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THE LIVED EXPERIENCE OF PARENTING A CHILD ADOPTED FROM AN  
INSTITUTION IN EASTERN EUROPE

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for  
the degree of Doctor of Philosophy

By

Kimberly A. Curry-Lourenco

December 2012

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Kimberly A. Curry-Lourenco

2012

THE LIVED EXPERIENCE OF PARENTING A CHILD ADOPTED FROM AN  
INSTITUTION IN EASTERN EUROPE

By

Kimberly A. Curry-Lourenco

Approved October 15, 2012

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## ABSTRACT

# THE LIVED EXPERIENCE OF PARENTING A CHILD ADOPTED FROM AN INSTITUTION IN EASTERN EUROPE

By

Kimberly Ann Curry-Lourenco

December 2012

Dissertation supervised by Dr. Lenore K. Resick

This study sought to explore the lived experience of parenting a child adopted from an institution in Eastern Europe. A hermeneutic, phenomenologic method following the Utrecht School was used. The setting for this study was a southern state on the east coast of the United States. The sample consisted of 11 participants, nine mothers and two fathers, self-identified as adoptive parents to children from institutions in Eastern Europe. Semi-structured interviews, with thematic analysis of transcriptions were conducted. Five major themes were identified: choosing-being chosen, weaving the fabric, the importance of doing, remaining mindful, and looking-in, looking out. Conclusions were that parents in this study value the importance of history and the moment in time that they chose to adopt their child, build the family by establishing their identity as mother/father, protectors and authority figures, actively seek out resources and

information for their children, possess heightened awareness of their children's need for security and safety, and measure normalcy of their experiences through comparison of adoptive parenting to biologic parenting. Implications for nursing practice include the need for on-going assessment of family health and functioning, as well as coordination of multiple resources, services and support. Implications for nursing education include enhanced content related to assessment and care of the family with internationally adopted children, effects of institutionalization, alcohol-related neuro-developmental disorder and reactive attachment disorder. Given the complex picture of the internationally adopted child and family, an inter-professional educational approach to these topics may be beneficial. Future research recommendations include replication with parents of children adopted from other geographic regions, quality of life studies, self-efficacy of healthcare providers in caring for internationally adopted children, and measures of stress augmented with biologic markers.

## DEDICATION

Dedicated to my husband, John,  
my dearest friend, confidant and soul mate.

## ACKNOWLEDGMENTS

Completion of this dissertation has been one of the most challenging and fulfilling life experiences. I am so very grateful for the encouragement and support of many special people along the way.

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To my sister, Donna--thank you for your priceless humor and clarity. Not many sisters share all that we do. I love you.

And in most loving memory, to my mother, Helen--thank you for teaching me to love life, learning, and laughter. You are with me always.



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# CHAPTER 1

## BACKGROUND

### 1.1 Introduction

International adoptions increased 292% between 1990 and 2006, according to the United States State Department. Data reflect that 11,058 international adoptions occurred in Fiscal Year (FY) 2010; 1,733 (16%) of those involved children from Eastern European countries ([http://adoption.state.gov/about\\_us/statistics](http://adoption.state.gov/about_us/statistics)). In foreign countries with international adoption programs, children who qualify for orphan status usually reside in institutional settings operated by the government or religious organizations (USCIS, 2008). The effects of institutionalization upon children have been widely studied and have yielded a grim reality. Developmental, cognitive, emotional, behavioral and psychological delays are common, ranging from mild to profound and are often life-long in nature (Lin, Cermak, Costner, & Miller, 2005). The dynamics of institutional daily life frequently foster a culture likened to “Darwinian survival” resulting in a variety of behaviors from aggression/violence to social withdrawal/depression (Narad & Mason, 2004). Autistic spectrum disorders as well as attachment and neuropsychiatric disorders are commonly the focus of scientific inquiry among post-institutionalized children. In children of Eastern European countries, Fetal Alcohol Syndrome is prevalent, with 14% of children residing in Russian orphanages having physical characteristics of Fetal Alcohol Spectrum Disorder (Miller, 2005). According to the World Health Organization,

Europe has the highest incidence of alcohol consumption worldwide. Current information on the prevalence of FAS and FASD in the United States is difficult to find.

Bertrand, Floyd and Weber (2009) reported that 1000-6000 children in the U.S. were born with FAS during 2005, out of the 4.1 million births reported by the Centers for Disease Control that year.

**Historical view of international adoption and Eastern European trends.** The advent of international adoption can be traced back to post World War II and Korean War eras. According to Miller (2005) 5,814 children were adopted by Americans from war-torn countries in Europe between 1948 and 1953. The United States has the greatest number of internationally adopted children worldwide. Recent statistics from the United States (U.S.) Department of State indicate that 9,319 international adoptions occurred in Fiscal Year 2011 ([http://adoption.state.gov/about\\_us/statistics](http://adoption.state.gov/about_us/statistics)).

Adoptions of children from Eastern European countries dramatically increased after the erosion of the Soviet Union. Russia and Ukraine top the list for countries with the greatest number of children adopted by families in the United States. The current hold on adoptions from Romania, due to allegations of government corruption, has influenced the increased interest in children from Russia and Ukraine. Slight differences in adoption procedures between Russia and Ukraine often attract families to choose one country over the other. For example, prospective adopting parents interested in Russia receive a photo and sometimes a video of the child being offered to them through an adoption agency. This allows parents to agree to a specific child before traveling to the country to adopt and also allows for physician review of the video prior to adoption. Prospective parents choosing to adopt from Ukraine travel “blind”, without prior referral of a specific child,

thereby allowing parents to “meet” more than one child and make a decision while in the country. In such cases, there is little or no opportunity for video examination or consultation with a physician prior to adoption. In addition, Russia is currently requiring two trips to complete the adoption compared to Ukraine’s single trip requirement. However, such stipulations are frequently changed depending upon current policy set forth by each country’s Adoption Ministry (Miller, 2005).

## 1.2 Purpose of the Study

The purpose of this study is to explore the lived experience of parenting a child adopted from an institution in Eastern Europe. This study investigates the meaning of being parent to a child who was living in an institution in Eastern Europe at the time of adoption. The aim of the study is to increase knowledge and understanding for nurses, and other health care professionals providing care to families with post-institutionalized, internationally adopted children.

## 1.3 Research Question

What is the lived experience of parenting a child adopted from an institution in Eastern Europe?

## 1.4 Definition of Terms

Within the context of this study, Eastern Europe will be defined as Russian- speaking regions of the Former Soviet Union (FSU). The term *child* refers to an individual less than 18 years of age. *Adoption* is defined as the taking in of a child in need of a home by an adult(s) who is not their biological parent(s). A parent-child relationship is established

through the process of adoption (Javier, Baden, Biafora, & Camacho-Gingerich, 2007). United States Department of State defines *international adoption* as the adoption of a child born in a country different than the country of his/her adoptive parents. A recent change in language designates “inter country adoption” as the more current term; however this study maintains the language used at the onset and as reflected in the research question. The term infers immigration of the child to the country of adoptive parents’ residence (<http://travel.state.gov/family/adoption/intercountry/intercountry>).

*Institution* refers to an orphanage. *Post institutionalized child* refers to a child who resided in an orphanage, prior to adoption. Within the context of this study, the term *health care providers* refers to physicians, physician assistants, nurse practitioners, and registered nurses.

## 1.5 Assumptions

This study represents an ontological approach to understanding the experience of parenting a post-institutionalized child adopted from Eastern Europe. Therefore, it is important to identify the following assumptions reflecting the emic perspective of this study:

1. Participants in this study will be able to talk about their experiences of being the adoptive parent of a post institutionalized internationally adopted child.
2. Participants’ responses will reflect honest feelings and experiences.
3. The meaning of participants’ experiences will result in heightened knowledge and understanding.



4. Participants will be able to verify or clarify textual interpretations of their experiences, thereby establishing reliability of the data.
5. Words used by participants during their interviews will reflect the ontological meaning of their experience.

## 1.6 Limitations

The findings of this study will be limited to the population who participated and are therefore, not generalizable to all parents of post-institutionalized internationally adopted children. This study does not address the experiences of parents with children adopted from within the United States nor internationally from regions other than Eastern Europe.

## 1.7 Personal Biography of the Researcher Related to the Study

The researcher is a registered nurse and mother to two siblings adopted from an institution in Ukraine. Interest in the research topic evolved from social interactions with other parents of internationally adopted children, specifically children from Eastern Europe, who had described a wide dichotomy between expectations and realities of their adoption experiences. Adoptive parents often described frustration about the limited understanding of health care providers regarding daily life with their internationally adopted child (ren). Such observations led the researcher to choose an interpretive approach to the research topic.

Initial fieldwork was conducted within a Children's Russian and Ukrainian Culture group for children adopted from Eastern European countries. The researcher's role was largely observational, consisting of social interactions with adoptive families and

children. This experience provided the researcher practice in keeping field notes which were used for reflection upon observations.

Subsequent fieldwork presented the researcher the opportunity to attend and observe a support group for parents with adopted children-some internationally adopted families and many who had adopted children via private domestic adoption (within the United States) or through local foster agencies. This faith-based group met once a month and consisted of a brief opening presentation by a parenting, counseling or education expert followed by open forum question and answer sessions from the audience. A commonly shared sentiment among the parents of internationally adopted children was, “None of this applies to our children.”

A third fieldwork opportunity placed the researcher within a local adoption agency that facilitates domestic, foster and international adoptions. Time was spent assisting case workers with interviews and screenings of parents interested in adopting a child as well as birth mothers/fathers considering placing children for adoption. This provided invaluable insight to the “other” side of the adoption process. Being an adoptive parent, it was essential that the researcher become familiar with adoption from this perspective. Proceeding without this view would have severely limited the context and history essential to the interpretive process.

The researcher’s personal history as a parent of children adopted from Eastern Europe has revealed a focus of inquiry that values understanding and interpretation of the *lebenswelt*, or life world defined by Husserl, as cited by Van Manen (2007) of parents who have adopted children from Eastern Europe. Furthermore, only one interpretive study, a dissertation by Ryan (2006) exists in the nursing literature to inform nurses

about the experience of parenting the post institutionalized child adopted from Eastern Europe. This study focused on parenting children with known Reactive Attachment Disorder. No other studies representing an ontological approach to adoption of post institutionalized Eastern European children have been found.

## 1.8 Significance

Internationally adopted children often present with health care issues indigenous to their country of origin and group living environments. Such needs are usually complicated by incomplete or inaccurate medical and family histories (Hostetter et al., 1991). Parents of the post- institutionalized child adopted from Eastern Europe often face the combined reality of institutional effects and unreliable health care histories. Only the dissertation study by Ryan (2006) has been found in the nursing literature which investigates the experience of mothers of post-institutionalized children adopted from Eastern Europe. This study is limited to children diagnosed with attachment disorder and only adoptive mothers participated in the study. According to Gribble (2006), the effects of institutionalization on children are complex. It is often difficult to isolate and definitively identify disorders since developmental and cognitive delays, emotional and mental disturbances, and neuropsychological deficits are usually concurrent. The dimensions of one or more of these issues complicate the clinical presentation and may impact diagnosis. Further, many “hidden” symptoms are often present in post institutionalized children and present as “unusual behaviors” or strong characteristics which impact interactions in relationships. The melding of complex effects from institutionalization often makes it difficult to determine which “diagnosis” is responsible for the behavior or delay being presenting. Gribble (2006) writes, “Issues of trauma,

abuse and neglect can make issues of diagnosis and treatment difficult” (p. 10). For this reason, the proposed study addresses institutionalization from a global perspective, embracing the broader meaning of being parent to a child who has emerged with this history.

Equally significant within the literature is evidence of the positive impact of adoption upon children. A meta-analysis of 62 studies comparing cognitive development and school performance between internationally adopted children, and children who remained in an institutionalized setting, or with their birth family in a deprived environment, indicated that adopted children had higher Intelligence Quotients (IQ), but slightly delayed language and school performance (van IJzendoorn, Juffer, & Poelhuis, 2005). The researchers write, “Most adopted children do remarkably well, certainly much better than their siblings or peers who had to stay behind in poor institutions or deprived families” (van IJzendoorn et al., 2005, p. 313). Through an integrative review of 38 studies involving adoptive families, O’Brien and Zamostny conclude, “Many adoptive families successfully negotiate the challenges associated with adoptive family life” (O’Brien & Zamostny, 2003, p. 695).

Evidence of challenges and successes related to international adoption exist within the literature, but no studies revealing the meaning of parenting an internationally adopted child from an institution were found. The aim of this study is to cast the widest net possible, inviting adoptive mothers and fathers to define the meaning of their experiences without limitation. A similar study by Linville (2003), a dissertation titled *Family Experiences Concerning Adopting a Previously Institutionalized Child from Russia or Romania*, was found in the human development literature. The Linville study takes a

descriptive approach to the pragmatic process of international adoption, through the early post-adoption phase within a family. The study does not explore the concept of *parenting*, but rather describes the experiences of family members as they moved through the adoption process and in the months that followed upon arrival back in the United States with their child.

No studies have been found which explore the meaning of *parenting* as a concept within the adoptive parent-child relationship. Further, no studies have been found which seek the meaning of parenting a child adopted from an Eastern European institution using an interpretive approach. There is a significant gap in the literature regarding the lived experience of parenting a child adopted from an Eastern European institution. The current studies have not brought readers into the experience, but rather, to the descriptions of the experiences. What remains therefore, is a need to enter the time and space of parents of these children. Heidegger (1956) writes of the early desire of the Greeks to seek the essence of all they observed and sought to understand. In his book, “*What is philosophy?*” he describes the concept of *sophon* or the “being in Being.” He describes the inter-mingling of the *sophon*, with *philos* (love) and *orexis* (yearning) and writes, “The love of the *sophon*-or- *philosophia*- is now especially sought.” A hermeneutic phenomenological study, with rich ancestral ties to *philosophia*, will provide the ontological knowledge that is currently absent, illuminating the “being in Being” known to be the hallmark of hermeneutic inquiry.

There are some concerning statistics related to internationally adopted children. Alarming, 18 deaths of internationally adopted children in 17 families have been reported in the United States since 1996. In all cases, parental neglect/abuse was proven

or suspected. Of the 18 cases, 14 were children adopted from Russia. Recommendations urging health care providers to be vigilant in their assessment of internationally adoptive families abound (Miller, Chan, Reece, Tirelia, & Pertman, 2007).

Johnson (2000a) states that international adoptees and parents present with physical, developmental and psychological needs not commonly seen in traditional pediatric populations. Despite recommendations for more vigilant family assessments, most providers have had minimal, if any, exposure to the process of international adoption, the health care needs specific to these children and the special needs of the post-institutionalized child (Iverson & Johnson, 2005). In 2005, Miller wrote that approximately forty pediatricians within the United States comprised the core group of the Subsection on Adoption and Foster Care (SOAFC) of the American Academy of Pediatrics (AAP), identifying themselves as “adoption medicine specialists” (p. 1). A recent review of the SOAFC directory conducted by this researcher found over 90 physicians listed (<http://www2.aap.org/sections/adoption/index.html>).

Further, a total membership of at least 200 now comprises the AAP SOAFC, representing growing inter-disciplinary interest. Affiliate membership is available to nurses, nurse practitioners, allied health care professionals, social workers, speech and language pathologists, educators and researchers with a defined focus in this area. Such acknowledgements strongly drive the call for enhanced family-focused care. In order to design plans of care for families with post- institutionalized adopted Eastern European children, it is imperative to investigate and understand the lived experience of their adoptive parents.

This study is significant to nursing in general, in ensuring that nurses understand the context of parenting a post- institutionalized child adopted from Eastern Europe as they interact with and design plans of care for this population. It is also of particular significance to family practice and women's health nurse practitioners as well as pediatric nurses, and other health care professionals, who are often the first- line resources for parents.

### 1.9 Summary

Adoptions of children from Eastern Europe increased dramatically after the fall of the Soviet Union. Statistics from Fiscal year 2010 indicate that 16% of all international adoptions involved children arriving from Eastern European countries ([http://adoption.state.gov/about\\_us/statistics](http://adoption.state.gov/about_us/statistics)). Children adopted from institutions in Eastern Europe often present with a complex physical, neuro-developmental, psychological and emotional issues not commonly seen in traditional pediatric and family health clinical settings (D. E. Johnson, 2000b). In the aftermath of disturbing statistics regarding harm to internationally adopted children at the hands of their adoptive parents, Miller (2007) urged health care providers to be vigilant in the assessment of adoptive children and their families. However, many pediatric and family health care providers have had limited, if any, preparation for the care of internationally adopted children and their families. Although studies have addressed descriptions of the experience, there is a significant gap in the literature regarding the lived experience from the perspective of the parents regarding parenting a child adopted from an institution in Eastern Europe. This study will bridge this gap by employing a hermeneutic phenomenological approach

to answer the question “What is the lived experience of parenting a child adopted from an institution in Eastern Europe?”



## CHAPTER 2

### REVIEW OF LITERATURE

#### 2.1 Introduction

The purpose of this chapter is to present an overview of the literature as guided by the proposed research question. Four concepts tightly related to the research phenomenon establish the framework for exploration of the literature: adoption, parenting, international adoption, and institutionalization.

#### 2.2 Adoption

Prior to the 1960s, few studies involving adopted children had been conducted. Since that time, an ever-expanding body of knowledge has developed addressing factors related to adopted children. The vast majority of these studies have been of quantitative design, conducted by researchers within psychology and the social sciences. Many early studies suggested that adopted children were prone to more psychological and behavioral problems than their non-adoptive peers. Through a meta-analysis of 66 studies, Wierzbicki (1993) determined that adoptees exhibited higher levels of maladjustment compared to non-adoptees. This observation was attributed to the number of studies indicating adoptees' over-representation in mental health services and special education populations (Brodzinsky & Steiger, 1991). A quantitative, longitudinal study conducted by Miller, Fan, Christensen, Grotevant, and van Dulmen (2000) compared the risk of adopted and non-adopted adolescents across domains including: school achievement and problems, substance use, psychological well-being, physical health, fighting and lying to parents. A survey, the National Longitudinal Study of Adolescent Health (Add Health)

was administered to 90,118 students in grades 7 to 12 from 1994 to 1995. This pen and paper questionnaire measures social and family contextual variables that influence health-related behaviors among adolescents. From April 1995 to December 1995, 20,745 students were interviewed in their homes using the Add Health Self-Administered Questionnaire (SAQ). Half of the interview was conducted by an interviewer and questions considered to be more sensitive were completed on a computer. Participants for the interview portion of the study were recruited through school rosters, so that most of them had already completed the Add Health survey. While adolescents were never asked directly about their adoption status, a question about their relationship with their parents did appear on the SAQ and was used to infer adoption status. The question asked the adolescent to best describe his/her relationship with each parent in the home. Those who responded “adoptive mother” and “adoptive father” were categorized in the adoption group. Data analysis was conducted using logistic regression analysis. Results indicated that adopted adolescents had more problems in all domains compared to their non-adopted peers. Specific characteristics that contributed to greater effect sizes included being male, Hispanic or Asian, older or younger adolescent (compared to mid-adolescent), residing with parents of lower socio-economic level or adolescents living in a group home. Indications are that adopted adolescents will be referred for mental health treatment more often than non-adopted adolescents. It should be noted however, that not all researchers agree about the significance of findings related to the prevalence of mental and behavioral issues among adopted children, citing flawed methodology or limitations in sampling as primary causes for the phenomenon. For example, Bramlett, Radcliff, and Blumberg (2007) noted an increased occurrence of learning disabilities, developmental

delays and special health needs among adopted children. In a secondary analysis, data from the 2003 National Survey of Children's Health was used to compare the health and well-being of adopted children with biological children and to determine if differences were associated with demographic characteristics and special health care needs. The sample consisted of 102,353 children, 2,903 of whom were adopted. Results indicated that adopted children were more than twice as likely to have special health care needs as biological children, but were also more likely to have insurance coverage and access to consistent preventative health care services. The study design did not control for specific adoption characteristics such as interracial or international adoption. Importantly, this suggests that children of interracial or international adoption may present with characteristics that contribute to increased special needs or problematic behaviors as noted in this study. In a meta-analysis of ten studies focusing on internationally adopted children, Bimmel, Juffer, van IJzendoorn, and Bakermans-Kranenburg (2003) noted that while international adoption presents a protective factor for many children offering opportunity for significant improvement in health and development, "parents, social workers and professionals should remain aware of the disadvantages that many adopted children have experienced, and of the influence that such disadvantages may exert on the adopted children's behavior" (p. 75).

The context of adoption studies within the literature is often criticized by researchers and adoption professionals for focusing on what can be called "the pathology of the adoptive experience" (Baden & Wiley, 2007). Heavy emphasis on feelings of loss, abandonment, and identity confusion among adoptees has painted a picture of poor outcomes that some researchers contend is misguided. Findings from recent studies

indicate that both domestic and internationally adopted children demonstrate impressive resilience, secure self-esteem and often make great strides in physical, mental and emotional health. Juffer and van IJzendoorn (2006) tested the applicability of a “Catch-up Model” to determine if adoption is an effective intervention for both domestic and internationally adopted children. A series of meta-analyses on over 270 studies, that included more than 230,000 adopted and non-adopted children, was conducted. Variables measured in the meta-analyses included physical growth of children, attachment, cognitive development, self-esteem and adjustment/behavior problems.

In another series of meta-analyses of 88 studies, Juffer, and van IJzendoorn (2007) compared self-esteem between 10,977 adopted children and 33,862 non-adopted children. Results indicated that no difference in self-esteem existed between adopted and non-adopted children.

Very few qualitative studies were found when reviewing the adoption literature. Of the qualitative studies identified, many focus on the concept of openness of communication within the adoptive family, specifically difference in how adoption status is revealed to adopted children and openness of relationship with biological mother or other biological relatives. A longitudinal study using phenomenological methodology was conducted by Berge, Mendenhall, Wrobel, Grotevant, and McRoy (2006) as part of the Minnesota-Texas Adoption Research Project (MTARP). Researchers examined adopted adolescents’ (n=152) feelings about contact with their birth mother or other biological relative. Interviews were conducted in two phases, eight years apart. Findings indicated diverse opinions about the adolescents’ desire and satisfaction with birth mother contact. Researchers offered implications for adoption agencies regarding legal

and regulatory guidelines for openness of adoption arrangements. Implications for health care providers, who are often first line resources for adopted adolescents and adoptive families were not addressed.

A study conducted by Dunbar, Van Dulmen, Ayers-Lopez, Berge, Christian, Grossman, Henney, Mendenhall, Grotevant, and McRoy (2006) used an in-depth case study approach to examine processes that influenced the degree of openness within adoptive families during the adopted child's period of adolescence. Also part of the MTARP, this longitudinal study was conducted in two waves. Wave I included 190 adoptive families and 169 birth mothers during the time the adopted children were ages 4 to 12 years old. Wave II was conducted eight years later and included 177 of those adoptive families and 127 of the birth mothers. Data were collected using semi-structured interviews. A coding team was designated by the first two study authors. Two coders were assigned to each case study. Once data were coded, thematic analysis was conducted. Rigor was met through establishing inter-coder reliability and an iterative discussion process between coders. Any themes lacking adequate support were eliminated and remaining themes were evaluated individually by the first two authors. Pervasive themes were brought back to research and coding teams for examination and development. Findings revealed four themes relative to the process of influencing levels of openness during a child's adolescence: gendered involvement in contact (birth mothers were universally more involved than birth fathers), divergent attributions about discontinuation of contact (each party blamed the other for discontinued contact), control and satisfaction (adoptive parents were controlling over family boundaries and were most satisfied when their perception of control was high) and shift in responsibility from adults

to adolescents (as adopted children came into adolescence, responsibility for maintaining openness became more theirs and less their adoptive parents'). Implications from these findings were identified for adoption agencies, clinical practice (therapists), research and policy.

Through review of the adoption literature, one point of strong agreement becomes apparent- that is, the uniqueness of each adoption story and experience. This is well noted by Kirk (1964) in his classic work "*Shared Fate*". He writes that research and practice with adoptees must maintain the sensitive balance between "rejection of difference and acknowledgement of difference"(p. 59). The many variables surrounding adoption present opportunity for continued research within this population.

### 2.3 Adoptive Parenting

Because adoption occurs within the social context of a family, factors related to adoptive parenting must also be considered (Friedlander, 2003). Parenting an adopted child brings the complexity of many variables into the family setting. Often thought of as a "happy event", adoptive parents may feel it is unacceptable to disclose negative feelings related to parenting. "The idea that adoption is a stressful situation runs counter to many prevailing myths and stereotypes about this form of family life that promote an ideal vision of adoption" (Kalus, 2006, p. 175). In a mixed-methods study by Gair (1999) depression was studied among 19 adoptive mothers in Australia. The Edinburgh Postnatal Depression Scale (EPDS) was administered to 19 adoptive mothers of babies and children five years or younger who were also part of a larger study examining adoptive mothering. Data analysis revealed that 32% of the adoptive mothers received an EPDS score indicative of risk for or actual depression. Qualitative data analysis revealed

frequent mention of stress, depression and anxiety during the pre-adoptive waiting period, but no increased mention of the same feelings during the post adoptive period. In the post-adoptive period, adoptive mothers related perceived stress to specific infant behaviors such as sleeplessness, colic, crying and child's difficult temperament. Gair (1999) called for more rigorous studies related to depression in adoptive motherhood, noting that these findings suggest that adoptive mothers appeared prone to the same pressures and stressors as non-adoptive mothers.

The question of whether adoptive parenting is more stressful than non-adoptive parenting is recognizable within the literature. While some authors refute that adoption introduces negative sequelae to parents and/or the family, it is widely acknowledged that each adoptive situation is unique and the experience of adoptive parents is determined by characteristics specific to the adopted child.

Predictors of parenting stress among adoptive parents of children from Eastern Europe were examined by Judge (2003). Two instruments, The Parenting Stress Index (PSI) and the Temperament and Atypical Behavior Scale (TABS) were administered to 109 parenting pairs (adoptive mothers and fathers). Multivariate analyses of variances (MANOVA) were used to determine differences in the amount and types of stress reported by parents. Hierarchical multiple regression analyses were performed to identify differences in mothers and father's sources of stress. Results indicated that adoptive mothers reported different perceptions of stress (depression and decreased sense of competence) than adoptive fathers (increased sense of isolation). The child's behavior problems, specifically, the quantity of problems, was the strongest predictor of reported stress for both adoptive mothers and father.

Mothers comprise the majority of respondents in most research studies. Researchers note that more adoptive mothers tend to complete the study than adoptive fathers. Through a longitudinal quantitative study, Palacios and Sandoval-Sanchez (2006) noted that specific characteristics of the adopted child were highly correlated with mothers' reports of stress. The Parenting Stress Index was administered to 393 adoptive parents in Spain in 1995 and again to 273 of these families in 2001. Parenting styles were assessed using a 20 item Likert scale instrument developed by the researchers. Chronbach's alpha for the scale is .79.

Perception of adoptive parents' stress similarities or differences with non-adoptive parents was measured using questions influenced by Kirk (1964) in his classic works about perceived differences of adoptive families. Chronbach's alpha for this measure was reported to be .52. Data analysis revealed high correlation between mothers' and fathers' scores when both parents answered an item. The researchers chose to work only with adoptive mothers' scores as these were the most complete data provided. Multiple regression analysis showed high correlation between mothers' stress and specific variables. These included male gender, presence of psychological or sensory impairment for the child, use of support services specializing in children's problems or in issues of adoption, adoption of a child with whom there had been a prior relationship and lower education level of the adoptive mother (as opposed to middle or higher education levels). Interestingly, review of the existing literature indicates that many post institutionalized children present with characteristics similar to those noted in this study. Behavioral problems as well as sensory and psychological impairment are common among post



institutionalized children and parents often seek assistance from support services in an effort to help their adopted child (Johnson & Dole, 1999).

Only one study related to stress among adoptive parents was found within the nursing literature. Smit, Delpier, Tarantino, and Anderson (2006) conducted a retrospective, descriptive experimental study which compared source and identity of stress for parents of 10 adopted and 55 biological hospitalized children. Adoptive parents (n=11) and biological parents (n=57), who had a child hospitalized for at least 24 hours in a large Midwestern pediatric hospital, were administered the Parental Stressor Scale (PSS): Pediatric Intensive Care Unit. The PSS has a reliability of 0.72-0.95 and validity of 0.58-0.92. Adoptive Parents were also administered the Impact of Adoption on Hospitalization questionnaire (Smit, 2000) which has an alpha coefficient of .87, measures parents' perception of their child hospitalization both quantitatively and qualitatively. Results of the study revealed that adoptive parents reported significantly higher levels of stress over their child's hospitalization compared to biological parents. Parents also completed the Behavioral Upset in Medical Patients-revised (BUMP-R) instrument to report the perception of child upset during hospitalization. Findings showed significantly greater levels of child distress reported by adoptive parents as compared to biological parents. Limitations of this study include the retrospective reporting of stress during hospitalization as well a small sample size.

This section has provided an overview of selected studies related to adoptive parenting. While vast in scope, the existing body of research, specifically on adoptive families, is diverse in focus and lacks attention to the experience of adoption for adoptees and family members. Friedlander (2003) concludes, "Systematic perspectives on the

concerns of adoptees, parents and siblings are almost non-existent in the [clinical] literature” (p. 749), thus affirming the need for studies that will provide the emic view that is currently absent.

## 2.4 International Adoption

**Health, development, and behavior of internationally adopted children.** Children of inter-national adoption present with unique needs arising from often unknown or unclear histories of prenatal exposure to alcohol, drugs, tobacco and living conditions that are commonly over -crowded or lacking in adequate hygiene, nutrition and medical care. Infectious disease, malnourishment and developmental delays constitute unique needs that may warrant specialized medical and therapeutic care (Miller, 2005). Schulte and Springer (2005) advise that thorough screening should be done in the pre-adoption period including, but not limited to, testing for Human immunodeficiency virus (HIV), Hepatitis B, syphilis, exposure to lead, presence of intestinal parasites, indications of rickets, hip dysplasia and congenital heart disease. Post adoption screenings should include vision screening and also hearing tests, since upper respiratory and middle ear infections are often chronic among internationally adopted children and can result in hearing loss. Dana Johnson (2000a), a pediatrician specializing in international adoption medicine and the founder of the first international adoption clinic in the United States, writes that the incidence of hearing loss among internationally adopted children is estimated to be 3.8% . Hearing disturbances are thought to contribute, at least in part, to the prevalence of language disorders within this population (Ladage, 2009). Other factors associated with speech and language disorders include limited access to early screening and intervention, as well as time spent in an orphanage resulting in limited verbal stimulation

(Glennan, 2002). Rarely do speech and language disorders occur in isolation of other problems, specifically behavior problems, Attention Deficit Hyperactivity Disorder (ADHD), and altered social-emotional functioning. A review of the nursing literature on this topic revealed one study in the *Journal of Nursing Scholarship*. Beverly, McGuiness, and Blanton (2008) conducted a longitudinal study to determine the incidence of communication and academic difficulties in children adopted from the Former Soviet Union. The sample for this study consisted of parents of 55 children who had also participated in a larger study (Time I) four years earlier. The purpose of this current study (Time II) was to examine the relationship between speech –language and academic outcomes for children adopted from countries associated with the Former Soviet Union. Mothers comprised 87% of the respondents and were asked to complete a questionnaire about the child’s speech-language development, school status, support services being used and behavioral concerns. In addition, the Child Behavior Checklist (CBCL) and Family Environment Scale (FES) were completed, but only by 46 of the 55 participants. Overall, scores on the Total Problems and Total Competence subscales remained unchanged from Time I (four years prior). FES subscale scores were more positive. Interestingly, 82% of the children were reported by their parents to have at least one special-education label, 62% of which were communication disorders. Twenty-five participants indicated a learning disability for their child and 23 indicated a diagnosis of attention deficit hyperactivity disorder (ADHD). Researchers concluded that a high percentage of children adopted from the Former Soviet Union presented with speech and language disorders that rarely occurred in isolation of other problems.

Health problems in children adopted from Romania were studied by Beckett, Castle, Groothues, O'Connor, Rutter, and the English and Romanian Adoptees study team (ERA) (2003). A random sample of 165 children adopted from Romania, by parents in the United Kingdom (UK) and stratified for duration of prior deprivation, were selected from 324 children adopted into the UK between February 1990 and September 1992. A normative sample of 52 non-deprived children adopted within the UK was included for comparison. Data were collected using semi-structured interviews of parents to assess health problems at the time of adoptions and any continuing health problems up to six years post adoption, including issues of attachment, willingness to go off with a stranger or child's lack of differentiation between adults. Parents also completed the McCarthy scale of abilities to evaluate their child's cognitive functioning, the Rutter scales to assess inattention/over activity and the Autism Screening questionnaire (ASQ) to assess for autistic tendencies. Statistical methods of data analysis were not provided. Results indicated that by age six, 17% of the Romanian adopted children had conductive hearing loss. Strabismus was found in 12% of the children, and those with quasi-autistic symptoms were more likely to have strabismus. Skin problems were identified in 35% of the children. Inattention/over activity was more likely to occur in children with histories of pre and post natal health risks, although health risks were not found to be associated with cognitive functioning or attachment problems.

Health care providers specializing in international adoption medicine strongly recommend an evaluation of alcohol related neuro-developmental disorder (ARNDD), particularly for children adopted from Eastern Europe where the rate of maternal alcohol use is known to be high. Chambers (2005), a pediatrician with the International Adoption

Clinic at the University of Alabama, wrote an article for pediatric providers who may be advising prospective adoptive parents. She reported that prenatal exposure to alcohol is cited in 12%-41% of pre-adoption medical reports from Eastern Europe. No studies were found in this review examining the lived experience of parents of children with ARNDD, or histories of alcohol exposure.

Currently, China, Ethiopia and Russia place the largest number of children in the United States. The social practice of institutionalization in these countries contributes to the similarity of needs seen in children from these regions (Chambers, 2005). Pomerleau, Malcuit, Chincoine, Seguin, Belhumeur, Germain, Amyot, and Jeliu (2005) compared the health status, cognitive and motor development of 123 children adopted before the age of 18 months from China, East Asia and Russia across the first six months of adoption for the purpose of determining which variables were most predictive of cognitive and motor development in the post adoption period. Variables included known medical problems, children's age at arrival, country of origin and anthropometric measurements collected at time of adoption, three and six months after adoption. Cognitive and motor developments were measured using the Bayley Scales of Infant Development. Internal consistency of the scales reportedly ranged from .78 to .93. Data analysis revealed that while all children in this study demonstrated some degree of nutritional, developmental or cognitive lag, age at time of time of arrival and the absence of neurologic concerns were identified as those most strongly predictive of cognitive and motor developments in the first six months post adoption.

**Protective influences of international adoption.** While concerns about physical and psychological status of internationally adopted children are well- noted within the

literature, the benefits of international adoption are also evident. In a follow-up study to one conducted by Beverly, McGuinness, and Blanton (2008), a longitudinal, descriptive study by McGuinness, Ryan, and Robinson (2005) examined the total competence of children adopted from Eastern Europe within the last five years. The study's secondary aim was to evaluate risks and protective influence of adoptive families upon children's competence. Children's ages ranged from nine to 12 years old. The CBCL and FES were administered to 47 adoptive families in the United States. Data analysis identified that birth weight was the most significant risk associated with children's total competence and cohesive family environment was the variable found to be most closely associated the child's total competence. Researchers noted that the adoptive parents in this study demonstrated a high degree of motivation toward helping their child and the majority of children in this study had been evaluated by a variety of specialists such as physical therapists and speech-language pathologists.

In a longitudinal study, Rutter, Beckett, Castle, Colvert, Kreppner, Mehta, Stevens, and Sonuga-Barke (2007) investigated the extent to which recovery from early institutionalization would be possible when followed by good conditions in middle childhood. The sample was comprised of 165 Romanian children, 144 of whom had lived in institutions adopted by parents in the UK before the age of 42 months. The sample was compared with 52 children adopted from within the UK. Measures of physical development (height weight, head circumference), development (using Denver Developmental Quotient), cognitive/language development (Intelligence Quotient and Autism Diagnostic Interview-Revised and Autism Diagnostic Observation Schedule) were studied. Other variables measured included disinhibited attachment, and quasi-

autism. Assessments were conducted when children were ages four, six and eleven years. Results indicated that “spectacular” catch up occurred in children in the first two years. Almost complete catch up in height and weight was evident compared to the children in the normative sample. Some Romanian children remained slightly below the norm in head circumference measured at age 11 years. Researchers suggested that brain development may be more susceptible to on-going deficits than height and weight following institutionalization. Cognitive and language deficits remained evident in some children at ages four, six and 11, and were more pronounced in children adopted from institutions. Autistic- like characteristics were reportedly found in a large number of the Romanian adoptees at ages four and six years. While a minority of the children still showed autistic patterns at age 11 years, most of the Romanian children displayed some type of socio-emotional impairment, specifically disinhibited attachment or poor peer interactions. The researchers report that most of the Romanian children were receiving some form of special education or mental health services. Overall, researchers concluded that massive catch up was evident in the physical and developmental measures, but persistent difficulty in socio-emotional function was evident in a majority of the Romanian children.

While cognitive function, speech and language disorders and socio-emotional problems may persist into adolescence for many young children adopted from orphanages, progress in these areas is still notable, according to Johnson, Miller, Iverson, Thomas, Franchino, Dole, Kiernan, Georgieff, and Hostetter (1992) . This observation is generally attributed to adoptive parents who are typically highly motivated to find assistive resources for their child and constitute a demographic population of higher

socio-economic means implying greater access to necessary resources, explain Bramlett, Radel, and Blumberg (2007). The ability of adoptive parents to positively impact a child's overall well-being is impressive within the literature, a point well expressed by Johnson (2002) who concluded that "three decades of data present adoption as a superior means for promoting normal child development" (p. 39).

## 2.5 Children in Institutionalized Care

**Prevalence of institutionalization in Eastern Europe.** Browne, Hamilton-Giachristis, Johnson, and Ostergren (2005) conducted a survey of 31 European countries for the purpose of determining how many children, age three and younger, were in institutionalized care. An estimated 23,099 children, three years old or younger were found to be living in institutions. Using a standardized survey from the World Health Organization (WHO), characteristics and reasons for placement of young children in institutional care for more than three months were compiled. Data was collected in five categories from 31 countries: general population statistics, statistics for children living in institutionalized settings and foster care, reasons for children's placement in institutions or foster care, costs of institutionalization and foster care, and provision of preventative services. At the time of this study, Romania and France had the highest number of children three years old and younger in institutionalized settings. Central and Eastern European countries had the highest number of children living in institutions, although institutionalized care was found to cost three times that of foster care. Reasons for institutionalization included abandonment, neglect, abuse, and physical or mental disability. A significant limitation of the study is difficulty in obtaining official data from countries on reasons for child placement in institutions. Another serious limitation is the



inconsistency of language among and between reporting countries as well as the absence of assessment criteria to evaluate quality of institutional care.

**Effects of institutionalization on children.** The effects of institutionalization upon children have long been realized. Ryan and Groza (2004) note that as early as the 1940s, researchers using observation as the primary means of study, wrote of the detrimental consequences that result from environments lacking in physical, visual and sensory stimulation, nurturing human interaction, nutrition and hygiene. Such conditions are known to directly contribute to the delayed growth and development, and often altered socio-emotional functioning observed in children adopted from institutional settings (Schulte & Springer, 2005). A longitudinal study conducted by Beckett, Bredenkamp, Castle, Groothues, O'Connor, and Rutter (2002) examined behavior patterns of 144 Romanian children adopted by parents in the UK when they were between the ages of “a few weeks” and 43 months. Data were collected when the children were six years of age, using semi-structured interviews of the parents. Questions focused on parents reports of specific behaviors such as rocking, eye poking, or head banging. Inattention/hyperactivity was assessed through parents’ and teachers’ completion of the Rutter Scales. Questions regarding unusual sensory interests were derived from the Autistic Screening Questionnaire. Findings indicated that at time of adoption, 47% of the Romanian children engaged in rocking; within three months this number declined to 29% and declined further to 18% at six years of age. Self-injury such as head banging or eye poking was reported in 24% of the children upon adoption and was noted to be more pronounced among the older children. These behaviors decreased to 16% at three months post adoption and further to 13% at age six years. Interestingly, 11% of the adopted

children exhibited unusual sensory interests such as smelling objects or fascination with texture or light. This number actually increased to 13% at six years of age. Sixteen children exhibited these behaviors at adoption and nine more developed them post-adoption. Fifteen of these twenty- five children were found to have other quasi-autistic characteristics. Findings of this study indicate that the sensory and social deprivation associated with institutionalization can have lasting effects upon patterns of behavior in adopted children.

Manifestations of autistic spectrum behaviors are evident in some post-institutionalized children, leading to a phenomenon referred to as “post- institutionalized autistic spectrum syndrome”. Hoksbergen,Laak, Rijk,van Dijkum, and Stoudtjesdijk (2005) conducted a study to determine the prevalence of post- institutional autistic syndrome among a sample of 80 Romanian children adopted by parents in the Netherlands. Data were collected from 72 adoptive parents using a semi-structured questionnaire developed by Hoksbergen. The questionnaire contained questions about demographics, the adoptive child’s behavior, medical problems, psychosocial problems and the use of any professional resources or special education. Next, the Auti-R scale, an instrument similar to the commonly used ASQ was used to guide interviews of the adoptive parents conducted in two phases. Chronbach’s alpha for the Auti-R was reported to be .95. The researchers note that the ASQ has no Dutch equivalent and therefore could not be used in this study. The first interview gathered data concerning the time of adoption and currently (all children had been in the home an average of four years). The second interview was conducted 1.5 years later, when the mean age for all children was 6.8 years and after all had been in the home an average of five years. Of the 80 children

studied, 13 (16%) scored within the autistic range. Of these 13 children, 70% were described as in poor or mediocre health upon arrival to their adoptive homes. Of the 67 remaining children, 48% were found to be in poor or mediocre health upon adoption.

Much is known about the effects of institutional living on children. A review of the international adoption literature suggests significant progress for these children once placed in adoptive families. Evidence also exists that some behaviors and challenges related to institutionalization may persist long after being placed with the adoptive family. Questions remain about which factors exert the greatest impact upon children's status and development. The studies reviewed utilized a quantitative or mixed- methods approach to asking these questions. The question that has not been asked is the experience of being parent to these children. The literature provides knowledge about what these children bring into the adoptive family upon placement, but fails to provide the meaning of parenting as these children transition into family life.

**The post-institutionalized child in the family.** Internationally adopted children from institutionalized settings are considered a high risk group (Meese, 2005). Despite evidence of the significant progress in the post-adoptive period, review of the international adoption literature suggests that most adoptive parents are challenged to help their child overcome some degree of physical, developmental, socio-emotional or cognitive delays. Given what is known about the effects of institutionalization, the ability of the child to fully integrate into the family structure has been widely studied. Unfortunately, stories of adopted children who seem unable to form caring relationships have surfaced in recent years, stimulating continued interest and research in the area of attachment. Some accounts have described tragic consequences for adopted children in

the form of disruption of the adoption (Federici, 2001) or harm suffered at the hands of their adoptive parents. Only one qualitative study, a dissertation, was found in the review of the international adoption literature. Ryan (2006) used a phenomenological approach to describe the lived experience of mothers who had adopted post-institutionalized children from Eastern Europe with Attachment Disorder. Thematic analysis was conducted and rigor was met through a number of ways, including inter-coder reliability, verification of researcher's descriptions with the participants, and journaling.

Findings revealed four themes:

- (a) "isolation of the heart- reflection of feelings of isolation after adoption",
- (b) "through the looking glass-darkly -description of a home where normal rules of child-rearing do not apply", (c) "unraveling of the Madonna tapestry –altered expectations of the mother as maternal parent" and (d) "chaotic checkmate - battle for control between mother and child" (p. 75).

Farina, Leifer, and Chasnoff (2004) conducted a quantitative study to evaluate the effects of institutionalization and parenting stress on the quality of attachment and behavior of Russian children adopted by parents in the United States. Twenty- nine adoptive families participated in the study and received pre-adoption counseling from a clinical team who reviewed medical histories and video-tapes of the children to be adopted. The average age of the children was 41 months, average age at adoption was 17 months and average length of institutionalization was 13.8 months. Data for this study was collected once children had been in their adoptive homes an average of 23.5 months. Instruments used in this study included an abbreviated version of the Waters and Deane Attachment Q-sort, the CBCL (specific to child's age at time of the study) and the PSI.

A demographic questionnaire was also completed, providing information about the child's length of institutionalization, age at adoption, length of time in the home, age at time of study, number of children in the family, parents' age and education and whether a diagnosis of ARNDD had been received. Twenty-eight adoptive mothers and one adoptive father participated in the study. Pearson's correlations were used to determine strength of the association between variables. Two-tailed t-tests were used to assess the significance of differences in the means between male and female children, and also between children diagnosed with ARND and those without. Results indicated that parenting stress was significantly associated with parents' perceptions of attachment to their adopted child. Parents who reported higher levels of stress were more likely to describe more severe behavior problems with their child, and attachment insecurity was highly correlated with the severity of behavior problems.

O'Connor, Bredenkamp, Rutter, and the English and Romanian Adoptees Study Teams (1999) conducted a study investigating child-parent attachment in Romanian children adopted by families in the UK. Comparisons of 111 Romanian children adopted after the age of two years, with 52 non-adopted children in the UK were conducted. Data were collected when all children were at the age of four years old, using semi-structured interviews with adoptive parents designed to allow parents to "rate" various attachment-related behaviors using "0" to indicate "no evidence", "1" to indicate "mild evidence" and "2" to indicate "marked evidence" (p. 17). Problematic behaviors were assessed using a modified Behar behavioral questionnaire, and cognitive abilities were assessed using the global cognitive index from McCarthy's Scales of Children's Abilities. Findings indicated that children adopted after two years of age displayed more severe

attachment disordered indicators, including disruptive and hyperactive behaviors and difficulty interacting with peers.

The persistence of disinhibited attachment was studied by Rutter, et al. (2007). A sample of 165 Romanian children adopted by families in the UK was included in the study. Fifty-eight of the children had been placed with adoptive families before the age of six months, 59 had been placed between six months and under 24 months, and 48 had been placed between 24 months and 42 months of age. Almost all of the children had lived in institutions since infancy and many had been moved between institutions prior to adoption. Data were collected through intensive interviews conducted around the child's fourth, sixth and eleventh birthdays. During the first interview, parents were asked to describe conditions of their child's institution, and rate the child's care received in the institution using a scale ranging from "0" very poor, to "3" good (indicating individual care by a primary care-taker in the institution). A number of variables were measured in this study including adoptive parents' education level, family functioning risks (using subscales from the Dyadic Adjustment Scale), and security of attachment using a "Strange Situation Procedure". Quality of peer relations was assessed using a combination of Rutter's Parents and Teachers scales. Assessment of adopted children's interactions and physical contact with investigators was conducted using a scale of "0-2" to rate behaviors observed by investigators while in the families' homes. Behaviors included instances of indiscriminate friendliness with the investigator, hand holding, and eagerness to cuddle or sit on the investigators' lap. Quasi-autistic behaviors were assessed using the Autism Diagnostic Interview and Cognitive function was evaluated using the Wechsler Intelligence Scale for Children (short form). Findings indicated that

there were no significant differences between boys and girls in the study among any of the variables evaluated. The researchers concluded that behavior patterns associated with altered attachment had been evident in children from pre-school years through age eleven years and disinhibited attachment was strongly associated with institutionalization, but not related to duration of institutionalization.

In a study conducted by Bruce, Tarullo, and Gunnar (2009) disinhibited social behavior was studied among 120 children ages six to seven years old. Children were classified as either adopted or non-adopted. All of the adopted children were internationally adopted before the age of 36 months. That category was further divided into children who had spent at least 70% of their lives in an institution and children who had spent at least 70% of their lives with a foster family. A modification of the “Strange Situation” procedure was used to collect observation data about the child’s willingness to interact with a stranger, such as hand holding and sitting on the lap of the stranger. Semi-structured interviews were conducted with parents to assess attachment related behaviors, cognitive skills were measured using the Wechsler Intelligence Scale for children and computerized tasks were used to assess children’s understanding of various emotions. A Children’s Behavior questionnaire was completed by parents. Children’s inhibitory control was assessed using two computerized tasks that measured delay of gratification. A series of statistical analyses was used to evaluate the data. One way analyses of variance (ANOVAs) were used to evaluate group differences among variables. Significant differences in groups were explored using Fisher’s least significant difference test. Pearson’s moment-correlations were used to examine the relationships between variables and a multiple linear regression was conducted to determine the predictability

of specific variables upon disinhibited social behavior. Results of the study indicated that disinhibited social behavior was predominant among the adopted children with a history of institutionalization. Interestingly, the same behaviors were present among children adopted from foster families. Researchers suggest that the major change in living environment due to international adoption may contribute to the similarity of behaviors seen in both groups.

Discussions of attachment in internationally adopted children are of complex nature, often eliciting conflicting opinions about the overall prognosis for the child and the family. In an article about evidence-based interventions for foster and adoptive families, Barth, Crea, John, Thoburn, and Quinton (2005) warn against blaming behavioral and socio-emotional problems solely on attachment, calling this practice “perilous”(p. 259). The authors urge caution over the tendency to “pathologize children” and suggest re-focusing on identification of interventions that may help families form more secure attachments (p. 259). While parenting stress has been highly correlated with altered attachment behaviors demonstrated by some post institutionalized children (Groza, Ryan, & Scottye, 2003), a study by Castle, Beckett, Colvert, Kumsta, Schlotz, Sonuga –Barke, and Stevens (2009) indicates that many parents of internationally adopted children still report high levels of satisfaction with the parent-child relationship and consider their adoption a success. This was part of a larger study being conducted by Rutter and the English and Romanian Adoptees Study Team. Adoptive parents of 165 Romanian children in the UK participated in the study and parents of 52 children adopted from within the UK were included for comparison. This study was conducted around the children’s 11th birthday. A semi-structured interview, lasting three hours, was



conducted to evaluate overall success rating of the adoption of their child. Two –three point scales were used to rate responses from “not rewarding” to “very rewarding” and ‘not challenging” to “very challenging”. Statistical data analysis revealed that even parents who rated the adoption of their child as very challenging reported high levels of satisfaction with having the adopted child in their family.

Overview of this literature demonstrates the great variability in reports of parenting among parents of internationally adopted children. Quantitative approach has been used for the vast majority of studies conducted, with varying degrees of rigor. The need for rigorous studies that provide insight and understanding to the meaning of adoptive parenting is evident.

## 2.6 Summary

Informed by the literature, health care providers know that internationally adopted children, particularly those who have lived in institutions, present with a complex array of physical, neuro-developmental, emotional and psychological issues. Histories of trauma and neglect are common, and sequelae from ARNDD and Autistic Spectrum disorders can have long-reaching impact as children settle into family life once adopted. There is evidence within the literature to suggest that many internationally adopted children make great strides once settled into their new family. However, many studies indicate that children adopted from institutions continue to struggle with integration into family life after adoption, showing difficulty in forming attachments, displaying problematic behaviors at school and home. In worst case scenarios, some children have suffered disruption (or absolution) of the adoption, or harm at the hands of their adoptive parents.

Despite calls for more vigilant assessment of internationally adopted children and families, the literature does not address the experience of being a parent of a child adopted from an institution in Eastern Europe. Hermeneutic inquiry into the lived experience of parenting the child adopted from an institution in Eastern Europe will fill a major gap in the literature. Findings from studies using an ontological approach will assist healthcare providers in providing assessments and care that are congruent with the lived experiences of parents of internationally adopted children and their families.

## CHAPTER 3

### METHODOLOGY

#### 3.1 Introduction

This chapter will present the hermeneutic phenomenologic research method used in this study. A discussion of definitions and concepts central to hermeneutic design opens the chapter, followed by a description of the study setting, sample, and data collection process. This chapter concludes with an explanation of the data analysis procedure and measures taken for the protection of human subjects.

#### 3.2 Design of the Study

The evolution of divergent traditions is evident in phenomenology's history. Spiegelberg (1960) emphasizes that evolution of the methodology is just that- a movement which endures and continues in dynamic manner. This hermeneutic phenomenological study employed the philosophy of the Utrecht School which Van Manen (1978) describes as a practical, rather than a philosophical, phenomenology. He writes, "...a phenomenology of practice operates in the space of formative relations [which] have pedagogical consequences for professional and everyday practical life." (p. 26). The following is a discussion of the historical and philosophical relationship between phenomenology and hermeneutic phenomenology. Also included is an explanation of the Dutch- inspired Utrecht School.

The first use of the term *phenomenology* dates back to 1764 by Johann Heinrich Lambert, a German mathematician, physicist and astronomer. The context of the term had more to do with illusion than description or meaning. His work influenced that of

Immanuel Kant, considered one of the great thinkers to emerge from the period considered the Enlightenment, who drew from the philosophical framework in writing the well know work *Critique of Pure Reason* (Spiegelberg, 1960). Despite this early indication of phenomenology's applications, Edmund Husserl is commonly credited with the development of modern phenomenological inquiry (Lavery, 2003). Husserl, tired of empirical approaches to inquiries of human experiences, emphasized the significance of *Lebenswelt*, or Life-world. His famous quote "To the things themselves" reminds researchers and philosophers to reduce their reflection to the essence of the inquiry (LeVasseur, 2003). Husserlian approach requires that the researcher suspend all former impressions, assumptions and notions about the phenomenon under investigation (Lavery, 2003). Bracketing is a technique suggested for accomplishing this end. Essentially, the researcher strips away all preconceived notions and theories about the phenomenon he wishes to study in an effort to see the experience *with* the participants. This is most commonly conducted through activities such as journaling or list-making which provide a means of "containing" *a priori* knowledge, and reducing researcher bias (Fischer, 2009). However, many scholars question whether complete suspension of one's pre-existing notions can be achieved. LeVasseur (2003) criticizes Husserl's presumption that bracketing must be employed, stating that the deliberate effort to detach oneself from that being studied retains shadows of the empirical, positivistic paradigm Husserl purported to reject.

Martin Heidegger also took issue with the Husserlian notion that one could suspend their own experiences to attain complete objectivity. A former student of Husserl, Heidegger expanded upon the phenomenological framework, emphasizing the concept

of the lived world (LeVasseur, 2003). In as much as Husserl is considered “father of phenomenology”, Heidegger is credited as the champion of hermeneutics (Draucker, 1999). Known today as hermeneutic phenomenology, this approach seeks understanding over description, achieved through interpretation of human experiences as shared by participants. Because one always exists within the world, it is impossible to suspend or detach oneself from experiences and elements related thereto (Draucker, 1999). Asserting that truly perfect reflection could not exist, Heidegger proposes that bracketing in search of a transcendental vantage point, as proposed by Husserl, is not possible. The mere reality of being human, the concept known as *Dasein*, makes separation of the researcher from the world impossible (LeVasseur, 2003). Heideggerian tradition which embraces an existentialistic approach to the study of phenomena, acknowledges that one is always already in the world and is therefore bound to incorporate one’s understanding of a phenomenon with that of the other’s. This melding provides the perspective of shared vision, as opposed to description of that which the other sees.

Questions of reliability and validity of the data often surround phenomenological inquiries. Empirical researchers question the influence of “shared viewpoint” or what Koch (1995) refers to as “co-constitution of the data” as potential threats. Beck (1994) states that the nature of phenomenological inquiry requires movement away from empirical concepts of validity and reliability as “cross-paradigmatic communication can result in ....different words with different meanings.” (p. 254). Rather, the idea of “trustworthiness” of the data is discussed relative to investigations seeking understanding. Much debate exists even among phenomenologists regarding how to best arrive at trustworthiness. At the core of this difference are schools of phenomenology

which seek description rather than interpretation. To this end, Beck provided a comparison of three stances on the issue of trustworthiness versus reliability and validity. He examined the works of Giorgio, Colaizzi, and Van Kaam, proponents of the Duquesne School of Phenomenology, which seeks description. Interestingly, Beck notes that Colaizzi's methodology for ensuring integrity of the data, lends itself appropriately to interpretive data analysis, as the researcher returns to the participant for "dialogal research" (p. 260). Beck writes, "Colaizzi stresses validation of the exhaustive description of the phenomenon under study by the participants themselves (p. 261). This approach is most consistent with Heidegger's hermeneutic phenomenology which he drew from Aristotle's definition of philosophy," [philosophy] makes it possible to see *being* in respect to what it is in so far as it is *being*" (Heidegger, 1956). The end goal of such "seeing" is an understanding of the essence of that being studied. Sandelowski (1991) writes that the purpose of such inquiry is to arrive at "...truths within the stories that contain them" (p. 165).

One specific tradition of hermeneutic phenomenology is the Utrecht School. The name arises from a group of scholars at the University of Utrecht whose combined works became known as the Utrecht School. Langeveld emerged as a great influence in the science of pedagogy specific to life experiences (Van Manen, 1978). His philosophical view of phenomenology mirrored Husserl's efforts toward constructing a science of the life-world, although he disagreed with detachment of the researcher from the interpretation of the phenomenon of interest. Van Manen (1978) identified four concepts considered critical to the pedagogy of phenomenological investigations: a) aims toward being a practical science b) central role of its execution is situation analysis c) situation

analysis results in life-word descriptions and d) knowledge produced has implications for practical action (p. 8). Inquiry into the lived experience of parenting, as proposed in this study, is well suited to the Utrecht tradition is for the following reasons: the study was conducted from the perspective of practical science inquiry with implications for practical action across healthcare disciplines. Situation analysis, that is, the immediate experience of reality (Brannigan, 2004, p. 12), was the driving role of the study. This analysis revealed understanding of the *Dasein*, or real world, as lived by the participants.

Researchers employing the Utrecht school tradition in phenomenological studies must acknowledge the role of their own historicity as they work toward interpretation of lived world experiences in the quest for usable, practical knowledge (Van Manen, 1978). Journaling one's experiences as well as careful mapping of the study's decision trail are essential mechanisms for establishing rigor among phenomenological inquiries (Whitehead, 2003). The implications that follow therefore, guide this researcher to reflect upon and acknowledge her own *Dasein* relative to the phenomenon under investigation. In a preliminary study, the researcher exercised bracketing prior to and following all interviews by answering the interview questions within a research journal. Written reflections were also journaled, providing a concrete means for containment of presuppositions gleaned from the researcher's personal and interview history. The same practice was conducted in this larger study.

### 3.3 Setting

The study was conducted within the northeastern, central and southeastern regions of a southern state on the east coast. After approval from the Duquesne University

Institutional Review Board (Appendix A) the preliminary study recruited participants from the southeastern portion of the state; however, the scope for this larger study was expanded for the purpose of facilitating recruitment efforts. Face to face interviews were conducted in private locations of the participants' choosing. The geographic scope of the setting was selected based on the researcher's ability to travel, with relative ease, for conducting face to face interviews.

### 3.4 Sample

The sample for this study was comprised of volunteer participants residing in northeastern, central and southeastern regions of a southern state on the east coast of the U.S. who had adopted one or more post- institutionalized children from Eastern Europe. Participants were located via purposive sampling and snowball technique. Sampling continued until data saturation was achieved. According to Morse and Richards, saturation occurs when data are replicated and no new information is appearing (2002).

Sandelowski (1995) writes that decisions of sample size are a matter of researcher discretion that weighs richness of data already collected against the overall purpose of the inquiry. She explains:

An adequate sample size in qualitative research is one that permits, by virtue of not being too large, the deep, case-oriented analysis that is a hallmark of all qualitative inquiry; and that results in, by virtue of not being too small, a new and richly textured understanding of experience (p. 183) .

Morse (2000) explains that in a phenomenological study, where richness of data is desired, six to 10 participants is an acceptable sample size, particularly since each



participant will be interviewed more than once. Based upon such recommendations, the researcher planned for recruitment of 10-12 participants out of a pool of approximately 250, to allow for attrition, with the knowledge that sampling would continue until data saturation was attained. Data collected from three participants during the preliminary study were included in this larger study.

After approval from the Duquesne University Institutional Review Board (Appendix B) early recruitment of participants occurred through two approaches- snowball technique and posting of the recruitment statement (Appendix C) on an organization's web-based discussion forum for international adoptive parents. After receiving permission from the site administrator, the recruitment statement was posted on the discussion forum inviting adoptive parents to contact the researcher. A protocol amendment was later submitted and approved by the Duquesne University Institutional Review Board (Appendix D), allowing the researcher to post the recruitment statement on the organization's social networking site. Other changes to the recruitment process were also approved in the amendment, including the distribution of hard copy fliers (Appendix E) containing the recruitment statement to study participants for dissemination at their discretion, as well as limitation of participant eligibility to the state of the researcher's residence. Prior to this, the researcher had received a large number of responses from parents across the United States. The researcher also had access to a small number of participants who had completed a preliminary version of this study. The researcher provided hard copies of the recruitment flier to one of these individuals for distribution to other prospective participants. Inclusion criteria were as follows: participants must have been 18 years old or older, able to speak and read English, and

identified themselves as the parent of a child adopted from an institution in Eastern Europe. The adopted child must have resided with them full-time at the time of the interviews. Adoption must have occurred within five years prior in an effort to capture the experience of parenting within a fairly recent timeframe and must reside within northeastern, central or southeastern regions of the state. After completion of the first interview, a one-time token gift in the form of a \$15 gift card to a convenience store was provided to participants as compensation for their time. According to Sears (2001), the gift model of compensation for research participation may raise the least concern about coercion and may be the most ethical in terms of respect for human subjects' time and offering of self. However, it may also create a challenge to recruitment efforts if the amount is too minimal. The amount of \$15 was determined as a moderate gesture of appreciation for participant interview time based upon economic norms for the state.

### 3.5 Procedure for data collection

Demographic data were collected on each participant and two semi-structured interviews were conducted and audio-taped with each participant. Audio-taped interviews were then transcribed with all identifying information omitted. The purpose of the first interview (Appendix F) was to collect data related to the experience of parenting a child adopted from an institution in Eastern Europe. A broad opening statement was used to initiate conversation, with follow-up questions as needed. Clarification, re-stating and probing techniques were utilized as necessary, to explore certain concepts offered by the participants. Congruent with hermeneutic design, the purpose of the second interview was to clarify and verify the researcher's interpretation of data collected in the first interview session. This approach enhanced rigor, and reduced researcher bias by allowing

participants to review the transcript from the first interview, comment on its early interpretation, and verify or correct early identification of themes. Further, the second interview offered the opportunity for conversation between researcher and participant, providing richer data (Cohen, Kahn, & Steeves, 2000). Both interviews were conducted at a private location of the participants' choosing. Although no time limit was established, initial interviews ranged from two to three hours in duration, and follow-up interviews lasted from 30 minutes to two hours.

### 3.6 Procedures for Protection of Human Subjects

Written consent was obtained and a copy provided to participants (Appendix G). Participants were given the option to withdraw from the study at any time and without reason. Participation in this study posed no risks greater than those encountered in everyday life. However, a list of mental health resource phone numbers was made available to participants if they conveyed emotional upset or distress. During the preliminary study, one participant asked for the list, but stated that she had already looked into mental health resources prior to the interview. All data were, and continue to be, securely maintained in a locked safe in the researcher's office; participant names and identifiers were initially encoded using pseudonyms. Pseudonyms have subsequently been changed to labels "mother [variable], and father [variable]" to protect participant identity. All references to geographic locations, occupations and personal information have been removed. Interviews were conducted at a private location agreed upon by the researcher and participants. Consent to audio-tape the conversation was received and questions regarding the nature of the study were invited. Participants were given the option to stop the taping or the interview at any time. Two semi-structured interviews

were audio-taped with each participant. Early in the study, audio-taped interviews were transcribed by a professional transcriptionist who signed a confidentiality statement (Appendix H). Later interviews were transcribed by a professional transcription service and another confidentiality statement was signed.

A data manager program, NVivo9 (© 2010, QSR International) was loaded on the researcher's password protected laptop and was utilized for organization of data. Transcripts were entered into NVivo9 (© 2010, QSR International) by the researcher. Upon successful defense of this dissertation, only de-identified tapes and transcripts will be retained by the researcher. Audio sound files and electronic transcripts will be deleted by the researcher. Hard copy transcripts will be shredded by the researcher using a personal shredder in the researcher's home office upon successful defense of this dissertation study. Demographic data were collected on all participants and are presented in aggregate form only (Appendix I).

### 3.7 Procedure for Data Analysis

Congruent with the Utrecht School tradition, data analysis was conducted with careful identification of common themes within the transcribed data using the process described by Barritt, Beekman, Bleeker and Mudlerij (1984). The researcher began by listening to the audiotaped interviews, and reading each transcription line by line. The transcript was read and re-read in its entirety for understanding. Sentences and parts of sentences were highlighted to illuminate language used by the participants. The researcher then identified common themes within the data, assigning tentative labels that reflect the essential meaning. Supporting phrases from the transcripts were written after each identified

theme. Interpretation of the data (identification of themes) was presented to the participants during a second interview session for review and clarification. Congruent with data analysis in hermeneutic inquiry, participants are often asked to validate themes identified by the researcher (Cohen et al., 2000). The second meeting also allowed for further exploration of themes, or any unclear or underdeveloped concepts.

Identification of common themes, and subsequent major themes, was conducted within and among transcripts for the purpose of grouping common patterns, or identifying variations across the narratives. According to DeSantis and Ugarizza (2000) a theme is an “abstract entity that brings meaning identity to recurrent experiences...” (p.400). In this study, sub- themes were also identified as a means of organizing patterns of language and experiences within a major theme. This process enabled the researcher to organize the major themes into a written description of the meaning of parenting a child adopted from an institution in Eastern Europe.

Data collection and analysis were conducted co-currently, solely by the researcher, until saturation was achieved. Rigor was met by ensuring that the data constructs the understanding; that is, the meaning of the lived experience emerged from the data through an inductive process that identifies pervasiveness of ideas, phrases or statements (Polit & Beck, 2004).

Inter-coder reliability was established by the researcher and faculty advisor. Lombard, Snyder-Duch, and Bracken (2002) define inter-coder reliability as the measure of how two independent readers make coding decisions about textual data.. The researcher shared three de-identified transcripts from the preliminary study, and three from this dissertation study, with the faculty advisor. Inter-coder reliability was achieved when

similar codes were identified by the researcher, by the faculty advisor, and no new codes were identified or assigned within the data.

### 3.8 Summary

The purpose of this study is to understand the meaning of parenting a child adopted from an institution in Eastern Europe. It is the hope of the researcher that such understanding will be used in planning care that is patient focused, reflecting the needs of these children and their families. The study used a hermeneutic phenomenological design. Purposive and snowball sampling efforts were used to recruit participants residing within the northeastern, central and southeastern regions of the state. Eligible participants were 18 years old or older, able to speak and read English, and identified themselves as the parent of a child adopted from an institution in Eastern Europe. The adopted child resided with them full-time at the time of the interviews. In an effort to capture the experience of parenting within a recent timeframe, the adoption must have taken place within five years of the first interview. Participants were interviewed twice. The purpose of the first interview was to collect data about the experience of parenting the child adopted from an institution in Eastern Europe. The purpose of the second interview was to verify the researcher's interpretation of the participants' parenting experience and to clarify inaccuracies or unclear concepts. Data collection and analysis occurred concurrently until saturation was attained.

The findings of this study will be used to inform healthcare providers, specifically nurses, and other health care professionals about the lived experience of parenting a child adopted from an institution in Eastern Europe. Moreover, the findings are expected to facilitate enhanced patient-focused care for these families.

## CHAPTER 4

### FINDINGS

#### 4.1 Introduction

In this chapter, description of the study participants will be presented using the demographic data collected at the first interview. Findings of the study will also be presented.

#### 4.2 Description of the Study Participants

The study consisted of 11 participants self-identified as adoptive parents of children adopted from institutions in Eastern Europe. Participants included two males and nine females (Table 1). Two married couples participated in the study, and were interviewed as dyads (Table 2). Nine initial interviews and eight follow-up interviews were conducted. One participant was not available for a second interview. In total, 17 interviews were conducted.

Age of the participants in this study ranged between 34 years and 48 years for nine out of eleven participants. Two participants were older than 48 years of age (Table 3). Marital status at time of the interview was identified as married for 10 participants. One study participant listed “widow” for marital status at the time of the first interview. All participants identified their marital status as married at the time of adoption (Table 4).

Time since adoption ranged from less than or equal to one year, to five or more years (Table 5). It should be noted that a discrepancy in language occurred between the inclusion criteria and the demographic form regarding the length of time since the adoption occurred. The inclusion criteria indicated that the adoption must have occurred within five years, yet the demographic form included an option for five or more years.

Two of the participants in the study identified the adoption as occurring more than five years prior to the interview. When this discrepancy was realized, the researcher consulted the dissertation advisor as well as the School of Nursing IRB representative. There were no adverse effects to the participants.

In aggregate, the participants in this study had eleven children adopted from institutions in Eastern Europe. Two participants out of eleven had two adopted children. Seven out of eleven children were adopted from Russia. Three children had been adopted from Ukraine, and one participant identified Siberia as the child's country of birth (Table 6).

Sharing a common culture with their adopted child was identified by two out of eleven participants. Ten participants indicated that they do not share a common language with their adopted child. English was considered the common language shared with the adopted child by one participant. Questions about shared ethnicity and religion were not asked in the preliminary study. This information is not available for three participants. However, these demographics were collected in the larger study. Eight out of eight participants from the larger study indicated that they do not share a common ethnicity with their adopted child and seven out of eight indicated that they do not share a common religion with their child (Table 7).



Table 1

Gender of Study Participants

Gender	Number of Study Participants
Male	n=2
Female	n=9

Table 2 –Interview Arrangements

Interview Arrangements	Number
Individuals	n=7
Dyads	n=2

Table 3

Age Ranges of Study Participants

Age Ranges	Number of Participants
34-41 Years	n=3
41-48 Years	n=6
>48 Years	n=2

Table 4

Marital Status of Participants

Marital Status at Time of First Interview	Number of Participants
Married	n=10
Widowed	n=1
Marital Status at Time of Adoption	Number of Participants
Married	n=11

Table 5

Time Since Adoption of Child/Children

Time Since Adoption	Number of Participants
Less than or equal to 1 year	n=2
2-4 years ago	n=4
5 or more years ago	n=5

Table 6

Birth Place of Adopted Children

Birth Place	Number of Children
Russia	n=7
Ukraine	n=3
Siberia	n=1

Table 7

Common Culture, Language, Religion and Ethnicity

Common Culture, Language, Religion and Ethnicity	Number of Participants		
	Yes	No	Not Asked
Common Culture with Adopted Child	n=2	n=9	N/A
Common Language with Adopted Child	n=1	n=10	N/A
Common Religion with Adopted Child	n=1	n=7	n=3
Common Ethnicity with Adopted Child	n=0	n=8	n=3

### 4.3 Study Findings

Early phases of data analysis using the process described by Barritt, Beekman, Bleeker and Mudlerij (1984) resulted in identification of 17 common themes (Table 8). The common themes emerged from frequently occurring language and experiences evident in the data.

Table 8

Common Themes

1. Life Changing-Decision	2. Spiritual Purpose/Higher Power
3. Qualifying for Parenthood	4. Preparation for Parenthood
5. Responsibility of Parenthood	6. Retaining Culture
7. Building Identity	8. Splitting
9. Searching for Resources	10. Feeling Hopeless
11. Choreographing	12. Remaining Alert/Hypervigilant
13. Safeguarding	14. Looking for causes
15. Vying for control	16. Comparing    17. Looking for understanding

Common themes were then reviewed within and across transcripts for overlapping or repetitive language and experiences, resulting in identification of five major themes (Table 9) that capture that essential meaning of the lived experience of parenting a child adopted from an institution in Eastern Europe. The five major themes were the following: 1) Choosing-Being Chosen, 2) Weaving the Fabric, 3) Importance of Doing, 4) Remaining Mindful, and 5) Looking in-Looking out.

Table 9

Major Themes

1) Choosing-Being Chosen
2) Weaving the Fabric
3) Importance of Doing
4) Remaining Mindful
5) Looking in-Looking out

To preserve confidentiality, participants are referred to as “Mother [letter] or Father [letter]” and parent couples are assigned the same letter, for identification of dyads (Table 10). All other identifying information has been removed.

Table 10

Participants

Mother A	Mother B	Mother C	Mother D	Mother E	Mother F
Mother G	Mother H & Father H	Mother J & Father J			

## **Theme 1- Choosing-Being Chosen**

All study participants elaborated on the process and the significance of choosing to adopt, or choosing their child. The stories of being in the institutions and meeting their children were prominent. Most participants opened the interviews with a long discussion of the adoption process and their experiences in the country of origin. This history seemed of great significance and necessary for them to tell. The majority also emphasized the feeling of being chosen, or destined to be their child's parent. This thread surfaced frequently throughout interviews with the participants, often framing their experience and rationale for doing what they do as parents. Several sub-themes were identified as related to choosing-being chosen. The sub-themes have been named with language used by the participants.

**Life Changing Decision.** The experience of making a deliberate and life-changing decision was described by four participants. Mother E stated, "We had our appointment in [*country*] and we told them we wanted babies...and the director of the [adoption commission] told us, 'Well, there are no babies'. But, you know, we want babies. There are no babies and she's like, 'Sorry.' And so basically – you know, you got like a half hour to make this life-changing decision. And we're looking through this book, you know, all you see is – you don't know if they're updated or not, or how old they are. And half the time, unless you actually look at the birth dates, they say they're this age, but you look at the birth date, you know, they're like 12 now...and you're trying to look through this and you're going, "I can't believe we have to do this like right now... And she was telling our guide that, they are not giving second chances. You're not gonna be able to get another appointment and so this is it. And I'm freaking out thinking, "Oh, my God. This

is – no....so in that moment when you realize everything has come to that time now, that this is it. This is it and, really you know nothing; you have nothing. Nothing is how it was supposed to be in your head. This was never a situation that you even considered.”

Mother E later described the experience of choosing in the following way, “This was almost like going in and picking out a library book that you want to read, but you’re gonna have to read it every day for the rest of your life, so it better be a good one.”

Mother F described the decision to adopt an older child from Eastern Europe who was being hosted by a local church group in the U.S. She said, “... this one woman who had organized the hosting trip walked up to me and pointed out that this one little girl was the only one who hadn’t been chosen, and it’s just – there wasn’t a family that had decided to go and adopt her, and there were 15 children, so that’s pretty impressive...we spent lots of time with her.... So my husband was fine with it and he was like, ‘Yeah, she’s mine.’” I really thought she’d be a great fit for us and I loved her already, so – which might sound a little crazy, but it – sometimes you just have that connection, and then it took us 14 months to get to her.”

Mother A explained the moment of decision while meeting her toddler son in [country] while the child was hospitalized, “It kinda scared us at first, I mean, he was sick. Our interpreter fought to get us into the hospital. We weren’t allowed to see him. I mean, why would these foreigners want to come see a sick child? You could hear behind closed doors doctors and our interpreter just, they were just screaming at each other in Russian. Finally, she took us in, and we’re following her around this hospital. They walked us from building to building to building and finally we saw him there, and he was so sick... he’s just, he’s just laying, he was just coughing, you can hear him just ugh, ugh,

you know, just heavy, heavy, heavy breathing and ah, he was so sick. He's like in this plexy-glass room and an all metal crib, it moved, this was the hardest thing. I was really like, '... let's grab him and run'. Oh, that's how I felt, like, we can't leave him in here... and as we were walking away, he pulled himself up to the bars, and we had this picture of him looking at us through these bars in this crib, through this plexy-glass window and it's like he was saying, 'don't go'. Oh, it was so hard, both [my husband] and I are looking at each other...we can't leave this child, we just can't leave him here, but we have to, we have to, and then we decided, right there in that moment...our life has changed...we're gonna go to court and yes, we want him...we want him."

Mother G described the experience of choosing in the following way, "So, the woman at the ministry of education.... pulled out a huge stack of papers that had information about all these children... and she was flipping through, flipping, flipping, flipping, flipping, flipping; she pulls one out and says well, we have this little boy, but he's very sickly and you won't want him... she gives me the paper and the translator reads everything to me and she tells me everything that she knows.....born to a [substance] addict...at [preterm] weeks gestation. So, I said you know, I mean, we gotta meet'm just because you don't know on paper.... So, they told us he's been in the hospital at least three out of every four weeks of his life with [disease processes]. We went to the orphanage and they said he's not here, he's in [village] in the hospital. We went to this little rundown, poorly equipped hospital that just was scary, really scary, third worldish you know, so, as we were going in, we had the social worker with us from the village there, and she says to our translator, in Russian, not knowing that I kind of understand her, this is a young, active couple, they aren't going to want this child, so,

again, someone's telling us we don't, we aren't going to want him. So they bring in this little boy and he, he just, he couldn't sit up by himself, none of these things, and he was happy and he had like a little spark about him, just something about him... he was making eye contact with us and giggling and just seemed so, and [my husband] held him and rocked him back and forth, and it was like just so, he looked so content and our translator said if you think you are interested in him, I'll talk to them here at the hospital and see if we can take him back to the orphanage and you can visit with him and spend some time with him. So we said we did and we took him and played with him and decided that day that he was our son, that was, that was it. Our decision-just like that."

Three participants described the emotional difficulty in having to decline adoption of other children while in the country of origin. Mother G's interview emphasized her pain in not being able to adopt the original child they thought they were traveling for. She said, "We had traveled to [country] and met a little boy and we signed the form saying we intended to adopt him and came home and waited for court, and then a month later got a call saying oh, they made a mistake, someone in the ministry of education had entered that he, he was available, but that he actually wasn't, his parents' rights had not been legally taken away....he had been removed from the home for neglect... so that was really devastating. I remember my husband who's not a demonstrative talker or anything saying to the little boy, '... I promise you we are coming to get you', and I just kept thinking about that. I still do." She described the second trip back to the country to try to adopt a different child. She said, "...there was this little boy ... we met him and I don't think I had ever thought about the fact that I might have to say no. You know... that made me feel like a bad person and I'm taking an opportunity away from



this child, it was horrible, horrible....and we had our doctor with us, from [city]. She thought he was okay, but I don't know...something wasn't right...his head was out of proportion... just something I felt...maybe from the way they just lay in the crib all day...but we declined. So they said, "Well there's a little girl available and they brought her in. She was only nine months old and she just seemed catatonic to me, just like a rag doll and just not making eye contact... and I was like, oh my God, oh my God, oh my God, oh my God, okay, what do we do...the doctor said she was fine, but I thought... what do we do, and I was already all wound up about having, having said no to this other little boy, and [my husband] said, 'I think that we should maybe take a chance with her', and I just couldn't, I just couldn't, I just said, I just, I feel like....no. What if.....this is how she'll be...forever... and I can't, there are things I can deal with; feistiness I can deal with... spiritedness, whatever, I can deal with those things- but the nothing, I don't, I can't. I held her and tried to you know, engage with her, and cuddle her and she was just....I almost wondered if she was drugged, you know, sedated. I really tried, I just couldn't."

Adoptive parents Mother H and Father H described the difficulty of meeting other children in the orphanage while adopting their daughter and choosing not to adopt them. Mother H explained, "We met another woman on our trip who was also there to adopt a child. We traveled together to the same place, they called it a hospital. Because she was adopting a baby, we went to see the babies first. It was all just like movies you see, you know, old building, very dark, and there is a doctor and a few nurses. And they brought the little baby. She was wrapped in- really, like a rag. And the baby couldn't even hold her head up, and it was like this, like limp." Father H added, "The eyes, the eyes looked

straight ahead. They never moved left or right.” Mother H continued, “And the significant thing was that the baby, when I looked at the baby, I thought she was about two months. The baby was 11 months, an 11 months baby.” Father H said, “So I saw this kid and it bothered me. I mean, I got really nervous because oh, my God, what’d we get ourselves into because what is [our child] gonna be like? Was she like this?” But we met [our child], and thankfully, everything was ok. So we spent time in the orphanage with all of the kids, waiting for the paperwork and to go to court. It’s, it’s incredible to think back, and I remember one night we were both (he and his wife)-we had tears in our eyes. We were crying ‘cause, you know, [my wife] – we both fell in love with another little boy there and unknown to my wife, he had a brother ...and I’m thinking we’ll take [our child] and this little boy. Mother H said, “I loved him...once we found out they were brothers, I said, ‘I take both or I take none.’ All they have in this life is each other. If we’re gonna adopt them, we’re gonna adopt both of them.” Father H continued, “So we’re going through this rollercoaster every night. We finally like the fourth night we said, listen, we gotta calm down. We’re going, we’re going berserk here. We’re just gonna focus on [our child]. Whatever decision we have, wait till we get back to the U.S. because, you know, we’re out of control...it was just so terrible to make the choice to say no.”

**Spiritual Purpose/Meaning.** Many of the participants mentioned faith, or spiritual guidance/meaning in becoming their child’s adoptive parent. Mother A described discomfort with how fast the adoption process was unfolding. She said, “We had to travel and accept him in ten days, but everything was with another agency and they’re shooting us off to [country], and we’d already paid’m, you know, it was thousands and thousands

of dollars we'd given them, I mean, close to ten thousand and I mean, it was all, this all too fast, no, we can't do it, we're just gonna sit up and doing nothing. And then we thought you know what, it's a leap of faith, it is a leap of faith, it's what it was."

Mother C described the role faith played in the adoption decision, "And we just kinda let it go after trying to do infertility, and then God just put foreign adoption on my heart, and we went to the *[adoption agency]*. Later in the interview, she described the experience of learning her son's diagnosis of Fetal Alcohol Syndrome (FAS). She said, "I tell people that I would have never have adopted him had I known this, but it was a God thing, because we know this is the child for us. And on the hardest days we've ever had, my husband can put him to bed and come downstairs and say, 'I love that kid'."

Mother E discussed the delays she and her husband had experienced in trying to get approval to travel to the country of origin to adopt. She said, "...so we went through the process, and then my husband medically had some problems; and then it put us back, and it put us back, and it put us back-- I mean, so it took us almost three years before we actually got to [country]. But two different times before that, we were already set up to go and something happened each time. And so my family – you know, our friends and family said, "Maybe this is, you know, God's way of telling you just, you know, not to do this." And I was like, "Well, He'd better be a little bit more obvious, 'cause that's not working for me." She also described "looking for a sign" that would help them know what child/children to adopt while in the country of origin. She stated, "Well, know, I'm sitting here literally praying for a sign or something obvious, because I was kind of figuring that I probably should go with the child my husband was really kind of into, because if it did turn out to be a bad decision, then I would always be blamed if

we'd chosen the other one. So I was just like, 'God, please. You gotta give me here. I can't go back there and still not have a clue'...if I had no faith previously, I would certainly have it now 'cause – at that point, it was such a whole faith-based journey because of so many things that should've told us – okay, just forget it. You know this is not gonna work out...I mean in your mind you know that's not logical, but that's what you're thinking, that God's already got it figured out and He's already got it. He will point to it.”

Mother F described spiritual purpose in adopting her son after the original child became unavailable for adoption, she said, “I figure, God had a plan, I don't know, and [child's name] was supposed to be our son, and if it had worked out with [the other child], we would have never met [our son].”

Adoptive parents Father J and Mother J described their decision to adopt an older child who had been previously adopted by another family, but was being disrupted from the home for severe behavior problems. Father J said, “We say it's in God's hands to decide to adopt.” When discussing the challenges of dealing with their adopted teenage daughter, with known FAS and Reactive Attachment Disorder Father J said, “I pray an awful lot and – spiritual beliefs bein' what they are, there have been a lot – there have been a bunch of key moments in my life – five or six of them – which I feel God has spoken to me very clearly. And at one of these dark moments, I got, ‘Your primary purpose on – for being here on this Earth is for this kid because you are the only person on the planet who can deal with her.’ And when I thought about life, I said, ‘Ya know, that probably is true’.”

**Being prepared-Not being prepared.** The concept of preparation was discussed by several participants. Being prepared or not being prepared was evident within and across transcripts as related to the adoption experience, adjusting to parenthood and/or not knowing what they were choosing, or “getting into”. Feeling unprepared for parenthood, was mentioned by a small number of participants. For example, Mother A said, “Biological families if you will, gave me a lot of advice at first and I wanted to say, ‘You have no idea what you’re talking about, I know that you gave birth to your children and were new parents, but in some ways, you, you weren’t. You had so much time to prepare. I didn’t. They started out with a child that doesn’t move, so if you wanna sit them down and go to the bathroom, you can. But for me, all of a sudden, I’m, I’m... I’ve had freedom and now I have a walking, talking, [Eastern European] toddler who has not experienced anything normal and all he wants to do is attach to me...climbing and sticking fingers in sockets” ... so I think in some ways... it was about me being able to feel ready for this. I hate to say, it sounds so stupid, but more of my independence was gone, compared to biological moms. I mean, that’s where it was. I just wasn’t prepared for the reality.”

Mother H described preparation for motherhood as something she worried about in the early days after bringing her child home. She said, “Our child was just so out of whack...you know...just four years old, taken from everything she knew, jet lagged and she was used to be surrounded by other children. Now she is alone with strangers. I hadn’t thought of that. I wasn’t prepared for that emotion. I knew we were helping her, but I was hurting for her. I worried that I wouldn’t know what to do. How do I be a mother? So my mother came to help me. She told me things like, ‘Don’t bring her to your

bed because then she gets used to it. You go to sleep with her in your room. Get an air mattress. Put it on the floor. She's used to having another person breathing in that room. Go to sleep with her. Imagine she's a baby. You sleep with her. You wake up with her.' It seemed so natural for my mom. Why didn't I know these things? My mother didn't stay past a week...she said, 'you have to learn to do this'...and I thought, how could she leave me to do this, I am not ready. I don't know what to do. I asked the doctors what should I do? What's most important? They told me, 'You are like all new mothers, you will learn.' No, I was not. I have a terrified four year old who doesn't know me, doesn't know anything here, doesn't know the language. I am not like all new mothers."

The notion of being unprepared in the way of not knowing what they were choosing, or not knowing what "they were getting into" was prominent among participants whose children had known or suspected FAS, RAD, Post Traumatic Stress Disorder (PTSD) and other developmental, neuropsychological or emotional challenges. Through tears, Mother D described the feeling of being unprepared for the severity of her son's psychological, emotional and developmental issues. She said, "We were never, ever talked to about the fetal alcohol syndrome, it was never brought up [by the adoption agency], it was never, there were never any issues brought up of, you know these children are prone to have X, Y, Z, none of that stuff was brought up to us and we were very naïve, we kinda placed our faith in their hands to guide you, thinking they would do the right thing...we just didn't know that this could be. Never were we prepared for what we have been through." Later in the interview she said, " Being told these things would have saved us a world of heartache... so, I think that we both [she and her husband] definitely feel like things need to be done differently and that parents needs to be made aware of what they're getting

into and what the possibilities are.

Mother B also described the feeling of being unprepared for the level of difficulty with her child, diagnosed with FAS, PTSD and RAD. She said, “I knew it’d be difficult, but I didn’t ever expect it would continue to be difficult year after year, after year, after year. When you adopt, you expect delays and some emotional issues. Never could I have prepared for this... who is prepared for violence and threats from a little child? Who is afraid of their young child? How do you prepare for that? Anyone thinking of doing this needs to know what the possibilities are. Here’s what could happen to you and your family.”

After one of the interviews with Father J and Mother J, Mother J said, “Thank you for letting us talk to you. People need to know what they are getting into when they do this.”

Mother C described the experience of learning that her son, adopted as a toddler, has FAS. She said, “I wasn’t prepared for anything like that. I didn’t know I had to prepare.”

It was common for the participants to reference their academic or professional experience as preparation that seemed to qualify them for parenting. This was most emphasized among parents whose children had FAS, RAD, PTSD and other challenges. During an interview with adoptive parents Father J and Mother J, this became a source of tension between them. Father J and Mother J shared very different perspectives on the experience of parenting their teenage daughter with FAS and RAD. Father J mentioned the following about his preparation for parenthood, “I’ve been in a – leadership positions my entire life. I’ve dealt with an awful lotta people at all different ages in all different circumstances – things of this nature. So, good and bad, it’s given me a little bit more patience, a little bit more seasoning that has maybe helped me do that. So, I don’t look

on it as, 'Oh, my God, the worst thing ever.' After a heavy pause in the interview, Mother J said, "I'm not as good a person as [he is] because I haven't been in all these wonderful leadership positions... I would think that 15 years of raising another son would be more of a – (*looking at Father J*) excuse me – more of a preparation to parent a child, but—I guess he doesn't think so. ..I gave up my job so I could be home for this child."

The interview with Mother C was heavily concentrated with references of her formal education. She stated, "I am a [professional] by trade-and I know a lot about this." Later in the interview, Mother C was discussing an on-line chat board for parents of internationally adopted children. She described reading a post by another adoptive mother who was experiencing extreme behaviors with her newly adopted teenage son. Mother C and her husband would later go on to adopt this child. She said, "Within one week of being home, the [original adoptive mother] posted, 'I think we made a mistake' and so because I'm trained by [*author*] to help parents, I had a real conflict, because we were hoping to add to our family, but at the same time, I wanna help people. This is how I'm trained. So, only I know the inward parts of my heart to know that I want to help people keep a child more than I was wanting to take a child, because it's best for that child not to have another break in their life, another disruption. I tried to teach them that to get them to hang on. Well, this family, they said, 'We are absolutely not interested in any help. We have made our decision. We just want him out of here.'"

During the interviews, Mother C often revisited her role in helping other parents. For example, she said, "And so, I've coached a lot of parents, but it's always for free. I don't ever take money for it. I mean, I could make some big money, but that's not what it's about." She described the time when she learned that her child has FAS. She said,



“When we got [our child], I went in like, ‘ I am a [topic] expert. I have a degree in [discipline]. I am a [professional] I know what I’m doing. This child was not exposed to this. This child is gonna be fixed within a year’, and then it was gonna be two years, and it was gonna be by age five, and then I didn’t even guess for age seven. That’s the point we started doing all the testing. And when we found out that [our child] had fetal alcohol syndrome, I went into total clinical depression... I was saying, ‘God, not only did you not allow me to have a child, you allowed me to adopt a child that’s brain damaged,’ and I grew up in the shadow of a [disabled relative].”

An unexpected finding emerged from the data related to the concept of preparation for parenthood. There was a subset of participants who had adopted children from other adoptive families. Known as “disruption of the adoption”, some families decide to have their children readopted in here the U.S., usually due to extreme behaviors exhibited by the children. Three participants had adopted children from disruptions, Father J and Mother J, and Mother C. Mother F had taken in a young adult from another adoptive family, after she was “disowned” for conflicts over the family’s religious values. All of these participants described lack of preparation as the reason the original adoptive parents did not or could not keep the children. For example, Mother C cited lack of preparation and not wanting the “work” of parenting the child. She stated, “Lack of preparation, lack of reading before they got the child... They didn’t read anything, and now they’re dealing with things... too many people wait too long to get help, because it doesn’t show from the outside, and people go, ‘Oh, you’re such a good person for adopting,’ and, ‘Oh, you guys are doing so great. Oh, your kid is so great.’ And then they go home and it’s hell, and eventually the hell gets bad enough, they go, ‘I don’t wanna do this anymore,’ and

they're so burned out. I've offered to – respite to families, and I've even had them say, 'I don't want respite. I want you to keep him,' and I said, 'I can't do that.' And the sad thing is that most people, by the time they get to me, they are ready to get rid of the kid and they just wanna know, 'Will you take him?' And I'm like, 'No, this is your child. You need to work through this,' and they don't wanna do the work.”

Father J referred to the original adoptive family of his daughter saying, “She [the daughter] was taken from the [birth] mom, put in the orphanage for about a year and then basically the other family, nice people, extremely well intentioned...but the road to hell is paved with good intentions... just as a further complicator, they already had five kids... they really didn't have any training... so it didn't work well and they had used like, everything on this, they spent forty grand on this adoption; they had no extra money or anything else like that to do counseling or anything else.” Father J went on to discuss the intentions of the original adoptive family saying, “I think they had every intention of trying to do the right thing, trying to do the right thing, but circumstances being what they are, you know...she shared a bedroom with one of the other girls and one night she woke up that girl and had thrown thumb tacks on the floor...you know...so she'd step on them....so they look at the situation as 'Hey, we got her over here to you guys.’”

Mother J added, “Yes, they think they did their part by bringing her to the U.S.”

Upon first meeting Mother F, she told me that she had recently taken in a [>18] year old girl who had been told to leave her adoptive family's home. She discussed the incidence of disrupted adoptions saying, “I think sometimes parents go and adopt with the best intentions. I think – I truly – and maybe I'm just looking at utopian view of it, but I think they go with the right intentions and then in the end some things go astray.

And I think they have unrealistic expectations of what it's going to be like and how it actually is... these are children. They're going to be defiant. They're going to cuss at you... they're going to disrespect you and be disobedient. And the two adoptions that I've seen that have been disrupted, the children are just being children, but the parents have unrealistic expectations. It's not the children, because both of these children are now in different households and they're doing fine. So, is it the family or is it the child?"

During two interviews, Mother F explained her reason for participating in the study, "I think there's so much bad in the media about these adoptions, and I think that – I'm not saying that any of them – that any of the parents did anything wrong or that they could have done anything differently 'cause sometimes you just – you get a child that is injured so deeply that maybe there is no way back, but I just – I would really like for people to know that there are also positive ones and that most of the time I think these kids are really good kids and that sometimes the parents aren't equipped. They think they are. They think, 'Oh, it's a child. How hard can it be?' But if you don't know all of the possibilities and different ways to put it and not to put them down and to build them up, I just think that's the problem."

**Greater Responsibility/Commitment to the Child.** Five parents expressed a sense of greater responsibility to their adopted children. In some cases, this responsibility fed a commitment to persevere despite some extreme difficulties, or was a source of personal or marital conflict for those struggling with extreme behaviors. Mother A stated, "...every decision that we make, I think 'Is this going to have an impact on who he is' and I don't mean that's not any different for biological children, but I think it's hard enough without having that crutch, you know, that concern that because they're adopted

you... just to know that they have a history and now you have that responsibility to them.”

During the interview with Mother H and Father H, Father H emphasized the difference in his experience from his wife’s. He said, “There was something I read before we’d gone [to the country]. It talked about how we don’t feel – some people don’t feel instant love, they feel responsible, and that was me.... when we went to court...there was a big judge and you know, she’s asking us why we would want to adopt. I stood up and I went into my ‘I’m gonna care.

She’s going to college. I’m gonna pay for this.’ You know, the responsible type of Response instead of that of a new father. For me being a father, when I first met [our child], I felt very responsible...commitment that's the first thing. I think there is, perhaps, a greater expectation of what we should do and how the child should be raised.”

Mother F described the feeling of responsibility to her adopted child saying, “Not only is it my job to love her with all my heart and soul, but it's also my job to give her the tools she needs to be successful... I don't think it's a greater responsibility than having a biological child. I just think you have more time to do it in when you give birth to the child. But when you have 12 and a half years that you have to make up for, if you're going to make them successful here – it's so different.” When asked what this is like for her, to make up for 12 years, she said, “...all the work that you missed out on from 0 to 12 now is in your lap and it is sitting on you and it is pressing on your chest and it's pressing on your head. And you have to get all of those lessons in in such a short amount of time. It's daunting. It's absolutely horrifying, the thought that I have this beautiful child in my household who is mine according to documents. But, I know

nothing about her, and she knows nothing about me, and we are starting from – she has language, she has memories, she has all this stuff that I didn't put into her, and now I've got to put into her everything that I have, everything.”

Mother G discussed feeling responsibility to inform healthcare providers of her young adopted son's history. She said, “I feel like I, it was my responsibility to go into him [pediatrician] and say these are some of the things we're concerned about... all moms are advocates for their kids. I just felt an extra responsibility... I feel privileged to have been given the opportunity to parent to him...and I feel like that added responsibility is what I signed up for.”

During the interview with Father J and Mother J, Father J referenced his commitment to his marriage as similar to that of being an adoptive father. He said, “We've been together for [number] years. Not all those have been great times... I've – I know there are people who have walked away when things got tough, when a partner got – when a spouse got other – when a wife got sick or somethin' like that. There was never any question of that. I had [serious medical problems]. She didn't walk away on me, and that's not – we just made a commitment and stuck to that. I made a commitment to this child. I'm stickin' with it.”

Mother B described the feeling of responsibility as a major source of strain in her marriage. She described the experience of daily life with her young daughter, diagnosed with FAS, RAD, PTSD, ADHD and suspected psychiatric disorders. At the time of the second interview, Mother B's daughter had been living in a therapeutic residential setting out of state. The time was approaching for the child to be discharged from the setting. Mother B expressed fear about bringing her daughter back home, but said her husband

would not consider placing her in another home. She commented, “He says it is ‘our responsibility’”. Mother B described great “frustration” (her term) at her husband. She said, “Of course he can say that- of course he can call it our responsibility-he goes to work all day and comes home telling me to stop being so negative about her. Well he didn’t have to hold her down, or pull her off her brother or drive her to the psychiatric hospital. I did and do every day. He says it’s our job- she will get better. I say-when? And how much do I have to take before then? And how about our son? Do we have a responsibility to him?”

### **Theme 2-Weaving the Fabric**

This theme refers to the experience of building the family as described by the participants. Four sub-themes were identified within and across transcripts. Most prominent was the effort to preserve their adopted child’s identity and culture, establish themselves as mother and father, maintain their relationship with their spouse, and find sameness with their child. Like weaving fabric, there seemed to be the creation of something integrated from many threads that although now part of the whole, were still visible.

**Retaining the Child’s Culture/Identity.** It was common for the participants to discuss ways they have tried to retain their child’s Eastern European identity and culture. For example, Mother F stated, “...I am so proud of her [ethnic] heritage, and we do celebrate [ethnic] holidays, and we do make [ethnic] food in the house, and we do go to the [ethnic] store, and so I’ve made it kind of like a part of our life...”

Mother G described trying to maintain elements of her young son's culture in their family life. She said, "I want him to be proud of his heritage, so we show him things that are [ethnic], we try and include [ethnic] things in our holidays, and in our daily life."

**Building Identity as Mother/Father.** The majority of the participants described the experience of building their identity as their adopted child's mother or father. For some, this referred to establishing themselves as the child's protector, instilling a feeling of security and safety for the child. In other cases, this meant establishing themselves as the authority figure in the home.

Mother C described feeling like a caretaker to her son in the early days after the adoption, she said, "...when you first get a child, you feel like you're their caregiver. You don't feel like the mom. It's like I'm taking care of somebody else's child, and eventually they're gonna come get the child, and over time the child begins to seek you out when they're hurt and just – it's just a process emotionally of just attaching and bonding...it takes time and you can't make it happen faster, but you can inhibit it."

In describing her identity as mother to her two adopted teenage children, Mother E said, "They'll still throw out the, 'Well, you're not my real mother.' Not so much [child's name], just pretty much [other child's name]. I think that's where he thinks he's really hurting me because he never really had his mother, which is why – I think he still likes to sit in my lap and be cuddled, and he still likes me to put my arm around him when I'm reading him stories...he still likes to be close, and I know it's 'cause he didn't have that from his mother. So I have no doubt that these guys know I'm their mom. I've never felt like I had to prove that, but I did have to give it some time to show them what a mom is."

Some of the participants described the identity of mother as something earned from

their children. For example, Mother F described emotional pain on her first Mother's Day, when her daughter did not acknowledge her. She stated, "When Mother's Day came around that's when she – basically like you're not my mother and I'm not celebrating with you. I did feel like, 'Oh, my God. Somebody take the knife that was just put in my heart and pull it out'... it hurt a lot because I – even though I didn't give birth to her, she's mine, and I would die for her, and I would kill for her if I had to. ...so for Father's Day she wanted to go out and buy all of these gifts...my husband said to her, 'Thank you. I appreciate this, but if we can't celebrate Mother's Day we can't celebrate Father's Day either. We'll just have to let those two days go because they're one – they're celebrating your parents, so you can't celebrate one parent and not celebrate both'. And so the next year I prepared myself to be stabbed again, but it was fine and now it's beautiful and I think 'Yeah. I'm her mom'".

Mother G described earning the identity of mother from adoptive children. She said, "I do think there is a connection that biology gives you. It's innate, but I feel it with my mom, that she would do anything for me, and I think when you adopt a child you have to earn that... The parent has to earn that from the child. You have to show that child – I love you so much – I tell them everyday... we have to create that connection because it's not there. That person is, in essence, a stranger. You are a stranger to that child..... I think that's where all that – the idea of cocooning when you bring them home... I think – and I'm sure that I'll have different thoughts on that when he's older, but I'm trying so hard to create that for him now, so that our connection is stronger when we get to the point where he wants to take the car out on a rainy night and I'm saying no, [and he says] 'Well you're not my mom', and I'm sure it'll happen".



Establishing oneself as the parental authority figure was mentioned by six participants. Both Father H and Mother H described this experience together. Father H said, “Our child knows we are the parents. No, there's no equality [*laughter*]. Mother H added, “I'm the boss. You're the child.” She went on to explain, “I think it's America. Children in general in America, they think – well, society will tell them ‘You're equal.’ It's nothing to do with adopted... just turn on Disney channel and watch a couple of episodes. No. I'm the boss. I'm the mom.”

The concept of parental authority was a source of disagreement between Mother J and Father J. They mentioned that their teenage adopted daughter calls them, “Mr. [first name] and Miss [first name], not mom and dad.” When Mother J described their adopted daughter's explosive outbursts, Father J mentioned Mother J's parenting style. For example, Mother J was explaining that she and Father J get very different responses from their child when she is asked to do something. Mother J said, “Well, his way of keeping the peace is letting her do pretty much whatever she wants to do, not askin' her to do anything.” Father J responded, “No. I call it choosing my battles and...” Mother J replied, “And he chooses next to no battles.” After a tense verbal exchange with Father J, Mother J said, “Because I'm the mom, I'm asking you to do this... her mother asked her to do something... we can't ask her to do small things. How are we gonna be able to ask her to do major things?” Father J responded, “Ok first of all, ya didn't ask her, ya told her. It's the degree of control, and it has to be done exactly and as fast... I get her to do all the stuff she needs to do, dear, but I go higher level and get the net effect done.”

Mother C likened parental authority to the role of a bus driver on a bus when speaking to her son. She said, “...if [child's name] is trying to be in control, I'll say,

‘There’s one driver on the bus... so have a seat, enjoy the ride. You’re not in control. Have a seat. You’re on the bus. You’re going where the bus is going. You’re not in control here.’”

Mother F described her daughter’s tendency to view herself as “head of the household” in the adoptive father’s absence. Mother F stated, “She saw herself as the head of the household in his absence and still to this day she – I think she feels like we’re kind of equal on certain things, and that’s when I started – I do take control. I’m like, ‘Oh, baby, we’re not on the same page. I’m an adult.’”

**Splitting-Teaming.** Splitting parents or teaming with the father against the mother was mentioned by eight of the participants. This was more common among families who had adopted older children and was described as strain upon efforts to try to build the family. Mother A mentioned the difficulty of adjusting to the adoption of their toddler. She said, “Just the adjustment, I think it could wreak havoc on a marriage, I think it would be so easy to do that.”

Mother F described her effort to reinforce the unity between mother and father with her teenage daughter. She said, “...in the beginning with [our child] she would snuggle up to my husband and when I would walk into the room, which it wasn’t inappropriate, but when I would walk in the room she would smirk at me like, ‘I’ve got him and you don’t.’ And I talked to my friends who are [professionals] and who did some adoption things, and they said that it’s common for these children to think that they’re gonna wedge in... they wanna kinda be like, ‘Ha ha. Look, I’ve got this over you.’ So what I had to come back to tell my husband was when she does that, when I walk into the room you need to get up and come to me, and you need to give me a hug and a kiss, and you

need to sit with me, and then later we will explain to her that we are partners and she is our child, and she can snuggle up on us and she can love on us, but she can't be a wedge between us."

Mothers of children with extreme behaviors described feeling "targeted" by their children, and not believed by their husbands when explaining the child's actions or outbursts. Many of the extreme behaviors tended to occur when fathers were not at home. It was common for these mothers to describe feeling that their husband "was not on my side". In recalling an eruption that occurred with her teenage son, Mother E said, "It was maniacal, eerie... my husband would never have believed it if he hadn't actually witnessed it one time. And then it's like, 'Whoa.'" Mother B described feeling resentful toward her husband and his tolerance of their adopted child's violent outbursts toward her. She said, "It's like he doesn't believe that it's this bad. He says she's just a little girl. Well, I'm your wife, where is your protection of me?"

Mother J discussed many of the interactions between her husband and their adopted daughter. For example she said, "He and [child] make pizza. I have to leave the kitchen...she tells me to leave and go to my room." At several times during the interview, Father J referred to difficulty between their adopted child and his wife. After Mother J recounted an incident when their child had become violent with her, he said, "Well you can see the two of them have issues." Mother J immediately added, "Did you hear that, he means me."

**Identifying with the Child.** The adopted parents' identification with their adopted children was often evident in the data. This meant looking for sameness of appearance, personality or experiences. Most of the parents referred to these similarities as

indications that they were meant to be family to their adopted children. Others expressed a greater understanding of their children because they identified with them in a specific way. Mother H stated, “She is like my sister in so many ways. She's a tomboy and my sister was a tomboy.”

Mother C identified with her son's diagnosis of ADHD and his FAS. She said, “When we struggle with our children, it's a sign that we have something inside of us that needs to be fixed and that maybe our childhood wasn't completed, that maybe we have something that needs to be reprocessed... I know a lot about this. I actually have [disorder] myself...and I have a sister [with disability]”.

Mother E described the similarities in appearance of her children to her nieces and nephews. She went on to explain that she understands her children's explosive reactions, saying, “Kids that have had any type of a violent history or an abusive history, you should just think what if you were adopted and came – they left everything they knew and came across to a new country and started over. I mean, hello. I don't think I could have done that. I was freaking out when we were in [country] and couldn't speak English to anyone.”

Mother F described being injured, like her daughter, saying, “I told her we had injuries ourselves. We wanted a child, so not only was it that she needed parents. We needed to be parents. So that's how we put it together... you're no more injured than we are, so we'll pull this together. We'll figure it out, and so that's what I tell her. Any time there's a huge issue, any time there's a problem, I say, “We got this. We got this. We can handle this together.” She discussed seeing similarities in her daughter. She said, “She takes what I say, and she'll say things that I said, and she's taken on mannerisms that I

have, so I can't just say that it's nature. I think there's some of that, but I think a lot of nurture goes into it also... she dresses like me. She wants me to bleach my hair because we won't let her dye her hair, so she wants me to have blonde hair 'cause she's blonde... she'll say, 'Everybody says I don't look like you.' And I said, 'Well, tell them you look just like your [grandmother].' So she does. She looks just like her [grandmother]."

During a discussion of his daughter's behaviors and impaired cognitive function, Father J recalled that she had received [treatment] in her former country as a toddler. He closely identified with her in this experience, stating, "...when I was [age], I was treated with the same [treatment] that she got, so I know what it did to me."

### **Theme 3-The Importance of Doing**

The concept of "doing" was pronounced within and across the transcripts. The data were saturated with various ways "doing" held significance in parenting for the participants of this study. Doing referred to the parents' search for information, or resources for their children. Among the parents of children with FAS, PTSD, and other developmental, neuropsychological or emotional processes, there were expressions of feeling defeated, looking for hope or feeling hopeless. Feeling misunderstood or judged by others, was overt and related to either "doing or not doing" something right with their child. Many of these parents also described scheduling and maintaining a predictable environment for their child as a very important thing that they do.

**Looking for information/resources.** It was common for participants to describe looking for information about adoption, the effects of institutionalization, FAS, or ways to help their adopted child learn English, adapt to American culture or adapt to family life. For example, Mother A talked about using videos in the car to help her young son.

She said, “We do this for the association for things, with the language of words to actions, to feelings, to sounds, to music, because those things are so much to teach. Getting beyond, beyond walls of our house, you know, and us constantly interacting...constantly thinking of what can we do next.”

Mother F described searching for early childhood books to help her teenage daughter acclimate to American culture and family life. She stated, “I ordered a ton of books online and read them from front to back. Took what I wanted from them and left the rest behind. When I don’t know or I’m kinda lost, I start looking again...I also found books to help [child] learn about life here...I bought the [children’s book series] ...they have all these books about lying, about being part of a family, about this about that...I did it not only for moral lessons, but also to help her with reading. Anything I can do, I do.”

Mother D mentioned getting a puppy to help her young son with his severe behaviors. She said, “We hope he will help [child’s name] with some of his emotional problems and maybe that would then help our other children...we are always trying to do something.”

Five out of six parents of children with FAS and other processes discussed the search for resources for their children or family. Descriptions of anxiety, emotional and financial strain were commonly mentioned as related to the search for resources. For example, Mother B stated, “The doctors that are specialized in this type of thing, they are very expensive and not close by, and as for the adoption agency, there’s no help as far as giving you resources...no help, no, it’s all self, you find your own, navigate your way through and good luck... insurance companies, they cover so little as far as mental health goes. I didn’t realize that mental health applies also to counselors. Getting her medication is not hardly covered by insurance...and she needs it- we need it... Everything

is self, self- research and everything has taken a long time to research, a long time to find the right people. And there's not too many therapists or doctors that work with these kids."

Mother D discussed the financial impact of her son's needs saying, "[Child's name] is basically ours to take care the rest of his life because he can't do it on his own, and so we need to set up a, basically a life plan for him because we can't even afford most of the stuff that he needs. He needs some major, major therapies that rack up to about \$20,000.00 a month and that's not even possible...it's come close to destroying us financially and destroying our marriage."

The search for resources was discussed by Father J stated, "...it's work, it's a lot of work, you gotta do a lot of this work on your own; you gotta hop on the web, find those resources..." He described feeling confident that resources will be available to help as his daughter reaches young adulthood. He said, "I have confidence that she'll get set up – where it will not be a monster burden on us and that type of thing. If there are programs, we will find them, and we will figure out what it does because, oh, by the way, she's not the only person on the entire planet who's got issues that will need assistance from society to overcome. She's not unique. She's rare, but she's not unique.... I have no doubt in my mind that we will figure out something for [her] to go on with life."

Father J emphasized Mother J's concern over the financial impact of finding resources for their daughter. He said, "[Wife's name] is extremely – extremely concerned about the long-term effect. Mother J is concerned that this kid is gonna be a yoke around our neck, that it's gonna completely ruin our retirement, we will work until the day we die – everything else like this." Mother J added, "Well, I'm looking at what she's done to us

financially over the last couple years... It's been awful. We've put easily \$100,000.00 into her for the last two years alone and I can't imagine what it's gonna be the next five years." This became a source of disagreement between them during the interview. Father J said, "Okay. Well, we haven't put \$100,000.00 into her." Mother J continued, "Yes, we have, dear. We put \$50,000.00 just in her education alone... and then, the adoption on top of it and then the lawyer fees for— [her criminal activity]... We have had to take out a loan to be able to save our retirement." Father J responded, "So, has been a stress financially...but ya know? We haven't killed our credit rating. We haven't gone bankrupt. We haven't been foreclosed – any of those other issues...but she [Mother J] is the one who worries about that." Mother J added, "Because, as you see, I'm the one who sees all the bills and pays all the bills."

**Choreographing.** Establishing predictability in the home environment through routines and schedules was emphasized by five of the 11 participants. The term "choreography" was used by two of the parents and describes the importance of structure and thoughtful planning in helping their children remain calm, or cooperative. This was most commonly described by parents of children with FAS, PTSD, and other processes, although several parents discussed the importance of maintaining routine for their children. Mother A stated, "Just twenty minutes being off schedule, it's enough to really just... he gets real crazy, and we have to get things back...you know...back to on time and normal."

Mother C referred to choreographing in describing the importance of predictability for her teenage son. She said, "I can see a relationship as a dance, because you're trying lead them while they're moving in a way that is going kind of in the direction that they're



heading without putting a wall up and putting a box around them and [*without*] making them feel squelched... so we would establish a routine so he knows what to expect... I don't think that we ever quit being predictable because of [child's] anxiety and even when he was... in first grade, he would say, 'What are we doing tomorrow?' 'Honey, you're getting up and going to school.' 'And then what?' 'And then we're going to speech therapy.' 'And then what?' 'And then we're going to come home and have dinner.' 'And then what?' 'And then you're going to go to Tae Kwon Do.' 'And then what?' 'You're going to go to bed.' 'And then what?' 'And then you're going to go to bed. You're going to have breakfast, you're going to go to school, you're going to go to therapy, to Tae Kwon Do, you're going to go to bed,' and I could never tell him far enough out what was going to happen because he just had this anxiety about what's next." She went on to say that a "typical day" is being the scheduler for her child with FAS. She said, "A typical day being [child's] mom is having to be the outward schedule regimenting him..."

Father J also likened predictability and scheduling as a type of dance. He stated, "We have – to be a scene setter. You have to say, 'This is what it's gonna look like. Okay? All these parts, we're gonna – Step 1, Step 2, Step 3, cha-cha-cha, out the door, in the car, cha-cha-cha'.... she can't handle any deviation from what she thinks is the standard, and, unfortunately, there are a lotta places to deviate. If something doesn't exactly – any kind of thinking combination, it just doesn't happen."

Mother G described the role that scheduling plays for her young son. She explained previously using a scheduling chart placed in her kitchen that displayed the plans for that day using pictures. She said, "We had it hanging in the kitchen; in the morning when we

would come down because he always wants to know, what are we gonna do today, so I said... why don't we talk about it and if we going to a doctor's appointment or something, something we had to do, I would say well, we have free time here, what do you think you want do there, we had pictures of things like books or puzzles or..... choices for restaurants if he wanted to eat at McDonald's that day...we had the golden arches logo...he thrives on structure...knowing what's expected...". Mother G shared that she no longer uses the board to depict scheduling; rather, she verbally informs her child of the plans for that day. She said, "I try to spell things out in advance, particularly if it's gonna be off schedule, off our normal schedule... I don't think he's gonna melt down if he- if something's off schedule, but I think he will hesitate moving into whatever is not part of the schedule and ask why are we doing this differently? Why is this happening?"

Mother E described the impact that failing to follow the schedule has on her adopted teenage children. With her hands to her face, she recalled learning the importance of the morning routine with her late husband. She explained, "... in the mornings, it's really important that, you know, we woke them up in a way that was more gradual, not just like, you know, get them up and running... I mean there was just too much going on, and so mornings would be horrible unless – I would have to get up like literally an hour before and gradually get them up and get everything so that it was easy, that I wasn't stressed; 'cause if I was stressed in the morning, [*Handclap*] it pretty much – – it really made a difference. It was pretty much up to – well, mostly me because if I was stressed out, well [*my husband*] would act the same way." She described a time when the morning schedule had not gone as planned. She said, "I can remember a morning that – we would

always get them up early and we could play a game in the morning before school...and that was one of the things [they expected]... And if there was a morning like, God forbid, I slept in or didn't hear the alarm or something and I got up and I was stressed, the whole – it would just be awful. They both can flip from one thing to another. So I would notice and so I would try really hard to just –stay on track and I remember one morning specifically, that [child's name] was just – we were playing a game and I don't know...she just lost it. I mean it was almost like... bipolar or something, or schizophrenic...and I don't know what happened but all of a sudden, she's like, you know– she threw the game and she, you know, threw the table and tipped over her chair and just started screaming. And it was just awful. It was scary ... And she's over there, she's banging her head on the wall and she's stomping her feet, and then she's kind of sliding down the wall and she's not saying too much. And then she's like saying stuff to me like, 'You're ugly. I hate you. I hate you.'”

**Self-doubt.** A significant divergence emerged from the data related to the major theme-*the importance of doing*. Six out of eleven participants had children with known FAS, RAD, PTSD and/or other neuropsychological, emotional or developmental processed. Expressions of doubt, defeat, hopelessness, or being judged were present in interviews with these parents. It was common for these participants to elaborate on feelings associated with what they do, or have done to try to help their child. These data represent an experience very different from that of parents whose adopted children did not have known FAS, RAD or PTSD.

Mother D described her feeling of defeat in trying to parent her young son. She said, “You feel just completely defeated, um, used, completely lied to, desperate, ah, hopeless,

I'd say all of those words rolled into one is kinda how you feel...I had to go on anti-depressants I was so depressed about the whole thing. My husband had to, I mean, I have to say nothing has been positive about it."

When discussing her young daughter, Mother B explained feeling that everything she does is wrong because her situation doesn't improve. She said, "You feel like you're always doing the wrong thing because it doesn't get better, it gets worse and you think, it must be something I'm doing or not doing."

During the interview with Father J and Mother J, Father J expressed doubt, questioning whether they could persevere, For example, Father J said, "...[the FAS]...it's incredibly frustrating. It shakes you. It really does. Sometimes you're – it's frustrating. It's overwhelming. This is where you get to the point of goin' – sometimes you get close to the point of goin', 'Can I – can we actually do this... ya know?'"

**Hope/Hopelessness.** Three of the participants strongly expressed feelings of hopelessness related to their parenting experience. Mother D described the experience of bringing her young son to a residential psychiatric facility when his behaviors became too much to manage at home. She said, "We were going to take [child] to a place .... about an hour away from here, it's a children's hospital. He'd been approved to go there... it was \$1,000.00 a day and so we assumed that it must be a great place and Medicaid actually approved it... we went up there with all intentions of leaving him there for the three or four month stint that they felt they needed to keep him...when we got up there, the place was like a sanitarium and we couldn't do it...I broke down and fell on my knees... I went into hysterics and thought I was going to get sick and said [to my husband] '...I can't do this to him... as much as our lives are being destroyed, I

can't put him here', and he said, 'I can't either', and we picked him up and walked out, and that's kinda what every day is like. You love him and just pray to God that one day some miracle gonna's happen and his brain is all of a sudden gonna get fixed, you pray and you hope, but you know it's not gonna happen."

Mother B described a similar situation with taking her young daughter to a local psychiatric hospital. She stated, "When we were talking with the counselor there, and I was waiting there with her, I just felt so sad, I had tears in my eyes the whole time and she kept asking me if I was crying. It was almost like she had no comprehension of what was going and how bad the situation was... they asked her a lot of questions which she was very honest about, surprisingly. She was honest with them that she hurts herself and that she hurts her family, and they wanted to keep her there for seven days to evaluate her and give us a break to regroup, but I couldn't do it. I wanted to, I wanted, I just kept thinking in my head, she's only seven years old, how could a seven year old stay in a place like this? I just feel extremely sad for what, what's going on, like I just don't even know what to do anymore, I don't know what to do with her anymore, I don't know, the time it takes to find her all these different therapies and the money that it takes, we can't keep doing it. There's no hope in it. I just don't know any more what to do, it's just frustration."

Father J described looking for hope that the relationship between his wife, Mother J and their adopted daughter will improve. He said, "...the only thing that really keeps me going is she's [daughter] got an incredible amount of hurt, and, unfortunately, I don't have any way to make that better for her. I wish to God I did, and I try and make an awful lotta really stupid and clumsy attempts. Underneath all that, on both sides – her

side and on this side [*gesturing toward his wife*] they both care for each other and will do things for each other – little things that both – neither of ‘em probably notice. But that’s there, and that’s what gives me the hope that someday that will get better.” He described the first time his adopted daughter called him “dad” and described that as a sign of hope. He said, “We did a [youth group retreat], and she called me Dad like 8 or 10 times over the course of this lock-in. It was the first time I’d ever had it, and I told her afterwards – I said, ‘... as far as I was concerned, that was – the best part of the [retreat] was you callin’ me Dad. I really liked that. You can do that...and that’s what gives me the hope that some – that inside there is a kid who eventually will get there.”

**Misunderstanding/Being Judged.** Although most pronounced among the parents of children with FAS and other processes, the feeling of being judged for their parenting was commonly described by participants. For some, this surfaced while still with their child in the country of adoption. Mother A laughed when she recalled caring for her toddler while still in Eastern Europe saying, “I tried... I was learning... I tried putting him on the toilet a couple times the first couple days when we were still in [country] and I, I dunked him in the toilet... we had a comedy of errors if you will, and all I kept thinking was ‘if the [ethnic group] saw me, they would take him back.’” Mother D also described discomfort over having to become firm with her toddler while still in the country of adoption. She said, “He pressed the limits right away...there were some moments I thought, “If the [ethnic group] saw me now. I actually, I hate, I don’t wanna say I had to be a mean mom, but I really had to get very stern, very fast and I didn’t wanna do it but I knew, this is the precedence that we’re setting right here. I worried about what the [ethnic group] would think.”

Mother D described extreme strain in the relationship with her husband's parents. She discussed feeling judged and attributed this to their lack of understanding. She said, "It's almost destroyed our relationship with my husband's parents because they, they live here, but they're not the type of grandparents that call and say, hey, can we help out today in some way...but they're the first to pass judgment on our relationship with [our child] and feeling like we're not loving to him when they don't even know what it's like to spend a day with him."

Feelings of being misunderstood were commonly expressed by the participants. The view that "no one understands" was most pronounced among the parents of children with FAS, RAD and other processes; however, many participants described having a unique experience in the country of adoption or living in a family situation that others would not understand.

Mother D shared the following about being misunderstood by other family members, "I think a lot of times, they feel like we're exaggerating, that we're making a lot of stuff up, or it's not really as bad as it really is, and I wish that sometimes we had a video camera just going non-stop in the house to show to my husband's parents because they have closed the door to thinking. I mean, for a long time, they thought, '[The child] will be fine, he'll get better, he'll go to college one day', and we're like, 'Are you kidding? Have you read anything about FAS; do you know?' And he's a [medical professional], and it just, it would blow my mind and I would literally get into a fight with them at a dinner table, going, 'If you would just pick up a frickin' book, you would see how wrong you are and what we're up against', and they just kept calling us, you know, so pessimistic..."

Mother D expressed feelings toward health care providers as well, saying, “I don’t think a lot of health care providers really know much about it. Every doctor he’s gone to – I’ve had a couple say, yes, he’s a FAS child, but yet they act like they don’t know anything about it or they just don’t get it...definitely Dr. [name], a specialist with these kids, has been a huge help. He at least, if nothing else, has validated everything we’ve said...he knows we’re not crazy...he gets it.”

Mother G also described the importance of being understood when looking for a healthcare provider for her toddler. She stated, “Well, I wanted him [physician] to know what the [country] had told us as far as his medical history, but I wanted him to know that we – I don’t know how to explain –that we were looking, for understanding... our special areas of concern with him because of his history. And that – I wanted him to know that [our child] wasn’t just a – an American baby who had super prenatal care and all that, that there were things that he might need to be looking out for ... But I just felt like [child’s name] was unique. Not something you just saw all the time and that we might need to see specialists and that we might - need more than he is used to.”

During an interview, Mother B said that no one could understand the experience of parenting an adopted child with FAS, RAD and other processes unless they lived it. She said that people tell her that “kids are kids”. She asked me if I can understand it. I asked her to help me understand how it is for her- if I were with her for a day, what would I see? What would I feel? She said, “You would feel beat up every day and alone.”



#### **Theme 4- Remaining Mindful**

All of the participants described a sense of heightened consideration or mindfulness in their parenting experience. The name of this theme came from one mother who said, “It’s [parenting] about being completely mindful of what’s going on.” Remaining mindful has different representations within the data, ranging from deliberate thought, attention, vigilance, hyper-vigilance or feeling “one edge” in their role as parent or in the home environment.

Mother E used the term “mindful” 17 times. She described the importance of remaining mindful of her own emotions and stress level as the most important factor in interacting with her children. Similar descriptions of mindfulness were given by Mother C, Mother F and Father J. This was another unexpected finding among the data, representing significant differences in parenting experiences from other participants in the study. For example, Mother E said, “When my kids are acting out, if I just respond to their disrespect... everything just escalates... I can see it...they pick up from my stress...what’s going on with me...so first I have to stay cool and think through what’s in front of me.” Mother E described a time when her teenage son displayed a violent outburst. She described the importance of remaining mindful in that situation, saying, “He just went berserk, I mean lost it. Just that really maniacal behavior and just evil... I guess I should have expected this. I should have. I mean throwing his textbooks, just losing it... and it's one thing when he was seven and he pulled a knife. It wasn't intimidating or frightening I... wasn't scared. But now he's not seven, and he's big and he's strong. And he could probably, if he wanted to, could really hurt me...but I just have

to stay calm and think... that he's afraid, he's stressed...he doesn't want to hurt me...I just have to think and tell him to drop the scissors...he pulled scissors this time...and I told him, 'Drop the scissors. Drop the scissors'...and I remember him laughing at me...this maniacal laugh...and I'm telling you...if I were a parent who didn't know as much as I know...I would have called the police." Mother E expressed a feeling of responsibility for that episode, saying that she should have been more mindful of the various factors leading up to her son's outburst. She said, "I should have seen it coming. I needed to think about all that was going on...he was very stressed at school...he had a recent bout of [illness] and our house was in total disarray-chaos from getting the [renovation]...I should have seen it, I could feel it building..."

Father J also described a type of mindfulness with his daughter. He said, "I step back and say, 'Okay, so whadda I got here, I got somebody who's over stimulated, over tired, over, over, everything'...it's just always thinking through what's in front of you...whadda I got here...just gotta remember...always remember and think..."

Mother C described a sense of fatigue that comes from her effort to remain mindful with her [adopted children]. She stated, "...it's emotionally exhausting... emotionally exhausted is when you look at your children, you don't even like them." Similar to the description given by Father J, Mother C discussed her thoughtful approach to interactions with her sons. For example, she said, "We do a lot of role play...it's about being child focused and seeing yourselves through the child's eyes... I always have to think, 'What's he seeing here, what's under this?'"

Mother F recalled the mindfulness that was required when she first brought daughter home to the U.S. at 12 years old. She explained, "I mean it's 12 years that you have to

make up for. You have to teach them. And still, there's still so many things she doesn't know about, and I don't even think about it, because , just everyday things... one day, she sat down with a bowl of soup and she grabbed a hold of the fork and she was like, 'Ow!', and I asked her why the fork was hot and she said because it was in the microwave...and I thought, 'Well, that explains why we've gone through two microwaves since she's been home'. But, I never thought – and of course, all I can do is laugh and then think, thank God, we didn't catch on fire and blow up...here are just all these little things that you forget to tell them about. Like – because you just – you know...but you always have to be thinking...for them, you know...what to tell them, teach them... you have to line this all up, line it all up... every little thing is new. Every little thing from walking in that door is new. How can you think of every single variable that's going to happen in life?"

For some parents, remaining mindful means being hyper vigilant, or “on-edge”. Mother B and Mother D described feelings of fear, anxiety and stress related to hyper-vigilance with their children. For example, Mother B stated, ““I think your body and your mind is just so stressed and tense not knowing what’s going to happen next and there’s no relaxing...I’m always on edge... wondering...it’s pure fear not knowing what she’ll do. Will she hit me today? Will she hit her brother? Will she pull her hair out by the roots? Will she throw something at us? Pick something bad, she’ll probably do it.”

With great emotion, Mother D discussed the experience of being hyper- vigilant with her son. She expressed an understanding for those parents who have injured their adopted children, saying, “I’m not saying it’s right, but I understand, I understand how these children get killed by their parents who’ve adopted them and they completely lose control one day because they can’t take it anymore. It’s so constant...you have to be on, on, on.

It's wrong, but I understand how it happens because I've come so close to snapping and I just have to leave the house, I mean, I don't care if I'm having to leave him in here for five minutes to destroy my house, I have to get out ... People who don't go through this, are like horrified, how could somebody do that to a child and they have no clue what's it's like... I understand how somebody could accidentally do harm to one of these kids because they push you, and push you and push you, and it may not be on purpose, but it doesn't matter at that point because you've completely lost all sense of sanity.”

Mother A described her early experience with her toddler son, soon after arriving home in the U.S. She described anxiety related to the demands of being ever-attentive. She stated, “He's either on or he's off... looking back on it, I'll often wonder, do you think he could have been sedated [in the orphanage]? For a long time I felt like I tried to push, not push him away, but you know, ‘Go to your dad, can you take him somewhere, can you?’ That's exactly what it was, and, and not that I didn't wanna be with him, but I felt like I never got a break because it was so, he was so intense with me all the time, it was just on, thinking all the time and it wasn't that way with [my husband], it was just with me.”

**Protecting/Safeguarding.** Remaining mindful for some participants means being alert to their child's need for security or safety and constant effort to establish that for the child. For other parents, in particular, those whose children were diagnosed with FAS, RAD and other processes, remaining mindful means protecting themselves or their other children from their adopted children's violent behaviors.

Mother C described her efforts to remain mindful of her son's need for security. She said, “[In the time right after we got him], it was just a matter of being selective in people

coming and just asking them to please wait and giving the child a chance to bond with us so that he knows what to expect and that no one is going to come get him; no one is going to take him...in most [social] situations [our child] would be like, 'Uh-uh, you're not leaving me.' He has an abandonment issue, even at [his age]... there's something about them [both adopted sons] that literally, if I dropped them off at the mall, I don't think they know that I would really come back." When describing some of her sons' outbursts, Mother C said, "You never know what brings these things on-we can have plans for a fun family day and boom- something just triggers and we have to do the whole intervention 'you're safe now' thing. It's just how we live." When asked her to describe the 'you're safe thing'. She said, "... trying to protect them from embarrassing themselves publicly while trying to remove them to a more private location and hoping that doesn't set them off more. Then it's just telling them to breathe and talk through what just happened, 'What just happened? What are you thinking? Did you just remember something? You are ok. Nothing bad is going to happen here.'" When asked to describe what it is like to for her to do that with her children, she responded, "It can be exhausting. Very draining, but it's my job. It's what they need."

Mother H recalled visiting friends out of town with her young daughter. She said, "...they [friends] speak [same language as the child] and she had not heard that in a few months, so when we walked in and they spoke to her, she freaked out...she ran to the bedroom and locked the door... I went there and said, '... it's Mama, come out-unlock the door'...and she opened the door and grabbed me in- shut the door behind me...she had this petrified face... she thought the [ethnic group] had come to take her back." Father H added, "I went to the room...same thing...opened the door...she shut it behind me."

Mother H described what this experience was like for her. She said, “I felt so bad that I didn’t think of that, you know.... to make her feel safe... always we need to think these things...”

Mother F described feeling great stress when taking her daughter to a health care provider in the early period after adoption. She said, “Most parents don’t have kids with some kind of history- you know, that maybe they aren’t aware of...but I always need to think about... I don’t know if she’s been sexually abused... so I told [doctor], “You’re not gonna do – do all the medical stuff. If you wanna check her here, check her here, but you’re not checking here and you’re not checking there and leave this alone’...when she was a little older, I scheduled our [gynecology] exam on the same day... because I wanted my daughter – I wanted us to be lined up and to let her know that ‘I’m not just doing this to you but we’re doing this together... this is gonna be a mother-daughter thing from now on until you get old enough to handle it on your own’, and my blood pressure was through the roof, and I’ve never had a problem with my blood pressure – ever – and the doctor was like, ‘She [daughter] needs to drive you home, your blood pressure is that bad, and I need you to contact your doctor and have an appointment within the next five days to check your blood pressure.’” But that shows how stressed out I was for my baby...I told my daughter, ‘I’m stressed because of you. I don’t want you to think I’m violating you, but I think that this is really important that we know that you’re healthy. And I said, “I’m really proud of you today.”’

Parents of children with FAS, RAD and other processes commonly described remaining mindful as taking measures to safeguard property, the living environment, other children in the family, or the adopted child from self-injury. Mother D described

this about her young son “Nothing is safe around [him] basically... we had to have a security system put in because of him..., he’s like this everywhere in the house constantly running out the doors, leaving the house... I wouldn’t even know when a door had opened and so, now 11 of our doors, there’s an alarm... it says ‘front door open’ or whatever... we now have to lock [older son’s] door every day. He has to lock it when he’s in there, and we have to lock it when he’s not in there because [adopted child] will go in there and destroy stuff in his room...if [older son] says ‘...Please don’t play with that’ [adopted child] would take it and slam it to the floor, purposely to break it.”

Mother D discussed times when it was necessary to restrain her young child. She said, “...it doesn’t matter how minute [a situation] is, it sends’m into a rage most of the time, and I can’t even remember what the issue was over the last time, but he went back to his room and I just heard things flying and I went in there and he has this pretty heavy red chair in there; he had flipped it over. He had pulled out the safety bar that we, that you would put on the side of the bed so a child doesn’t roll out. He had ripped that outta of his bed, he had pulled his mattress on the floor, he was throwing toys across the room, he had taken the door and pushed it as hard he could against the wall so that it would push a hole in the drywall, and I went in there, and I literally had to just take him, grab him you know, with his arms wrapped around him and throw him on the bed, and just lay on’m and I probably did that for about five minutes before he finally calmed down and I think to myself, ‘if this is a [age] year old and he’s only 45 pounds or whatever, there is no way I’m gonna be able to handle him when he’s a teenager, no way, and I don’t want to.’

When asked to describe that experience Mother D said, “It makes me terrified...terrified for [youngest child-biological daughter] when she gets older because he’s going to have

the hormones of a teenager, yet he's gonna have a little teeny tiny child's brain and he's gonna react on those hormones and we've been told that already- and I tell you, if he ever touches [daughter], he'll be gone...I'm very scared about the future...not so much the future...but what I'm gonna think in the future...the precious time I lost with my other children.”

Mother B described similar experiences with her young daughter who also has FAS, RAD and other processes. For example, she stated, “She does things...screaming, sometimes throwing things, sometimes slamming the door, sometimes hitting me or hitting herself in the head... She needs constant direction, but she doesn't wanna hear anything from anybody to help her. Last week, there was one day that I had to take her to the psychiatric hospital. It got to the point where I was scared for her and for myself. She was hitting herself in the head and just wouldn't calm down at all... she just, it just didn't stop. She was pulling out her hair that day too which she had done a couple of months ago a lot... horrible, horrible rages and nothing works, you can't hold her, you can't talk to her...” Mother B shared another time when she sought help with her child and described the need to remain mindful of safety. She said, “...she was just out of control in the car and she was hitting, trying everything she could. Screaming, trying to basically attack me and I pulled over on the side of the road, and got out of the car with her and we sat down. I tried to talk to her and tried to console her and she just was still raging and trying to hit me. We were near the speech therapy office so I took her over there. The speech therapist ended up taking her into another room and calmed her down. It was a great thing that we were near that office, because I don't know how I would have calmed her down....and I kept thinking, ‘What started this, what did I miss’...I always need to be



thinking, you know...safety, because she just loses it.” When asked what it is like for her to “always be thinking safety”, Mother B responded, “I think it’s like having to go back to your abuser. There’s all this protection for children, wives and the elderly, but not moms like me. It’s OK for me to get beat up? Or for me to have to pull her off my son and then I get it too?”

During interviews with Mother J and Father J, Mother J described remaining mindful in similar ways as Mother B and Mother D. Often the target of her adopted daughter’s rage, Mother J said, “I have to watch, you know, be careful...I usually walk away.” Mother J shared the following, “...she hit me, when I asked her to come out and help me weed the flower beds out front.... she’s very proud of that fact, that she’s now like fifteen pounds, weighs fifteen pounds more than I do and is probably about .... six inches taller than I am... she had told me, she told me early on that she needs a bigger mom than I am...one day she stood there and screamed at me for an hour ...when she escalates, I don’t try to stop it because she just seems to get uglier and uglier with me...I just leave the room... go to my room and sometimes she’ll follow me in there, just screaming at me...it usually starts in the morning...when she gets up...I try to say good morning to her real nicely, trying to think real hard all the time...and she just starts on me.”

Mother J discussed the importance of remembering to lock up her purse in their home. She said, “I can’t leave it out-she stole money from my purse...it’s not safe just being left out.” She also described being kicked down the stairs by her daughter, saying, “She kicked me down the stairs.” Father J added, “Tried to kick her down the stairs.” Mother J explained feeling the need to be “alert” for what might happen. She said, “I never know what thing is going to set her off.”

Father J explained the period of time when their daughter was under house arrest saying, “One of us had to be with her at all times... She was convicted of [number of offenses]...and so that meant we had to be here...watch her...all the time.”

**Looking for Triggers/Causes.** All parents described mindfulness related to looking for causes for their child’s reactions or behaviors. For parents of children with extreme behaviors, this meant looking for triggers behind the outbursts. Mother A described seeing what she called “orphanage behaviors” in her toddler son. She attributed several of his ritualistic behaviors to institutionalization. For example, she said, “There’s some things about [him], that I still think are orphanage related. Like getting dressed and a routine. It’s almost like obsessive compulsive about some things. Once there was a plastic tablecloth on a picnic table and it had the plaid [pattern], and he got so obsessed with making the lines line up to the edge of the table, and this was shortly after we brought him home that he forgot about the plate, so that went off the table, but he could not stop, he couldn’t stop focusing on those lines, the plaid lining up with the square table...I still see little bits of it [orphanage related behavior], you know, like the food plate falls off, he will do nothing until every piece is picked up off the floor. He will eat it.”

Mother G discussed looking for reasons behind certain traits or behaviors with her young son. She stated, “I find myself always tying behavioral things into – well you know he’s adopted from [country] and he was in an orphanage. Things like that, and it may be connected, and it may just be his personality...but I do wonder.” During the second interview, she explained that she participated in the study in order to share a positive view of international adoption. Although she voiced frustration with the negative

media attention, she acknowledged that she does have concerns about the unknown in her child's future. She said, "My whole purpose for participating in this study was to let people know that there are good adoption stories out there. It seems we only hear the horror stories. People have to know that this can work and it's the best thing ever... I mean, I get it- I've heard all the scary stories too about the kids with FAS and RAD. It happens- I'm not going to say it doesn't. And I do wonder sometimes. I mean, you can't help it, really. You know, there's times I'll put [my child] in bed at night and if he's mad or had a tiring day, he'll say, 'One day I'm going to burn this house down.' And I'll admit, it makes me afraid for the future." When asked to describe being afraid, she continued, "I'm afraid that other things will surface as he grows. You know, you hear about that mom who sent her child back to Russia. I don't agree with it. Obviously she wasn't prepared. But that kid said the same thing and so, I wonder- is there gonna be more inside my child that comes out, or is he just a tired little boy who's had a really hard day?"

The role of information in looking for causes behind children's behavior was discussed by four of the participants. During the interview with Mother H and Father H, different perspectives on the amount and type of information were evident. They both referred to information received while preparing for their adoption. Mother H described the lasting impact that the information had for her. She said, "Sometimes I feel they [adoption agency] give us a little too much information. I think ...that to this day I still think about it, the last final folder that they send us, that it tells you about what to expect... I suppose it sort of gives you an idea, the little language you need to learn. They talk about the children, and I think they really scared us a little too much about all this ... what is this thing the kids have? Um, attachment ... she was just a scared four-

year-old. That's it. She needed hug. To this day my sister and I will talk about the night that she finally came to hotel to stay, and she sat in the middle of the bed and cried. You know what? All she wanted was to have me pick her up, bring her to bed and hug her and sleep with her... We were thinking should we touch her? Should we not touch her? Oh, do you think she has attachment problem? So it gives you all these thoughts. They are children. That's it. They need love. That's all they need."

Father H followed with, "This is where we differ. To me there wasn't enough information...I read, I read all of it... I went online, and I was still very very interested in more....and when we were in [country] and had [our child] with us at the hotel, there was a day when we were walking back and [our child] is having a fit. I mean, she's going berserk. She's yelling, screaming, crying. I didn't pick her up. I walked into the hotel... she was just – and we didn't know how to control her. We had no idea how to control her... and the fear that [my wife] had was that we're not gonna bond... just because we were both very naïve about parenting and the process ..." Mother H interrupted, saying, "Again, you call it naiveness. I call it too much information. You just go with that. If you know they're children, they might be scared. They're gonna cry sometimes. When you think, 'Oh, my God, I shouldn't say this... Do you think this is attachment issue or this is alcohol syndrome or is this?' No, it's none of these things. It's a scared child. They just need love and attention and hug. That's it. Life goes on."

Mother H and Father H described differences in looking for causes in their child now, several years after their adoption. Mother H explained, "... I truly think adopting a baby is – or a child – is exactly the same as giving birth to a child. And both are enjoyable. Both has frustration. Both – and the minute the baby comes, you think to myself, 'Oh,

my God. I know nothing about parenting, whether they're adopted or they're natural. That's it. I truly – I still think too much information ... instead of getting me ready for motherhood, they were giving me information about what this child – what could be wrong. I never forget the last piece of paper that they send, which I wish I never read, was about the signs and symptoms of attachment issue. When we adopt, they don't prepare us for motherhood, they make you prepare to deal with – to recognize if there's anything wrong, send it back... why we give birth and we don't ask for a guarantee? But we adopt, we expect guarantee. There is no such thing.” Again, Father H offered his view, “We agree to disagree... for me, if I had a better understanding of how everything was gonna work, from the adoption in [country] and all the stuff that it takes, and to what type of reaction a child's gonna have with this process, because, like I said, [my wife] was fearful that there was never gonna be a bond. Now, whether that was because she read from that last piece of paper?” Mother H added, “It's not that I disagree with him, but a man's need is different from a woman's need.” She went on to say that the behaviors she sees in her daughter are a function of personality. Father H agreed saying, “Yeah- personality, but again, here's where I think a little differently, sometimes you do wonder, because you don't know... is it something else related to her history or the adoption.”

Mother C described the role of information in helping to understand behaviors in adopted children with FAS or other processes. She stated that the best resources are other adoptive parents, saying “There just wasn't information, and I even went to a psychologist, who is an expert on bonding, before I got him, and she looked at me and said, ‘There are no experts, and if someone tells you an expert, they're lying...the only

experts are other adoptive parents.” When discussing looking for triggers with her children, she referred to a term she had read in a book. She said, “Well [author] calls it ‘the window of tolerance.’ In other words, there are days when my kids get up that I can see that if I push it, it’s not going to be a good day. They don’t have the tolerance ... when you see your child explode at something and you go, ‘Come here and sit down and let’s talk about this for a minute. All I did was ask you to put your shoes... by the front door. And instead of just picking them up and putting them in there, something exploded. What happened here? What were you thinking? What were you feeling? What was it that happened? What does this remind you of? Did something happen in the past that you have this feeling about?’ And helping them because whatever is inside of them has to be reprocessed to get it out and I believe that very strongly. I really do.”

During the interview with Father and Mother J, Father J discussed the complexity of his daughter’s diagnoses and the difficulty this presents in trying to identify a cause or trigger for her behaviors. He said, “If we see an effect, it could be caused by one of seven different things, or most likely a mix... there are so many conflicting things that you could tie to... she’s been diagnosed with of course, with fetal alcohol, with RAD, with ODD [oppositional defiant disorder] and there might be a little bit of ADHD involved, we’re not totally certain...”

Remaining mindful was also related to some participants’ feeling of empathy or hurt for their children. Heightened awareness of their child’s history or special needs often caused them to feel emotional pain. Mother A emotionally described a time with her toddler son that she called, “A peek inside his soul.” She said, “I had taken him up to his room [and said] ‘You can play, I’m just gonna read, I’ll be my room, or right here’ and it

was all he could do to get in my face and attention, attention, attention. He couldn't stand the fact that I was reading that magazine, so I kinda chose to continue to read and he got more intense and more intense and there was a little table next to the chair, and he got up on top of that, and he was just tinker-toying just, and this isn't every day behavior, flips onto his back, under the lamp, under the chairs, just like this whole thing, and started crying and I was kinda frustrated and I picked'm up and I held tight, and I sat down and squished'm, because I had a magazine, and I knocked a mirror off and he started screaming, scared the daylights outta him...so I was like, '...it's okay, just take a deep breath', so I'm like shocked. It was desperation like, 'Don't leave me mommy', like he thought that it was his fault, it was a whole chaotic moment. Chaos. But although he has said, 'Don't leave me' before, it wasn't like that, it was like a little plea... it was like a desperate moment of 'don't leave me mommy', and I said, 'I'm not gonna leave you, and then he looks up and he said, 'I gotta pick up my toys', like it was, 'I've gotta put my toys away, like I've gotta be a good boy' kinda, I don't know, it, it was really- something came back, something- whether he can remember, whether something came back, but, it was a very eye opening thing, because he's a tough little kid, I mean, he's a very big personality... he appears to be very confident and loving and I think it made me realize like, 'You're so very vulnerable, you are. You're not as far along as even maybe I think'. There's so much more there and what's inside, that they recall. It just was, it was, it hasn't left me yet. It was, it was so hard to hear, it was heartbreaking, honestly. I was probably about as close to tears for that, you know, for my son who's hurting. I mean it was beyond that whole, that whole needing mommy thing, it was a bit of a pain, yeah, it was fear, and I might never touch that in him, I might never know any more, he might

never put into words; it's just a little something that's there. It's not gonna ever be healed. It was, a little peek inside his soul, and just to realize how, how much love they need..."

Mother F described being always aware of the hurt her daughter has experienced before adoption. She said, "I don't ever want anyone to hurt her. I don't want her to have to hurt anymore."

Mother E described the importance of understanding her children's behaviors. She discussed, "hurting for them, for what they've been through" and stressed the need for adoptive parents to be mindful of the factors behind certain behaviors. She stated, "Whether it's lying or acting out or stealing, or even just being compulsive about something or whatever, obsessive about something... I don't think parents recognize the fact that if you're really, really concerned about that issue, you need to look beyond the issue and not just throw them into a psychiatrist and stick them on medication ... 'cause you need to figure out and understand why that's the way it is... They might not be able to change it but at least they understand it. It changes how you react..."

### **Theme 5- Looking In-Looking Out**

Looking in- looking out refers to the comparison of adoptive experiences to biological experiences commonly described by participants in this study. This emerged within and across transcripts as comparison of adoptive parenting to biological parenting, and adoptive children to biological children. This theme is so named because comparing self to others involves looking inward and looking outward. For example, Mother C stated the following, "...I had read all these books, because I had to come to the point where I went, 'My child is not normal, and all these parenting books on normal kids is not gonna help me... the most important thing is to take all the books on parenting and



throw them away... I think parents of have children who have been adopted internationally need to be reading books about children who have been adopted internationally or have special needs.... another problem is people treating children like bio children or like normal children, and it's not gonna work. These children have differences.”

Mother F described the tendency of others to ask her if she worried that some of her teenage daughter's behaviors were adoption-related. She stated, “A lotta people say, ‘Oh, it's that adoption issue?’ Like if she does something, it's always an adoption issue, right? She was caught shoplifting last month... but she was with a girl who's born in America, born to a bio family, and they both got caught. So people wanna say, ‘Is that an adoption issue?’ And I'm like, ‘No, it's a freaking teenage issue.’ ... I think it's normal teenage stuff. The experts can prove me wrong, but all of my girlfriends who have bio kids say the same thing.” The word “normal” was used 20 times by Mother F. She emphasized “normal” teenage behaviors, characteristics of normal mother-daughter, and father-daughter relationships. She passionately described her reasons for participating in this study saying that she would not “normally” do so. She stated, “I think a lot of people want to read into everything. They want to have – they want to define it to be abnormal or ‘those kids’ – And that drives me absolutely crazy, because they're kids. First and foremost, they're kids, and they're coming with all the problems that kids come with. They're not going to be perfect just because you adopted them. But seriously, one of the only reasons why I wanted to be a part of this [study] is because I normally wouldn't do this, just so you know, was because I was thinking there has to be so many bad stories out there that I can't let that go.”

Mother E also compared her son's behaviors to "normal" teenage behaviors. For example, she said, "It's hard sometimes to differentiate between what is the biological reasons [referring to FAS] versus what is the teenage, 'I'm cool now and I...' you know. And the gender stuff. You know the whole thing about don't put your stuff back where it goes. Put it near where it goes. Now, I think every kid does that at some point. Or they can't find their stuff because they didn't put it back...but it's almost like he's not capable of doing it. I mean it literally – it's rare that he will put something back...like even a saltshaker...does he not remember where he got it from? So maybe that's not teenage?"

Mother D described comparing her parenting experience to that of parents with autistic children. She wondered which situation would be more difficult. She said, "...I have to remind myself, it could be a heck of a lot worse with some of the other kids that I've seen out there, as far as, severely autistic children who can't communicate. But sometimes you wonder is that easier on the parents? Our son can communicate, but you know, he'll tell us he loves us, but in the same sentence say, 'I wanna an egg sandwich, I love you'. It doesn't mean anything to him. So what's worse?"

Comparison of adopted children to biological children was prevalent in the data from Mother and Father H's interview, but in different ways. Mother H was firm in identifying her child's behaviors as "normal" and frequently compared adoption to birth. Father H tended to look at other adoptive families for comparison. For example, he said, "But the issues we have are minor, and when you look at some of the issues that the other parents, adoptive parents are having, you know, that's totally different. Whether it is attachment or some of 'em are – I know they've had just real – just violent, difficult, you know, doing violent behavior... like alcohol syndromes and stuff like that." Mother H asked if these

cases are prevalent and stated, “There are extremes, but are they prevalent? I don't think so. Don't we have kids that are not adopted and they are violent?” In comparing adoptive parenthood to biological parenthood, Mother H stated, “When you give birth, you automatically have bond with that child, but – so you don't think. It is. You hold the child. You sit one night with a child who has fever, you are – this is it. That child is in your heart forever. It doesn't matter. But the thing is, all your life you always think mother's love is a natural thing the day she give birth. It just happen. I don't think so, because look at how many losers are giving birth to children. God knows. They don't even pick them up from the school. Or the life they do to the child, so...It doesn't matter-adoption or not. The day I got on that plane, my heart was whatever [child's name] is going to do. I didn't even know it was an [child's name]. I didn't. I was on that plane. When it took off from New York, I remember the exact – I even wrote it down in my journal: ‘At this moment, when I get there, I don't care she's pretty, she's blind, she's defect- doesn't matter. She is my daughter as of this one.’ Now that I am in this place, she's my daughter.”

Mother A described looking for benchmarks for comparison of her young son's development. She said, “I do watch other children the same age to help see what is normal, cuz I tried very hard not to read into, you know, it's an adoption thing, or because of the institution, or it's, you know, he's behind, or he's ahead, I mean, I just kinda like to benchmark you know, and some things he's way ahead of everybody, and other things, he's still- we like some times, think maybe [the orphanage] lied about his age... in school we had a real problem for a while, with biting, and hitting and pushing. He seems to be moving out of that. We felt kinda isolated with that ... because they

don't tell you what the other kids are doing, you just feel like your kid is horrible.”

Mother J expressed her daughter's behavior toward Father J as a “normal teenager's” and different than the treatment toward her. She said, “I mean, she treats [my husband] like you would kind of expect a normal teenager to treat a parent, but no, she treats me basically, I tell her she treats me like shit and so then, what am I supposed to do?” Father J described talking with biological parents of teenage girls about their daughter's behavior. He stated, “Quite frankly, talkin' to other parents with normal [teenage] girls... they don't think that anything we're seein' is unusual.”

Father J compared his parenting experience to biological parenting saying, “...it's totally, it is worlds of magnitude different than your standard parenting experience of, of a birth child or even an adopted child from a standard situation, adopting an infant in a healthy situation.” He referred to he and his wife as “not standard” saying, “[We're] unique, we're not standard... I've had [serious illness] twice and then [wife's name] developed [chronic illness].”

Mother G mentioned that adoptive and biological parenting have common experiences. She mentioned that her adopted son's life would become more “normal” in time, saying, “...the older he gets and the better, more normalized, his life becomes, the less of an issue it is. But I do think that ... just like with parenting any child, there is joy and sorrow, and concern, and disappointment and pride. That being adopted from [country] is just where he started from. It's sort of not where he is now, and not where he's going and I wouldn't – unless you were someone who is thinking about adopting, or someone who had an adopted child, I probably wouldn't dwell on that part of it.”

Mother B gave the following description of her experience as an adoptive mother.

She said, “I think it’s impossible to even compare to any other type of mothering or parenting because there’s nothing about it that’s normal or traditional... there’s no normal discipline, there’s no, we don’t find any discipline to work, there’s no normal ah, like loving and caring that, that we seem to see, we see the difference, like our [biological] son, we see that he grows in different stages and different, like he’ll catch up in different things at different times, but there seems like there’s actual stages to him, his progression, and with her, there’s no stages, there’s no, there’s not the same kind of time line, it’s like one step forward, and three steps back, she regresses so easily, she’s a hard-it’s ah, she’s a hard child to love.”

### **Titles given to parenting experiences**

Margarete Sandelowski suggested that researchers invite study participants to place a title on their narrative or lived experience (personal communication, July 30, 2008). In this study, all participants were asked to place a title on the experience of parenting their child (ren) adopted from an institution in Eastern Europe. One participant stated that she could not think of a title for her experience. One participant stated three titles for her story: “Lord Help Me, or Mothering the Difficult Child, or Why did I do this?” Mothers and fathers voluntarily chose individual titles for their parenting experiences.

In aggregate, the following titles were offered:

- “Our Excellent Adventure”
- “The Gift of Life”
- “[Child name’s] House”
- “The Pilgrimage to [child’s name]”
- “My Russian Blessing”
- “Peeling back the Layers of an Onion-One at a Time”

- “Surrendering Control-Letting the Dream Die”
- “Hopeful but Hopeless”
- “Living in [child name’s] World”
- “How did my Life Come to this Level?”

The range in titles supports the range of experiences evident in the data. Linkage to major themes occurs through participants’ language that reflects sub-themes within the data. For example, spiritual purpose/meaning can be seen in the use of language such as “pilgrimage”, “blessing” and “gift”. Looking for triggers/causes is conveyed through the “peeling back the layers of an onion”. Hope/hopelessness and self- doubt can be seen in the titles “Hopeful but Hopeless”, “Lord Help Me”, “Why did I do this” and “How did my Life Come to this Level?”

#### 4.4 Summary

Five major themes and 15 subthemes were identified through analysis of the data. The findings in this study illustrate linkages among meanings seen within and across transcripts. Connections are seen among the themes and subthemes related to the lived experience of parenting a child adopted from an institution in Eastern Europe.

The first major theme is “Choosing/Being chosen”. The experience of choosing who to parent is conveyed within four subthemes: life-changing decision, spiritual meaning/purpose, being prepared/not being prepared and greater responsibility/commitment.

The major theme, “Weaving the Fabric” refers to creation of the family by integration of many parts into the whole. This theme is supported by four sub-themes: retaining the child’s identity/culture, building identity as mother/father, splitting/teaming, and

identifying with the child.

The Importance of Doing is a major theme that depicts the meaning of parenting as what is done or not done. Five sub-themes were identified: looking for information/resources, choreographing, self-doubt, hope/ hopelessness, and misunderstanding/being judged.

The fourth major theme, “Remaining Mindful”, illustrates the experience of parents’ heightened attention or awareness with a broad range of manifestations. Two sub-themes were identified: protecting/safeguarding and looking for triggers/causes.

The major theme “Looking in/Looking Out” refers to the experience of adoptive parenting juxtaposed with biologic parenting. No subthemes were identified within this major theme.

## CHAPTER 5

### DISCUSSION OF FINDINGS, CONCLUSIONS, AND IMPLICATIONS

#### 5.1 Introduction

The inquiry of lived experience is fundamental to nursing. Nurses are challenged to formulate plans of care for individuals and families with diverse histories, living situations, experiences, cultures, and values. The aim of this study was to discover the meaning of parenting a child who had been adopted from an institution in Eastern Europe, from the adoptive parents' perspective. One research question guided this study. The research question will be examined relative to the identified themes. The hermeneutic phenomenological perspective, guided by Van Manen's four lifeworld existentials (2007), will be discussed briefly as the framework for discussion of the findings. Conclusions and implications for nursing practice, education, research and policy will be presented. Implications for interdisciplinary education and practice will also be presented at the close of this chapter. It is important to note that data received from the two participants who adopted more than five years prior to the study, do not show differences that would alter the findings of this study.

#### 5.2 Interpretation of Findings

The research question guiding this study was: What is the lived experience of parenting a child adopted from an institution in Eastern Europe? The findings suggest that, for the participants in this study, the parenting experience means having made the choice to be their child's parent. The magnitude of choice in "choosing their child" was depicted as a point in time that they clearly remember as a historical and life-changing



moment. In this study, parents described the role of a higher being, or destiny in becoming their child's parent. Recognizing the "right child" implied that a child had already been chosen for them by God or fate. This parallels findings from a study of white international transracial mothers who described the adoption of their child as "God's will" (Crolley-Simic & Vonk, 2011).

The feeling of parenting the child who was meant for them was directly related to participants' expressions of greater responsibility or commitment to that child. Greater responsibility and commitment bolstered parents' conviction for protecting and providing for the child. In some cases, responsibility and commitment influenced the parents' choice to persevere in the presence of extreme difficulty. This mirrors earlier descriptions of "devotion" expressed by parents of children who had adopted children with FAS (Granitsas, 2004).

Participants in this study described being prepared for their choice, or not being prepared in the way of not fully knowing what they were choosing. This concurs with findings from a study comparing discrepancies between pre-adoption expectations and post adoption experiences among international adoptive parents (Chesney, 2008). No studies were found that examined choice or preparation for international adoption; however in an article about international adoption of institutionally reared children, Gunnar, Bruce and Grotevant (2000) wrote that the preparation process for international adoption is aimed at approving prospective adoptive parents, not preparing them for the realities of the effects of institutionalization that vary in acuity and are often long lasting. One of the unexpected findings of this study was a subset of parents who had adopted children from disruptions- original adoptions of children from institutions in Eastern

Europe by parents who subsequently placed their children for adoption once here in the U.S. Within these data, choice remains a robust theme in several ways. This population of parents made a choice to adopt a child, formerly chosen by another adoptive family who eventually chose to dissolve their adoption. The subset of participants in this study attributed disruptions to the original adoptive parents' lack of preparation in choosing to adopt a child from an institution. While no studies focusing on the role of choice in international adoption were found, a body of knowledge exists known as the Psychology of Choice, leading to the development of Choice Theory (Glasser, 1998). Models of decision making, autonomy and problem solving are explored within this body of work. The relevance and applicability to choosing in the context of parenting is not known.

The lived experience of parenting in this study meant building a family as one would weave fabric. The family fabric was woven from the threads of several identities and relationships: identity of the child, identity as parent, identity as a family unit. Construction or clarification of relationships included parent/child, parent/parent and husband/wife. Participants described honoring their child's birth country through the inclusion of cultural foods, celebrations and positive, respectful discussions as important to their child's identity. Building parental identity meant establishing themselves as protector and /or authority figure for their child. Although represented differently within transcripts, an emphasis on control and power resonated across transcripts, relative to the parent/child relationship. A dichotomy of paradigms emerged. Descriptions of self-control versus control of the child were identified. Some participants rejected the philosophy of parenting from a power dynamic. Others described the importance of maintaining power as the authority figure in the relationship. The importance of control

in the parent-child relationship was common and robust across all interviews. Parents described remaining attentive to, and in control of, their own stress and reactions to their child's behaviors. For some this was an introspective exercise, controlling thoughts and stress. For others, this meant exerting intellectual or physical control over a situation in front of them. This theme is supported by findings from other studies examining stress and coping among adoptive parents that suggest adoptive parents feel a responsibility to remedy their child's past, quickly establish a safe and secure relationship with the child and identify boundaries for behavior (Bird, Miller, & Peterson, 2004; Judge, 2004).

In this study, cohesion of the parent-parent or husband-wife relationship was threatened by differences in the perception or responses to the adopted child's behaviors. This was most prominent within and across data from parents of children with FAS, RAD, PTSD and other processes. Mothers of these children often described being the recipient of their child's rage and anger. Feelings of not being believed by other family members, including their husbands were common. This concurs with long-standing findings from multiple other studies involving children with RAD that indicate a prevalence of aggressive child behaviors directed toward mothers or other female caregivers (Golden, Lyndon, Shaeffer, & Termini, 2009; Howe & Fearnly, 2003; Jacobsen & Straker, 1981; Lyons-Ruth, 1996; Reeves, Wimmer, & Vonk, 2010; Ryan, 2006).

The search for sameness with their adoptive children was described as related to weaving the family fabric. Looking for common physical or personality traits was described by many of the participants and reinforced feelings of having chosen the right child. It was also identified as important in building identity as family. Studies yielding

similar findings have focused on the efforts of adoptive parents to establish similarities, particularly studies involving children of biracial adopted children conducted by Friedlander et al. (2000) and children adopted from China (Fong & Wang, 2000; Rojewski, 2005).

In this study, parenting the child adopted from an institution in Eastern Europe meant doing. The data are abundant in descriptions of what parents do with, or for, the adopted child. Participants described looking for information and resources, or maintaining structure and order. Among the subset of parents who had adopted children from disruptions, there was a sense of doing what others could not, or would not do. For many of the parents of children with RAD and FAS, parenting meant looking for hope, feeling hopeless because of persistent challenges despite what they do, or feeling judged by others for what they do or do not do.

The lived experience of parenting a child adopted from Eastern Europe meant remaining mindful for participants in this study. Within the data, remaining mindful is represented as mental alertness, attention and consideration. All parents conveyed the responsibility of advocacy for their child in raising the awareness of mindfulness of healthcare providers to their child's known and unknown history. Remaining mindful of their child's experiences prior to adoption evoked strong feelings of empathy in all parents.

All parents discussed the significance of their child's history in their daily life. This meant looking for, or remaining cognizant of causes or triggers for their child's reactions and responses.

Many parents described dramatic consequences of failing to remain mindful of an array of variables. For some parents remaining mindful more accurately meant being on-edge or hyper-vigilant with related to protection or safeguarding of self, the adopted children other children in the home or property. Descriptions of stress, fear and anxiety were common among those parents who perceived mindfulness as a state of persistent hyper-vigilance. This concurs with findings from a study by Banyard, Englund and Rozelle (2001) that found that parents and caregivers of children with a history of trauma, were themselves subject to higher levels of stress due to multiple factors, among them- an increased state of alertness.

In this study, the lived experience of parenting the child adopted from an institution in Eastern Europe meant looking for a frame of reference, or looking in- looking out. The data depict a search for a measure of normalcy for parents in this study. While not found in the international adoption literature, the “search for normal” by mothers of low birth weight babies was described in a study by (Deatrick, Knafl, & Murphy-Moore, 1999). This parallels findings from multiple studies in the literature on parents of chronically ill children (Branstter, Domian, Graff, Piamjariyakul, & Williams, 2008; Greenberg & Meadows, 1992; B. S. Johnson, 2000; Lyne & Lowes, 1999). While RAD and FAS are not considered chronic illnesses, they are recognized as chronic conditions.

#### **Interpretation of the study findings related to the four lifeworld existentials.**

Temporality, or lived time, is experienced as the abstract concept of being in the world (van Manen, 2007). One’s “horizon” in the world is created from the continuum of time as experienced in past, present and future. In this study, the lived experience of parenting reflects time as a continuum. The parents in this study valued the importance of history as

supported by their descriptions of the point in time when they choose their child. They also described a sense of cosmic time, wherein the child meant for them had already been chosen, even prior to their meeting. History remained important in defining their child's identity, seeking healthcare and understanding their child. In this way, past time is therefore, not past- but still experienced in the present as integral components of daily life and decisions. The time continuum is evident in the data as parents often linked the past to the present with phrases such as "... it still does, I still do, he/she still does".

Spatiality, or lived space refers to a place of being in the world, or that space which is felt (van Manen, 2007). In this study, space was represented by descriptions of physical and psychological space. Descriptions of physical space in safeguarding self, child or home supported creation of a psychological safe space for parents and children. Likewise, comfort and reassurance shown to the child established a safe and secure space for the child in the child-parent relationship. Two participants named their parenting experience with titles that indicate living in their adopted child's space: "[Child name's] House" and "Living in [child name's] World". The theme "weaving the family" reflected the process of creating a space for the family unit that included the child, with space for the child's culture and history, creating space for parents/spouses, and other children in the family.

Corporeality, or lived body, refers to one's physical existence in the world (van Manen, 2007). For participants in this study, the physical way of being in the world is reflected in their descriptions of doing for and with their child. Within this theme, choreographing referred to physical structure of scheduling of the lived environment. Recollections of their in-country adoption experiences are abundant in descriptions of the physical appearance of settings or children. Adoptive parents in this study often looked

for similarity of appearance, behavior and personality with their children as physical indications of sameness or belonging. Descriptions of physical care for their children, or providing physical protection also support being in the world through lived body. Perhaps this is best described by the one participant who described the responsibility of adopting a 12 year old in a physical, palpable way. She said, "... it is sitting on you and it is pressing on your chest and it's pressing on your head."

Van Manen (2007) defined relationality as the "lived relation we maintain with others in the interpersonal space we share with them." (p.104). In this study, the major theme "weaving the fabric" specifically, establishing the relationships within the family, supports the idea of lived relationship in shared space. Definitions of identity within the family as protector and authority figure were seen as important aspects of building lived relationship. Likewise, weaving elements of the child's culture into family life reflected integration of the familiar into shared space as a means of establishing relationality between parent and child.

In this study, the four lifeworld existentials are not isolated or exclusive of one other. Rather, an inter-relatedness exists between them, wherein the lived experience of the adoptive parents becomes a dynamic intersection and communication of time, space, body and relationality, as supported by the major themes identified.

### 5.3 Conclusions

The role of history and context are important in understanding the findings of this study. Parents of children adopted from institution in Eastern Europe value the history of the adoptive experience as well as their children's history. Having chosen "who to

parent” provides context for the way they see their world, whether this means not knowing what they were choosing or, feeling prepared and “meant to be” in this experience.

The findings of this study suggest that adoptive parents are living an experience not understood by others. Establishing a frame of reference for comparison is seen as important in helping them interpret their own experiences.

#### 5.4 Limitations

The findings of this study are limited by the self-selection of participants, and cannot be generalized to the larger population of parents who have adopted children from institutions in Eastern Europe. This limitation was identified at the onset of the study. All of the participants in this study adopted from either Russia or Ukraine which might render the findings non applicable to parents who have adopted from other countries in Eastern Europe. The majority of the participants in this study were adoptive mothers, only two adoptive fathers participated. The findings may have differed had a larger number of adoptive fathers been represented in the data.

#### 5.5 Implications and Recommendations

Nurses are responsible for communication, assessment and implementation of plans of care that are individualized and congruent with the values, beliefs, culture and needs of persons within a population. Understanding the meaning of parenting a child adopted from an institution in Eastern Europe is of key importance to nurses and other health care providers as they interact and formulate plans of care for internationally adopted children and their families. Knowledge from this study will inform nursing practice and education.



Opportunities for future nursing research as well as inter-professional research also exist related to this study's findings.

### **Nursing Practice**

The role of "history" was very important to adoptive parents in this study as they interacted with healthcare providers. Parents expressed a responsibility to inform health care providers about components of their child's health history or experiential history, in order to ensure proper assessment, treatment, or to facilitate a therapeutic environment for their child. Many parents described specific concerns for their child's future well-being. Providing time and space for parents to communicate with health care providers is essential.

It is recommended that Pediatric, Adult Health, and Family Practice nurses and health care providers regularly conduct assessments of family health and functioning. The range of parenting experiences depicted in this study indicates the importance for on-going evaluation of family well-being, support and resources.

Parents in this study were highly informed and attentive to their child's overall health, development, and diagnoses, where applicable. Nurses and other healthcare providers would benefit from involving parents as valuable resources and partners in the assessment, design and delivery of care.

Parents of children with FAS, RAD, PTSD and other processes often described feeling misunderstood, or subject to judgment in their parenting situation. Feelings of being in a rare or "different" situation were common. For some of parents, safety was of primary concern for themselves or their children. It is of critical importance that nurses and health care providers establish priorities that are congruent with those of the adoptive parents.

Assessment of the adoptive parents' values, beliefs and practices will assist in designing appropriate plans of care. Lastly, the search for supportive or financial resources was described by several parents as exhausting and isolating. It is suggested that nurses and health care providers maintain a current list or library of available resources for adoptive parents. Ideally, a case manager would be available for coordination of multiple services, assistance or support.

### **Nursing Education**

The findings of this study support recommendations for inclusion of content related to international adoption at the baccalaureate and master's levels of nursing education. Registered Nurses, as well as Advanced Practice Nurses may encounter adoptive parents, or children adopted internationally, in acute and primary care within pediatric, adult, family, emergency, community or mental health settings. Nursing curricula may be enhanced at both the entry and advanced practice levels by inclusion of concepts related to health and physical assessment of the internationally adopted child. Potential effects of institutionalization, trauma, and pre-natal substance exposure are important topics to be included. In addition, students in schools of nursing are would benefit from content related to the implications of Alcohol Related Neurodevelopmental Disorder (ARNDD) also commonly known as FAS, and Reactive Attachment Disorder. It is suggested that assessment of the international adoptive family be emphasized.

The complex depiction of parenting the post institutionalized child in this study suggests the opportunity for an innovative model of interdisciplinary education .Students within the disciplines of nursing, medicine, psychology, social work, counseling , education, speech therapy and occupational therapy are likely to benefit from

collaborative learning experiences focused on care of the internationally adopted child and family. As stated in the Institute of Medicine report, the *Future of Nursing: Leading Change, Advancing Health* (2011) , “Inter-professional education is thought to foster collaboration in implementing policies and improving services, and prepare students to solve problems that exceed the capacity of any one profession... it is expected that graduates of programs with inter-professional education will be ready to work effectively in patient-centered teams ...resulting in safer, more effective care and greater clinician and patient satisfaction” (pg. 203).

### **Nursing Research**

Findings from this study suggest a number of opportunities for future research using both quantitative and qualitative approaches. It is possible that changing the research question to examine the experience of adoptive fathers would allow for comparison of lived experience between mothers and fathers. In addition, changes in study design to longitudinal design may be of benefit in examining changes in the lived experience over time. Recommendations for future research also include replication of the study with parents who have adopted children from regions other than Eastern Europe.

Many of the parents in this study described feeling poorly understood by health care providers, and discussed difficulty in finding providers who were familiar with internationally adopted children. Therefore, measure of health care providers’ knowledge and self-efficacy in providing care to post institutionalized children may be a valuable area for inquiry.

Since no such studies have been found in the literature, an opportunity for research may be measures of quality of life among families who adopted children from institutions

in Eastern Europe and other regions. Comparison of perceived stress among adoptive parents, with biological markers of stress and inflammation, is another suggested area for future research. Findings from such a study may lead to follow-up interventional studies.

### **Policy**

Many parents in this study expressed lack of healthcare coverage for their adopted child's psychological, behavioral, therapeutic or pharmacologic needs. In addition, they expressed concern over their child's ability to become independent in the future. The exact number and cost of programs in the U.S. designed to help children with RAD or FAS transition to young adulthood and independent living is unknown. In this study, most parents of children with RAD and FAS had already incurred significant financial burden and expressed concern over financial security for the future.

Creative programs to provide respite for parents of children with RAD and FAS may help be of help to parents who described stress and fatigue from the demands of caring for their children. It is recommended that sources of funding for such programs be explored in order to limit further financial strain on parents.

### **Summary**

The findings of this study contribute to nursing's body of knowledge as well as the body of knowledge on international adoptive parenting. The participants in this study shared their perspectives on the meaning of parenting a child adopted from an institution in Eastern Europe. They represented a population interested in informing prospective adoptive parents and health care providers about their lived experience. The exploration of lived experience brings nurses and health care providers an understanding of what is important and valued by the patients and families they see (Finch, 2004). In this study,

identification of themes brought to light the importance of information and resources, understanding and wanting to be understood, remaining mindful of their child's history, experiences, and triggers, and looking for a frame of reference for their parenting experience.

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## Appendices

Appendix A



# DUQUESNE UNIVERSITY

## INSTITUTIONAL REVIEW BOARD

424 RANGOS BUILDING ♦ PITTSBURGH PA 15282-0202

Dr. Paul Richer  
Chair, Institutional Review Board

Human Protections Administrator  
Phone (412) 396-6326 Fax (412) 396-5176  
e-mail: [richer@duq.edu](mailto:richer@duq.edu)

July 24, 2008  
Ms. Kimberly Curry-Lourenco  
1256 Paramore Drive  
Virginia Beach VA 23454

**Re: The lived experience of parenting a child adopted from an institution in Eastern Europe (Protocol # 08-85)**

Dear Ms. Curry-Lourenco:

Thank you for submitting your research proposal to the IRB.

Based upon the recommendation of IRB member, Dr. Kathleen Sekula, along with my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, the research is approved under 45CFR46.101 and 46.111 on an **expedited** basis under 45CFR46.110.

Attached is the consent form with our approval and expirations dates. You should use it as original for copies that you distribute.

This approval must be renewed in one year as part of the IRB's continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if you are still utilizing your consent form in one year, you will need to have it renewed. In correspondence please refer to the protocol number shown after the title above. If, prior to the annual review, you propose any changes in your procedure or consent process, you must inform the IRB of those changes and wait for approval before implementing them. In addition, if any unanticipated problems or adverse effects on subjects are discovered before the annual review, they must be reported to the IRB Chair before proceeding with the study.

When the study is complete, please provide us with a summary, approximately one page. Often the completed study's Abstract suffices. You should retain a copy of your research

records, other than those you have agreed to destroy for confidentiality, over a period of five years after the study's completion.

Thank you for contributing to Duquesne's research endeavors.

If you have any questions, feel free to contact me at any time.

Sincerely yours,

A handwritten signature in blue ink that reads "Paul Richer". The signature is written in a cursive style with a large initial "P" and a distinct "R".

Paul Richer, Ph.D.

C: Dr. Kathleen Sekula  
Dr. Lenore Resick  
IRB Records

Appendix B



DUQUESNE UNIVERSITY  
INSTITUTIONAL REVIEW BOARD  
424 RANGOS BUILDING PITTSBURGH PA 15282-0202

Dr. Joe Kush  
Chair, Institutional Review Board  
Phone (412) 396-6326 Fax (412) 396-5176  
e-mail: [kush@duq.edu](mailto:kush@duq.edu)

June 20, 2011

**Re: The Lived Experience of Parenting a Child Adopted from an Institution in Eastern Europe – Protocol # 11-46**

Dr. Lenore K. Resick  
School of Nursing  
Duquesne University  
Pittsburgh PA 15282

Dear Dr. Resick:

Thank you for submitting the research proposal of your student, Kimberly Curry-Lourenco. Based upon the recommendation of IRB member, Dr. Karen Paraska and my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, the research is approved under 45CFR46.101 and 46.111 on an **expedited** basis under 45CFR46.110.

The consent form is attached stamped with IRB approval and expiration date. Kimberly Curry-Lourenco should use the stamped form as original for copies that she distributes or displays.

The approval must be renewed in one year as part of the IRB's continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if the consent form is still in use in one year, it will need to be renewed by our office. In correspondence please refer to the protocol number shown after the title above.

If you and Kimberly Curry-Lourenco propose any changes in procedure or consent process, you must inform the IRB of those changes and wait for approval before they are implemented. In addition, if any unanticipated problems or adverse effects on subjects are discovered before the annual review, they must be reported to the IRB Chair before

proceeding with the study. When the study is complete, please provide us with a summary, approximately one page. Often the completed study's Abstract suffices. You or Kimberly Curry-Lourenco should retain a copy of research records, other than those destroyed for confidentiality, over a period of five years after the study's completion.

Thank you for contributing to Duquesne's research endeavors.  
If you have any questions, feel free to contact me at any time.

Sincerely yours,

*Joseph Kush*

Joseph Kush, Ph.D.

C: Dr. Lenore K. Resick  
Kimberly Curry-Lourenco  
Dr. Karen Paraska  
IRB Records



## Appendix C

### Recruitment Statement

Duquesne University  
IRB - Protocol #11-46  
Approval Date: June 20,  
2011 Expiration Date:  
June 20, 2012

**To:** Email will be addressed to the IA adoptive parents list serve

**Subject:** Invitation to participate in a research study about international adoption.

***[Body of email]:***

You are being invited to participate in a study about what it is like to parent a child adopted from an institution in Eastern Europe. The purpose of this study is to discover and describe the meaning of parenting a child who has been adopted from an Eastern European institution. Findings from this study will add to the knowledge about the international adoption experience with the ultimate goal being to improve health care to families and children adopted from Eastern Europe.

Participants will be asked to allow me to interview you twice and to audio tape both interviews. One \$15 gift card to a local convenience store will be provided to all participants as compensation for your time after the first interview. Because face to face interviews will be conducted, only residents of Virginia are being recruited for this study.

If you are interested in participating in this study, please contact me by email or cell phone:

Kim Curry-Lourenco, PhD (c), MSN, MEd., RN  
Doctoral Student  
Duquesne University School of Nursing  
PhD Program  
currylourencok@duq.edu  
Cell: 757-567-9399



DUQUESNE UNIVERSITY  
INSTITUTIONAL REVIEW BOARD  
301A ADMINISTRATION BLDG. ♦ PITTSBURGH, PA 15282-0202

Dr. Joseph Kush  
Chair, Institutional Review Board  
Duquesne University  
Email: [kush@duq.edu](mailto:kush@duq.edu)  
Web site: <http://www2.duq.edu/research/policies.cfm#human>  
412-396-6326

November 4, 2011  
Dr. Lenore Resick  
School of Nursing  
Duquesne University  
Pittsburgh PA 15282

**Re: The Lived Experience of Parenting a Child Adopted from an Institution in Eastern Europe (Protocol # 11-46 AMENDMENT)**

Dear Dr. Resick,

Thank you for submitting the amendment to Protocol #11-46 to the Institutional Review Board at Duquesne University.

You propose to make minor changes with regard to two aspects of your study: changing the recruitment procedures and changing the advertisement/recruitment letter. The changes are consonant with procedures and documents originally approved by the IRB and pose no foreseeable risks to subjects or potential subjects.

The research remains subject to all stipulations put forth in this IRB's original approval letter and annual review remains on the cycle determined by the original approval. The protocol number is shown above. Please use it in correspondence with our office.

The amended consent form is attached, stamped with current approval date but original expiration date. You should use the amended stamped form as original for copies that he distributes or displays.

Sincerely yours,

A handwritten signature in blue ink that reads "Joseph C. Kush".

Joseph C. Kush, Ph.D., Chair  
Institutional Review Board



**Are you the parent of a child adopted from an institution in Eastern Europe?**

You are being invited to participate in a study about what it is like to parent a child adopted from an institution in Eastern Europe. The purpose of this study is to discover and describe the meaning of parenting a child who has been adopted from an Eastern European institution. Findings from this study will increase knowledge about the international adoption experience with the ultimate goal being to improve health care to families and children adopted from Eastern Europe.

Participants will be asked to allow me to interview you twice and to audio tape both interviews. A \$15 gift card to a local convenience store will be provided to all participants as compensation for your time. Because face to face interviews will be conducted, only residents of Virginia are being recruited for this study.

**If you are interested in participating in this study, please contact me by email or cell phone:**

**Kim Curry-Lourenco, PhD(c), MSN, MEd., RN**

**Doctoral Student**

**Duquesne University School of Nursing**

**PhD Program**

**[currylourencok@duq.edu](mailto:currylourencok@duq.edu)**

**Cell: 757-567-9399**

## Appendix F

Duquesne University  
IRB - Protocol #11-46  
Approval Date: June 20,  
2011 Expiration Date:  
June 20, 2012

### Semi-structured Interview Questions

**Script for opening of interview:** We have talked a little bit about where you are from, and have talked a little bit about your family. Now, I am very interested in learning from you about the experience of parenting a child adopted from an institution in Eastern Europe.

Can you tell me about that?

- Tell me about the first day you met your child.
  - Probe: Tell me what you remember the most about that day.
- Tell me about the time when you first came home with your adopted child.
  - Probe: Tell me more about that time.
- Think about a typical day with your child. Can you tell me about that?
  - Probe: Tell me about yesterday with your child.
  - Probe: Tell me about a day last week with your child.
- If you could place a title on your story of being a parent to your internationally adopted child, what would it be?
- Is there anything else you would like to tell me about that we haven't discussed?
  - Probe: Is there anything else you would like me to know?

Appendix G

Duquesne University  
IRB - Protocol #11-46  
Approval Date: June 20,  
2011 Expiration Date:  
June 20, 2012



**DUQUESNE UNIVERSITY**

600 FORBES AVENUE PITTSBURGH, PA 15282

**CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

- TITLE:** The Lived Experience of Parenting a Child Adopted from an Institution in Eastern Europe.
- PRIMARY INVESTIGATOR:** Lenore K. Resick, PhD., CRNP, FNP-BC, FAANP  
Phone: 412-396-5228 Email: resick@duq.edu  
Email: resick@duq.edu
- CO-INVESTIGATOR:** Kim Curry-Lourenco, PhD (c), MSN, MED. RN  
1256 Paramore Drive  
Virginia Beach, VA 23454  
757-567-9399  
currylourencok@odu.edu
- SOURCE OF SUPPORT:** None. This study is being performed as partial Fulfillment of the requirements for the doctoral degree in Nursing at Duquesne University.
- PURPOSE:** You are being asked to allow me to audio-tape two interviews with you. Each interview will take approximately one hour, will be audio taped, and then transcribed by a professional transcriptionist who will sign a confidentiality statement. The purpose of the first interview is to gather information about your experience of parenting a child adopted from an institution in Eastern Europe. The second interview will occur within six months of the first interview. The purpose of the second interview is to clarify and verify my interpretation of information obtained in the first interview.

Spouses and /or parenting partners may choose to be interviewed together, or separately. You will also be asked to complete a demographic form. These are the only requests that will be made of you.

**RISKS AND BENEFITS:**

There are no risks greater than those encountered in everyday life. However, should the nature of the information shared during the interview process create distress or emotional upset, resource phone numbers for psychological counseling will be available upon your request. The information you offer in this study may help expand and change health care practices in relation to the care of families with children adopted from an institution in Eastern Europe.

**COMPENSATION:**

Upon completions of the first interview, a \$15 gift card to a local convenience store will be provided as compensation for your time in participating in this study. Participation in the project will require no monetary cost to you.

**CONFIDENTIALITY:**

Your name and all other identifying information Will never appear on any of the interview transcriptions. No identity will be made in the data analysis. Your name and the names of others, will never appear on any study forms, or any information provided by you. All written materials and consent forms will be stored separately in a locked safe in the researcher's office. All computerized data will be stored on the researcher's password protected laptop. When not in use, the laptop will be stored in a locked closet of the researcher's office. Results of the study may be published or presented for professional purposes, but your name or identity will not be associated with any specific quotes or information obtained during the interview.

Information obtained from our interview may be shared with members of my dissertation committee or research team. Only transcripts with pseudonyms will be retained by the researcher for further studies or professional purposes. Upon completion of this study, all audio files will be destroyed by the researcher.

**RIGHT TO WITHDRAW:**

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time and without explanation.

**SUMMARY OF RESULTS:**

A summary of the results of this research will be supplied to you, at no cost, upon request. I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any further questions about my participation in this study, I may call:

Primary Investigator: Lenore K. Resick,  
PhD,CRNP, FNP-BC, FAANP, Duquesne  
University School of Nursing 412-396-5228

Co-Investigator: Kim Curry-Lourenco,  
Doctoral Student, Duquesne University  
School of Nursing 757-567-9399

Chair, Duquesne University  
Institutional Review Board  
Paul Richer, PhD 412-396-6326

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher's Signature

\_\_\_\_\_  
Date

Appendix H

Duquesne University  
IRB - Protocol #11-46  
Approval Date: June 20, 2011  
Expiration Date: June 20, 2012



# DUQUESNE UNIVERSITY

600 FORBES AVENUE PITTSBURGH, PA 15282

## Confidentiality Statement

As transcriptionist, you have direct access to study participant interview audio-tapes. By signing this document, you agree to maintain this information in a confidential manner at all times. This includes but is not limited to:

- Disclosing confidential information or allowing physical access to research data other than the principle investigator;
- Intentional or negligent mishandling of confidential information; or
- Leaving research data unattended.

I acknowledge and agree to the above requirements.

Name: \_\_\_\_\_  
(Please print)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Please sign & date)



## Appendix I

### Demographic Tool

#### The Lived Experience of Parenting a Child Adopted from an Institution in Eastern Europe.

Demographic questions will be asked by researcher using the following script:

“Thank you for agreeing to participate in this study. Before I ask you some questions about your adoption experience, I would like to ask you some general demographic questions. If there are questions you prefer not to answer, you do not have to answer them”.

**(By observation ) Gender: Male \_\_\_\_\_ Female \_\_\_\_\_**

**What is your current age?** 18-25 yrs \_\_\_\_\_ 26-33 yrs \_\_\_\_\_

34-41 yrs. \_\_\_\_\_ 41-48 yrs \_\_\_\_\_

> 48 yrs \_\_\_\_\_

**What is your current marital status:** Single \_\_\_\_\_ Married \_\_\_\_\_

Divorced \_\_\_\_\_ Domestic partner \_\_\_\_\_

**What was your marital status at time of adoption?**

Single \_\_\_\_\_ Married \_\_\_\_\_

Divorced \_\_\_\_\_ Domestic partner \_\_\_\_\_

**How long ago did the adoption take place?**

Less than or equal to 1 year ago \_\_\_\_\_

2-4 years ago \_\_\_\_\_

5 or more years ago \_\_\_\_\_

**How many children have you adopted internationally?**

1-2 children

2-4 children \_\_\_\_\_

> 4 children \_\_\_\_\_

**What is your adopted child/ren's country of birth?**

\_\_\_\_\_  
\_\_\_\_\_

**Do you share a common ethnicity with your internationally adopted child?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes, what is it?** \_\_\_\_\_

**Do you share a common culture with your internationally adopted child?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes, what is it?** \_\_\_\_\_

**Do you share a common religion with your internationally adopted child?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes, what is it?** \_\_\_\_\_

**Do you share a common language with your internationally adopted child?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes, what is it?** \_\_\_\_\_