Children in Adoptive Families: Overview and Update

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ABSTRACT

Objective: To summarize the past 10 years of published research concerning the 2% of American children younger than 18 years old who are adoptees. Method: Review recent literature on developmental influences, placement outcome, psychopathology, and treatment. Results: Adoption carries developmental opportunities and risks. Many adoptees have remarkably good outcomes, but some subgroups have difficulties. Traditional infant, international, and transracial adoptions may complicate adoptees’ identity formation. Those placed after infancy may have developmental delays, attachment disturbances, and posttraumatic stress disorder. Useful interventions include preventive counseling to foster attachment, postadoption supports, focused groups for parents and adoptees, and psychotherapy. Conclusions: Variables specific to adoption affect an adopted child’s developmental trajectory. Externalizing, internalizing, attachment, and posttraumatic stress disorder symptoms may arise. Child and adolescent psychiatrists can assist both adoptive parents and children.


Adoption has changed in the United States. In the early 1900s, it became closely associated with child welfare. Often, too many children were available for adoption; adoptive parents could be selective. Adoptive families were expected to mirror biological kinship. Children were placed according to race, religion, and predicted physical and intellectual characteristics. Children’s lives were made to appear as if they had begun the day that they joined their adoptive families. Records were sealed, cutting the adopted child off from his or her past. Older, nonwhite, and disabled children and sibling groups were often considered unadoptable.

Beginning in the 1970s and continuing until today, many more middle-class parents were seeking to adopt than there were “matched” children available, especially infants. Private agency and attorney-arranged adoptions became more prevalent and often expensive. The nature of international adoptions also changed. After the World War II, many families adopted orphans from war-torn European countries. Today, most adoptive parents are childless couples (Bimmel et al., 2003). With the number of adoptable children diminishing, the foster care system became the source of more adoptions. Because some children were not legally free and others with special needs required unavailable subsidies (Rosenfeld et al., 1997), more children entered the foster care system than moved into permanent homes. Assisted in part by federal legislation, permanency planning and child-centered policies with a goal of timely adoption of foster children gradually evolved (Howe, 1999).

About 120,000 young people are adopted annually in the United States. Adoptees younger than age 18 years total about 1.5 million, just over 2% of American children. Of these, two thirds were placed with biologically...
unrelated parents. The remainder of these children were adopted by relatives or stepparents (Evan B. Donaldson Adoption Institute, 2003a; Fields, 2001). In most states, adoption of a healthy infant may be arranged by attorneys with no agency involvement. In 1992, private agencies completed 47% of adoptions, public agencies 16%, and independent arrangers 37% (National Adoption Information Clearinghouse, 2004; Stolley, 1993). In the past decade, international adoptions have doubled to 20,000 annually. Adoptees do not have uniform life experiences. Some adopted children have experiences that are virtually identical to those of children raised by their biological parents; others have suffered severe deprivation and multiple disruptions of their caretaking environment before adoption.

Other important aspects of adoption have also changed. Nontraditional arrangements such as transracial, single-parent, kinship, and gay adoptions have become more frequent; open communication with birth families is now more likely (Grotevant and McRoy, 1997). Reunions between late-adolescent or adult adoptees and their birth parents are common (Moran, 1994). Because fewer children are available from the racial and ethnic backgrounds that some adopters prefer, birth parents have become empowered, particularly in private adoptions in which a birth parent may now choose among several prospective adoptive couples (DellaVecchio, 2000).

For children in the child welfare system, federal legislation allows earlier termination of parental rights. The Adoption Assistance and Child Welfare Act of 1980 provided federal funds to cover state-subsidized adoption payments. The Adoption and Safe Families Act of 1999 and the Promoting Safe and Stable Families Amendments of 2001 increased the number of nontraditional adoptions as well as those in later childhood. The InterEthnic Placement Act (Section 1808 of the Small Business Job Protection, Personal Responsibility and Work Opportunity Reconciliation Act of 1996) now prohibits considering the race, color, or national origin of potential adoptive or foster parents when placing children. Failing to comply was made a violation of the Civil Rights Act of 1964. Despite legal efforts to make adoption more “fair,” legislatively driven placement choices may not best serve the interests of minority and older children (Howe, 1999).

Until recently, few well-designed research studies studied various aspects of adoption; many reports were anecdotal. Fortunately, in the past decade, some well-designed studies of traditional and nontraditional adoption have been published.

**Placement Outcome**

The cognitive and emotional adjustment of many adoptees is favorable, but that outcome may depend on both the child’s preplacement experiences and the age at which he or she is placed. “Adoption may even be considered a protective factor” (Bimmel et al., 2003) because when adopted children are compared with illegitimate children who were institutionalized, remained with their mothers, or who were later returned to their mothers, adopted children fared far better, especially those in two-parent families (Miller et al., 2000b). Follow-up studies of children placed as infants show almost uniformly positive outcomes. Fergusson et al. (1995) reported a 16-year longitudinal study of a cohort of 1,265 New Zealand children born in 1977, 3.5% of whom were adopted at birth. The remainder of the sample remained with their birth families, 88.8% with both parents, and 7.7% with a single parent. Adolescents living with one biological parent were most likely to exhibit externalizing behaviors, but these behaviors were also more prevalent in the adolescent adoptees than among adolescents living in two-parent birth families. The groups did not differ in the prevalence of internalizing problems. Because most adoptees had grown up in advantaged homes and as a group did not manifest a higher prevalence of internalizing problems, the authors speculated that their higher externalizing scores may reflect some genetic risk, whereas the lower level of externalizing problems compared with children from single-parent homes may be a result of the good homes in which they grew up.

Despite the common belief that better outcomes are associated with earlier placement, Moore and Fombonne (1999) studied a clinical population of British adoptees and found that although both boys and girls were at increased risk of disruptive behavior disorders, including conduct disorders and attention-deficit/hyperactivity disorder, it made no difference whether the child was adopted before age 2 years or much later; however, lack of an adopted, nonclinical comparison group makes it difficult to assess how representative these children were of the adopted population at large.
Benson et al. (1994) used a variety of self-report scales to study 715 adoptive families in the United States, including 881 adolescents adopted domestically or internationally before 15 months of age, 78 nonadopted siblings, and 1,262 parents. On the whole, these adoptees felt well-adjusted and had good self-esteem. The vast majority of parents felt that they were deeply committed to their child; 95% endorsed the statement, “I feel deeply attached to my child,” 87% “My child and I couldn’t be closer,” and 79% “I deeply understand my child.” The authors attributed their positive results to the children’s early adoption, which gave them the opportunity to form solid early attachments.

Children adopted at older ages and boys are more likely to have their placements disrupted (Rushton et al., 1995). Although only about 3% of infant-placed adoptions are disrupted, 7%–21% of children placed from foster care in the United Kingdom have their adoptions disrupted (Rushton et al., 1995). This difference is usually attributed to the later-adopted children having been more traumatized. They are likely to have suffered prenatal malnutrition and drug and alcohol exposure, postnatal trauma (Barth, 1994), losses of biological or foster parents, social instability, and stigmatization (Rosenfeld et al., 1997, 1998).

Older studies identified several variables associated with successful later-child adoption: relatively young age at placement, female, placement with biological siblings, and adoption by one’s own long-term foster parent or by parents with strong parenting skills. Children with cognitive limitations or physical handicaps generally are not at high risk of adoption disruption.

ATTACHMENT AND LOSS

Successful adoption requires that the child attach to a new family, even though the very concept of “adoption” contains an element of its opposite: rejection and relinquishment. For that reason, the idea of loss is important to adoptees and their adoptive and birth parents. Children adopted from overseas may feel rejected not only by birth parents but by the entire country of origin. Adoptive parents have the difficult task of disclosing and discussing the adoption with their child (Nickman, 1996). It is not surprising that children often respond to this information with painful emotions that may persist in one form or another for many years; parents need to support this long-term process. Nickman found that children expressed three types of loss: “overt loss” of relationships and familiar environments, “covert loss” of self-esteem because they had been relinquished or removed, and “status loss” arising from feelings of stigmatization within the family or society at large. Today, almost all adopted children manifest at least one of these types of loss. Pilowsky and Kates (1996) describe how previous abuse and neglect can distort a foster child’s internal working model of what an average caregiver is like and create the expectation that substitute parents will be like the abusive and negligent parents (i.e., bad and unreliable). That inner conviction impedes their ability to quickly make an adequate, nurturing attachment.

Parental attachment to their adopted infant has also been studied (Juffer et al., 1997; Lee and Twait, 1997; Stams et al., 2002). Disappointment about infertility can strain a marriage. Although infertile parents may need time to mourn the biological child they cannot have, they may on short notice receive an adoptive child they are not yet entirely prepared for emotionally. Adopted children may sense parents’ ambivalent feelings (Brinich, 1995) and respond with anger and diminished self-esteem. Dynamics in the extended family also matter: adoptive parents whose own parents support adoption are helped in their new roles. Long delays between the adopted child’s placement and the adoption’s being legally finalized can also jeopardize parental attachment because adoptive parents may feel “on trial” and less legitimately and permanently connected to their child (Cohen et al., 1996). When children are placed later and in open adoptions, they do far better if their biological parents sanction attachment to the adoptive family and when their adoptive parents respect the biological family (Pavao, 1998; Shapiro et al., 2001).

The practical and emotional factors can be complicated. An inherent tension exists in trying to balance an adopted individual’s need for information and continuity with the past, the birth parents’ privacy rights, and the adoptive parents’ right to raise their child as they see fit (Appell and Boyer, 1995; Davis and Chiacone, 1996). Some legal scholars (Holmes, 1995; Woodhouse, 1995) assert that the United States needs to change its laws and policies to make them more child centered. This would make stable, nurturing relationships a higher priority than rights to biological connection. Holmes (1995) also illustrates how complex the
issues are by proposing that present policy be changed to
acknowledge that adopted children have a connection to
their birth families and legitimate rights to knowledge
about them.

"Open adoption," which allows various degrees of
contact between birth parents, adoptive parents, and
the child, is one contemporary approach to resolving
this dilemma (Demick and Wapner, 1998; Grotevant
et al., 1994; Grotevant and McRoy, 1997.) In some lo-
calities, open adoption has become the most prevalent
type. For instance, Lee and Twaite (1997) studied 238
adoptive mothers who had had contact with biological
mothers before birth and during the child’s first two
years. They found that adoptive mothers who had
met the birth mother beforehand tended to feel favor-
ably toward her; that attitude was maintained when
contact continued. Grotevant et al. (1994) reported
similar findings. Grotevant and McRoy (1997) found
that for 4- to 11-year-old children in Minnesota, open-
ness neither helped nor interfered with self-esteem and
socioemotional adjustment.

Special problems arise when adoption follows months
or years of institutional care. A study of children adop-
ted from eastern European orphanages found that those
placed in adoptive homes at 8 months or older showed
predominantly disorganized attachment at age 4
(Chisholm, 1998; Marcovitch et al., 1997). Furthermore,
endocrine changes have been found in maltreated,
institutionalized children (Carlson and Earls, 1997;
Carlson et al., 1995). Rutter (1998) documented cogni-
tive delays and recovery. Later, O’Connor and Rutter,
with English and Romanian Adoptees (ERA) Study
Team and the ERA Study Team (2000) and their study
team compared three groups of Romanian children
reared in “profoundly depriving” institutions and placed
in British homes before age 6 months \((n = 58)\), between 6
and 24 months \((n = 59)\), and between 24 and 42 months
\((n = 48)\) to a group of children born in the United King-
dom and placed in adoptive homes before age 6 months
\((n = 52)\). All of the children were evaluated at ages 4 and
6 years, except the latest-placed Romanian children, who
were evaluated at age 6 years. The frequency of serious
attachment problems increased with institutional dura-
tion. Reactive attachment disorder symptoms did not di-
minish in the 2-year period after placement in adoptive
families. Romanian adoptees placed before they were
6 months old differed little from the British-born sample
in Ainsworth’s Strange Situation Test and demonstrated
little if any attachment disturbance. The authors specu-
lated that some recovery may occur over time in the later-
placed children. Later (Rutter, O’Connor, and ERA
Study Team, 2004), the segment of the Romanian popu-
lation who remained in the institutions between 24 and
42 months was compared at 6 years of age with U.K.-
born children who had not been deprived and had been
placed before age 6 months. The majority of Romanian-
born children showed substantially normal cognitive and
social functioning after family rearing. A substantial mi-
nority had persistent deficits, suggesting that institutional
depprivation could lead to some form of early damage but
that these effects were not inevitable.

RISK AND PSYCHOPATHOLOGY

Numerous studies have found that adopted children
are overrepresented in mental health settings (e.g.,
Brand and Brinich, 1999). Recently, many contributing
factors have been identified.

Ingersoll (1997) emphasized that adopted adoles-
cents are in treatment more frequently because they
have more problems, particularly acting-out behaviors
that “tend to be more distressing to parents compared
with internalizing problems such as depression” (Miller
et al., 2000b). Sharma et al. (1998) noted that adoptees
constitute “between 10% and 15% of [children] in res-
idential care facilities and inpatient psychiatric set-
tings,” far higher than their percentage in the general
population. Previous work had found that, even con-
trolling for the level of behavioral disturbance, adopted
children were more likely than nonadopted children
to receive psychiatric treatment. Following that line
of reasoning, Ingersoll (1997) concluded, as have several
others, that the overrepresentation of adopted children
in clinical populations is the result of complex factors,
including more frequent problems as well as a referral
bias because adoptive parents, who today are often both
more educated and of higher socioeconomic status, are
more likely to seek help for their adopted children
(Miller, 2000a).

For any child, chronic malnutrition, low birth
weight, physical and emotional neglect, and stimulus
depprivation before adoption affect physical growth
and cognitive-emotional development (Cermak, 2001;
Johnson, 2002). Howe (1997) investigated the effects
of early care on later problems. He compared interviews
with the adoptive parents of 122 children placed as
infants who had a history of satisfactory preadoptive care, the parents of 20 children adopted later in childhood after their birth parents’ initially adequate caretaking became substantially worse, and the parents of 69 children adopted later in childhood whose early care was deficient. The later-adopted children who had received deficient early care experienced the most problems. However, one fourth of the early-adopted, satisfactory early-care group showed significant problems during adolescence, and 28% of the later-adopted, adverse early-care group did not show serious adolescent problems. Clearly, statistically, good early care was protective against behavioral and psychiatric problems, even when things worsened in the biological family later on. However, these children were more likely to be compliant and anxious. Interestingly, in the one fourth of the early-adopted, satisfactory early-care group who became difficult adolescents, the only risk factor that emerged was the presence in the home of nonadopted siblings, raising the possibility that in comparison with these siblings, the adoptees felt stigmatized within their families or were treated differently.

Does adoption improve the lot of children who are placed after foster care? Not surprising, data indicate that later placement and poor early care increase risk, whereas good early care is protective (Fergusson et al., 1995; Howe, 1997). Clinically, the situation for foster children improves after adoption, yet many remain troubled because their extensive deprivation and traumatic life experiences leave lasting effects (Rosenfeld et al., 1997; Rushton et al., 1995). Problems may also arise from stigmatization associated with being adopted or having been fostered. Well-designed studies by Cadoret et al. (1995) concluded that adverse adoptive home environments interact with biological background factors to increase rates of aggressivity and conduct disorders among adopted adolescents.

Some work suggests that in addition to vulnerabilities, adopted children have certain strengths. For instance, Sharma et al. (1996) found that although adopted children had a small but consistently lower level of adjustment on factors such as drug use, negative emotionality, antisocial behavior, optimism, and school adjustment, they also had a significantly higher score in prosocial behavior (Sharma et al., 1998). The latter study also notes that adopted children showed fewer social problems and withdrawn behavior as compared with norms.

SINGLE-PARENT, INTERNATIONAL, TRANSRACIAL, AND GAY ADOPTIONS

Concern has arisen about possible problems when the adopted child is culturally or racially different from the adopting family or when the family itself is “nontraditional.”

Studies of international adoption when abuse, neglect, or late placement is not involved indicate that children placed with single parents and with couples had equally good social adjustment (Benson et al., 1994; Kim, 1995). Kim (1995) reviewed 15 follow-up studies of Korean children adopted at various ages. Although some studies bore out the familiar observation that later placement leads to more frequent problems, generally the results were favorable; one study found Korean-born adopted children faring better initially than did an American-born adoptive sample even though the Korean-born children were placed somewhat later (5.3 years versus 3.2 years). Kim hypothesized that the results were so positive because internationally adopting parents tended to be family centered, racially tolerant, college educated, middle income, and biculturally oriented, and before placement, the children had lived in well-supervised foster homes rather than in impersonally run orphanages. Even within an early-adopted sample, there is variability. A longitudinal study of 146 children adopted internationally before age 6 months and studied to age 7 years found that higher mother–infant attachment security predicted better social and cognitive development in middle childhood (Stams et al., 2002). Furthermore, a recent meta-analysis (Bimmel et al., 2003) comparing 2,317 internationally adopted youngsters with 14,345 nonadopted adolescents found that although the majority of the adopted adolescents were well adjusted, as a group they showed more externalizing (but not internalizing) behavior disorders.

Recently, pediatric clinics have been developed that specialize in pre- and postadoption evaluation of children from outside the United States (Barnett and Miller, 1996; Miller, 2005; Miller et al., 1995). Preplacement pediatric review of available information is useful, and a thorough physical examination soon after arrival is essential, particularly when the personal and medical care in the native country was suboptimal. Early clinical findings suggest that good-quality preadoptive care predicts better development, as does a child’s
age-appropriate competence in speaking his or her native language (Miller et al., 1995).

Domestic transracial adoption has also been studied. In a 16-year longitudinal study, Vroegh (1997) examined racial identification, general adjustment, and self-esteem in 52 adopted adolescents of African-American descent. The 34 adolescents adopted into white families and the 18 adopted into black families were predominantly well adjusted; however, problems of serious clinical concern were found in 3 of the 34 transracial adoptees, whereas none were found among those raised in black families. Of the transracial adoptees, 33% identified themselves as black, whereas 83% of the intraracial adoptees did so. Other factors may have been involved; those identifying as black were more likely to have two black birth parents and to have darker skin color. In a review of the literature on interethnic adoption, Fensbo (2004) concluded that late age at adoption, neglect, and institutionalization are risk factors for psychological and behavioral problems in adoptees.

Gay and lesbian adopters often face stigma and rejection. Some states have enacted legislation denying homosexuals, whether individuals or couples, the right to adopt. American adoption agencies and many in foreign countries that place children in the United States may share this prejudice. However, in the past decade, many infants from abroad have been placed with gay parents. When adopting domestically, gay parents are more likely to be successful in having older or special-needs children placed with them than they would be in obtaining infants (Evan B. Donaldson Adoption Institute, 2003b). Research does not indicate that children raised by homosexual parents are at risk in any way, nor are they more likely to develop same-sex orientations than are children raised by heterosexual couples (James, 2004).

CLINICAL MANAGEMENT AND PSYCHOTHERAPY

Increasingly, child and adolescent psychiatrists serve adopted children not only in their families but also in schools, social services agencies, clinics, inpatient units, juvenile courts, and residential programs.

Well-designed research protocols studying psychotherapy with adoptees are lacking, but numerous case reports (e.g., Bonovitz, 2004) suggest that simultaneous empathy with adopted children and their parents is essential. Countertransference awareness is also needed, particularly in relation to therapists’ opinions about abandonment and rescue. Professionals may have pre-existing attitudes toward adoption that interfere with objective, empathic treatment. Some researchers have noted that therapists or healthcare workers assume that adopted adolescents are less psychologically healthy than are other teens. If that becomes a self-fulfilling prophecy, then it may not be surprising that Nickman and Lewis (1994) found that parents of later-adopted children often perceive mental health professionals as lacking in understanding.

Freerark and Routbort (1996) described time-limited groups to help parents of preschool children with adoption-related issues. Network approaches have also helped parents of special-needs children. In one careful long-term follow-up of network care, the most successful parents tended to be older and more pragmatic, with large families and strong religious beliefs. Many had previous experience as foster or adoptive parents (Fine, 1993).

Clinicians agree that a child should know that he or she was adopted; they differ on when and how adoption should be discussed. Most psychotherapists and adoption workers support disclosure as an intermittent process that begins in the preschool years and unfolds over time. Others think that although truthfulness is desirable, the child’s maturity and cognitive capacities need to be taken into account.

Both adopted and nonadopted children of all age groups seem to understand the process somewhat better, but according to older research, neither group really seems to understand the facts until age 8 or 9.

When adopted children need psychotherapy, the parents must be fully included in the process. Bonovitz (2004) describes how parents’ and adopted children’s fantasies can interact in a destructive way and demonstrates the value of painstaking work to help parents and children be more open with and accessible to each other. The question of what happens when parents lack sensitivity to their child’s adoption-related emotional needs or when they bring substantial ambivalence into their relationship with their child (Brinich, 1995) is not one that lends itself easily to research protocols, but many clinicians are familiar with such families. One example is parents’ persistent fear of their child’s supposed bad heredity, leading to negative expectations and a self-fulfilling prophecy (Rosenfeld, 2004, personal communication).
Group therapy for adopted children is a new modality that had its origins in inpatient units and now also occurs in outpatient settings and in some schools. It has yet to be studied systematically (Pavao, 1998).

Issues that commonly arise in psychotherapy with adopted children and adolescents include feelings of worthlessness (Brinich, 1995), fear of abandonment, special aspects of transference and countertransference (Zuckerman and Buchsbaum, 2000), and confusion about origins, loyalty, and personal narrative (Nickman, 2004). Adoptees may devalue themselves because they were relinquished and may devalue or idealize birth parents and adoptive parents at different times, leading to intense and conflicted relationships with therapists. An adoptee may also fantasize that the therapist (or, for that matter, a favorite teacher or minister) is his or her biological parent. Not surprising, issues related to adoption follow adoptees into adult life. Close relationships, having one’s own children, and losing a loved one all may fuel emotions or increase curiosity in an adopted person. Some states have passed laws to open the sealed adoption record for an adult adoptee. In other states, an adoptee may petition the court to open the birth record, even if a birth parent does not consent or has died. Commonly, agencies maintain a file of adoptees and birth parents who have written seeking information, and when both are interested, the agency provides nonidentifying information. It can then mediate an exchange of letters that sometimes leads to the individuals’ mutually identifying themselves.

Clinical approaches to attachment problems include controversial, highly directive holding techniques aimed at creating attachments de novo (Hughes, 1997), psychodynamic psychotherapy making use of attachment research and established attachment measures (Blom, 2003; Rutter, 1995), and preventive programs designed to foster attachment within the newly constituted family (Belfer and Fine, 1997; Cohen and Duvall, 1996). Juffer et al. (1997) described an intervention to facilitate parent–child attachment in 90 families with infants adopted from Sri Lanka and Korea, all placed before age 5 months. Families were divided into a control group and two intervention groups. The first intervention group received a book on sensitive parenting, and the second received the book but also viewed three video feedback sessions focused on mother–infant interaction in their home. They found that the group that had experienced feedback demonstrated more sensitive responsiveness as well as better infant competence and infant–mother attachment than both the control group and those who had only received the book.

FUTURE DIRECTIONS

The question is no longer whether adopted children and adolescents show more global disturbance than their nonadopted counterparts. Instead, specific variables are identified as linked to certain aspects of later adjustment. Age at placement, psychodynamics within the family, the nature of the child’s preplacement experience, and demographic factors (e.g., whether an adoption is domestic, international, same race, or transracial) are among the important variables.

Pertman (2000) has claimed that the newer forms of adoption, by virtue of their emphasis on diversity, have broadened the definition of family and thus advanced America’s democratic, melting-pot tradition. This optimistic view may be justified; however, research during the past 10 years suggests that risks remain for certain adoptee populations. Additional research needs to address the question of why some deprived children show severe attachment disturbances and others do not (O'Connor and Rutter with English and Romanian Adoptees (ERA) Study Team, 2000). Treatment of these disturbances is relatively new, and it remains to be seen how families who adopt institutionalized children fare. How are clinically identified attachment disturbances and insecure and disorganized attachment patterns related? Neuroendocrine (e.g., Carlson and Earls, 1997) or imaging studies may eventually prove useful in predicting which institutionalized children will respond best to therapeutic interventions.

Review of the literature on high- and low-risk adoptees suggests a continuum of attachment disturbances. Neglect, abuse, and impersonal care certainly contribute to them. Should the milder problems with self-esteem and identity formation long recognized in some early-placed children be seen as representing the low end of this continuum, and if so, then by what could these effects be mediated? This may be a difficult but rewarding topic for investigation.

Findings concerning children who are adopted when they are older, especially from foster care, have important clinical and social implications. They may require social and mental health services long after the adoption is finalized. Because research overwhelmingly indicates
that adoptions are more likely to succeed when children are younger, children in foster care deserve to have their plight resolved as early as possible. When there is no hope of family reunification, child welfare services and the courts ought to accelerate the termination of parental rights for infants and preschool children.

Finally, at present, little is known about the long-term course of relationships between adoptees, their birth parents, and their adoptive parents in open adoption and after reunion in late adolescence or adult life. Open adoption and reunion are understood as remedying an inequitable system in which birth parents have been stigmatized and adoptees deprived of their birth heritage. The concept of extended family has been promoted for combined family systems, and the phrase “adoption triad” (for adoptee, adoptive parent, and birth parent) has been suggested. Yet society has few rules or traditions to guide developing customs, and an exciting opportunity arises for research into what form new relationships will take and how they will affect the children and families who take part in them.

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REFERENCES


Davis N, Chiacone J (1996), Open adoption: is it a good option? ABA Child Law Pract 15:155–159


Fensbo C (2004), Mental and behavioural outcome of inter-ethnic adoptees: a review or the literature. Eur Child Adolesc Psychiatry 13:55–63


Ingersoll, BD (1997), Psychiatric disorders among adopted children: a review and commentary. Adoption Q 1:57–73

James WH (2004), The sexual orientation of men who were brought up in gay or lesbian households. J Biosoc Sci 36:371–374


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Shapiro VB, Shapiro JR, Paret IH (2001), Complex adoption and assisted reproductive technology. New York: Guilford


