions, leaving adoptive
parents and adopted children vulnerable. Regulations on the international adoption process were issued not until 50 years after Harry and Bertha Holt opened the first international adoption agency. Current restrictions set by other countries as well as by the United States help to ensure protection of the children, birth parents, and adoptive parents involved, as well as to decrease the frequency of inhumane and illegal international adoption practices within the United States. Although restrictions are rigorous, they are enforced in order to prevent criminals from operating illegal practices, which has occurred in the past (Erichsen, 2007).

In the United States, approximately one third of parents who adopted in 2002 were single women. These women adopted children from China, Russia, Kazakhstan, India, Romania, and Peru. At that time, those countries allowed single adoptive parents of either gender to adopt their children (Miller, 2005). Some countries no longer allow single individuals or same sex couples to adopt children from their country.

**The home-study process.** The home-study process has been affected greatly by the Hague Convention. One way that the Hague Convention has affected the process is the implementation of the Structured Analysis Family Evaluation (SAFE) home-study methodology. The SAFE method is the standardized method used throughout the United States. With the Hague Convention now in effect, the home-study process has come under intense scrutiny. In fact, pressure for a higher quality of home-study has increased, as it is a critical piece in the process of international adoption (Crea, 2009).

During the home-study process, prospective parents may be asked to specify the disabilities in children that they are not willing to accept. Although some regard the
restriction of disabilities a prospective parent is willing to accept as an act of discrimination, this disclosure ensures that disabled children receive appropriate care in their adoptive home. Over the years, special-needs adoptions have increased (Miller, 2005).

Mental-health restrictions. Part of the home-study process involves the social worker’s assessment of current and past mental-health functioning of adoptive parents. Many countries with children available to adopt place restrictions on allowable parental mental-health diagnoses as well as on the use of psychiatric medication by prospective parents. Some information available to potential adoptive parents states that there is a restriction for individuals with “severe mental-health problems,” such as depression, although, depression is treatable with the use of short-term cognitive behavioral therapy and/or psychiatric medication. Given the background of individuals interested in international adoption and their possible history of grief and loss, no history of any mental-health concerns seems unrealistic. Surely a history of depression or anxiety does not indicate that the individual will not be able to provide a loving home for a child.

Timeline. The home-study process can take several months to a year, depending on the availability of the individuals involved. The time from initial interest in international adoption to the child’s arrival to the United States to live with the family or individual varies greatly. The process is never described as quick and painless. After deciding on an adoption agency, the couple must complete a dossier. A dossier is a set of legal documents pertaining to the adoption process. The couple also must complete forms for the United States Citizenship and Immigration Services (USCIS).
Reasons for adopting internationally. According to Miller (2005), the majority of parents hoping to adopt internationally have a deep yearning to become a parent. These individuals include single parents, couples with infertility problems, and individuals looking to begin or expand upon their already existing families (Miller, 2005). Other individuals become interested in international adoption after having lost an infant or child (Miller, 2005).

Parents who decide to adopt internationally may choose international adoption over domestic adoption in the United States because of perceived obstacles and delays in domestic adoption. Parents may feel that if they adopt a child domestically, the child will be more likely to have been born exposed or addicted to drugs or alcohol. Parents are also likely to have motivators for going abroad to adopt children. They typically research countries before making a choice that best fits their wants and needs. Another reason parents adopt internationally may be a desire to rescue foreign children in need. Many Caucasian people try to match their own ethnic background by adopting from countries such as Russia and Romania. Other individuals may attempt to match their heritage by adopting from countries from which their ancestors came, such as Italy or Greece.

Post Adoption

Child’s initial adjustment and struggles. Upon arriving in the United States, some children raised in orphanages may display signs of malnutrition, poor hygiene, and neglect (Miller, 2005). These problems, may contribute to initial adjustment difficulty for both the child and the adoptive parent. Parents typically seek help for problems such as medical concerns, but not for other problems related to the child’s behavior. Parents seem
comfortable dealing with any behavioral issues that may arise by reassuring the child or ignoring the behavior. Consistent with these findings, Fisher, Ames, Chisholm, and Savoie (1997), conducted a study involving parents of 46 internationally adopted children who spent at least 8 months in a Romanian orphanage and parents of 46 children who were Canadian born. Parents in this study had not sought professional help at the time of the study.

Another challenge is that parents who do seek help upon arrival to the United States may not receive adequate specialized care for their child (Miller, 2005). Considering their living conditions prior to adoption, most children adjust fairly well. Typically, children make rapid gains in overall health, as well as in physical, developmental, and emotional growth (Miller, 2005). Some children, however, experience learning, emotional, and behavioral problems that may have been related to lack of prenatal healthcare for their mothers, lack of formative experiences in institutions, and the overall effects of adoption (Miller, 2005). Some countries place children in foster care. These children tend to have fewer fine motor and gross motor delays than do children who are raised only in orphanages.

When international adoption first became a phenomenon, specialized care was not available for adopted children. Now most large children’s hospitals in the United States have established specialized clinics that are familiar with and devoted to treating children adopted internationally (Miller, 2005).

Medical concerns. Because of their history, children who are adopted internationally may have unique sets of medical and developmental needs. The number of
children adopted internationally has raised concern for medical professionals and therefore prompted interest in the specialization of treating internationally adopted children (Miller, 2005). In 2005, 40 pediatricians were designated as treating internationally adopted children, a number that definitely is rising (Miller, 2005). Parents are choosing to seek out specialty treatment from pediatricians, prior to adoption and post-adoption, who are trained specifically in treating internationally adopted children (Miller, 2005).

Medical concerns most commonly associated with children who are adopted internationally include infectious disease, failure to thrive, and HIV and AIDS exposure (Miller, 2005). A number of other behavioral, developmental, and psychological problems also face internationally adopted children and families after the adoption.

*Sleep problems.* Among a number of changes that children adopted internationally have to face upon entering their new homes in the United States are changes in sleep pattern. Most likely, children will be traveling with their new family across one or several time zones. Because of this change in time zone, children may experience difficulty falling asleep. Also, the sleeping environment is typically different in drastic ways. A child may go from sleeping in a room with 100 other children and several adults to sleeping in a quiet room alone. Understandably, children have initial adjustment difficulty with sleeping patterns. One study examined the sleep patterns of children raised in a Romanian orphanage compared to those of children not raised in orphanages. The investigator found that children raised in Romanian orphanages tended to have greater frequency of sleep problems than children not raised in orphanages. For
instance, Romanian orphans demonstrated sleep problems, such as lying quietly in bed without signaling wake-up, likely a learned behavior related to institutionalization. Romanian orphans also were reported to sleep too much or to wake up screaming, behaviors that were not reported among children not raised in Romanian orphanages (Fisher, et al., 1997).

*Language development.* Upon entering the United States, internationally adopted older children are at a disadvantage because they are not yet able to speak English well or at all. Children adopted internationally also may have a background of being delayed in their native language (Miller, 2005). This delay may be the result of having restricted opportunities and exposure to expressive and receptive language. One may think that language development should be the least of a parent’s concerns; however, language development also affects other areas of development. Learning and mastering the English language are imperative skills in order for the child to be accepted in this country. Language development also affects other important areas of development, such as cognition, social and emotional development, and adjustment (Miller, 2005).

Although a child may not be exactly on target for his or her age, the term *language delay* may not be appropriate. For example, if a child enters the United States at 24 months old and is not yet able to speak English, this child should not be considered as having a language delay. If, however, the child was delayed in his or her native language, and has been in the United States for a longer period of time, and still is not learning the English language, then the term language delay may be more appropriate. There is an important distinction between whether the child is experiencing a true language delay and
whether the child has just not caught up in the learning of a second language. Also important to note is the age at which the child entered the United States. A child who enters the United States at age 4 weeks would be expected to have less difficulty learning the English language than would a child who enters the United States at age 4 years.

Children raised in orphanages may be at a disadvantage in the development of appropriate language skills. They are exposed to a number of prenatal and postnatal experiences that can delay their language development. Some of the negative prenatal experiences include exposure to substances, family history, and prenatal infection. Some negative postnatal experiences include prematurity, drug exposure, lead exposure, lack of language input during institutionalization, hearing impairment, cortical damage from lack of auditory input, auditory hypersensitivity, developmental delays, environmental toxins, and deprived oral sensorimotor experiences. To add to the difficulty with language development, children are finally exposed to a new language (Miller, 2005).

**Institutionalization and brain development.** Children adopted internationally typically are raised prior to their adoption in institutions where they may have experienced crowded living space, poor nutrition, and limited caretaking because of the ratio of adults to children (Miller, 2005). Early adversities such as institutionalization can have severe negative effects on children. Institutionalization, no matter how well developed the institution, affects various aspects of development, including children’s emotional development as well as neurobiological development. Emotional regulation in children who have been institutionalized seems to be altered. Children who spend more time in orphanages were found to have differences in brain physiology, decreased ability
to regulate emotion, and increased symptoms of anxiety (Tottenham et al., 2008). Children who were institutionalized also may have increased prevalence of anxiety disorders (Ellis, Fisher, & Zaharie, 2004). Some evidence suggests that permanent differences in neurological make-up may be associated with the way these children process emotional information if they were raised in an orphanage (Tottenham et al., 2008).

**Behavioral problems.** A child going through such a drastic transition would expectedly exhibit some unwanted behaviors that may or may not have been present prior to the adoption and move to the United States. Problematic behaviors in children typically are categorized as either internalizing or externalizing behaviors. Fisher et al., (1997) found that Romanian orphans demonstrated more problems, specifically internalizing problems, on the Child Behavior Checklist (CBCL) when compared to children not raised in orphanages (Achenbach, 1991; Achenbach, 1992). Elevated scores on the CBCL were positively correlated with the amount of time spent in the orphanage (Fisher, et al., 1997). Apparently the longer a child spends in an institutional setting, the more likely he or she is to display internalized behaviors. Internalizing behaviors may be a learned response, as caregivers in the institution may not be able to respond to the child’s needs.

**Eating problems.** Some children adopted internationally also experience eating problems. Experiencing eating problems may not come as a surprise, as diet drastically changes for many of these children. Children adopted from other countries often are immersed immediately into the American way of eating, which is drastically different
from their native diet. In addition to adjusting to the cultural differences in diet between their native country and the United States, children also are adjusting to eating in a noninstitutionalized setting. The environment where eating takes place may contribute to some of the eating problems seen in some internationally adopted children. Also, many children raised in orphanages suffer from failure to thrive, and trouble with eating is to be expected. Eating problems were reported in children raised in Romanian orphanages but were seen rarely in children not raised in Romanian orphanages. In one study, 65% of children raised in a Romanian orphanage had a problem with eating behavior. Specifically, these children refused solid food or ate too much (Fisher, et al., 1997).

Children raised in institutionalized settings tend to overeat. Sometimes overeating or hoarding food may be a sign of neglect.

Stereotyped behaviors. Stereotyped behavioral problems (rocking, moving hands stereotypically) was another behavior reported in children raised in Romanian orphanages but seen rarely in children not raised in Romanian orphanages. Such behaviors may be consistent with behaviors seen in the orphanage. This behavior also may be a new behavior that reflects the child’s way of reacting to a change in stimuli. Stereotyped behavior also may result from a lack of opportunity for learning. In other words, children who are understimulated may exhibit stereotyped behaviors (Fisher, et al., 1997).

Social problems. Internationally adopted children may have trouble with social adjustment in school or with friends. Romanian children raised in an orphanage were reported to have more problems with peers than those experienced by children not raised in orphanages. For instance, they may avoid peer contact or feel overwhelmed by
attention from peers (Fisher, et al., 1997).

**Identity.** Children adopted internationally not only are faced with typical developmental issues, but also must deal with issues of adoption, such as living in a family with a different ethnic and cultural background. They may be faced with not having direct access to their heritage, with racism, and with other barriers to developing typically like many of their peers (Levy-Shiff, Zoran, & Schulman, 1997). As a result, children adopted internationally may have difficulty forming a positive self-concept and integrated identity (Simon & Alstein, 1987). When these children grow older, they may face serious barriers to obtaining complete, true records of their birth family (Levy-Shiff et al., 1997). These barriers may add to their disappointment and struggle with identity development.

**Trauma.** Children are adopted at all ages, depending on the country of origin. The more open the adoptive parent is to older children and children with disabilities, the easier or quicker an international adoption may be completed. For example, if an individual is willing to adopt only a baby or toddler younger than the age of 2 years, the wait may be longer. Also, if an individual specifies that he or she is not willing to adopt a child with a known cognitive disability, the wait may be longer. Some children who are available for adoption are older, have emotional problems, and are physically disabled. Most likely, they have experienced institutionalization and severe trauma, whether physical or emotional. Studies report that the older the child at the time of adoption, the less likely he or she will be able to adapt effectively (Levy-Shiff et al., 1997). Depending on the child’s age and experience, the adoption process alone can be considered a trauma,
and therefore, alter the child’s adjustment and the family’s ability to function (Levy-Shiff et al., 1997). Of course, not every child adopted internationally is traumatized and unable to recover from the experience. Many children adopted internationally do not experience long-lasting effects of the adoption process as a traumatic event. At a very young age, the trauma experience likely is not being encoded in language. It may be encoded more in terms of a fight-or-flight anxiety response.

**Adjustment.** While some studies show likely postadoption struggles for children and families, other studies show results consistent with adjustment, which is very understandable considering all the changes the children go through during the international adoption process (Levy-Shiff et al., 1997). Some studies even show that children adopted internationally seem to adjust similarly to nonadopted children and children adopted domestically (Bagley, 1992).

**Parents’ struggles.** The time following the adoption is an adjustment period not only for the child, but also for the parent. Often the focus is on the child’s behaviors and adjustment such that parental functioning gets overlooked. Levy-Shiff, et al. (1997) recognized not only struggles the children would face, but also some of the struggles that parents who adopt internationally may encounter. For instance, a study of 100 Israeli families assessed the following factors: psychological distress, parental behaviors and coping with parenting, family relations and marital adjustment, and coping with adoption issues (Levy-Shiff et al., 1997). In terms of psychological distress variables, outcomes of individuals who adopt children internationally seem to be consistent with those of individuals who adopt domestically. Internationally adoptive parents used more problem-
focused ways of coping and support-seeking strategies than did the domestically adoptive parents. Also, mothers tended to use more support-seeking strategies than did fathers as a way to cope with parenting (Levy-Shiff et al., 1997).

Individuals who adopted internationally were found to be more overprotective, intrusive, and controlling than parents who adopted domestically. The reasons for these findings are unclear. Mothers of both domestically and internationally adopted children were more involved in caregiving and were more supportive and overprotective than were fathers. Mothers tended to be preoccupied with issues such as triangulation and also with their child’s ability to cope with the issue of being adopted. Mothers also felt deprived because of infertility. Mothers and fathers who adopted internationally viewed parenting as a challenge more than did mothers and fathers who adopted domestically. More mothers than fathers viewed parenting as a challenge and even as a threat. More than half of international adoptive parents (58%) sought psychological counseling, slightly more than parents who adopted domestically (51%). Previous loss of a child seems to be an obvious explanation for these findings (Levy-Shiff et al., 1997).

During the period of expectancy, the stress of adoption did not seem to affect the psychological adjustment of adoptive parents, or at least they were not perceiving or reporting so. Adoptive parents may believe that the adoption of a child would be the happy ending to their past struggles and longing for a child (Levy-Shiff, Bar, & Har-Even, 1990).

In addition to their own feelings, adoptive parents frequently are influenced by the feelings of others. The outside influence may affect their adjustment to the adoption
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process. Most individuals view adoption as a positive process and believe adoption serves a useful purpose. According to Pertman (2000), only about half believe that adopting a child is as good as having a biological child and about 25% think that loving adopted children is harder than loving biological children. Only one third believe that children who are adopted could love their adoptive parents as much as their birth parents (as cited in Miller, 2005). These are all issues that adoptive parents are faced with regardless of whether or not they hold these beliefs personally.

**Depression.** Women who become pregnant sometimes experience parental depression, and many women struggle with depression after giving birth. Becoming a parent and taking on a new role is an immense adjustment for many families. In addition to this adjustment, women are experiencing hormonal changes. Not all women who become a parent give birth, however. Adoptive mothers and adoptive fathers also may experience depression. This is called postadoption depression and is a popular topic among professionals in the field of international adoption.

One study showed that mothers who are pregnant are significantly more depressed than adoptive mothers (Levy-Shiff et al., 1990); however, adoptive parents who are experiencing parental depression cannot be left out of consideration. In other words, just because a parent did not give birth to a child, does not mean that she should be excluded from consideration in research on parental depression. The experience and perception of depression in adoptive versus birth parents may be different however. Also, the way adoptive and birth parents report depression may differ, but both are important to consider.
One reason parents may report depression differently is the consequence of reporting/having mental-health problems for parents who adopt children internationally. Because of the nature of the adoption process, a difference in reporting symptoms of depression is likely because the adoptive parents are being followed by an agency to assess their parenting ability. For example, birth parents may not need to worry about their child being removed from their care because they are dealing with depression. However, adoptive parents, at the time following the adoption, already have gone through a rigorous process proving that they are fit to be parents. Most likely, they have waited at least 1 year to become parents, and this time does not include possible prior attempts to become a parent. Their mental-health has been assessed, and therefore, struggling with depression after the child they have been waiting for has finally arrived would be hard for these individuals to admit. Therefore, these parents actually may be experiencing more depressive symptoms than they are reporting. This difference in reporting may account for the findings that depressive symptomatology is seen more frequently in birth parents than in adoptive parents.

Adoptive fathers, same sex couples, and single parents cannot be excluded from consideration either. These individuals also may have experienced a history of grief and loss. They also are a part of the home-study process and have had a thorough examination of mental-health problems, past and present. Adoptive fathers and same-sex couples also may suffer from parental depression, but underreport symptomatology.

Depression in both adoptive parents and birth mothers may be present for a number of reasons. Depression in pregnant women could be related to hormonal changes. Other
reasons for depression may include added stress of pregnancy or expecting a child, the idea of a lifestyle change about to come, a history of loss of a child, a history of depression, or unmet expectations after adoption/birth. For parents who adopt internationally, stressors may be even more complicated. Therefore, not only the pregnancy itself contributes to depression, but other external factors that both birth parents and adoptive parents may experience as well.

Much of the research on the effects of child loss on parents shows that losing a child is devastating for parents. However, some of these studies focus only on the functioning of these parents, without also comparing their level of functioning to general levels of symptoms of distress. Therefore, whether levels of functioning of parents who have experienced the loss of a child are significantly different from those of a control group is unknown (Dijkstra & Stroebe, 1998).

Apparently bereaved parents have more trouble with psychological, physical, and psychosocial functioning than do parents who are nonbereaved; however, no empirical evidence points to the areas for which this statement is true. Some findings indicate that bereaved parents struggle with health and marital problems; however, more evidence is needed (Dijkstra & Stroebe, 1998). Some couples tend to demonstrate greater perceived closeness after bereavement for a lost child, while other couples experience an opposite outcome, depending on the relationship of the couple prior to their loss (Dijkstra & Stroebe, 1998).

disorders with postpartum-onset may include the following symptoms: fluctuations in mood, mood lability, and preoccupation with infant well-being. These symptoms may present from overconcern for the infant to having delusions about the infant. Many people believe that when women suffer from postpartum-onset mood episodes, they are unsafe around their infant. An important difference exists between postpartum-onset mood disorders with and without psychotic features. Infanticide occurs with women with postpartum-onset mood episodes with psychotic features and command hallucinations to kill the child. Infanticide also may occur when women experience delusions that the child is “possessed.” Typically, women with postpartum-onset mood episodes do not commit infanticide (4th ed., text rev; DSM-IV-TR; American Psychiatric Association, 2000).

According to the DSM-IV-TR (2000), postpartum mood episodes, such as major depression, manic episodes, or mixed episodes, occur only in approximately .001 to .002% of deliveries. Women who have struggled with past postpartum mood episodes or have a history of a mood disorder may be at higher risk of developing postpartum episodes with psychotic features (4th ed., text rev; DSM-IV-TR; American Psychiatric Association, 2000).

Many women who suffer from postpartum depression also experience other problems of adjustment to the infant. Some women suffer from anxiety disorders, specifically panic attacks. Other women may experience disinterest, fear of being with the infant alone, or overintrusiveness toward the infant (4th ed., text rev; DSM-IV-TR; American Psychiatric Association, 2000).

As many as 70% of women experience some degree of mood alteration, sometimes
called baby blues. Baby blues are a temporary change in mood and typically occur 10 days after the birth of the child. They do not impair parental functioning. Anxiety symptoms and mood during pregnancy and the development of the “baby blues” may increase the risk for future postpartum Major Depressive Episode. Other contributing factors include a past history of a mood disorder and family history (4th ed., text rev; DSM-IV-TR; American Psychiatric Association, 2000).

Women may experience depression or other mood disorders before, during, and after pregnancy. Depression in postpartum women may be present only once, or may be chronic or recurrent (Cohen et al., 2010). During the time following birth, birth mothers experience neuroendocrine alterations as well as many psychosocial adjustments to having a new child in their care (4th ed., text rev; DSM-IV-TR; American Psychiatric Association, 2000).

*Postadoption depression.* Some research initially focused on the adjustment process of children adopted internationally, and less focus was given to the adjustment of parents and families (Levy-Shiff et al., 1997). Postadoption depression, however, is becoming more of a focus in the adoption community. Some parents are experiencing preadoption depression, and the adoption process is acting as a stressor, leading to postadoption depression. Other individuals may not experience depression until after the adoption.

*Grief and loss.* Parents who adopt children internationally may have a history of grief and loss. Greater marriage satisfaction is experienced by adoptive parents versus birth parents, and satisfaction may be the result of the duration of marriage, and living through stresses of infertility and the adoption process itself (Levy-Shiff et al., 1990).
However, many struggles come along with living through grief and loss, such as adjusting to new stressors and re-experiencing unpleasant events. Individuals who have a history of grief and loss may have more difficulty adjusting and coping with the struggles after international adoption.

**Resilience.** Resilience is “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (Masten, Best, & Garmezy, 1990). People are resilient if they attain good outcomes despite exposure to a significant threat (Luthar, Cicchetti, & Becker, 2000). The study of resilience began during the 1960s and 1970s. Psychologists began exploring this topic by studying children growing up in high-risk environments. They observed that even though some children were exposed to and raised with adversity, they were still able to develop well (Positive Psychology Resources, 2010). Since the 1970s, the study of resilience has expanded to various populations and is a popular topic in the positive psychology movement today.

According to the Child Welfare Information Gateway (2008), the following factors may reduce parental ability to cope effectively with the daily stresses of raising a child: multiple life stressors, a family history of abuse or neglect, health problems, marital conflict, domestic or community violence, and financial stressors, such as unemployment, poverty, and homelessness. This finding is important to consider because parents who adopt children internationally often are faced with many day-to-day stressors while raising their children. Many children, including children who are adopted domestically and internationally, are faced with multiple developmental challenges. Dealing with these struggles presents parents with daily stress, and therefore resiliency is presumed to be
helpful in adapting successfully to these life stressors. Parents with higher levels of resilience likely also demonstrate resilience after international adoption. These parents also may have lower levels of depression after international adoption. Because high levels of depression are associated with greater frequency of cognitive distortions, parents with increased resilience likely have fewer cognitive distortions and lower levels of depression. Therefore, parents with increased resilience may have an easier adjustment after international adoption.

One factor that may affect resilience in parents is a history of grief and loss. Parents who have experienced grief and loss related to becoming a parent may have decreased resilience and therefore higher levels of depression and frequency of cognitive distortions. This study seeks to explore parental experience after international adoption, with specific attention paid to mothers’ emotional experience.
Chapter Three: Research Questions

Interview Questions

A semi-structured interview with parents who have adopted children internationally will be comprised of the following open-ended questions:

Research Question: What is the emotional experience of mothers who adopt children from countries of a different origin?

1. Describe the unique challenges you faced during the first year after adoption that were related to the fact that your child was adopted from a country of different origin.

2. How would you describe the process of attaching emotionally to your child that first year?

3. Describe the emotional highs and lows as well as other emotionally charged events that occurred during that first year.

4. In what ways do you feel your first year as a mother was different because you adopted a child from a country of different origin who had visible ethnic or racial differences from yours?

(supporting questions)

Do you feel you are different as a mother or have a different sense of family than you would have, had you been able to birth a child?

Money: Were you ever asked how much you paid for your child or what the adoption cost?

Language: Did anyone ever ask if he/she was your natural/real/adopted child?
Did anyone ever ask if your children were “real sisters?” Did anyone ask “what do you know about your daughter’s/son’s parents?”

Multicultural: Has any family member or friend commented on how similar or different your child is from you or the rest of your family? Were the differences due to the fact that he/she was adopted? Even though your child’s appearance reflects the fact of his/her adoption, did anyone ask if you were going to tell he/she was adopted?

Paperwork: Were there times during the first year that you needed to fill out paperwork that spotlighted the adoption or called for information you did not have/know?

Attachment: How did you feel you attached to your child (Instantly, differently, long time to attach)?

5. What multicultural issues did you encounter related to your child?

6. Discuss experiences you had with adjustment difficulties, including expectations of what motherhood would be like, how the child accepted you, and letdown after bringing your child home.

   (supporting question)

   How have your views of international adoption changed from before getting your child to the experience of having your child after 1 year?

7. Discuss how well you felt others were able to relate to the uniqueness of your situation and understand what you were going through.

   (supporting question)
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Did you feel others tried to minimize the fact that adoption was different from their experience?

8. Describe any instances when you felt friends and family would not understand your feelings if you shared them.

9. Discuss the emotions that best described your typical moods during the first couple of months after the adoption.

10. In what way would seeing a therapist regularly have supported you during that first year?

Justification for Research Questions

The research questions were designed to explore the following areas: unique challenges to international adoption, attachment, emotional highs and lows as well as typical moods, feeling qualitatively different from birth parents, multicultural issues faced, adjustment difficulties, uniqueness of international adoption, minimization of difference of international adoption, feeling misunderstood, and the need for therapy and postadoption support.
Chapter Four: Methodology

Design and Design Justification

This study followed a qualitative design in order to capture the experiences of 10 mothers who adopted children internationally. The qualitative methodology was used in order to illustrate and understand the experiences of participants. The qualitative design intended to elaborate on the experiences of the participants in order to reveal more complex meanings within their responses (Kazdin, 2003). Individual semistructured interviews were administered and used to obtain information and data and to capture the in-depth experience of mothers who adopted children internationally. Qualitative research studies are exploratory in nature, and therefore the information and data obtained from the interviews were examined thoroughly to uncover common trends and themes across interviews (Kazdin, 2003). The goal of the present study was to use qualitative research methodology to identify common trends and themes among mothers who adopted children internationally.

Participants completed a demographic interview, which assessed for a history of grief and loss, among other factors. Convenience and snowball sampling were used in this study to represent the population of individuals who adopt internationally. The sample of participants was taken from individuals from the tri-state area (including New Jersey, Pennsylvania, and Delaware) who adopted a child internationally.

Participants

Participants in this study consisted of 10 mothers who adopted children internationally. The child must have had visible ethnic differences from the mother.
Participants consisted of only mothers who were engaged in a male-female relationship. There was no age restriction for this study. Age restrictions already may have been placed during the adoption procedures. Participants in this study were all Caucasian. Participants were recruited from the tri-state Delaware Valley area; however all participants ended up being from central and southern New Jersey. Convenience sampling and snowball sampling were used to recruit participants.

Typically, individuals who adopt internationally are married couples involving a man and woman or they may be single women. The average age of couples and individuals who adopt internationally is older than the average age of individuals and couples who have birth children. A number of same-sex couples and single men also adopt internationally (Miller, 2005). For the purposes of this study, only women were used in order to keep the sample participants as similar as possible.

**Inclusion and Exclusion Criteria**

The examiner screened individuals to see if they met criteria by asking them a list of inclusion criteria questions. When an individual meeting criteria was identified, the examiner then asked if she would like to participate in the research study.

**Inclusion criteria.** Participants must have adopted a child from a foreign country. The child must have lived in their home. Participants were women married to men. Individuals who participated must have adopted as a couple, but only the mother was interviewed. The child must have been adopted legally or have been in the process of being adopted legally by the couple. The mother who completed the demographic interview as well as the verbal interview must have been able to speak, understand, read,
and write in English.

**Exclusion criteria.** Participants were excluded from the study if the child was removed from the home at any point because of involvement with child protective services. The child may not have resided outside the home of the participant for more than 1 month between the time of adoption and participation in the study (unless for hospitalization). Grandparents were not permitted to participate in this study. Participants who only were fostering a child were excluded, but individuals participating in the study may have had foster children residing in the home if they also had another child meeting criteria. Also, participants who fostered the child prior to adoption were excluded. Therefore, only new placements with intentions of adoption were permitted to participate in the study. Inclusion and exclusion in the study were determined by the researcher prior to the interview.

**Screening procedures and recruitment.** The examiner screened the participants for inclusion and exclusion criteria. The screening procedure occurred over the phone or through the use of email. The examiner reviewed all inclusion and exclusion criteria. After the willing participant was screened, the examiner recruited the participant for the research study. At this time, the examiner obtained consent from the recruited participant. The participant then was informed of her rights as a research participant, rights to confidentiality, and the right to withdraw at any time from the study. The examiner and participant set up a scheduled time to meet for the interview, which took place at the participant’s home. A quiet and convenient setting also was offered as a meeting place, but all participants declined this option and preferred the interview to be conducted in
their own home. Participants were asked if they knew of anyone who might be interested in participating in this study. If a participant was referred, the examiner’s contact information was given to the participant or permission was given for the examiner to contact the new participant. This process was repeated until 10 participants were obtained.

**Plan for Informed Consent Procedures**

Participants were given a consent form to read and sign prior to beginning the interview. The purpose of the study and the interview process were explained. Participants were encouraged to use the researcher’s contact information if they had any questions after the interview session was over. Participants were informed that they were able to discontinue participation in the study at any time.

**Measures**

Participants in this study completed a demographic interview. The demographic interview gathered information about marriage or partnership, length of marriage, country of origin of the child, age of the child at adoption, current age of the child, date the child entered the United States, age of legal adoption, history of grief and loss, loss of a child, inability to have a child, failed procedures, length of time between initial decision to have a child and the child entering United States, mental-health history, mental-health struggles within the first year after adoption, and current mental-health functioning. A verbal interview was completed also.

**Procedures**

After determined to meet all criteria for the study, participants were considered
eligible and interviewed. Consent forms were signed upon initial face-to-face contact. Participants completed the pencil-and-paper demographic interview first; then, the semistructured interview was conducted individually with each participant. Open-ended research questions were asked by the examiner in order to lead a discussion on the topic. Ten core questions were asked, as well as supporting questions. Participants also were given a resource list to assist them if they wished to seek services.

Interviews took place at the participant’s home, in a private area where distractions were minimal. All interviews were audio recorded to ensure that all information was recorded and understood accurately and so that themes could be derived later. Audio recordings may have named participants by their first name, but their last names were kept confidential. This procedure was followed to ensure confidentiality for participants. The principal researcher for this study transcribed each audio-recorded session. Two research assistants were involved in helping the principal researcher code the interview transcripts. Transcribed interviews included only codes for participants to ensure participant confidentiality.

This study focused on the experiences of mothers who adopt children internationally. The study was explorative. The goal of the study was to gain insight into the mothers’ emotional experiences in order to gain a more comprehensive perspective of parental functioning postadoption.

Confidentiality

Only first names were used in the audio recordings. Code names, which appeared on the written transcripts as well as on the measures and demographic interview forms,
were given to each participant. Only code names were available to the two research assistants to increase participant privacy. Audio recordings were transcribed by the principal researcher, which also helped to ensure participant privacy. All audio recordings, transcripts, and scales were kept in a locked file to ensure security.

**Data Analysis**

The type of data analysis used for this qualitative research study is called thematic analysis. Data, which in this case were transcripts from audio-recorded semistructured interviews, were scrutinized for emerging themes. These themes occurred across participant interviews. Themes that are identified from qualitative research help to guide future research. Theories, that are developed out of qualitative research, are formed by identifying and analyzing these emerging themes (Rubin & Rubin, 1995; Strauss & Corbin, 1990).

The principal researcher reviewed each audio-recorded interview and transcript several times. Doing so helped the principal researcher to become immersed in the data, become acquainted with each mother’s experience, and be able to draw out themes from the data effectively. Transcripts also were scrutinized by two research assistants in order to expand upon the principal researcher’s own discovery of emerging themes (Strauss & Corbin, 1990). The two research assistants were students in clinical psychology. A great deal of information was elicited from each interview, and therefore, the principal researcher maintained organization of the data to ensure confidentiality.

The coding team consisted of the principal researcher and two research assistants. The entire team was trained in the grounded theory coding system, which allowed the
coding team to identify themes from the data effectively. A grounded theory is “inductively derived” from the phenomenon meaning that it is discovered, developed, and verified (Strauss & Corbin, 1990, p. 23). Data collection and data analysis were used to accomplish this goal. First, an area of interest was determined. In this case, the area of parental functioning after international adoption was established. Then, areas of relevance to parental functioning emerged (Strauss & Corbin, 1990).

In order to be trained in grounded theory, one must study grounded theory procedures. This ensured that all researchers understood how to build theory cautiously and accurately. Researchers followed procedures closely while demonstrating openness and flexibility to adaptation (Strauss & Corbin, 1990). Because of their background in clinical psychology and training in grounded theory, the principal researcher felt confident that the other research assistants were providing input that was internally consistent.

As part of the grounded theory system, open coding was used. According to Strauss and Corbin (1990), open coding involves selecting and naming categories from data analysis in order to describe common features of the information under study. An outline that involved the identified phenomenon then was then developed. Variables were identified, labeled, and organized into categories, which were then described (Strauss & Corbin, 1990).

The next step in the coding procedure was axial coding. Strauss and Corbin (1990) described this process as a way of rearranging the data in original ways. The principal researcher sought causal relationships between categories as well as made associations
between categories and sub-categories. In order to do so, the principal researcher explained relationships between categories and understood how they related in the bigger picture (Strauss & Corbin, 1990).

The two research assistants helped to increase validity in this study by the use of a system called triangulation. According to Kazdin (2003), triangulation helps to ensure multiple viewpoints in the coding process. Triangulation also helps to decrease the chances that the principal researcher brings biases to the coding process by providing multiple viewpoints on the contents of the interview material (Kazdin, 2003).

The process of transcribing and analyzing began after the first interview was completed. The principal researcher listened to and read each story with caution in order to better understand the mothers’ personal stories. When all of the interviews had been recorded, transcribed, read, and analyzed for emerging themes, the principal researcher then developed interpretations of the material being uncovered (Strauss & Corbin, 1990).

Analysis of Risk/Benefit Ratio

Participants in this study may have been at risk for retraumatization resulting from the personal and emotional content of the interview questions related to their history of loss. To minimize this risk, the participants were not required to answer questions they did not want to answer. Participants’ identifying information was kept confidential, and therefore minimal risk was involved with this study.

Participants may have benefitted from participation in this study because of the therapeutic nature of the interview. Participants had the opportunity to discuss relevant issues and feelings that may have been beneficial to them. This study allowed parents to
have a voice with regard to their experience as well as to voice any issues or concerns with the process. Participants may not have benefitted directly from this study, however. Their participation in this study may have added to the minimal fund of knowledge currently present on this topic or expanded upon this topic for future studies and treatment of this population. Results of this study may have suggested that a discussion surrounding mental-health functioning may need to be included as part of the home-study process in the future in order to decrease the amount of struggle and the number of disrupted adoptions. Results may provide information regarding ways to better prepare future adoptive parents. The benefits of this study outweighed the risks of this study.

**Procedures for Maintaining Confidentiality**

In this study, all data were deidentified in a data set. All names were changed to pseudonyms (except for first names on audio recordings). This procedure ensured that confidentiality was maintained for each participant. Data were stored in a locked file. Any data kept on a computer were stored in a password-protected file.
Chapter Five: Results

This study examined themes, concepts, and categories of emotional experiences of mothers in New Jersey who adopted children internationally. Ten women were interviewed over the course of 4 months. The purpose of the interviews was to gather information about the mothers’ experiences after international adoption.

Data Collection

The data for this study were collected over a period of 4 months, during which 10 mothers who met the study’s eligibility requirements were interviewed. All interviews were conducted in the home of the participant, although a neutral location also was offered as an alternative. All interviews were audio recorded and transcribed at a later date. Interviews were, on average, 45 minutes in length, with the entire session lasting about 1 to 1 ½ hours.

Data Analysis and Interpretation

After the interview and audio recording were completed, the principal researcher transcribed the interview, listened to the audio recording, and read through the transcript. This process continued after each of the interviews during the data collection phase. Once all of the interviews were completed, the principal researcher continued to read through transcripts as well as to listen to audio recordings and make note of patterns emerging from the data. The principal researcher continued analysis of data upon completion of all 10 interviews. The coding process began with the principal researcher and was completed by the team. The team consisted of the principal researcher and two doctoral-level students in clinical psychology. Information was broken down into concepts and then
grouped into categories. Themes were formulated across all 10 participant interviews and then cross validated. Themes that were found to be consistent across transcripts then were finalized. Themes were generally consistent with topics chosen for interview questions by the principal researcher.

Discussion of Findings

Findings were broken down into two sections: demographic findings and descriptive summaries. The first section, demographic findings, explains variables of the participants and provides an understanding of generalizability of this study. The second section, descriptive summaries, provides summaries of participant responses to each question asked during the interview. Pseudonyms were used to refer to participants in order to provide confidentiality.

Participant demographics.

This study sample consisted of 10 Caucasian women. All women in the study were married to a male partner. Length of marriage ranged from 5 years to 37 years at the time of their interview. The mothers adopted from three different countries: six children were from Korea, three were from China, and one was from Ethiopia. The children entered the United States between 1982 and 2010. The age of the children at adoption ranged from 8 weeks to 19 months. The current ages of the children at the time of the interview ranged from 2 years to 29 years. Four mothers reported a history of loss, while six mothers reported that there was no history of loss. Six of the 10 mothers reported the death of a child or miscarriage, while four reported never having had a death of a child or miscarriage. All 10 participants were unable to have a birth child. Six of 10 mothers
sought medical assistance in trying to have a birth child. Four participants did not seek medical assistance. The length of time between the initial decision to become a parent and the time the child entered the United States ranged from 9 months to 4 years. Four participants reported a history of anxiety or depression; six reported no history of anxiety or depression. One participant reported that she struggled with anxiety or depression postadoption. The other nine participants reported that they did not struggle with anxiety or depression after their child was adopted. Three adoption agencies were used: six mothers used Holt International, two mothers used Adoptions from the Heart, and one used Wide Horizons. One participant did not go through an agency. Table 1 describes participants’ demographic information collected during the interviews in detail.
Table 1

*Participant Demographics*

<table>
<thead>
<tr>
<th>Code</th>
<th>Abby</th>
<th>Brenda</th>
<th>Carol</th>
<th>Denise</th>
<th>Elise</th>
<th>Fran</th>
<th>Grace</th>
<th>Hannah</th>
<th>Irene</th>
<th>Jess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of marriage</td>
<td>12 yrs.</td>
<td>9 yrs.</td>
<td>13 yrs.</td>
<td>8 yrs.</td>
<td>31.5 yrs.</td>
<td>11 yrs.</td>
<td>37 yrs.</td>
<td>5 yrs.</td>
<td>25 yrs.</td>
<td>10 yrs.</td>
</tr>
<tr>
<td>Country</td>
<td>Korea</td>
<td>Korea</td>
<td>China</td>
<td>Korea</td>
<td>Korea</td>
<td>China</td>
<td>Korea</td>
<td>Ethiopia</td>
<td>China</td>
<td>Korea</td>
</tr>
<tr>
<td>Age at adoption</td>
<td>11 mos.</td>
<td>5.5 mos., 9 mos.</td>
<td>19 mos.</td>
<td>11 mos.</td>
<td>9 mos.</td>
<td>17 mos.</td>
<td>3 mos., 4 mos.</td>
<td>4.5 mos.</td>
<td>8 wks.</td>
<td>4 mos.</td>
</tr>
<tr>
<td>Current age</td>
<td>2.5 yrs.</td>
<td>5 yrs., 3 yrs.</td>
<td>8 yrs.</td>
<td>2 yrs.</td>
<td>20 yrs.</td>
<td>7 yrs.</td>
<td>29 yrs., 28 yrs.</td>
<td>3 yrs.</td>
<td>18 yrs.</td>
<td>23 yrs.</td>
</tr>
<tr>
<td>Loss</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Death or miscarriage</td>
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<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Unable to have birth child</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</tr>
<tr>
<td>Medical</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Length of time</td>
<td>3 yrs.</td>
<td>2 yrs.</td>
<td>13 mos.</td>
<td>3.5 yrs.</td>
<td>18 mos.</td>
<td>2 yrs.</td>
<td>9 yrs., 6 mos.</td>
<td>3 yrs.</td>
<td>4 yrs.</td>
<td>18 mos.</td>
</tr>
<tr>
<td>History of anxiety or depression</td>
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<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>PAD</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Agency</td>
<td>Holt</td>
<td>Holt</td>
<td>Adoptions from the Heart</td>
<td>Holt</td>
<td>Holt</td>
<td>Adoptions from the Heart</td>
<td>Holt</td>
<td>Wide Horizons</td>
<td>Lawyer</td>
<td>Holt</td>
</tr>
</tbody>
</table>

Note. PAD = postadoption depression
Descriptive Findings

The following is a description of findings derived from the interviews. Sections are broken down into topics covered during the interview. The topics discussed include unique challenges of international adoption, attachment, emotional highs and lows, feeling different, insult, multicultural issues, adjustment difficulties and letdown, changing views, uniqueness and others’ understanding, and the need for therapy and support.

Unique challenges of international adoption. The responses given when asked, “Describe the unique challenges you faced during the first year after adoption that were related to the fact that your child was adopted from a country of different origin” seemed to revolve around the theme of feeling unprepared. Eight of 10 mothers were challenged by feeling unprepared during this process. Three concepts were derived: having a lack of information about the child, having a lack of information about others involved with the child, and having a lack of prenatal care. These concepts were found to be common among the sample. These concepts may also be found with domestic adoption and not necessarily specific to international adoption.

Carol was challenged by knowing no medical history and having no information about the child’s genetic background. She felt stressed and anxious. Fran talked about not knowing what to do to meet the needs of her child and stated, “It was different. I didn’t know what to do for her anymore than a stranger when she cried.” Elise also agreed, “We didn’t know,” and explained that having no access to medical history was challenging.

Jess also discussed having no information about family medical history. Denise
stated that “We didn’t have information about her background or caregivers” and that never being able to have contact with the people who cared for her child was distressing. Grace stated, “We wished we had the health information of the birth mother and father.”

Jess and Hannah discussed the lack of prenatal care as being a challenge. In Hannah’s case, the lack of prenatal care was of particular concern because “nutrition was poor.” Both she and the baby experienced medical issues, such as contracting salmonella.

Five mothers faced the unique challenge of not having access to important paperwork for the child. Carol struggled with not having a birth certificate for her child and stated, “Signing her up for town sports was hard and for school, she didn’t have a birth certificate.” Fran said it was “hard in the beginning because she didn’t have a birth certificate yet.” Denise and Hannah wished they had been given paperwork for doctor’s appointments. When Denise was asked about challenges she reported, “In the beginning, doctor’s appointments, they all want to know,” referring to paperwork and medical information about the child.

Evidently, almost all of the mothers experienced unique challenges related to the fact that their child was adopted from a country of different origin. Challenges were related mostly to feeling unprepared and having lack of in information about the child, not knowing who cared for or was related to the child, lack of prenatal care, and lack of paperwork.

**Attachment.** Participants in the survey were asked, “How would you describe the process of attaching emotionally to your child that first year?” Answers included instant, delayed, inconsistent, and mixed. Abby reported, “Acceptance and attachment from day
one,” and Brenda reported, “It was as if I gave birth to him.” Carol reported that the attachment was “immediate,” and Elise reported that it was “almost instantaneously.” Grace said “it was the same as if [she] had a child.” Elise found that her child fit right in and was easy to attach to because he was a loving child. Jess said the attachment was “immediate,” and Irene said the attachment occurred “the minute [she] saw her.”

While Brenda found that with her first son adopted from Korea there was a “strong bond,” with her second son, it took a “long time to attach.” She described that 2 years went by before the child attached to her, and affected how she attached to her child. Leading up to her meeting her second son, she had a “weird feeling” and a “pit in her stomach.” She felt nervous, and her son “didn’t attach to [her].” Carol reported that her daughter wanted nothing to do with her initially.

Three of the 10 mothers described an inconsistent attachment. Brenda’s second child was attached to her husband right away, but not to her until 2 years later. Carol’s child “took a long time” to attach to her husband. Elise’s husband had a hard time because his child went to every other man except for him.

Three of the participants had mixed feelings about the process of attaching to their children. Denise stated, “I was surprised that she attached to me quicker than I attached to her because I was the one who wanted this.” Fran described a nerve-wracking process because of her fear that she would not attach to her daughter. Hannah described her son as having a “temperament that attached easily,” which made attaching to him easier. However, she explained that at times she felt that “this is not my kid,” and she “had to intentionally work on it.”
Two participants described what they thought to be “immediate attachment” or having an “incredibly quick bonding process.” However, they also were describing possible signs of attachment difficulties. For example, Brenda’s son needed to call her on the phone every time she left the house because he felt as though something bad might happen to her. This issue may not necessarily have been related to the fact that her child was adopted internationally because this behavior is seen also in children who are adopted domestically and also in birth children. Carol stated, “No one could hold her.” She believed no one could hold her because her daughter was attached to her, but it also could have been a sign of poor attachment. This behavior could have been a sign of some attachment difficulty, or it could have been specific to the relationship between this specific mother and her child.

Within the area of attachment, several mothers brought up the idea of making conscious attempts to bond with their child. Brenda “tried holding him, comforting him.” Hannah made sure to be “intentional about attachment kinds of things.” Denise tried the technique of “fake it ‘till you make it,” and forced herself to do bonding exercises with her child.

Seven participants also described a phenomenon in which the child was bonded to the foster parent or previous caregiver. Carol said, “It was hard for her [child] to leave the foster mom.” Abby remembered the foster parent having difficulty handing over the child to her, and Abby felt bad for taking the child from the foster parent. Hannah said, “You love him so much, but you’ve taken him from someone else” and later described this feeling as “haunting.” Jess expressed guilt about taking the child from the foster mother.
She remembered having a picture of her sad looking foster mother. Fran explained that her child wanted to stay with the foster parent and that she felt sad for her child when she took her away from her caregiver. Brenda was sad when her child “cried for Oma” in the beginning. Denise felt guilty about not knowing how to soothe her and wondered if her caregiver would have known what to do when she did not.

**Emotional highs and lows.** Mothers responded to the following: “Describe the emotional highs and lows as well as other emotionally charged events that occurred during that first year.” Within their responses, they described a number of highs as well as lows. Later in the interview they also were asked to “discuss the emotions that best described your typical moods during the first couple of months after the adoption.” These questions were grouped together because of the similarity of their responses.

Highs included getting the child home, realization of motherhood, when the child bonded with his or her father, and getting a picture of the child. Four of the 10 mothers described getting the child home as the ultimate high of the experience of adopting internationally. One mother (Carol) said she felt happiest when she realized she finally had her baby. Another mother stated that her emotional high was “getting her home finally and knowing she’s finally [hers].”

Realization of motherhood was a high for three of the 10 mothers. When asked about emotional highs, one mother (Carol) said “the first time she called me mama” was the highest moment she could remember. Another mother (Grace) said, “when the child was put in my arms,” and another mother (Denise) said, “knowing I’m finally a parent.” Carol said “the first time she bonded with my husband” was also a high. Grace said that
receiving a picture of her child at birth was a high.

Emotional lows included feeling that they were stealing the child from their foster parent or culture, anticipation and waiting, poor health of the child, adjustment difficulties, and typical worries. Three of the 10 parents expressed guilt about taking the child from his or her foster parent and culture as being the low. Three of the 10 mothers said that the waiting was the hardest part. Two of the mothers experienced adjustment difficulties. Brenda said, “With our second son, it was low most of the time.”

Postadoption moods ranged from positive moods to negative moods, and included even mixed emotions and feeling tired. Brenda described her mood as being “on cloud nine” and living “the dream life.” Grace felt “elated, proud, complete.” Carol and Irene felt stressed out often.

Four of the mothers felt a mix of moods. One mother (Denise) described her mood as an “emotional rollercoaster” feeling anxious, happy, content, nervous, and numb. Fran felt sensitive and defensive, and she experienced “ups and downs.” Four of the mothers (Jess, Irene, Elise, Hannah) described feeling tired when asked to describe their typical moods.

**Feeling different.** Participants were asked, “In what ways do you feel your first year as a mother was different because you adopted a child from a country of different origin who had visible ethnic or racial differences from yours?” Within this category, numerous concepts emerged.

Some mothers felt that family was not about blood. Carol said, “Having a nonbirth family makes you realize family is not about blood.” Others felt that there was no
difference between having a birth child and adopting. A total of seven out of 10 mothers felt that there was no difference because they adopted a child from a country of different origin. Brenda stated, “It doesn’t matter where they came from; they’re my own.” Irene stated, “Challenges as a mother were not any different than any mother of any infant.” Irene also recognized that “others saw her as being different;” however, she did not feel the same way.

Two mothers discussed their experience as being different not because their children were adopted internationally, but because their children were not infants when they were adopted. Denise stated “It was hard not because she was from Korea, but because she was an older child already. I wasn’t getting a tiny cuddly baby.” When Denise talked about having an “older” child, she was referring to having had a child who already was crawling and moving around and not an infant.

Two mothers made comparisons to pregnancy. Carol stated, “My pregnancy was the waiting,” and Grace said, “The plane ride was our labor.”

Three mothers felt as though others discriminated against their children because they were ethnically different from them. Two mothers made the inability to birth a child a positive experience. For example, Brenda said, “I didn’t get to experience the pain. I’m good without all the stuff that goes along with it for 9 months.” Carol said that her friends used to say she was able to keep in shape because she had not birthed a child. She agreed with her friends. Carol also felt as though she was rewarded because she did not have to “do the newborn thing.”

Sense of family. When asked the supporting question “Do you feel you are
different as a mother or have a different sense of family than you would have, had you been able to birth a child,” the mothers answered in three different ways: that there was no difference, that friends are family and family are friends, or that they did feel a different sense of family.

Four mothers felt as though their sense of family was no different from their sense of family had they been able to have a birth child. Elise felt that motherhood rounded her out. Irene felt that her relationship with her child “was never any different from any other mother and child.” Carol explained that their “idea of family is broad and inclusive” and said “family is not about blood.” Hannah said that having other close family friends who are treated like family made adoption easier for them. She also stated “Knowing he has another family has made the way we talk about family different.”

Three mothers believed that having adopted a child from a country of different origin gave them a different sense of family. One said that even though she would like to say no to this question, in all honestly, adopting is just different.

**Insult.** Feeling insulted was a major part of the experience of mothers after adopting a child internationally. All 10 participants discussed feeling insulted in some way by comments made by other people. One interesting concept was distinguishing between whether the people making the insults were being just nosy, or they were trying to gain information for themselves to help them in the process of adopting.

Five mothers felt that people were nosy and were insulted by their comments, but they also were willing to answer questions and help if they felt the person was truly interested or was considering adopting internationally. Carol said “When asked about it
by someone pursuing it, I didn’t mind.” Elise told people, “I’m sorry. That’s privileged information. You don’t need to know that.” Fran was offended not only because people asked rude questions but also because “they asked in front of [her] daughter.” Elise found herself frustrated because people “didn’t think before they opened their mouth.”

Three mothers were worried about others’ rude comments hurting the feelings of their child. Elise tried not to make a scene when people would make rude comments because she “didn’t want [her son’s] feelings to be hurt.”

Six of 10 mothers were insulted in public. Most of the time the insults were made in a grocery store, but sometimes they were made in a restaurant or convenience store. People made comments, such as “What isle did you buy that from? (Irene), and Where’s she from?” (Denise). Two mothers were asked where their children came from. Elise responded with the name of the town in New Jersey in which they reside. People would stop the mother, stare at or touch the child, make rude comments, and stare as if they were noticing the ethnic differences between the parents and child. Elise felt insulted by the comment, “I really admire what you did. Bringing a child like that into your home.” She felt that this comment implied that there was something wrong with her child, and she was doing good by accepting a child with a defect.

Six of 10 mothers were asked questions about their children being “real.” Hannah was asked if her child was her “real child,” and then the person asked her if she was going to have any of her own, as if the child was not her own just because he was adopted. Grace was asked if her children were “real brother and sister.” She responded, “I say yes, even though it’s not how they meant it.”
Three mothers dealt with rude comments by using defenses. Two mothers used humor (Elise, Irene), and one mother (Brenda) dealt with the insults by using lies to “brush people off.”

During the interview mothers were also asked, “Were you ever asked how much you paid for your child or what the adoption cost?” Nine of 10 mothers were asked this question by friends, family, acquaintances, or strangers. Some mothers were asked at the store, in the street, or at work. Grace’s response was “many people asked how much it cost. We said the same as if we had our child in a hospital. It was just rude and none of their business.” Denise said she was asked this question frequently and felt, “It’s annoying that they think based on assumptions they make, that they have the right to invade my privacy and hurt her [daughter’s] feelings.” Irene would discuss the issues with them candidly if they were interested in adoption, but not if they were just asking. Fran felt that people were nosy and was offended that they asked this question in front of her child. Abby explained during the interview, “We didn’t pay for her. We paid for services to get her here.” When Carol was asked, she just walked away and thought it was incredibly rude; however, when asked by someone pursuing adoption, she did not mind.

The supporting question, “What do you know about your daughter’s/son’s parents?” was intended to pull for feeling insulted that people would assume that these woman were not their child’s “real” parent. What the principal researcher found, though, during the interviews was that nine of the 10 participants believed that the person was inquiring about the child’s birth parents. Responses included the following: not giving out that information, being honest with the person, explaining what the child would have
to do to get a hold of the birth parents, explaining that they do not know about her birth family, giving information about the birth family, and sharing with curious people but shutting down nosy people. In Hannah’s case, people assumed that the child’s birth family was deceased, which was not the case at all. His birth mother and siblings are living in Ethiopia.

Participants were asked, “Has any family member or friend commented on how similar or different your child is from you or the rest of your family?” Six of 10 mothers reported that someone had told them how much their child was like them, either in how they looked or acted. Carol’s mother told her, “She is you at that age,” and Carol said, “She is the child I was meant to have. She suited who I am.” None of the participants experienced being told that their child was different from them.

When seeing the mother alone with the child, others assumed that her husband shared the same ethnicity as that of the child. This occurrence happened in seven of the 10 cases. Brenda was asked if her husband was Korean. Someone said to Carol, “Oh, I guess the father is Chinese.” When someone asked Irene if the child’s father was Chinese, the mother replied, “Why, yes, he is,” meaning that the birth father was in fact Chinese.

During their interviews, mothers were asked, “Even though your child’s appearance reflects the fact of his or her adoption, did anyone ask if you were going to tell him or her if they were adopted? Five of 10 mothers had been asked this question. Hannah was asked this question “only in jest.” Jess took this question as being “a really rude question” and was asked the question until her child was in elementary school. All
mothers intended on telling their children they were adopted. Carol found the question funny. Elise wondered how she could not tell her daughter and said the question was never an issue. Jess joked, “Yeah, you don’t think she’s going to notice?” Fran could not believe that people would not tell their children they were adopted.

**Multicultural issues.** Various multicultural issues arose for these mothers after adopting a child from a country of different origin. Participants responded to the following question: “What multicultural issues did you encounter related to your child?” Some of the responses included issues related to physical differences, attempts at maintaining and exposing children to their culture, discrimination, questions about culture, denial of culture, and being open about the adoption.

Elise and Hannah discussed adjusting to the Mongolian spot at the base of their child’s spine. In Elise’s case, someone thought that she and her husband were beating their child and that the spot was a bruise. She explained that this was an issue she would not have had to deal with had she had a birth child with her husband.

Six of 10 mothers discussed attempting to maintain and provide exposure to the child’s culture. They did so by: cooking food from their child’s culture, going to cultural events, researching Korean school and Korean drum classes, practicing food traditions around holidays, spending time with other multicultural families, making the child aware of his or her background, celebrating Chinese New Year, going to Chinatown, having others speak their language to them, and exposing the child to as many different cultures as possible.

Elise’s experience was different. She tried to help maintain culture by offering to
send her child to Korean camp. The child refused because he did not want to be a part of it. Carol believed that her child was “an American kid” and therefore did not try to maintain the culture.

Three of 10 families experienced discrimination. In Elise’s case, her child was “picked on” by the African American children in school. While out in Montana, her child was mistaken for being Native American, and they experienced discrimination in a store. The discrimination was so offensive that they had to drop all of their souvenirs and leave the store immediately. Grace’s child had quite a different experience. Her child was protected by the African American children in high school but picked on by other children in the school. Irene dealt with narrow-minded parents once her child reached high school and became of dating age.

Hannah was asked questions about how often she washed her son’s hair and the type of lotion to use. When questioned by some of her African American friends about how she was planning to handle discrimination, she said, “Some conversations didn’t go well.” Hannah’s husband was approached in a grocery store and accused of stealing the baby because the baby was black and he was white.

Seven of 10 mothers discussed being open with the fact that their children were adopted. Elise gave her child enough information from the beginning. Brenda told her child that his mommy could not take care of him and that he did not come from her body. She framed pictures of his foster family in his bedroom and made very clear to him that he was from Korea. Carol’s child knows her birth mother had to give her up, she was in an orphanage, they could not find her birth mother if they tried, and her birth mother
wanted her to have a better life. One of the reasons Carol went to China to adopt was so that her child would know she was adopted. Elise’s child asked, “So who’s my mother?” She and her husband gave enough information to their child as he could handle for his age. Although he was only 3 years old, Hannah’s child “knows he has a family in Ethiopia and tells the kids in preschool when they ask.” Irene told stories to her child from the beginning to get used to talking to her about this topic. Denise planned on being open with her child, and Fran talked about adoption all the time with her child. They looked at pictures they took while they were in her child’s country, and they pointed to the country on a map.

**Adjustment difficulties and letdown.** Participants were asked to “Discuss experiences [they] had with adjustment difficulties including expectations of what motherhood would be like, how the child accepted [them], and letdown after bringing [their] child home.” Seven of 10 mothers reported having difficulties with adjustment and letdown after bringing her child home. Some of these adjustment difficulties included realization of parenthood; realization of having taken a baby from his or her family; basic adjustment problems; and medical, behavioral, developmental, and language issues.

Carol stated, “Your life is no longer your own.” She said she became obsessed with everything about her daughter after adoption. She went from being an independent woman to feeling like her daughter was her life, and that was a big adjustment for her. Fran felt “weird adjusting to being responsible for another human 100% of the time.”

Hannah mentioned that “in some ways motherhood was easier” for her because the father could share in parenting. She did experience adjustment difficulties, though. She
said she was not prepared for living knowing that she loved her son so much, yet she had “taken him from somebody else.” She went on to explain, “I didn’t expect it to be as haunting as it is.” She would not adopt internationally again because of the lack of contact with the “first family.” She felt there was a “stark permanence of the separation” and felt too far removed from his family and culture. At the time of the interview, more than 3 years later, she was still adjusting to this realization.

Three mothers discussed basic adjustment difficulties, such as knowing if they were feeding or holding their babies correctly and adjusting to the “new baby thing (Jess).” Elise had a hard time “adjusting to baby stuff.” These mothers seemed to have reported difficulties with adjustment to being a mother, which is something that birth mothers, as well as mothers who adopt domestically, also may experience.

Three of the 10 mothers dealt with medical issues. Two of the children had double eyelids, and one had congenital scoliosis and an extra vertebra. One child had parasites, salmonella, and failure to thrive. In this case, the mother (Jess) also had salmonella, which complicated this time further for them postadoption.

Three of the 10 mothers described behavioral difficulties. Abby reported that her child had “tantrums over nothing” and that she could not take her child to the store. This behavior may occur in birth children or domestically adopted children as well, but the severity of the behavior was so great that she was unable to bring her child into the public. Therefore, this behavior was considered a problem; however, it may or may not have been related to the fact that the child was adopted internationally, as this behavior also is seen in other children. According to Brenda, her child experienced separation
anxiety and bad dreams and nightmares. Again, these behaviors also are seen in birth children and children adopted domestically. Brenda also stopped going out because her son was “too difficult” to take anywhere, which had not been her experience with her first son who also was adopted from Korea. The reasons she was unable to take her son to the store are difficult to pinpoint because the measurement of depression in this study was subjective. It is possible that they were some parenting or adjustment difficulties. Carol experienced behavioral difficulties surrounding bedtime. These difficulties seemed to be consistent with behaviors typically displayed by all children at that developmental level.

One of the mothers (Hannah) experienced adjustment to developmental delays in her child. Her child had trouble sitting and seemed to hit all of his developmental milestones “right at the end of the curve” for many skills. He also was late getting teeth and late walking, which raised some concern for her.

Three of the mothers adopted children who they felt had language delays. They described them as “speech difficulties,” their child being “delayed in speech,” not knowing if they were “getting through to her [the child],” and “slow to talk.” Although these three mothers reported that their children had language delays, after close consideration, the principal researcher determined that only two of the children experienced language delay. The other child took some time to learn the English language, but likely was not language delayed.

Eight of 10 mothers experienced some form of letdown after adopting internationally. Letdown may have included unmet expectations, feeling like a failure, second-guessing the adoption, feelings that the child was a stranger, or feeling that the
process was jaded. Some said they would not go through the international adoption process again.

The comment that stood out during the interviews as most closely capturing the idea of letdown came from Irene. She said, “To tell that story when you, if you, adopt because you’re unable to have a birth child, every time you think about adopting it’s acknowledging your failure as a woman. That you can’t do seemingly what every 16-year-old walking down the street can do. And for some people, when they can’t get past that grief, that internal grief, on their own, to tell their child that they were, that they are not birth children is extremely painful.” By accepting and telling the story, she said, “you are acknowledging a death of yourself in a way.” One mother explained the adoption as being “final.” It was a final realization that she was not able to have a birth child. Carol said she “had such high expectations” for the adoption, which may be the reason she experienced letdown after bringing her child home.

Second-guessing was not something most of the participants anticipated from the adoption process. However, five mothers experienced second-guessing after adopting their child. Abby questioned, “Is this right for me? Is this right for the child?” She found herself asking, “What did I do?” Carol also wondered if she had made the right decision. Elise second guessed whether she was ready or too old to have adopted. Hannah found herself thinking, “This is kind of weird. I wonder if I would feel differently if I had birthed a child.” Fran felt like she had taken the baby away from whom she knew and wondered if her situation was ever going to get better.
Another phenomenon that was not anticipated by the mothers was the concept of feeling that the child was a stranger to them. Four of the 10 mothers felt that their child was a stranger in some way. Hannah said during her interview that she asked herself, “Who is this strange little person?” Denise felt as though she was a stranger to her child. Fran felt as though she “didn’t know what to do for her [child] any more than a stranger.”

**Changing views.** The supporting question, “How have your views of international adoption changed from before getting your child to the experience of having your child after 1 year?” was also asked. One mother reported feeling a “little jealous that the process became quicker.” She would adopt internationally again if she could. One mother reported feeling “jaded” and felt that finding ways to be ethical is really hard with international adoption. She felt that “it’s not the best way to help a country by taking their children out of their country.” Hannah also felt that adopting older children was acceptable, but that infants should remain in their country. Irene said there are “too many people that can mess things up with the money involved.” She remained skeptical about the process because she felt that “countries are not regulated.” It is important to note, though, that her reaction was the result of her personal experience and that some countries are much more regulated than others. She hoped that regulations are getting better and believed that the process should be as legal as possible. Jess had an overall positive experience, but felt slightly jaded because of other people’s experiences with international adoption. She was aware of bribes, babies being taken away, mothers changing their minds, people taking babies back, and parents not being informed that they were sick babies.
**Uniqueness and others’ understanding.** Participants were asked to “Discuss how well [you] felt others were able to relate to the uniqueness of your situation and understand what you were going through.” As a supporting question, participants were asked, “Did you feel others tried to minimize the fact that adoption was different from their experience?” They also were asked, “Describe any instances when you felt friends and family would not understand your feelings if you shared them.” Some of the reactions that emerged from these questions included skepticism, feeling misunderstood, anticipating rejection, feeling jealousy, experiencing a lack of support, and minimizing differences.

Two of the mothers discussed skepticism. At first, Brenda’s husband was not in support of adoption. He wanted her to have tests and go through fertility treatments. He felt that all of the paperwork was “ridiculous.” His parents were “old school” and would ask “Don’t you want your own children?” Carol’s family was also skeptical about the adoption. Her mother was not initially supportive.

Elise discussed anticipating rejection from others. Her father had been stationed at Guadalcanal and she was concerned about “how he was going to feel about an Asian child who could pass for Japanese coming into the family.” When she told him she was going to adopt internationally, he was happy for her and said, “The war is over.”

Five of the mothers discussed feeling mis-understood. Abby stated, “No one knows what you are going through until they go through it.” Carol said, “I don’t think anybody could understand what I’m going through.” Denise felt “no one understood, and it was annoying for them to talk about it because they had no clue. Everyone wanted to
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put their two cents in.” She was afraid to tell people she did not know if she loved her child. She felt that they would not understand. Fran felt that “no one understands unless they’ve been there.” She did not want to share that she was afraid she would not love her child because she did not want to seem ungrateful. Hannah said that others’ understanding “depended on how close they were to the process.” She said she has not met a biological mother who fully understood what she was talking about when she talked about “feeling kind of haunted” or “always having [the biological mother] with [her].” She felt that “even some adoptive parents did not understand.”

Hannah admitted to having felt jealousy toward birth mothers. She said, “A lot of people could take time off work, but I couldn’t.” She felt as though she did not get the same rights as others who had birth children.

Elise felt that her core friends understood what she was going through and she did not care what anyone else thought. Irene also felt that close friends and family were very supportive. Jess found support and understanding from her next-door neighbor who also had adopted children internationally. She felt this shared experience was extremely helpful.

Irene’s friends did not understand or support her through this time. She said, “Some friends were not supportive because they felt [she] wouldn’t be the same friend with a child.” She felt that they did not understand and therefore “said goodbye to them.”

Three of the mothers discussed others minimizing differences between having a birth child and adopting a child internationally. Hannah said, “Others minimized that adoption was different from their experience to make me feel like things were the same,”
but she did not want them to act that way. Hannah’s family would try to make her feel better when she said, “I don’t feel like he’s totally my own.” She said her family did not understand, and by trying to dismiss her feelings of being different, she felt that they did not totally understand what she was going through. Denise’s friend told her that her child had some of the same behaviors as Denise’s child. Denise, however, felt that because her experience was different from her friend’s experience, that her adopted child could have had different reasons for doing the same as her friend’s child did (e.g. sleep or food difficulties). Denise stated during the interview, “I don’t need you to make it better by saying that.” She did not want others to minimize the differences between having a birth child and adopting internationally. Fran said that “people were not sensitive to the fact that her experiences were different,” referring to her internationally adopted child.

**Need for therapy and support.** Participants were asked, “In what way would seeing a therapist regularly have supported you during that first year?” Answers ranged greatly. Some felt a need for therapy post adoption exists. Others felt that therapy was not needed. Most mothers felt as though they had enough support, and therefore, there was no need for formal therapy. Also, mothers seemed to feel prepared by the agency, and they knew what to expect.

Although six of the 10 mothers reported that they felt a need for therapy exists after adopting a child internationally. After examining the data, it was determined that it may be more appropriate to say that six of the 10 mothers felt that therapy could be helpful during the postadoption stage. Brenda said that therapy would have helped with adoption and family issues. She had been in therapy prior to the adoption and was not sure why she
had not gone back to therapy. She thought perhaps it was a result of her “stubbornness.” Carol felt that therapy would have helped during the time after the adoption of her daughter, but she also felt that therapy would help for any parent. She received the best advice from her spinning teacher about behavioral approaches to difficult behaviors surrounding bedtime. Hannah felt that seeing a therapist regularly would have helped to validate that “things were normal as much as normal happens with adoption.” She felt that she could have used help with “being intentional about attachment.” She met with Dr. Jane Aronson, The Orphan Doctor, who she felt that she did an excellent job providing her and her husband with the support they needed after the adoption. The social worker from the adoption agency also did an excellent job in preparing them and offering them support. Hannah also said that she would have felt the same way about needing support had she given birth. Grace felt that therapy was not needed in the beginning but could have been useful when her child reached high school and explained and other children treated her child differently. Denise thought therapy would be useful to “share feelings about things [she] didn’t want to tell anyone else.” Fran did not think she needed it at the time, but looking back felt as though “it would have been helpful as long as it was [with] someone who had experience with adoptive mothers.” Perhaps one solid reason for endorsing therapy postadoption is that there is an adjustment period when adopting that does not exist in the same way when a birth child is born. There is an adjustment for the parents and for the child as well.

Six of the 10 mothers felt they had sufficient support. Some found support with family and friends, while others found support through groups, such as Families of
Adopted Children from China. Others found that local families who had adopted internationally were a support for them. As mentioned before, Hannah found that Dr. Jane Aronson was “one of the most formational people” and felt lucky to have had her as a support. Mothers found support from other mothers going through international adoption or from the group that went through the adoption with them.

Elise did have therapy after the adoption. She stated, “Therapy is a good thing as long as it’s the right therapist offering the right treatment.” She felt that therapy was integral at that time in helping to keep the family together.

Two of the 10 mothers said that there was no need for therapy after international adoption. Irene stated, “I don’t think it would have made any difference because I don’t feel like I was stressed.” She felt that therapy just would have added more stress. Her only struggle was being tired, and she felt having to attend therapy would make her only more tired. She also felt that therapy would have cost too much money, which would add to stress. Irene stated, “Nothing at that time would have changed as a result of therapy.” Jess would not have had time for therapy and feels that therapy is not needed after international adoption. She did say that if she had adopted a child that was behaviorally challenging, there may have been a need.

Perhaps these mothers did not feel the need for postadoption therapy because they went into the adoption process feeling prepared by the agencies. Eight of the 10 mothers discussed being prepared well by the adoption agency. Abby felt well prepared by Holt International. Brenda said their views did not change at all because they were well prepared. Carol felt that the process went well and was “exactly what [the agency] said.”
She felt that the adoption was not “anything but a well-organized, respectful, joyous experience.” Elise was informed about the home-study, visits, and paperwork, and said “they [the agency] were really really good.” Hannah was prepared by the social worker, felt prepared for being a transracially adoptive family, and would highly recommend their agency to others. Grace was well prepared by the agency and had a good experience as a result. Fran was prepared to experience challenges. Denise was prepared by the agency and also did much research, which made her prepare for the worst, but that was not her experience.

Two mothers chose to use spirituality to help them cope after the adoption. Elise stated, “God gave us a child that was going to fit well in our home.” When others told Irene that she was a blessing for helping her child, she stated, “they [the child] were a blessing themselves by helping us.”
Chapter Six: Discussion

Scope of the Study

The aim of this study was to examine the emotional experience of mothers after adopting a child internationally. It specifically examined the emotional experience of 10 mothers residing in New Jersey. This study found four of the mothers experienced anxiety or depression prior to the adoption, but only one mother experienced anxiety or depression after the adoption. All mothers reported having been insulted in some way by rude comments made by others. Other issues that arose for at least one mother were as follows: feeling unprepared for the adoption, experiencing attachment and bonding issues, experiencing emotional highs and lows, feeling qualitatively different because of adopting, dealing with multicultural issues, having difficulty adjusting, experiencing letdown, feeling misunderstood, and needing postadoption support. Some of these issues also may arise with birth mothers as well as domestic adoptive mothers, and that they may not be specific to mothers who adopt children internationally.

Limitations

Despite the attempt to make this qualitative study as reliable and valid as possible, this study still had many limitations. Participants were selected from a convenient location in the tri-state area. All participants were from central and southern New Jersey. Mothers who adopt internationally in this area may not accurately represent mothers who adopt internationally in other parts of the country or in urban areas. Information may not be generalized to the broader population of mothers who adopt children internationally in all of New Jersey, in the tri-state area, or the in United States. Other qualitative studies
should be completed in other parts of the country in order to compare findings.

Only mothers who were married to men were used in this study. Gay and lesbian couples and single mothers were excluded. Only the mothers were interviewed. The experience of the mothers interviewed may not reflect accurately the experience of all mothers, such as single mothers, or mothers in a same-sex relationship, or of fathers. Also, only mothers who were unable to have a birth child were used for this study. Therefore, information may not be generalized to all mothers who adopt internationally. Other studies should be completed to include the following groups: mothers who choose to adopt internationally as their first choice and not because they are unable to have a birth child, mothers in same-sex relationships, fathers who adopt internationally, and single parents.

The sample was not limited to mothers who had adopted within the previous year, thus errors in memory likely played a role in the results, especially with participants who had adopted years earlier. Although none of the participants stated anything regarding not being able to recall details, some events likely were not remembered accurately in detail. As a result, future research must focus on limiting the time frame that is used for the sample.

One female and two male clinical psychology students were used to code the interviews as part of the validation team. All of the participants in the study were women. The fact that they were all women could have had an effect on the results, as male views may differ from female views. Because the male members of the coding team could not understand fully what being unable to have a birth child feels like, their
opinions and contributions to the coding may have been altered. If it had been an option, the principal researcher would have used an all-female coding team.

The principal researcher had biases toward international versus domestic adoption because of her involvement in the Division of Youth and Family Services system and her experience with foster care and adoption in the United States. This experience likely affected her personal views of international adoption, and therefore, her interpretation of the data. For example, the principal researcher knows that the number of children available for adoption in the United States is vast and, therefore, believes that people interested in adopting children should look to their own country first. The researcher also feels as though domestic adoption is an excellent option for individuals who are unable to have a birth child. Because the principal researcher’s experience with international adoption is more limited than her experience with domestic adoption, she attempted to remain as open minded as possible when working with participants and coding data. The principal researcher also has an authoritative parenting style. This parenting style also may have affected the types of behavior what constitute a behavior problem. Also, the principal researcher’s knowledge of and experience working with the 0 to 3-year-old population likely affected her views on the development and adjustment of the children whose mothers participated in this study.

There was no comparison group for this study. Originally, the use of a control group of birth mothers was explored. However, comparing birth parents to adoptive parents is not equivalent, and, therefore a control group of birth mothers was not used in this study. Birth parents are dealing with a different set of issues from those of adoptive
parents. Birth parents experience typical stress related to the pregnancy, and adoptive parents are in a more positive stage prior to the adoption. They feel accomplished because they are finally about to become parents (Levy-Shiff et al., 1990). In this study, however, four of the mothers had anxiety or depression prior to the adoption.

This study focused on mothers who adopt children internationally as opposed to including birth mothers because mothers who adopt internationally are faced with the pressure of making a good impression upon the adoption agency, whereas birth mothers are not faced with this dilemma because they are not being chosen. The tedious home-study process might sway adoptive parents into attempting to appear as if they have no problems so that the adoption process is not jeopardized in any way (Levy-Shiff et al., 1990).

Conclusion

The principal researcher thought prior to collecting data for this study that mothers who are unable to have birth children and decide to adopt internationally would struggle with anxiety and depression. Experiencing numerous stressful situations, possible losses, and medical procedures is surely difficult. Prior to adopting, parents are anticipating becoming a parent. They have been through a tedious adoption process and may have experienced several unsuccessful attempts at becoming pregnant. There is a realization of loss for these mothers who might have found out they are unable to birth a child or have lost a child. Research suggests that this realization may result in prolonged grief, depression, or anxiety (Boelen & Prigerson, 2007). The principal researcher
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hypothesized that because the process of international adoption can be stressful, these feelings of anxiety and depression would resurface post adoption.

Some would say adoptive parents experience a sense of “impending fulfillment” leading up to the adoption. Although the adoption process can be stressful, it also can be very exciting. The excitement an adoptive parent who finally fulfills the dream of becoming a parent might overshadow the stressful aspects of the adoption process. These parents may see the positive aspects of adoption and minimize the negative aspects. This outlook could change when the stress of the initial adjustment occurs.

In this study, four of the 10 mothers reported having struggled with anxiety or depression prior to the adoption. The principal researcher thought prior to beginning this study that this number would have been higher. Also, only one mother reported having struggled with anxiety or depression post adoption. The principal researcher thought that the stress and adjustment of adopting a child internationally might have contributed to a higher number of mothers re-experiencing some anxiety or depression. For example, if four mothers experienced anxiety or depression prior to the adoption, the principal researcher thought that perhaps those four mothers also would experience post adoption depression or anxiety. In the case of this study, only one mother reported having struggled with anxiety or depression. After the completion of the data collection, however, one additional mother reported having struggled with depression for 4 years. This information was not reported during her interview. She did, however, disclose on the demographic interview that she had struggled with anxiety or depression prior to the adoption. Knowing this may offer limited support to the examiner’s initial hypothesis
about adoptive mothers wanting to present as the perfect loving parent. During her interview, she denied any depression, but after the interview, she reported that she had been suffering from depression for 4 years and at the time of the interview.

Another hypothesis of the principal researcher was that mothers would hide or deny some of the depression and anxiety in order to present as the perfect parent during the home-study process in order to sway the social worker into thinking that they were not suffering. Knowing that countries have very stringent restrictions for adopting children internationally, this was something these mothers may have thought had to be done in order to get through the lengthy adoption process. The principal researcher thought that mothers might minimize any mental-health problems they had in order to present more favorably. This concept seems not to have been an issue for the majority of these mothers. Although one mother did experience postadoption depression or anxiety, she did not mention trying to minimize her struggles during the home-study process. Rather, she reported that rather because of adjustment difficulties post adoption, she experienced anxiety and depression during that period. Even though only one mother reported having experienced depression or anxiety post adoption, this number is 10% of the sample studied. If one takes into consideration the other mother who did not disclose during the interview but disclosed after the data collection was completed, this percentage rises to 20%. This phenomenon should be studied with a larger sample size in order to better understand the percentage of the population that struggles with depression and anxiety both before the adoption and struggle post adoption.
The principal researcher also hypothesized that mothers waiting to adopt might feel such disparity to become a parent that they might not be receptive to the training given during the home-study process. If the mothers were desperate to adopt, they may not have been receptive to the information given about possible postadoption struggles. The information that the principal researcher found was quite to the contrary. Eight of the 10 mothers reported feeling well prepared by their adoption agency. They felt that they knew what to expect going into the adoption and, therefore, were not surprised about difficulties with adjustment.

The principal researcher thought that mothers who had anxiety or depression prior to adoption would be more likely to re-experience those feelings if they were faced with one or more of the following in regard to their child: an overwhelming adjustment with unreported health problems, stunted physical growth, developmental delays, attachment issues, and the stress of parenting the child. Of the mothers interviewed, three mothers adopted children with medical issues, three with behavioral difficulties, one with developmental delays, and three with reported language delays. Originally, the principal researcher thought that these difficulties would have an effect on the emotional functioning of the mother. Although these difficulties were reported, none of the mothers seemed to be bothered by these issues, and therefore, they did not seem overwhelmed. Also, the incidence of developmental, behavioral, speech, and language difficulties was not as high as the principal researcher expected. Perhaps it was not as high because of the countries used in this study. The outcome would be interesting to see if similar numbers were found had other countries, such as Russia and Romania, been included.
The principal researcher thought that if mothers’ anxiety and depression resurfaced post adoption, therapy would be needed. Six of the 10 mothers reported that there was a need for therapy. The principal researcher interpreted that the mothers felt as though therapy would have been helpful post adoption. Although only one mother in this study actually sought therapy post adoption, others felt that the need was there. Perhaps these mothers did not seek post adoption therapy because they went into the adoption process feeling prepared by the agencies. Also, six of the 10 mothers reported that they felt they had sufficient support from family or friends after the adoption. Support seemed to come from family, friends, and others who had adopted internationally. An important aspect about receiving support from others who had adopted internationally was the feeling that these people understood their situation. This factor may be missing if a therapist working with a mother has not been through this process.

Two other strong findings that were not anticipated prior to collection of data were the high number of mothers who felt insulted by others and felt letdown after international adoption. All mothers felt insulted at one point or another by others. Eight of 10 mothers felt some form of letdown after the adoption, a feeling that may also occur with birth mothers and domestic adoptive mothers as well. Overall, with the exception of two mothers, this group of mothers did not seem to have residual or resurfacing anxiety or depression post adoption as initially suspected. In general, the principal researcher gained the impression that most of the mothers had a positive experience and were happy with their decision to adopt internationally. They were well prepared and did not seem to have any lingering feelings of loss that remained unresolved or denied.
Support for mothers who adopt internationally seemed to serve as a buffer against depression and anxiety. Therefore consider the role of support as it relates to adoption is important. Many supports exist for individuals who adopt internationally. For example, some agencies offer postadoption counseling. Also, many agencies provide individuals who are adopting with information on support groups for adoptive parents. Individuals also may find support from services such as adoption blogs, where they can ask questions about adoption and receive answers from other individuals who may have had a similar experience. Individuals who adopt seem to look to others who have adopted internationally for support. Sometimes agencies form groups of individuals who adopt at the same time. These groups travel to the country together. Some mothers mentioned other mothers in their “group” as playing a major support role in their postadoption experience. These groups or support groups of other mothers who have adopted internationally are important because mothers were expressing the need to feel understood. Some felt as though therapy would have been helpful if it was provided by someone who had experience working with mothers who adopted internationally. They also expressed that they would feel more comfortable working therapeutically with someone who had similar experiences. Support also may come from family members or friends, which raises the idea of adoption agencies providing intervention for friends and family. Perhaps adoption agencies should place importance on giving parents information about support as early in the process of international adoption as possible.

Knowing now that support was important to the mothers in this study who adopted internationally, future research should consider whether the participant knows someone
who has adopted internationally. Having the support of someone who has adopted internationally could be crucial to the participant’s experience with international adoption. Having a mentor to go to for education and support may be an important item that was missed during this study. Interestingly, two of the mothers in this study discussed having the same family as a support and mentor during their adoption experiences. Also, one mother discussed being a mentor for others, and this particular mother had no mentor when she was going through the process of international adoption.

Another aspect to consider is the role of resiliency and adoption. Resiliency in individuals is discussed within the field of positive psychology. Positive Psychology is a study that focuses on strengths that enable individuals and communities to thrive (Positive Psychology, 2010). As discussed earlier, healthy attitudes and resiliency are beneficial for parents in stressful situations. Negative attitudes and decreased resilience may be related to postadoption depression, and therefore, adoption agencies or support members should aim to promote positive attitudes and cognitions, as well as to increase resilience in parents who adopt internationally. Adoptive mothers must continue to demonstrate healthy daily functioning post adoption because postadoption experiences and emotional resources of adoptive parents could have an impact on the developmental outcomes of the children (Gunnar et al., 2000).

Depression and anxiety were assessed in this study by self-report. This is a problem because it assesses only subjective depression and anxiety. The study also did not take into consideration the age of the mother at adoption. Younger mothers are expected to be more anxious. Whether or not the mother knew someone else who had adopted before
they adopted also was not taken into consideration. This factor could certainly affect the level of anxiety or depression experienced. Also, some answers would be expected to be different depending on the popularity of international adoption at the time these mothers adopted their children.

**Future Directions**

The goal of this study was to gather information from the demographic and inperson interviews that might be useful for professionals who work with mothers who adopt children internationally. Also, the principal researcher hopes that psychologists working with this population will use the information to best match the needs of the mothers to existing treatment techniques. For example, therapists or psychologists may use techniques to help reduce stress and work on emotional regulation and expression if they do identify a mother experiencing residual anxiety or depression.

Future research might focus on one particular country in order to better understand problems specific to adopting internationally from that specific country. Also, future research should explore a sample of mothers who all had experienced anxiety or depression prior to the adoption. Anxiety and depression may be measured objectively to ensure consistency. A population of mothers who adopted internationally within 1 year of their interview should be explored. Doing this would help make easier to objective measure of current anxiety and depression rather than asking participants to report on the feelings they remember during the first year after adoption.

An area of focus in the future may be the exploration of any possible discrepancy among idealized images of the child, how adoption made them feel, and having a child
who matched their expectations based on information they were given initially about the process and the actual child they received.

Perhaps the most beneficial study would include a control group. Adding a control group would highlight typical problems that any parent may face. The control group may consist of birth parents or domestic adoptive parents. By doing so, mothers who adopt children internationally could be compared fairly to another group of mothers who may have experienced the same levels of anxiety, depression, adjustment, behavioral difficulties, and problems with language development. An important consideration is not to assume that mothers who adopt internationally experience anxiety and depression any moreso than any parent of any child.
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Appendix A: Inclusion and Exclusion Criteria

Researcher: “The following is a list of inclusion and exclusion criteria for this study. If you meet all criteria for the study, you will be given an informed consent form and considered a potential participant for this study. After reading the informed consent form at your leisure, please decide if you would like to participate in this study. If you would like to participate in this study, please contact me to set up a day and time for a two-hour interview.”

Inclusion Criteria:

1. Are you a mother who has adopted a child from a different country of origin?
2. Does your child have visible ethnic or racial differences (e.g. Caucasian mother, Asian child)?
3. Do you have a male partner?
4. Did/Does your child reside in your home with you (e.g. If the child is older, did they live in your home while you were raising them)?
5. Are you the legal adoptive mother of the child (e.g. The participant can not be the child’s grandparent).
6. Did you attempt to have a birth child but were unable to?

Exclusion Criteria:

1. Is your child of the same country of origin?
2. Do you have an active/open DYFS case?
3. Does your child reside outside of your home?
4. Are you a grandparent, father, or live in nanny to the child adopted internationally?
5. Were you able to have a birth child?
Appendix B: Demographic/Background Interview

Length of marriage/partnership:____________

Country of your child’s origin:________________________

Date your child entered the United States:____________

Age of your child at adoption:____________

Current age of your child:____________

Do you have a history of loss?____________

Did you ever lose a child to death or miscarriage?____________

Were you unable to have a birth child?____________

Did you seek medical help in trying to have a birth child?____________

What was the length of time between the initial decision to become a parent and the time your child entered the United States?____________

Have you ever suffered from anxiety or depression for two or more weeks during your life, that made it hard to carry out your normal routine or activities?____________

Do you believe you struggled with depression or anxiety within the first year after your child came to live with you, beyond feeling normal stress of parenthood?____________
Appendix C: Semi-Structured Interview for Mothers Who Have Adopted Children Internationally

**Interviewer’s Instructions to Participant:** “I would first like to thank you for participating in this interview about your experience with international adoption. I will be asking you some open-ended questions over the next hour. All of these questions will be related to your decision to become a parent to an internationally adopted child. The information you share with me during this interview will help me to better understand what other women who adopt children internationally may be experiencing. Please answer my questions as thoroughly as possible. If you are unsure about any of my questions, please feel free to ask any questions. Your participation in this interview will help me to better understand the experiences of other women who have adopted children internationally. Give open and honest answers, as this will provide a better understanding of your experiences. It may also give a better idea of what services or areas you feel as though you may have required additional support through the adoption process.

First you will be asked to complete general demographic information. This will allow for you to discuss your personal experience. Then I will be asking more specific, clarifying questions. I will be doing this to make sure that I understand what you are saying correctly.

You may choose not to answer any questions, for any reason. If you do choose not to answer any question, I would like to understand why you do not wish to answer that particular question. After the semi-structured interview is completed, you may share
any other information you feel is important or that I have not already asked about if you feel it will add to the topic we have been discussing.

I will be recording the interview via audio recorder so that later I can write out the interview. This will help me to better understand your thoughts, feelings, and opinions about your experience of international adoption. Do you have any questions? If not, let’s begin.”

**Open-Ended Questions:**

1. Describe the unique challenges you faced during the first year after adoption that were related to the fact that your child was adopted from a country of different origin.

2. How would you describe the process of attaching emotionally to your child that first year?

3. Describe the emotional highs and lows as well as other emotionally charged events that occurred during that first year.

4. In what ways do you feel your first year as a mother was different because you adopted a child from a country of different origin who had visible ethnic or racial differences from yours?

(supporting questions)
Do you feel you are different as a mother or have a different sense of family than you would have, had you been able to birth a child?
Money: Were you ever asked how much you paid for your child or what the adoption cost?
Language: Did anyone ever ask if he/she was your natural/real/adopted child? Did anyone ever ask if your children were “real sisters?” Did anyone ask “what do you know about your daughter’s/son’s parents?”
Multicultural: Has any family member or friend commented on how similar or different your child is from you or the rest of your family. Were the differences due to the fact that he/she was adopted? Even though your child’s appearance reflects the fact of his/her adoption, did anyone ask if you were going to tell him/her if they were adopted?
Paperwork: Were there times during the first year that you needed to fill out paperwork that spotlighted the adoption or called for information you did not have/know?
Attachment: How did you feel you attached to your child? (Instantly, differently, long time to attach)?

5. What multicultural issues did you encounter related to your child?

6. Discuss experiences you had with adjustment difficulties including expectations of what motherhood would be like, how the child accepted you, and letdown after bringing your child home.

   (supporting question)
   How have your views of international adoption changed from before getting your child to the experience of having your child after one year?

7. Discuss how well you felt others were able to relate to the uniqueness of your situation and understand what you were going through.

   (supporting question)
   Did you feel others tried to minimize the fact that adoption was different from their experience?

8. Describe any instances when you felt friends and family would not understand your feelings if you shared them.

9. Discuss the emotions that best described your typical moods during the first couple of months after the adoption.

10. In what way would seeing a therapist regularly have supported you during that first year?
Appendix D: Resources for Parents

The Postpartum Stress Center, LLC
http://www.postpartumstress.com/pages/offices.html

The Postpartum Stress Center, LLC
1062 Lancaster Avenue, Rosemont Plaza, Suite 2
Rosemont, PA 19010
Phone: 610.525.7527
Fax: 610.525.3997

The Postpartum Stress and Family Wellness Center
Barry Brown Health Education Center
106 Carnie Blvd., Suite 104
Voorhees, NJ 08043
Phone: 856-745-8847

The Postpartum Stress and Family Wellness Center
405 Hurffville-Crosskeys Road, Suite 211
Sewell, NJ 08080
Phone: 856-270-2415
Fax: 856-270-2403

International Pediatric Health Services, PLLC
http://www.orphandoctor.com/

Dr. Jane Aronson,
FAAP 338 East 30th Street, #1R
New York, NY 10016
Phone: 212.207.6666
Fax: 212.207.6665

New Jersey Early Intervention System
1-888-653-4463
Appendix E: Informed Consent

TITLE OF STUDY

Emotional Experience of Mothers After International Adoption: A Qualitative Study

TITLE OF STUDY IN LAY TERMS

What do Mothers Experience after Adopting Children from Other Countries?

PURPOSE

The purpose of this research is to find out what mothers who adopt children from other countries experience during the first year after adoption with specific focus on their emotional functioning. Questions will focus on unique challenges of international adoption; emotional attachment of mother to child; emotional experience, including highs and lows in mood; feeling different because of adopting a child with visible racial or ethnic differences; multicultural experiences; expectations of motherhood being met or not met; isolation; feeling misunderstood or not understood; and perceived need for psychological services. Although this is a qualitative study and the study design does not require formal research hypotheses, the investigator will explore the possibility that mothers who adopt children from different countries may experience difficulties related specifically to the fact that their child has visible racial or ethnic differences from their mothers, and that mothers may face challenges that are unique to raising children adopted from different countries of origin.

You are being asked to be in this research study because you were unable to have a birth child and adopted a child from a different country of origin. If you did not adopt a child from a different country because you were unable to have a birth child, you cannot be in this study.

INVESTIGATOR(S)

Principal Investigator: Bruce S. Zahn, Ed.D., ABPP
Philadelphia College of Osteopathic Medicine
Department: Psychology

Co-Investigator: Lindsay Foster
Institution: Philadelphia College of Osteopathic Medicine
Department: Psychology
The interview you are being asked to volunteer for is part of a research project.

If you have questions about this research, you can call Dr. Zahn at (215) 871-6498.

If you have any questions or problems during the study, you can ask Dr. Zahn, who will be available during the entire study. If you want to know more about Dr. Zahn’s background, or the rights of research subjects, you can call the PCOM Research Compliance Specialist at (215) 871-6782.

**DESCRIPTION OF THE PROCEDURES**

If you decide to be in this study, you will be asked to complete a demographic/background interview, then participate in an audio-recorded interview consisting of ten open ended questions. Upon completion of the interview, the investigator will take the audio recording with her. The investigator will privately listen to the audio-recorded sessions and transcribe the audio recording into a typed transcript of the session. Upon completion of transcription and coding, the investigator will destroy the audio-recording.

The study will take about 120 minutes for each session. There will be 1 session(s) over the course of 1 day, for a total of 120 minutes of your time.

**POTENTIAL BENEFITS**

You may benefit directly from participating in this study because it offers an opportunity for you to engage in an interview where you will get a chance to talk about your feelings. Participating in this study will offer you a chance to voice your opinion on the process of adopting a child from a different country. You may also benefit from the reference list, which will be given at the completion of the interview, including references for in home Early Intervention services for zero to three-year-olds and outpatient counseling.

You may not benefit from being in this study. Other people in the future may benefit from what the researchers learn from the study.

**RISKS AND DISCOMFORTS**
It is possible that while answering questions, you may re-experience difficult times you may have had. Some of the questions are geared toward unpleasant events that may have happened and/or that may have been difficult for you. You may become upset about questions you are answering. At the completion of the interview, you will be given a hand out which includes information on support services such as in home Early Intervention services for zero to three-year-olds and outpatient counseling. If you feel as though you were upset by the interview and need additional support, you will be able to contact the references on the sheet provided and obtain services to address your concerns.

**ALTERNATIVES**

The other choice is to not be in this study.

**PAYMENT**

You will not be paid for being in this study.

**CONFIDENTIALITY**

All information and records relating to your participation will be kept in a locked file. Only the researchers, members of the Institutional Review Board, and the U.S. Food and Drug Administration will be able to look at these records. If the results of this study are published, no names or other identifying information will be used.

**REASONS YOU MAY BE TAKEN OUT OF THE STUDY WITHOUT YOUR CONSENT**

If health conditions occur that would make staying in the study possibly dangerous to you, or if other conditions occur that would damage you or your health, the researchers may take you out of this study.

In addition, the entire study may be stopped if dangerous risks or side effects occur in other people.

**NEW FINDINGS**

If any new information develops that may affect your willingness to stay in this study, you will be told about it.
EMOTIONAL EXPERIENCE

INJURY

If you are injured as a result of this research study, you will be provided with immediate necessary care.

However, you will not be reimbursed for care or receive other payment. PCOM will not be responsible for any of your bills, including any routine care under this program or reimbursement for any side effects that may occur as a result of this program.

If you believe that you have suffered injury or illness in the course of this research, you should notify the PCOM Research Compliance Specialist at (215) 871-6782. A review by a committee will be arranged to determine if the injury or illness is a result of your being in this research. You should also contact the PCOM Research Compliance Specialist if you believe that you have not been told enough about the risks, benefits, or other options, or that you are being pressured to stay in this study against your wishes.

VOLUNTARY PARTICIPATION

You may refuse to be in this study. You voluntarily consent to be in this study with the understanding of the known possible effects or hazards that might occur during this study. Not all the possible effects of the study are known.

You may leave this study at any time.

If you drop out of this study, there will be no penalty or loss of benefits to which you are entitled.
I have had adequate time to read this form and I understand its contents. **I have been given a copy for my personal records.**

I agree to be in this research study.

Signature of Subject: ____________________________________________

Date: _____/____/_______  Time:____________AM/PM

Signature of Investigator or Designee____________________________________

(circle one)

Date: ____/____/_________   Time:______________AM/PM