A Study of Adult Adoptees in India Placed Domestically in India through BSSK, Pune

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Introduction

Bharatiya Samaj Seva Kendra (http://www.bsskindia.org/) is involved in 'Seva' or service as a non-profit making, non-political Indian Charitable Trust. BSSK provides professional social, welfare services to children, women and families in need. BSSK's programs include a Child Care Centre, Foster Family Care, Adoption and a Community Center that supports children for Educational Sponsorship activities. BSSK operates the adoption program under auspices of CARA, the Central Adoption Resource Authority (http://www.adoptionindia.nic.in/). CARA is an autonomous body under the Ministry of Women & Child Development, Government of India. It functions as the nodal body for adoption of Indian children and is mandated to monitor and regulate in-country and inter-country adoptions. CARA is designated as the Central Authority to deal with inter-country adoptions in accordance with the provisions of the Hague Convention on Inter-country Adoption, 1993, ratified by Government of India in 2003.

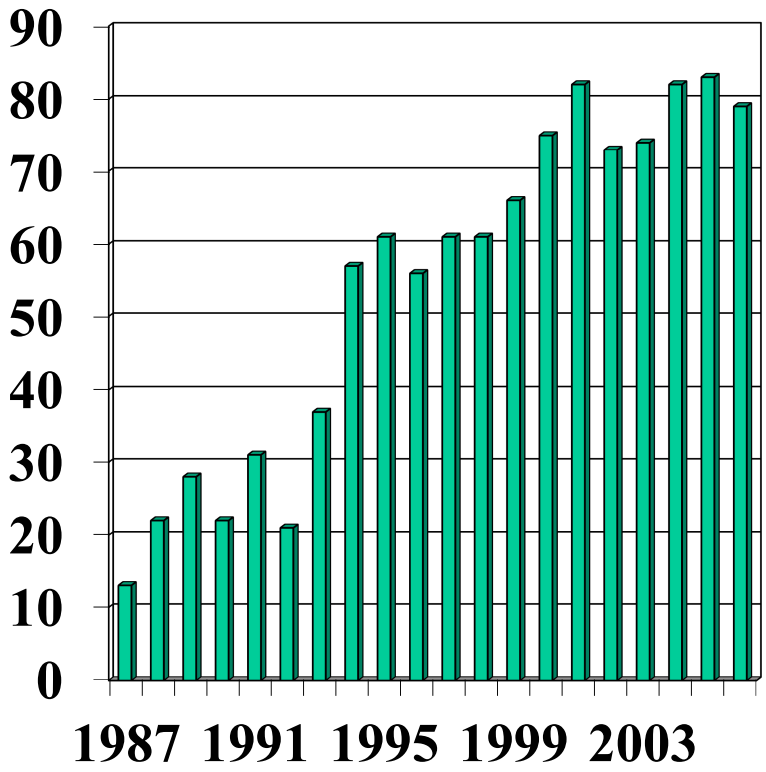
In 2000, BSSK undertook the planning for their first study of domestic adoptions with support from Holt International Children Services and under the leadership of Dean Hale. Since that first effort to follow up with adoptive families who adopted through BSSK, they have conducted additional studies including Norwegian adoptive families of Indian children and American adoptive families of Indian children. All the children were adopted through BSSK and most were under the age of 18 when these studies were undertaken. This report represents a new initiative for BSSK because the study focuses on adult adoptees.

Starting in 2010, BSSK worked with the US research team to develop a project to study adult adoptees in India who were adopted through BSSK and placed domestically. The study was designed to focus on early adulthood. Little is known about this period for adoptees in general and domestic adoption in Indian in particular. This is the first known study of adult adoptees in India that uses scientific methods such as standardized measures and sampling strategies. Results from this project will have implications for both policy and practice at BSSK at the micro level and for adoption practice in India at the macro level. It will help strengthen pre and post adoption services. This is timely since currently some major restructuring is happening in adoption and services for children in India.

Domestic Adoptions by BSSK

BSSK has been operating since 1979. As the figure below clearly demonstrates, BSSK has been steadily increasing domestic adoptions. Even in some years when the number of placements may be down from previous years, the general trend has been to increase the number of domestic adoptions.

Figure 1. Number of Placements by Year



According the UN Convention on the Rights of the Child and The Hague Convention of 29 May 1993 on the Protection of Children and Co-operation in Respect of Intercountry Adoption (henceforth referred to as The 1993 Hague Convention), in situations where a child is permanently without parental care, domestic solutions are the first intervention. In respecting the subsidiarity principle highlighted in Articles 20 and 21 of the UN Convention on the Rights of the Child and Article 4b of The 1993 Hague Convention, domestic adoption should be considered as the first permanent care option only after all efforts for the child to remain within or return to the family of origin or the extended family have proven unsuccessful or not in the best interests of the child. India ratified The Hague Convention of 29 May 1993 on the Protection of Children and Co-operation in Respect of Intercountry Adoption (henceforth referred to as The Hague Convention, www.hcch.net/index_en.php?act=conventions.text&cid=69). As such, a program such as BSSK that promotes domestic adoption is consistent with The Hague Convention, the subsidiarity principles of The Hague Convention, and the Convention on the Rights of Children (http://www.unicef.org/crc/).

Brief Review of Relevant Literature on Adoptees

There is no doubt that orphaned and abandoned children fare much better being raised in a family, particularly if the only alternative is group care or an orphanage/child institution

(Nelson, Zeanah, Fox, Marshall, Smyke & Guthrie, 2007; Zeanah, 2009). The adoptee enters a family who wants him or her. The family goes through an adoption process to be approved to adopt and then is matched to an adopted child. The adoptive family offers material and emotional advantages, including positive childhood experiences with a caring adult or adults (Fergusson, Lynskey, & Horwood, 1995).

Post-adoption follow-up studies provide important insights into the impact of changed rearing circumstances on adoptee's development over the life span. In general, results are very positive for adult adoptees placed as infants or at a very young age. When compared with non-adopted children from similar birth circumstances who are raised by their birth family, adoptees generally show fewer behavior problems in childhood and adolescence and more positive educational achievement (Bohman & Sigvardsson 1985; Fergusson, Lynskey, & Horwood, 1995; Maughan & Pickles, 1990).

That is not to say that adoptees are immune to negative outcomes. Some adoptees have significant mental health and behavior problems, including higher reports of suicide attempts (Slap, Goodman & Huang, 2001), and the incidence of behavior problems may be somewhat higher in adoptive populations (Bohman & Sigvardsson 1985; Fergusson, Lynskey, & Horwood, 1995; Maughan & Pickles, 1990; Hjern, Linbald & Vinnerljung, 2002; Hersov, 1990; Verhults) although most adopted children do not have behavior problems (Bimmel, Juffer, van Ijzendorn & Bakermans-Kranenburg, 2003).

There are several theories postulated about why adoptees may have more risk for psychosocial problems. First, their pre-adoptive experience in either the birth family or in a group/institutional setting may place them at risk. Second, adoptees may be at risk due to an increased prevalence of psychopathology among relinquishing mothers and fathers *(*Bohman & Sigvardsson, 1985; Cadoret, 1990). Third, the clinical literature, largely dominated by psychoanalytical and post-psychoanalytical perspectives, suggest adoption is a loss that has the potential to create trauma or stress in adoptee psychological development throughout the lifespan (Brodzinski, 1990; Brodzinsky, Schecter & Hening, 1992; Findeisen, 1993; Lifton, 1988).

There are mixed results from the studies that have assessed psychological adjustment in adoptees; there are studies indicating more problems and studies suggesting no more difficulties. Bohman and Sigvardsson (1985) found no differences between adoptees placed as infants and controls in registrations for criminality or alcohol problems at age 23. Borders, Penny, and Portnoy (2000) studied adult adoptees ages 35 to 55 placed as infants. The researchers compared the adoptees to a matched group of their friends and found no significant differences for current life view between the two groups. Collishaw, Maughan, & Pickles (1998) compared the psychosocial functioning on a number of life-domains of a sample of adoptees, non-adopted children from similar birth circumstances, and other members of the birth cohort. Adopted women showed very positive adult adjustment across all the domains examined in this study while adopted men had some difficulty in two specific domains, including employment and social support. There is some indication that those men who had behavior problems in adolescence continued to have some adjustment problems. In contrast to these findings, Sullivan, Wells & Bushnell (1995) conducted an epidemiological survey and found that adoptees placed as infants at age 26, on average, had increased risks of antisocial personality and drug use/dependence, especially for males. Passmore, Fogarty, Bourke, and Baker-Evans (2005) evaluated a sample of 100 adoptees living in Australia whose age ranged from 18 to 70 years and compared them to 100 nonadoptees whose demographics were similar. Adoptees scored lower on self-esteem. Nonadoptees reported higher levels of maternal care and lower levels of

maternal overprotection. Feeney, Passmore, and Peterson (2007) included 144 adult adoptees who were adopted as infants and compared them to 131 adult non-adopted adults; all were born in Australia. There was a tendency for adoptees to more likely have insecurely attachment (preoccupied, fearful, avoidant, anxious). Adoptive status predicted perceived risk in intimacy and reports of family and social loneliness. Adoptive status explained more variance in social loneliness for younger adults than for older adults.

Even with higher incidence of problems as reported in some studies, the vast majority of adoptees do not have significant problems and the preponderance of evidence suggests most adoptees do well across the life cycle (Juffer & van IJzendoorn, 2007). The great majority of adoptees fall well within the normal ranges in adjustment (Loehlin, Horn, & Ernst, 2007).

Even studies examining the impact of adoption on identity development do have not uniform results. Benson, Sharma, and Roehlkepartain (1994) report on a sample of 881 white adopted adolescents living in 715 American adoptive families. The more adoptees experienced their family relations as supportive, cohesive, and permitting personal growth, the higher their self-concept. Later adoption predicted higher risk of maladjustment. Openness to adoption was related to better adjustment but reunion with one or both biological parent had no impact on distress symptoms. 27% of adopted adolescents reported that adoption is a big part of how "I think about myself" and 41% said they thought about adoption at least 2-3 times per month or as frequently as daily but 22% had no strong feelings about adoption (at least at the time the study was conducted). Lydens and Snarey (1989) conducted a longitudinal study of 101 Korean adoptees and found that early adoptees (adopted at age one or below) had higher self-concept scores at adolescence (age 12-17) than later adoptees (adopted at age six or older). However, the difference subsided by early adulthood (age 22-27). Levy-Shiff (2001) conducted a longitudinal of 91 Israeli adoptees and a control group of 91 nonadoptees. The participants were approximately 18 years old during the first phase of the study and around 28 years old during the second phase. She found that adoptees had lower self-concept scores but adoptive status explained only 4% of the variance of self-concept while family environment, those they were born to and those that raised them. Grotevant (1997) indicates that while nonadoptees trace their "differentness" by referencing a birth family member, adoptees who know little or nothing about their birth families have no such reference points. Adoptees must construct a narrative that somehow includes, explains, accounts for, or justifies their sense of separation and loss brought about through disconnection from one's family or birth.

Questions about the birth parents are a normative part of adult adoptee development (Brodzinsky, Schecter & Hening, 1992; Rosenberg, 1992). It is clear that there is a continuum of adoptee experiences in relation to the birth family. This continuum ranges from no questions to some questions to many questions to active searching for contact to brief contact with birth parents to an ongoing relationship with birth parents. Schooler (1995) offers a variety of reasons why adoptees search; they include the need for medical information, the need to look like someone, the need for more information such as why an adoption plan was made, the need for a birth family connection and the need for an adventure. These motivations need not be mutually exclusive. According to several studies (Benson, Sharma, & Roehlkepartain, 1994; Stein & Hoopes, 1985; Sobol & Cardiff, 1983), between 30% and 65% of adopted persons expressed a strong desire to search or were actually searching for their birth parents.

In the USA and UK, since the early 1970s, there has been a dramatic increase in the frequency with which adult adoptees search for information about or seek contact with their birth families. Several studies (Aumend & Barrett, 1984; Sobol & Cardiff, 1983) compared

psychological functioning of nonsearching and searching adult adoptees, finding little difference. However, Cubito and Brandon (2000) found differences with searchers compared to nonsearchers, suggesting searching is either a stressful process or a marker for psychological distress. In their study of 716 adoptees (73% female, n=525) who were placed at less than age 2 and ranged from 21 to 61 years at the time of the study, male searchers and reunited adoptees reported higher depression scores. Adolescent searchers who were interested in searching had lower self-esteem, a less positive sense of identity, more family problems, and thought that life is harder due to adoption (Hoopes, 1990; Feigelman & Silverman, 1983; Kaye, 1990; Kaye & Warren, 1988; Raynor, 1980; Stein & Hoopes, 1985). Adoptees with favorable relationship with their adoptive parents search to satisfy their curiosity or to gain knowledge about their genealogical history vs. adoptees with poor relationship with adoptive parents search with a desire to establish a parent-child relationship with their birth parents. Adoptees who wanted to contact their birth parents were more likely to have experienced adverse factors (death of adoptive parents, marital discord in their adoptive family, poor adoption experience, poor relationships with adoptive parents) than those who requested background information only. Passmore, Fogarty, Bourke, & Baker-Evans (2005) evaluated a sample of 100 adoptees living in Australia whose age ranged from 18 to 70 years and 100 nonadoptees whose demographics were similar participated in the study. Adoptees scored lower on self-esteem. Nonadoptees reported higher levels of maternal care and lower levels of maternal overprotection. Reunion adoptees reported lower self-esteem than both the non-reunited adoptees and the nonadoptees. Reunited adoptees and non-reunited adoptees reported similar use of information processing style. Parental variables taken together contributed to the prediction of self-esteem. In a subsequent study, Feeney, Passmore, and Peterson (2007) evaluated 144 adoptees who were born in Australia and adopted within two years of birth participated in the study. The study examined the possible impact of secrecy within adoptive families on interpersonal relationships of adult adoptees. Overall, greater secrecy in adoptive families was associated with less emotional closeness to adoptive parents, greater perceived overprotection and control from parents, greater family loneliness, greater social loneliness, and higher risks in intimacy (avoidant/anxious attachment). Earlier discovery about adoption was much appreciated by adoptees. Adoptees reported that it was helpful in developing their sense of identity and belonging. Adoptive parents' openness had a positive impact among adoptees that searched/reunited with birth parents.

It is clear that adoption may bring unique challenges but also that adoptions are more positive than negative. In outcome research of adopted persons, there is much debate about who should be the comparison group for adoptees to better understand how adopted persons are comparable or different in terms of emotional, behavioral, cognitive, and social outcomes. Javier (2007) suggests three comparison groups: non-adoptive parents with children, non-adoptive parents with children that have comparable socioeconomic backgrounds and family composition as the adoptive parents, and non-adoptive parents with socioeconomic backgrounds similar to that of the biological parents of the adopted children. The most common comparison is the first; comparing adopted children to the general population of children who live with their biological parents. Van IJzendoorn, Juffer, and Poelhuis (2005) conducted a meta-analysis of studies of adopted children to the general population of nonadopted children on cognitive and school performance. Van den Dries et al. (2009) conducted a meta-analysis of attachment in adopted children and found that several studies had used nonadopted peers as the comparison group. McGue, Sharma, and Benson (1996) compared adolescent adoptees to a matched control group

of nonadoptees to compare emotional, behavioral, and family functioning. Kim, et al. (1999) compared nonbiological siblings, also termed as environmental siblings, on school competence.

This project planned to use friends of the adoptee as the comparison group with this rationale. First, since most of the adoptees in India were placed with infertile couples without children, it was not going to be possible to have a comparison adoptee living in the same household. Second, since we were dealing with adults, we wanted to give them as much choice of possible in making the decision on the comparison group. Three, since this is the first study of its kind in the Indian context, it was considered appropriate to make a comparison with a 'friend' as named by the adoptee, so as to keep socio-economic circumstances and schooling/work experiences similar to those of the adoptee.

Adoption and India

Children form about one third of the population of India. It is estimated that there are over 304 million children in India. Of these, about 4% are estimated to be orphaned (over 1,200,000 children) and over 100,000 were in institutions in the 1980s (Bharat, 1993); the number of children in institutions in India now is not known but in 2007 UNICEF estimated there were over 25 million orphaned children in India and most were living in institutions (ChildlineIndia.org, n.d.). According to Raju (1999), the number of destitute children, especially in major cities, is growing due to pervasive and persistent poverty. In addition to poverty as a risk factor, a large percent of children are abandoned or voluntarily relinquished or surrendered because of the stigma of being born to a single mother (Baig & Gopinath, 1976).

Since the independence in India from British rule in 1947 in India, legal adoptions have been occurring. In 2011 there were 244 organizations recognized by for placing children in adoption, out of which approximately 25% are licensed to place children through intercountry placement. Almost one third of the organizations are supported by government grants and the rest are non-government organizations. On average, 3500 children are place in adoption each year in India. Although the trend over the last eight years has been an increase in domestic adoptions, approximately 1000 children are placed each year through Intercountry adoption.

While CARA has recently specified guidelines for adoption processes, the system reflects a lack of supervision and poor monitoring leading to huge variations in the operations of the various organizations in this hugely diverse country with a population of over 1 billion people. Each organization is dependent on individual effective leadership, professionalism and commitment to purpose. The evolving quality of practice in organizations is a critical corner stone in adoption outcomes.

Adoption is not a panacea to the multiple problems that result in children entering the child welfare system. However, it is a vital component in a system of care that promotes permanency and well-being for children. Adoption is seen as the best means to restore family life to a child deprived of his or her biological family (Gokhale, 1967). In India, adoption is as old as Hindu law (Chowdry, 1980) and is part of Indian mythology (Stiles, Dhamaraksa, de la Rosa, Goldner, & Kalyanvala, 2001) and histories of kings (Baig & Gopinath, 1976).

The experience of BSSK, a leader in the adoption field in India, will be different than what is found in many other organizations. The adoption service providers' beliefs and practices, rooted in an Indian cultural (with intra cultural variations) understanding about human development guide their practice. Most organizations in India do not engage in research and evaluation; BSSK is the exception. In 2001, BSSK conducted their first study of domestic

adoptions (Groza**,** Kalyanvala, & BSSK Research Team, 2003; Groza, Kalyanvala, Boyer, & Nedelcu, 2003**).** Out of 138 families solicited to participate in the survey study from Pune, 94 responded to the survey (68% response rate), 113 families from Pune participated in interviews (82% of 138 families), and 136 families from outside Pune responded to a survey (50% response rate). Families evaluate the agency practices positively and adoptions are quite positive. Most of the children are developmentally appropriate and have no health problems, sensory difficulties or behavior problems. Parents report good parent-child relations and the adoptions are very stable.

The biggest issue for families was related to when and how to discuss adoption with their child. Many families openly talked about their struggles with how and when to tell. Some wanted to use the interview during the study as the opportunity to disclose the adoption to their child. Some refused to discuss adoption and had no plans to disclose the adoption to their children. The vast majority, however, struggle with how to discuss the issue, when to discuss it, what to do if a child didn't want to talk about it, what to do if the child wanted to talk about it all the time, and the issue of talking about adoption appropriate to the child's level of development. Some believed if it was mentioned when the child was young, there was no need to talk about it again. What emerged from the interview was clear indication that dealing with adoption issues, including the birth family, were ongoing struggles for many families.

There are no formal supports for the adoption and often families are very alone in their unique situations. Most of the families received informal support from their extended family and friends. Families suggested that they needed informal, social contacts with other adoptive families. For families who received the newsletter, many commented on its usefulness for keeping them informed about the agency.

Subsequently, BSSK studied two other groups of children they placed for adoption. In 2003, they conducted a follow-up study of Indian children adopted to Norway (Groza, Chenot & Holtedahl, 2005). In 2006-2007, they conducted a follow-up study of Indian children adopted to the US (Groza & Cannavo, 2007). In these subsequent studies, results remained position. The adoptees had fare very well, adoptions were stable and parent-child relationships were very strong. In 2011, BSSK embarked on this new project to understand early adulthood for Indian adoptees placed domestically.

Bhargava (2005) discusses several concepts relevant to adoption and self-identity in India. She suggests that self-identity among Indians is heavily influenced by the Indian kinship system, which consists of caste, class, and religious identity (p. 63). Possessing certain physical features is considered desirable and representative of a higher class in India (p. 95). Depending on when the adopted person was exposed to the notion of adoption and how the parents dealt with the information, the adoptee may have different views on adoption, levels of self-esteem, or comfort level with their adoptive identity. The author discusses three types of communication regarding adoption. Some children are exposed to the notion of adoption since the beginning and get to readily communicate about adoption. Some parents tell the minimum but without giving false information, whereas others will keep the adoption process a secret (p. 118).). Since academic achievement is prized in India, general success in academics have a strong impact on self-esteem. Parental support is the key to high self-esteem among Indian adopted children (p. 212).

Research Questions

The study was organized around the following questions developed by BSSK in collaboration with the researchers:

- What are adoptee experiences with adoption?
- What factors influence adoptee experiences/attitudes towards adoption?
- What questions and feelings do adoptees have about their birth families?
- What factors affect adoptees' feelings about their birth family?
- What factors influence adoptee self-esteem?

Methodology

Sample

Keeping in mind the sensitive nature of the study and the fact that adoptees may not know of their adoptive status, contact with the adoptees was established through the parents. Initially 387 families were identified as possible candidates for the project. This was a census of all adoptions of families living in India who had adoptees that had turned eighteen by January 1st, 2010. The adoptive parents received a letter introducing the research project and a consent form to participate in the project. The letter and the parent survey were in both English and Marathi, the language of most inhabitants from Pune (Poona). A prepaid envelope was inserted in the mailed survey as well. To families who did not respond, another consent letter and survey form was sent as well as a prepaid envelope six weeks after the first round of mail.

From the initial mailing of 387 families, no correct address was found for 30% (n=116) of the adoptive families. Five percent (n=20) had not disclosed the adoption, .8% (n=2) of adoptive parents were deceased (n=2), 2.1% (n=8) of the adoptees had died, .5% (n=2) adopted a child with a disability that prevented participation, and 2.8% (n=11) refused to allow contact with the adoptee although all 11 claimed the adoptee knew about the adoption. This resulted in a potential sample of 227 adoptive families.

Having deliberated for several months on how to make sure the project was minimal risk for adult adoptees. In Stage 2, only the adoptees who knew that they had been adopted were to be involved in the study. To operationalize this intent, adoptive parents had to verify twice that the adoptee knew about the adoption. If the adoptive parent in the first questions said the adoptee knew but in the second question said no or left it blank, we did not contact the adoptee. Only adoptees that the parents verified twice that they knew they were adopted and provided contact information were contacted. With that contact information, we mailed a consent form and a letter describing the nature of the study to the adoptees. All documents for adoptees were in English and Marathi. We also asked about preferred method to participate in the study (mail survey, Skype, phone, face-to-face) and place of interview if it is face-to-face (BSSK adoption agency, neutral location).

For adult adoptee participants, the consent form had to be mailed or delivered by to the agency before an interview could be arranged. At the beginning of the interviews, the consent form was reviewed with the participant. We assume that adoptees uncomfortable talking about their adoption would not participate in the interview. Should an adoptee whose parents reported they knew about the adoption indicate they did not know they were adopted, the protocol was for the interview to stop and the adoptee was to be referred to BSSK for professional services. No such experience was reported.

In Stage 2, after the interview with the adult adoptee, the adoptees were asked to give their best friend a questionnaire similar to the one they completed, without the adoption-specific questions. A letter of consent was included to give to their friend of his/her choice.

Collected data were coded to mask the participant's identity. There were no links to individually identifiable data for the research team. For the interview part, only the interviewers knew adoptee specific information but all results were aggregated for reporting purposes. The Indian staff members conducting interviews were professionals working with BSSK. They provided no services to the adoptee or adoptive parent. They were trained about basic interviewing skills and in the project protocol, including confidentiality and the safeguards for human subjects. The interviewers were reminded that they are prohibited from discussing identifiable results obtained from interviews. Halfway through the interview process, the team of interviewers Skyped with the PI to review the project, what we were learning, and whether any changes needed to be made in the protocol. The only change was to make sure the length of time for the interview and location of interview were recorded on the questionnaire.

Measures

The four criteria used to secure measures were: (1) ascertain the measures that would answer the research questions, (2) the measure would be easily obtained/publicly available, (3) the measure had to be free, and (4) our Indian colleagues had to evaluate their face validity and utility for use with Indian adoptees. A parent questionnaire, adoptee questionnaire and friend questionnaire was developed. The adult adoptee questionnaire included three standardized tests were used: the Self-Esteem Rating Scale (SERS; Nugent & Thomas, 1993), the Health Survey Short Forms (SF-36; Ware & Keller, 1994), the Brief Screen for Depression (BSD; Hakstian & McLean, 1989) and the Open Adoption Scale (OAS, Brown, Ryan & Pushkal, 2007). The friend questionnaire included the SERS, SF-36 and BSD only.

The SERS assesses level of self-esteem; the scale was 40 items. Nugent and Thomas (1993) provided evidence that it was valid and highly reliable (alpha=.97). Subsequently, Nugent (2004) provide evidence for the equivalent of reliability and validity for two shortened forms (SERS-A, SERS-B) although no norms were established. The shorten forms were created because of the length of time it took to complete the 40 items. This study used 32 of the original 40 items based on the face validity for use in India. Up until the time of this report, this scale had not been used outside of the US and was used predominantly for clinical practice.

The SF-36, Version 2, assesses health and level of general health leading to a profile of functional health. It is a generic measure of health as opposed to one that targets a specific age, disease or treatment group. The experience with SF-36 included about 4,000 publications; citations for those published from 1988-2000 are available (Turner-Bower, Bartely & Ware, 2002). Most studies suggest reliability statistics exceed the minimum of .70 (Ware, 2000).

The BSD screens for depression and contains 4 questions. The alpha for depresses was .65 and for non-depressive was .63. Good test-retest was established (Hakstian & McLean, 1989).

The OAS was designed to measure myths as they relate to open adoptions of children in the US public child welfare system. It is comprised of Birth Parent (alpha=.85), Adopted Child (alpha =.89) and Adopted Parent Subscales (alpha=.82) with a global alpha of .92. The Birth Parent Subscale had to be revised for this project as the items included in the original scale were irrelevant in the Indian context. The OAS is a valid and reliable tool (Brown, Ryan & Pushkal, 2007). It has been used in the US with adoptive and foster parents (Ryan, Harris, Brown,

Houston, Smith & Howard, 2011). The differences between the original birth parent and revised birth parent questions are found in the following table (Table 1). The requested revisions were requested by BSSK staff and questions had face validity for the Indian context; the American version was not relevant to the situation for birth parents in India.

Table 1: Comparison of Original Items to Revised Items on the OAS

Original Question	Revised Question
Biological parents who have lost custody of their children because they are in prison should not have contact with their biological children.	The birth parents that have made plans of adoption for their child as the child was born out of wedlock should not be contacted by the child or by the agency.
Biological parents who would choose drugs over the needs of their children are never capable of being trusted to put their children first.	The birth parents that have made plans of adoption for their child as the child was born out of wedlock should have no right to contact their children.
Biological parents who abuse their children so badly that they lose parental rights don't have anything positive to offer their children.	It is pity that some people do not have any other resources to raise their children hence they abandon their children.
Biological parents who lose their children to the state because of abuse don't deserve the privilege of seeing them.	The birth parents who abandon their child due to helplessness at one stage should be allowed to explore the where about of their lost child at a later stage.
Biological parents who neglect their children so badly that they lose parental rights don't have anything positive to offer their children.	The parents who abandon their child due to child's sickness or disability that they are unable to handle, in a way help the child in the long run.

In addition to these standard measures, we developed questions regarding satisfaction with the academic and professional career of the adoptee, as reported by both the adoptive parent and adoptee questionnaires. For the adoptee questionnaire, we added questions about the disclosure of adoption, the adoptee's birth family, and the effect of adoption on the adoptee.

These assessments allowed us to make recommendations about when and how to disclose the fact of adoption to adoptees, what conversation about birth families the adoptive families should engage, and what level of expectations and support regarding academic and professional career the parents should provide. We wanted measures that would lead to results that could be translated into interventions and services that can provide help or support to adoptees and adoptive families as part of the post-adoption program.

All quantitative data were analyzed with SPSS version 20 unless otherwise noted. Qualitative data were analyzed using MAXQDA version 2k1 R030801-E (Kuckartz 2001).

Response Rate

Adoptive Parents. Of the potential 227 potential adoptive families who could participate, 76 families responded for a 34% response rate. There are several reasons for this low response rate. First, these adoptions occurred from 20 to 30 years ago; families moved during this time period but if they did not inform BSSK, there would be no record of their current address. Hence,

while the survey was delivered to the address on file, the family may not have lived there but had the occupant not responded to let the project know, they would still have been counted as delivered. Second, during this period of adoption there was not an age restriction on adoptive parents; a significant number of these parents were over 50 at the time of the adoption, meaning they would be in their 70s or 80s at the time of the study. As such, a number of them may have probably expired and BSSK did not know about it or at the older age not feel inclined to participate in such a study.

Adoptees. The only way adoptees would be contacted is if the parent verified twice that the adoptee knew about the adoption. Fifty nine adoptees met the criteria and 48 participated in the study. This number is 81% of eligible adoptees and 63% of the families who responded Most adoptees (77.1%, n=37) were interviewed face-to-face. The other methods of interview were Skype (6.3%, n=3), mailed (6.3%, n=3) and phone interviews (10.4%, n=5). Demographic data were analyzed by type of response and no difference was found.

A comparison was made for those adoptees who participated in the study to those who did not participate. Adoptees who participated were not significantly older ($t=1.9$, $df=57$, $p=.06$, equal variances not assumed) at the time of the study (mean =24.5, σ =3.7) than those that did not participate (mean =23.6, σ =2.3). Nor was age at adoption statistically significant ($t=1.8$, $df=56.4$, $p=.08$, equal variances not assumed). There was a significant difference for gender (chi-square=6.6, p=01). Table 2 compares gender of those who participated to those who did not participate. For the sample, 59% (n=228) were males and 41% were females (159). If there was no gender bias, about the same percent should have participated as did not participate. As evidence in Table 2, more females participated than expected and fewer males participated than expected. That means results are biased toward female adoptees. This is an interesting finding; 20-30 years there was a parental preference for boys for adoption since male children were expected to be a social support in their old age.

Table 2: Comparison of Participants by Gender

	Participated	Did not Participate
Males	37.8% (n=17)	59.1% (n=107)
Females	62.2% (n=28)	40.9% (n=181)

Friends of Adoptee. We also asked each adoptee to give a friend a questionnaire that included the health items and attitudes towards adoption. While initially most adoptees (n=36, 78%) said they would give their friend a questionnaire with only 10 declining (20%), most adoptees did not give the questionnaire. We received only 13 friend responses. Even this was a lesson learned; the adoptee may know that they were adopted but this did not mean they shared the information with others. A number of adoptees either had not told their current friends or had moved and the friends that knew about their adoption were not their current friends. The friends who knew about their adoption were those that they grew up with; now in their 20s and older, their circle of friends had changed and many of the current friends did not know about their adoption. Also, a few friends refused to participate and we could not determine the reason for their refusal. We were hoping to build a comparison group from the friends of the adoptee but this did not work as planned. Still, on a few select items we were able to compare the adoptee to their friends.

Results

Adopted Family Demographics

As reported early, 76 adoptive parents participated in the study. We did not collect a great deal of data from adoptive families as the focus on the study was adult adoptees. In responding, about one-third of surveys were completed by the adoptive mother (34.2%, n=26), the adoptive father (31.6%, n=24) or both parents together (34.2%, n=26). Parents reported on more females (57.3%, n=43) than males (42.7%, n=32). Parents reported the adoptee ranged in age from 1.5 months to 84 months at adoption; on average, they were 10.5 months at adoption (σ[1] =14.9). Twenty five percent were placed at 3 months or younger, 50% were placed at 5 months or younger and 75% were placed at 8 months or younger. Fourteen children (18%) were placed after 1 year of age, 8 (11%) children were placed over the age of two years, and 5 (7%) over 3 years of age. At the time of the study, adoptees ranged in age from 20 to 31 years; average age was 24.1 years (σ =3.0).

Most children had been in an orphanage before adoption (86.5%, n=64). The situation of the child before adoption was that they were surrendered by the birth parent (37.3%, n=38), abandoned (24.0%, n=18) or the parent did not know (38.7%, n=29). While this information is now routinely discussed with adoptive parents as a matter of policy and practice currently, it was different 20-30 years ago. As adoption processes and counseling practices have evolved over time, information discussed with parents prior to and at the time of adoption is open, with more information being documented systematically and being shared. However, it is unclear whether these parents knew and forgot, knew and did not want to disclose, or did not know the information.

Of parents who responded, 93.2% (n=68) reported the adoptee 'knew' about the adoption and mostly it was both parents (67.6%, n=46) or the adoptive mother (19.1%, n=13) disclosed the adoption. The following also disclosed the adoption: extended family (5.9%, n=4), neighbors (2.9%, n=2), and a friend, the adoption social worker or someone else for one case each (1.3%). Parents report that the adoptee was 7.8 years, on average, when the adoption was disclosed (σ =4.9). Twenty five percent were told at 4 years or younger, 50% were told at 7 or younger and 75% were told at 11.5 years or younger. Parents report that the adoptee began to understand what it meant to be adopted around 9.7 years (σ =4.98) and began to accept the adoption around 11.3 years (σ =6.1). Of these parents, 93.3% (n=70) verified twice that the adoptee knew about the adoption. However, only 79.7% (n=59) permitted contact with the adoptee.

Parents were asked about who usually initiates a discussion about adoption. One-fifth (20.3%, n=14) report that adoption is forgotten and never discussed, 24.6% report the parents bring up adoption topics, 18.8% report the adoptive mother brings up adoption topics, 5.8% report the adoptee brings up the topic and 29.0% (n=20) report the parents and adoptee equally bring up adoption issues/topics. Interviewers indicated that those who reported that adoption is forgotten indicate that parents/adoptees do not want to go back into discussing the adoption "because it has already happened in the past and nothing can change it; it has been left behind." It is only in some situations, such as searching for a suitable marriage partner (arranged marriages) particularly at this stage in adult life. that the topic of adoption comes up.

[1] This symbol (σ) is used to designate the standard deviation.

Since high academic achievement of children is viewed as a concern and an important outcome of parenting in Asian middle class families, parents were asked about their child's academics and career. In regards to academics, 40.3% (n=29) report the adoptee met their expectation, 26.4% (n=19) report the adoptee exceeded expectations and 33.3% (n=24) report that the adoptee did not meet expectations. In regards to the adoptee's career or job, 21.5% (n=15) were extremely satisfied, 41.4% (n=29) were very satisfied, 27.1% (n=19) were somewhat satisfied, 5.7% (n=4) were slightly dissatisfied and 4.3% (n=3) were very dissatisfied.

Adopted Person Demographics

As reported, 46 adult adoptees participated in the study. As reported earlier, most of the adoptees who participated (63%, n=29) were female. Age at time of study ranged from 20-32 years; average age was 24.2 years. There was no significant difference (t=-1.1, df=43.9, p=.29, equal variances not assumed) for age at study between males (23.6) and females (24.5). Age of the time of adoption ranged from 2 to 60 months; average age was 12.2 months (25% placed under 6 months, 50% under 5 months & 75% under 18 months). There was no significant difference for age at adoption (t=.68, df=18.4, p=.51, equal variances not assumed) between males (14.6) & females (10.8).

Most adoptees were college graduates (43%) or had a master's degree or above (26%). Most reported that they met or exceeded parent education expectations (84%). Most reported that their parents extremely or very satisfied with their career choice (80%); only 7% reported their parents were extremely dissatisfied.

Adoption Disclosure and Birth Parent Concerns as Reported by Adoptee

Most adoptees were told by their parents about their adoption; 55% reported that both parents told, 34% reported that Mom was the one who told & 4% that Dad was the one who told. The remainder of adoptees were told my siblings, neighbors, friends or extended family (7%). On average, adoptees were told about their adoption during latency age (9.8 years, on average). 25% were told under age 6, 50% were under age 10, & 75% were under age 13. There was no significant difference for age at adoption disclosure (t=.05, df=41, p=.96, equal variances assumed) between males (9.8) & females (9.7). From the qualitative data, adoptees who always know they are adopted never reported a big shock about being adopted or significant adjustment after disclosure. Being older when told or being told by someone other than the parents resulted in more adjustment difficulties, at least initially. A 24 year old female adoptee who had her adoption disclosed at age 5 said 'Initially. I didn't understand. Once I was older and understood, the more I thought it was good'. A number of adoptees reported that they "Did not understand initially" or "was angry did not speak" when the adoption was first disclosed but later understood and accepted their adoption.

Yet disclosure does not necessary lead to integration of the adoption experience, based on the qualitative data. Adoptees heard parts of their life stories piecemeal. More than half (n=26) have unasked, unspoken and unanswered inquiries about adoption. A 24 year old male adoptee when asked if he had questions about his birth family wanted more information to complete his birth story, He wanted to know why they (the birth parents) left him? He also wanted to know his religious background.

In search of answers, a 21 year old male adoptee wondered ‘Why couldn't his birth family care for him? Others wantedto know more about the circumstances in which the birth parents were at the time when they gave me up” (surrendering for adoption) and had questions about “Why did they leave me?” A 27 year old woman questioned, ‘"Why she was given up for adoption? Was she not wanted because she is a girl?"

Half (53%) of the adoptees reported that they think about their birth families. This number is probably higher but a number of the adoptees comments that it would be disloyal or hurt their adoptive parents if they reported thinking about their birth family. A 27 year old female adoptee said she would like to know about her birth parents, but doesn't want her adopted parents to feel insecure. A 22 year old female adoptee said "Wanting to know about my birth parents isn't about them but about my own self reflection." Another male adoptee wants his adoptive parents to "I will still be close to them even if I speak about my birth parents."

In examining the written comments, most commonly they adoptee wanted to know why they were placed for adoption and what were the circumstances that lead to placement. Another major theme was questions about whether the birth parents were alive and who were they. These are very typical questions reported that other adoption researchers (Howe & Feast, 2000).

Adoption Attitudes

Both specific questions about adoption and questions that were part of an attitude scale towards open adoption were asked. Adoptees were asked their general feelings about being adopted. The majority (82.6%, n=38) reported that they felt positive about being adopted; the rest (17.4%, n=8) reported feeling neutral or mixed about being adopted with many emphasizing that they felt neutral. No adoptee reported feeling negative about being adopted. Adoptees were asked how they felt about being placed for adoption. The majority (63.6%, n=28) reported feeling positive about being placed for adoption, 31.8% (n=14) reported feeling neutral or mixed about being placed for adoption and 4.5% (n=2) reported feeling negative about being placed for adoption. Adoptees felt a deep sense of gratitude towards their adoptive parents. As a 25 year old male said "…which other children could be as fortunate?" A 20 year old female said ‘with adoption her life has been altered to her advantage." Another 27 year old male adoptee said adoption has given him "… love, opportunities, family and security. It has given me a new life with a good family, education and neighbors."

Table 3 compares mean scores for the Indian adoptees on scales measuring attitudes towards open adoption. The three subscales access attitudes as they relate to the adoptee, the adoptive parent and the birth parent. The Cronbach’s alpha for each scale is a follows: Adoptee Scale (.71), Adoptive Parent Scale (.63), and Birth Parent Scale (.33). The Birth Parent Scale is not a reliable scale. Even if the item, “The birth parents who abandon their child due to the child's sickness or disability that they are unable to handle, in a way help the child in the long run”, is deleted, the Cronbach alpha only increases to .56. While an improvement, the Birth Parent Scale is not a very reliable scale with this sample of adoptees from India. However, in the computation of scales, this item was not included in computing the total score on the Birth Parent Scale.

Table 3: Adoptees Attitudes toward Adoption Openness by Indian Adoptees with US Comparisons (means & standard deviations)

Scale Question	India Adoptee (n=46)	US Public Child Welfare Workers (n=122)	US Foster Family (n=127)
Adoptee Scale			
Children will bond better with their adoptive parents if they have no contact with their biological family.	6.4 (1.33)	3.22 (1.85)	4.44 (2.26)
Children's sense of belonging to the adoptive family is strengthened if they sever contact with their birth family.	5.5 (2.21)	3.05 (1.70)	4.18 (2.06)
It will create confusion in the adopted person's mind if the contact with birth parents continues.	6.1 (1.5)	Not available (n.a.)	n.a.
It is best for adoptees to start over fresh, without any contact with their biological parents.	5.98 (1.95)	2.99 (1.70)	4.48 (2.15)
A**doptive Parent Scale**			
Adoptive parents wouldn't adopt children if they would have to deal with the children's biological family.	5.96 (1.94)	3.80 (1.72)	4.55 (2.21)
Adoptive parents will feel less entitled to the role of "parent" if the adoption child still has contact with his or her biological family.	5.2 (2.19)	3.75 (1.68)	4.29 (2.22)
To develop a strong family identity, adoptive parents need a closed adoption.	5.6 (2.02)	2.98 (1.71)	4.66 (2.16)
Adoptive parents' bonding to their newly adopted child will be enhanced if there is no fear of contact with the child's birth parents.	6.1 (1.69)	3.68 (1.79)	4.83 (2.11)
It would be impossible to recruit adoptive parents if they thought they would have to deal with the biological family.	5.9 (1.85)	3.63 (1.86)	4.45 (2.16)
Birth Parent Scale			
The birth parents that have made plans of adoption for their child as the child was born out of wedlock should not be contacted by the child or by the agency.	5.3 (2.07)	n.a.	n.a.
The birth parents that have	5.1 (2.24)	n.a.	n.a.

made plans of adoption for their child as the child was born out of wedlock should have no right to contact their child.			
It is a pity that some people do not have other resources to raise their children, hence they abandon their child.	5.4 (2.21)	n.a.	n.a.
The birth parents who abandon their child due to helplessness at one stage should be allowed to explore the whereabouts of their lost child at a later stage.	5.8 (2.03)	n.a.	n.a.
The birth parents who abandon their child due to the child's sickness or disability that they are unable to handle, in a way help the child in the long run.	3.2 (2.37)	n.a.	n.a.

The questions were on a scale of 1 to 7, 1 being strongly disagree and 7 being strongly agree.

These data were analyzed with an online program (quickcalcs online caculator for scientist; http://www.graphpad.com/quickcalcs/ttest2.cfm) . T-test analysis was used to examine the difference between the adoptees and US public child welfare workers and between the adoptees and US foster parents for the items that had data available. No analysis was conducted on the birth family scale items since they were created for the projects. Table 4 presents the results of the analysis.

Table 4: Comparison of Adoptees' Scores to US Samples

Scale Question	India Adoptee compared to US Public Child Welfare Workers	India Adoptee compared to US foster parent
Adoptee Scale		
Children will bond better with their adoptive parents if they have no contact with their biological family.	t=10.7, df=166, p<.01	t=5.6, df=171, p<.01
Children's sense of belonging to the adoptive family is strengthened if they sever contact with their birth family.	t=7.5, df=166, p<.01	t=3.6, df=171, p<.01
It is best for adoptees to start over fresh, without any contact with their biological parents.	t=9.8, df=166, p<.01	t=4.0, df=171, p<.01
Adoptive Parent Scale		

Adoptive parents wouldn't adopt children if they would have to deal with the children's biological family.	t=7.1, df=166, p<.01	t=3.8, df=171, p<.01
Adoptive parents will feel less entitled to the role of "parent" if the adoption child still has contact with his or her biological family.	t=4.6, df=166, p<.01	t=2.4, df=171, p=.02
To develop a strong family identity, adoptive parents need a closed adoption.	t=8.4, df=166, p<.01	t=2.6, df=171, p=.01
Adoptive parents' bonding to their newly adopted child will be enhanced if there is no fear of contact with the child's birth parents.	t=7.9, df=166, p<.01	t=3.7, df=171, p<.01
It would be impossible to recruit adoptive parents if they thought they would have to deal with the biological family.	t=7.1, df=166, p<.01	t=4.1, df=171, p=.01

All adoptee and adoptive parent scales were significantly different between the adoptees and public child welfare workers and adoptees and US foster parents. The direction of difference is always the same with adoptees scoring higher on the scales, indicating more agreement with each item.

Table 5 summarizes describe data about the 3 scales. These scales by themself tell us little information; they will be more useful when we try to understand how they affect and are affected by other variables in the research questions.

Table 5: Descriptive Data on Adoption Attitude Scales

	Adoptee Scale	Adoptive Parent Scale	Birth Parent Scale
Mean scores (standard deviation)	24.0 (σ =5.2)	28.9 (σ = 6.2)	21.4 (σ = 5.7)
Range of minimum to maximum	12-28	11-35	8-28
Mode	28	35	28
Median	27	30	22

Self-Esteem

Since the entire scale as published was not included in the study, there are no norms for which to compare scores on the self-esteem measure. Items were recoded so that higher scores reflect more positive self-esteem. The scale of the 32 items are reliable (α=.74); eliminating any

single item would not increase the reliability substantially. The top score for self-esteem is 224; as a group, the average score for the adoptee was 186.8 (σ = 24.5). Self-esteem scores ranged from 138 to 277; 25% of adoptees had a score of 172 or lower, 50% had a score of 186 or lower, and 75% had a score of 201 or lower.

Average self-esteem scores were compared on several variables, none that demonstrated statistically significant differences. There was no difference between males ($\bar{x}$ [2] =186.9, σ =32.8) and females ($\bar{x}$=186.8, σ = 19.2) on self-esteem scale (equal variance not assumed, t=.002, df=18.1, p=.98). There was no difference between those adoptees who met (mean=186.8, σ =27.7), exceeded ($\bar{x}$=184.0, σ =21.7) or did not meet ($\bar{x}$=182.6, σ =24.5) parent's educational expectations (F=.29, p=.75). It was also unrelated to adoptee's reports about how their parent feel about their career choice, whether they think about their birth family, discussions in the adoptive family about adoption, or feelings about adoption. In later analysis we will examine what variables, if any, predict self-esteem. Details of these analyses are not reported here but are available from the lead author upon request.

Health

There are 36 items that measure eight health dimensions: physical functioning (PF), social functioning (SF), role limitations due to physical problems (RP), role limitations due to emotional problems (RE), mental health (MH), energy/vitality (VT), bodily pain (BP), and general health perceptions (GH). All scores are summed and linearly transformed to a 0 to 100 scale (SF-36 Manual). The scores are also calculated into norm based scores with an average of 50 and a standard deviation of 10. They are summarized into two major scales, Physical Component (PC) and Mental Component (MC). The PC is composed of PF, RP, BP, and GH. The MC is composed of MN, RE, SF and V.

For the study, minor modifications to the wording of the original questionnaire were made to make it acceptable in the Indian content. For example, several items we had as dichotomies (yes/no) were ordinal in the software provided by Quality Measurement Health Outcomes (QMHO) Scoring Software 4.5 (www.qualitymetric.com). For these items, we used the middle rank of sometimes when the respondent indicated there was a problem unless there was a note on the survey specifying the degree of problem. This may have had an impact on the QMHO indicating the quality of the data was poor. As such, these data must be interpreted with caution.

The Cronbach's alpha, as a measure for reliability, were as follows for each scale: PF (.87), RP (.74), BP (.76), GH (.74), VT (.64), SF (.68), RE (.49), MH (.67). The least reliable scale is the RE; the other scales are near or above the minimum for an indication of reliability.

Table 6 presents the data based on the 100 point scale and the Normed Based Scores

[2] $\bar{x}$ is the symbol for mean or average

Table 6: Results from the SF-36, Version 2, Health Survey

	Scores 0-100	Normed Based Scores (mean score=50; σ = 10)
Physical Functioning	87.7 (σ =18.4)	52.8 (σ = 7.1)
Role Limitations due to physical problems	89.7 (σ = 15.2)	53.5 (σ = 5.5)
Role Limitations due to emotional problems	90.6 (σ = 13.9)	52.2 (σ = 5.8)
Social Functioning	72. 0 (σ = 16.8)	51.1 (σ = 7.4)
Mental Health	74. 3 (σ = 16.3)	50.5 (σ = 8.5)
Vitality	84. 5 (σ = 18.5)	57.1 (σ = 8.0)
Bodily Pain	79.7 (σ = 22.2)	53.8 (σ = 8.95)
General Health	78.9 (σ = 17.2)	56.5 (σ = 8.2)
Physical Component	--	54.9 (σ = 7.4)
Mental Component	--	51.7 (σ = 7.3)

For each of the scales, the average scale based on the Normed Based Scores puts the adoptees, as a group, near the or slightly above the average. Table 7 summarizes the percent of the sample of adoptees and their friends that are above, at or below the General Population Norms as provided by QMHO. In the general population, about 18% score positive for depression screening; in the adoptee sample, 14% scored positive for depression and in the friend sample 0% scored as depressed.

Table 7: Percent of Adoptees and Adoptee Friends Scoring Above, At or Below the Norms on the SF-36 Health Survey

	Above the Norms		At the Norms		Below the Norms	
	Adoptee	*Friend*	Adoptee	*Friend*	Adoptee	*Friend*
Physical Functioning	54%	*58%*	8%	*25%*	38%	*17%*
Role Limitations due to physical problems	58%	*75%*	15%	*17%*	276%	*8%*
Role Limitations due to emotional problems	60%	*67%*	19%	*25%*	21%	*8%*
Social Functioning	50%	*58%*	10%	*33%*	40%	*8%*
Mental Health	31%	*58%*	17%	*25%*	52%	*17%*
Vitality	65%	*58%*	8%	*42%*	27%	*0*
Bodily Pain	48%	*50%*	15%	*25%*	38%	*25%*
General Health	65%	*50%*	10%	*33%*	25%	*17%*

Physical Component	59%	*50%*	11%	*42%*	30%	*8%*
Mental Component	35%	*67%*	17%	*25%*	48%	*8%*

Overall, except for the Mental Health Score, on each item the majority of adoptees are at or above the norms on each scale. The friends of adoptees overall scored at or above the norm on all subscales. To further explore what factors are associated with health outcomes, several analysis were conducted for each subscale. These results are reported later in the monograph.

It is concerning that slightly over half of the adoptees scored below norms on Mental Health Scale and almost half scored below norms on the Mental Component Scale; it is also concerning that 40% of the adoptees scored below norms on the social functioning scale. The next section focuses on one specific mental health issue, depression, as part of furthering evaluating the mental health data.

Mental Health-Depression

The four questions that make up the depression screening scale (Hakstian & McLean, 1989) are in Table 8. As a group, the Indian Adopted Persons (IAP) score statistically significant lower than depressed persons (DP) but statistically higher than the typical persons (TP) on which the score was normed in the US except on one item.

Table 8: Brief Screen for Depression items with means and standard deviations for depressed person, typical (normative) person & Indian Adopted Person

	U.S. Depressed Persons (n=196)	U.S. Typical Persons (n=161)	Indian Adopted Persons (n=46)
How many times during the last 2 days have you been preoccupied by thoughts of hopelessness, helplessness, pessimism, intense worry, unhappiness, and so on?	3.41 (.73)*	1.57 (.67)*	1.89 (1.04)
How relaxed have you been during the last 2 days, compared to how you normally are?	6.04 (1.85)*	2.40 (1.56)*	3.33 (2.79)
To what extent have you had difficulty starting and following through an ordinary job or task to completion during the last week compared to when you feel things have been going well?	7.17 (2.39)*	1.98 (1.69)*	2.94 (2.47)
How satisfied are you with your ability to perform your usual domestic duties (i.e. shopping, meals, dishes, home	7.04 (2.17)*	2.62 (1.41)*	2.44 (1.73)

repair, cleaning up, child care, etc.)?			

*p<.05

For the item, "How many times during the last 2 days have you been preoccupied by thoughts of hopelessness, helplessness, pessimism, ect.", IAP had significantly lower scores than DP (F=9.4, df=55.8, p<.01) and IAP had significant high scores than TP (F=-1.97, df=56.1, p<.05). For the item, "How relaxed have you been during the last 2 days . . .", IAP had significantly lower scores than DP (F=6.3, df=54.6 p<.01) and IAP had significant high scores than TP (F=-2.2, df=53.3, p<.05). For the item, "To what extent have you had difficulty starting and following through . . .," IAP had significantly lower scores than DP (F=10.7, df=24.0, p<.01) and IAP had significant high scores than TP (F=-2.5, df=57.6, p<.05). For the item, "How satisfied are you with your ability to perform your usual domestic duties . . .", IAP had significantly lower scores than DP (F=15.4, df=81.8, p<.01) and IAP had lower scores than TP that were not statistically significant (F=-.65, df=563.1, p=.5)

So, while the SF-36 suggests more mental health problems overall for half of the adoptees, the problem does not appear to be depression (a finding also supported by SF-36). Several additional analyses were conducted to explore factors associated with mental health.

Gender has no association with mental health (t=-.07, df=2, p=.94, equal variances assumed); males had a mean score of 50.4 (σ = 7.7) and females had a mean score of 50.6 (σ = 9.2). Meeting parent educational expectations had no association (F=.56, p=.58) with the mental health component; the scores were as follows: met expectations ($\bar{x}$=51.3, σ = 7.4), exceeded expectations ($\bar{x}$=53.9, σ = 4.2), did not meet expectations ($\bar{x}$=52.6, σ = 6.98). Parent satisfaction with adoptees educational achievement had no association (F=.89, p=.45) to the mental health component; the scores were as follows: extremely satisfied (mean=52.4, σ = 8.3), very satisfied ($\bar{x}$=50.1, σ = 7.6), some satisfied ($\bar{x}$=52.4, σ = 4.8), or very dissatisfied ($\bar{x}$=56.9, σ = 4.3). The following were not correlated with the Mental Health Component: age at the time of the study (r=.19, p=.19), age at adoption (.01, p=.92) or age at adoption disclosure (.10, p=.52). Neither thoughts of the birth family, discussions of adoption in the home, feelings about being adopted nor feelings about being placed for adoption yielded significant results. In essence, in the absence of a theory to guide additional analysis, statistically significant associations of variables to mental health were not found.

An additional scale was developed to examine mental health that examine only those cases that were more than one standard deviation from the Normed Based Scores. Ten percent (n=5) of the adoptees scored very low on the Mental Health Component; given the small sample size, a few outliers can bring down the scores for the group. The same analysis was conducted with the same results. Factors associated with poor mental health could not be determined.

Comparing Adoptive Parent and Adoptee on Select Responses

In this section, we compare response of the 46 adult adoptees in the study with their matched parent responses. Table 9 compares selected data reported by the parents and adoptees.

Table 9: Comparison of Adoptive Parent and Adoptee Results on Select Survey Items

	Adopted Parent Report	Adoptee Report
Average age at adoption in months (standard deviation)	10.9 (σ =14.1)	12.2 (σ =14.7)
Average age at study in years (standard deviation)	24.2 (σ =3.1)	24.2 (σ = 3.1)
Average age of adoption disclosure in years (standard deviation)	7.5 (σ =4.9)	9.8 (σ =4.6)
% who never talk about adoption	15.2%	37.2%
% met or exceeded academic expectations	71.1%	84.4%
% extremely or very satisfied with career choice	60.5%	80.0%

There is no statistically significant difference between parent report and adoptee report for current age of the adoptee or the age of the adoption, even though it appears that parents reported disclosing adoption at an earlier age than adoptees reported disclosure. More adoptees report that adoption is discussed less often at home than do adoptive parents, a difference that is statistically significant ($p<.05$)[3]. Also, while adoptees perceive to a greater extent that they meet or exceed academic expectations, the difference is not statistically significant. However, adoptees perception that their parents are extremely or very satisfied with their career choice compared to parent responses are significant different ($p<.05$). So, different perceptions emerge when comparing adoptee and adoptive parent data.

Further Analysis

Up until this point, only descriptive analysis and some comparisons between normative scores and adoptee scores have been conducted. The next series of analysis focuses on the questions that have yet to be answered. They are:

- What factors influence adoptee attitudes towards adoption/feelings about their birth family?
- What factors influence adoptee self-esteem?

An additional question was added related to some of the results obtained. That question is what factors influence adoptee's mental health?

[3] Difference of difference in proportions calculated via an Excel Program available from the lead author.

It is important to keep in mind that because of the nature of the way data were collected (cross-sectional), we cannot determine cause and effect. The data that has been collected can give information about associations; only when longitudinal data are collected can cause and effect be determined.

Factors Influencing/Influenced by Adoption Attitudes/Feelings about the Birth Family

Table 10 presents several factors that were evaluated for their impact on adoption attitudes. Bivariate correlations were computed for interval level data. Three variables were significant. The age at adoption was significantly correlated with attitudes towards adoptive parents; the older the age at adoption, the less positive are attitudes towards adoptive parents. The correlation was moderately strong. Self-Esteem Scores and the Mental Health Component were significantly correlated with attitudes towards birth parents; the higher the self-esteem and the higher the mental health, the more positive were attitudes towards birth parents. The correlations are moderately strong.

Table 10: Select Factors Affecting Adoption Attitudes

	Attitudes towards Adoptees	Attitudes towards Adoptive Parents	Attitudes towards Birth Parents
Age at study	r=-.12, p=.43	r=-.03, p=.83	r=.15, p=.35
Age at adoption	r=-.21, p=.21	**r=-.45, p=.006**	r=-.17, p=.33
Age at adoption disclosure	r=-.05, p=.77	r=-.07, p=.97	r=.02, p=.91
Self-Esteem Score	r=.29, p=.08	r=.19, p=.25	**r=.45, p=.004**
Physical Health Component	r=.24, p=.12	r=.04, p=.78	r=-.06, p=.70
Mental Health Component	r=.02, p=.88	r=-.04, p=.82	**r=.41, p=.007**

Perhaps one of the more interesting findings is how few factors that were evaluated were correlated with attitudes towards the birth family.

Factors Influencing/Influenced by Self-Esteem

Table 11 presents several factors that were evaluated for their impact on self-esteem. Two variables were significant. As presented in the previous section, attitudes toward the birth parents were moderately correlated to self-esteem; the more positive the attitudes towards birth parents, the higher the self-esteem. Also, the age of adoption was negatively correlated; the higher the age at adoption, the lower the self-esteem.

Table11: Select Factors Affecting Self-Esteem

	Self-Esteem Score
Age at study	r=-.8, p=.65
Age at adoption	**r=-.4, p=.02**
Age at adoption disclosure	r=.27, p=.10
Physical Health Component	r=.25, p=.13
Mental Health Component	r=.12, p=.47

Factors Influencing/Influenced by Mental Health

Table 12 presents several factors that were evaluated for their impact on mental health using two indicators, the mental health subscale and the mental health component. Two factors are significant correlated and both were moderate; the higher the physical health component, the lower the mental health component and vice versa. For both mental health scales, more positive attitudes were associated with higher mental health.

Table 12: Select Factors Affecting Mental Health

	Mental Health Scale	Mental Health Component Scale
Age at study	r=.10, p=.52	r=.19, p=.20
Age at adoption	r=-.07, p=.66	r=.01, p=.94
Age at adoption disclosure	r=.24, p=.12	r=.10, p=.52
Self-Esteem Score	r=.18, p=.26	r=.12, p=.47
Physical Health Component	r=-.04, p=.81	**r=-.37, p=.01**
Adoptee Attitudes	r=.08, p=.62	r=.02, p=.88
Adoptive Parent Attitudes	r=-.04, p=.82	r=-.04, p=.82
Birth Parent Attitudes	**r=.31, p=.04**	**r=.41, p=.007**

Summary

Overall, the adoptees in the study were physically very healthy. The Indian adoptees overall were well adjusted and doing well academically. Parents' psychological resources and support are critically important in child outcomes. Most of the Indian adoptive parents at the time of adoption were mature and older than the typical birth parent. Mature parents, with more robust psychological well-being, are better able to provide adequate stimulation to their children (Belsky, 1984, 1990).

More than half (n=26) adoptees have thoughts and questions about their birth family. At the same time, the vast majority are happy about their adoption and being placed for adoption.

The one area of concern is mental health. About half of the adoptees scored below the norm for mental health. Yet, the mental health problem did not seem to be depression; the vast majority of adoptees are not depressed. Good physical health was associated with positive mental health. Positive attitudes towards the birth family were associated with better mental health.

Project Limits

No matter how innovative or social science based a project might be, there are always a number of weaknesses that must be acknowledge. One key problem was the small sample size that raises questions both about generalizability and statistical power. A second problem are the

measures used in the study; some have not been used in India, some had to be modified to fit the situation, and all measures were translated from English into the local dialect of Marathi but not back translated for accuracy in errors. This may have resulted in measurement errors. To score the SF-36, Quality Metric Software was used and the program rated the data quality as poor. It is unclear how the poor rating was obtained but it does mean the health data must be evaluated with caution.

Conclusion

There is some indication that childhood health influences health and economic status throughout the life course (Case & Paxon, 2010). Health is strongly related to economic status in that wealthier people live longer and have lower morbidity. Yet many of the models of health do not take into account situations where children may have poor health initially but are then adopted into higher resource families that result in their health and development taking on a different trajectory.

A compelling argument can be made to adoptive parents that their influence on their children's IQ, and to a lesser extent, personality may not be great (Barth, 2002). Neither can their attempt to forget the birth family or protect their adopted children from questions about their birth family. Genetics, as opposed to environment, tends to have a greater influence as individuals age (Barth, 2002) so it is not unusual for questions about the birth family to arise. But the influence is probabilistic, not deterministic (Rutter, 2006). Scarr and McCartney (1983) suggest that as children grow older, they have increasing control over their environments and actively select opportunities that fit their genetic disposition.

Much of the challenge of working with adoptive parents over the life span has to do with the fit between their expectations and the characteristics that children present (Barth, 2002). Adoptive parents are likely to overestimate the impact of the environment and underestimate the impact of prenatal and genetic influences. Helping adoptive families cope with educational performances of their children that do not meet their expectations is likely to require changes in the way that parents view themselves and their children (Barth, 2002). Strong family influences tend to shape the behavior of younger children more than they do older children (Barth, 2002). The family and social environment helps to moderate difficulties that children might otherwise have; from an epigenetic perspective, the environment might turn off or turn on genetic risks. A key benefit of adoption is that adoptive families continue to invest substantial personal and financial resources in their children throughout the life cycle (Barth & Brooks, 1997).

This project allowed adoptees to have a voice, one of the first systematic attempts to do so in India. While it has some weaknesses, it offers a glimpse into the lives of the adoptees who participated in the project.

The project was organized around a number of questions. The first question probed adoptee attitudes towards adoption. Adoptees are mostly positive about their adoptive family and being placed for adoption. Over half stated they had questions about their birth family; probably more had questions but were reluctant to express it since they thought it would hurt their adoptive families. The most common question adoptees had about the birth family was about the reason they were placed for adoption/the circumstances that lead to an adoption decision. Secondary questions included what they look like, whether they were alive and,

although not explicitly stated but inferred, whether they would be open to contact. There were few factors that influenced attitudes towards adoption/the birth family, self-esteem or mental health. Attitudes towards the birth parents had a moderate association with mental health and vice versa. Older age at placement had an association with self-esteem. Yet, many of the quantitative factors explored had any association.

As a result of the data collection from adoptees as well as adoptive parents along with key informant interviews and community forums where results were presented, several implications are warranted. First, adoption is a lifelong process. While the needs of adoptive families may not be a prominent during early adulthood for the adoptee, the adoptee and their families have unmet service needs. Post-adoption programming must meet the needs of adult adoptees and families. These needs might include having a neutral forum to share how adoption continues to shape their life experiences as well as just having the opportunity to meet other adoptees. Post-adoption programming means helping adoptees sort through their feelings about their birth family/adoptive family and it may include an array of services linked to the birth family--from obtaining non identifying information to conducting searches and meeting birth family members to securing genetic testing to confirm maternity or paternity. Search for biological roots is a fairly new concept in India and will require extensive community education campaigns so the adoptees who want birth family information and contact are not seen as pathological/ or as a reflection of parenting but searching is seen as part of normal adult development. While search has been more associated with adoptees, it is not unusual for any adult person to think about their historical and biological roots. An entire industry has developed to help people explore their genealogy (see www.ancestry.com) including American television programs (*Who Do You Think You Are*). Children, grandchildren and great grandchildren of immigrants often explore the family country of origins as part of developing a greater sense of adult identity. It is, therefore, not usual for adoptees to have the same feelings and desires.

Another implication is related to disclosure, given the response pattern in the current study. While parents may feel the communication is complete it may not be so from the perspective of the adoptee. There are indications to suggest that although adoptees have a positive self- esteem it may not be reflected in the disclosure of their adoptive status; in other words, adoption is a protected status and not directly related to disclosure, particularly with their peers. Adoptees are cognizant of their status and learn to manage it within the context of Indian society.

For many adoptees, the study was the first time they could talk with someone about their adoption without being judged. A number of them became emotional during the interviews and when asked if they wanted to stop talking, none of them wanted to. They wanted to talk about their adoption. This study was beneficial, if for no other reason than it gave the adoptees a voice.

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Appendices

BRIEF SCREEN FOR DEPRESSION (BSD)
By A. Ralph Hakstian and Peter D. McLean (1989)

1. How many times during the last 2 days have you been preoccupied by thoughts of hopelessness, helplessness, pessimism, intense worry, unhappiness, and so on? (Circle number)

1	2	3	4	5
Not at all	Rarely	Frequently	Most of the time	All of the time

2. How relaxed have you been during the last 2 days, compared to how you normally are? (Circle number)

1	2	3	4	5	6	7	8	9	10
Quite calm and relaxed physically								Extremely tense (i.e. wringing hands, muscle tremors, etc.)	

3. To what extent have you had difficulty starting and following through an ordinary job or task to completion during the last week compared to when you feel thingis have been going well? (Circle number)

1	2	3	4	5	6	7	8	9	10
Start and finish jobs as well as most other people								Put things off/starting and not finishing for a long time, if at all	

4. How satisfied are you with your ability to perform your usual domestic duties (i.e. shopping, meals, dishes, home repair, cleaning up, child care, etc.)? (Circle number)

1	2	3	4	5	6	7	8	9	10
Very satisfied								Very dissatisfied	

SELF-ESTEEM RATING SCALE (SERS), revised for project
By William R. Nugent and Janita W. Thomas

This questionnaire is designed to measure how you feel about yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

1= Never
2= Rarely
3= A little of the time
4= Some of the time
5= A good part of the time
6= Most of the time
7= Always

Please begin:

1.____I feel that people would NOT like me if they knew me well.
2.____I feel that others do things much better than I do.
3.____I feel that I am an attractive person.
4.____I feel confident in my ability to deal with other people.
5.____I feel that I am likely to fail at things I do.
6.____I feel that people really like to talk with me.
7.____I feel that I am a very competent person
8.____When I am with other people I feel that they are glad I am with them
9.____I feel that I make a good impression on others
10.___I feel confident that I can begin new relationships if I want to.
11.___I feel that I am ugly.
12.___I feel that I am a boring person.
13.___I feel very nervous when I am with strangers.
14.___I feel confident in my ability to learn new things
15.___I feel good about myself
16.___I feel ashamed about myself
17.___I feel inferior to other people.
18.___I feel that my friends find me interesting.
19.___I feel that I have a good sense of humor
20.___I get angry at myself over the way I am.
21.___I feel relaxed meeting new people.
22.___I feel that other people are smarter than I am.
23.___I do NOT like myself.
24.___I feel confident in my ability to cope with difficult situations.
25.___I feel that I am NOT very likable

26.___ My friends value me a lot.
27.___ I feel afraid I will appear stupid to others
28.___ I feel that I am an ok person.
29.___ I feel that I can count on myself to manage things well.
30.___ I wish I could just disappear when I am around other people.
31.___ I feel embarrassed to let others hear my ideas.
32.___ I feel that I am a nice person.

HEALTH SURVEY SHORT FORMS (SF-36 & SF-12)

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, how would you describe your health? (Circle one)

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. Compared to *one year* ago, how would you rate your health in general now? (Circle one)

Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same as one year ago	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

3. The following items are about activities you might do during a typical day. Does *your health now limit you* in these activities? If so, how much? (Circle one number on each line)

Activities	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities, such as running, lifting heavy	1	2	3
objects, participating in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, pushing	1	2	3
a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking, more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Circle one number on each line)

	Yes	No
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Were limited in the kind of work or other activities	1	2
d. Had difficulty performing the work or other activities	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious) (Circle one number on each line)

	Yes	No
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Didn't do work or other activities as carefully as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Circle one)

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

7. How much bodily pain have you had during the past 4 weeks? (Circle one)

None	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very severe	6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle one)

Not at all	1
A little bit	2
Moderately	3
Quite a bit	4
Extremely	5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks; (Circle one number on each line)

	All Of the Time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps That nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt down hearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.? (Circle one).

All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5

11. How true or false is each of the following statements for you? (Circle one number on each line.)

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

Openness of Adoption Scale

Please answer the following questions on a scale of 1 to 7, 1 being strongly disagree and 7 being strongly agree.

_____1. Biological parents who have lost custody of their children because they are in prison should not have contact with their biological children.
_____2. Biological parents who would choose drugs over the needs of their children are never capable of being trusted to put their children first.
_____3. Biological parents who abuse their children so badly that they lose parental rights don't have anything positive to offer their children.
_____4. Biological parents who lose their children to the state because of abuse don't deserve the privilege of seeing them.
_____5. Biological parents who neglect their children so badly that they lose parental rights don't have anything positive to offer their children.
_____6. Children will bond better with their adoptive parents if they have no contact with their biological family.
_____7. Children's sense of belonging to the adoptive family is strengthened if they sever contact with their birth family.
_____8. Children will form a better attachment to their adoptive family if they have no contact with their birth family.
_____9. Children who are placed in adoptive homes will be confused if they continue to see their biological parents.
_____10. It is best for adoptees to start over fresh, without any contact with their biological parents.
_____11.Adoptive parents wouldn't adopt children if they would have to deal with the children's biological family.
_____12. Adoptive parents will feel less entitled to the role of "parent" if the adoptive child still has contact with his or her biological family.
_____13. To develop a strong family identity, adoptive parents need a closed adoption.
_____14. Adoptive parents' bonding to their newly adopted child will be enhanced if there is no fear of contact with the child's birth parents.
_____15. It would be impossible to recruit adoptive parents if they thought they would have to deal with the biological family.

Questionnaires without Scales

Questionnaire for Adopted Indian Persons

We are conducting a survey on your experiences with adoption. Your answers are very important to us and will be kept strictly confidential. First of all, we would like to ask you a couple demographic questions.

1. What is your gender? (INTERVIEWER CAN RECORD)
    a. Male
    b. Female

2. What is your age? _____

3. What is the highest level of education you have completed?
    a. Some high school
    b. High school graduate
    c. Some college
    d. College graduate
    e. Master's degree or more

4. Did you feel as though you met your adoptive parents' academic expectations?
    a. Met expectations
    b. Exceeded expectations
    c. Did not meet expectations

5. Are you currently:
    a. Student
    b. In search of a job
    c. In the process of setting up own business/professional practice
    d. Employed full-time
    e. Employed part-time
    f. Temporarily unemployed
    g. Homemaker

6. How do your parents feel about your choice of career/job?
    a. Extremely satisfied
    b. Very satisfied
    c. Somewhat satisfied
    d. Slightly dissatisfied
    e. Extremely dissatisfied

7. Which of the following categories includes your total annual household income before taxes?
    a. Under Rs. 2,00,000/-
    b. Rs. 2,00,000 to 4,00,000/-

c. Rs. 4,00,000 to 6,00,000/-
d. Above Rs. 6,00,000/-

Now we would like to know about your adoption history.

8. How old were you when you were adopted? _____ years ____ months old

9. Who disclosed the fact of adoption?
a. Adoptive Parents
b. Adoptive Mother Only
c. Adoptive Father Only
d. Adoptive Step-Mother Only
e. Adoptive Step-Father Only
f. Other Adoptive Siblings
g. Extended Adoptive Relatives
h. BSSK
i. Neighbors
j. Friends
k. Self-discovered
l. Other (Specify:_____)

10. How old were you when the fact was first disclosed? _____ years old

11. How was the adoption disclosed? Please describe.
_____
_____
_____
_____

12. When you and your parents talked about adoption, who usually started the conversation?
a. We (almost) never talked about adoption
b. Parent(s)
c. Self
d. Parent and self equally
e. Other people (siblings, relatives, friends)

13. How did you perceive the disclosure when you learned that you were adopted?
_____
_____
_____

14. How do you feel about being adopted?
a. I feel positive about being adopted
b. I feel neutral/mixed about being adopted
c. I feel negative about being adopted

15. How do you feel about being placed for adoption?
    a. I feel positive about being placed for adoption
    b. I feel neutral/mixed about being placed for adoption
    c. I feel negative about being placed for adoption

16. Do you ever have any thoughts coming to your mind about your birth family? Yes / No

17. If you said yes, what questions come to mind about your birth family? What do you wish to know about your birth family?

_____
_____
_____

18. When do you think about your birth family?

_____
_____
_____

19. Please describe your marital status:
    a. Single
    b. Married
    c. Engaged/committed
    d. Divorced/widowed

20. Do you have children?
    a. Yes, I have a biological child/children
    b. Yes, I have an adopted child/children
    c. No, I have no children (skip to end)

21. Does the experience of having a child change your perspective on adoption?

_____
_____
_____

22. (If Q20=a) Does parenting a child bring back the issues of the missing link?

_____
_____
_____

1. To what extent has your adoption altered your life?

2. What is the most important thing you would like your parent to know (that you have never told them) about how it is to be adopted?

3. Please describe your current relationship with your adoptive parents. You can talk about how emotionally close you are, to what degree you can confide in them, how much you feel supported by them, how proud you think they are of you, etc.

4. How do you look back on the fact that you were adopted?

5. How would you summarize your feelings (about being adopted)?

6. If you had to give a message to prospective adoptive couples, what would it be?"