The Relationship between Attachment and Development in Internationally Adopted Children: Is Love a Necessary Ingredient for a Healthy Development?

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The purpose of this thesis was to investigate whether the lack of selective attachment - the lack of a relationship with a responsive caregiver - could be considered to be the primary cause of disturbances of attachment in internationally adopted children. Studies along with literature on the subject were examined and the findings from that examination indicated that this variable can indeed be considered to be the primary cause of disturbances of attachment. Internationally adopted children that have been lacking a consistent and responsive caregiver, appear to be in danger of having to deal with disturbances in attachment and related difficulties. That conclusion is furthermore in accordance with the ecological attachment theory of John Bowlby and his emphasis on selective attachments and the consequences of the failure to develop selective attachment relationships. Finally, intervention to help adopted children and their families was discussed and revealed that methods that focus on improving the child-caregiver relationship seem to be most effective. Interestingly, using those kinds of methods is also in accordance with ecological attachment theory.

1. Introduction

A Special World

A special world for you and me
A special bond one cannot see
It wraps us up in its cocoon
And holds us fiercely in its womb.

Its fingers spread like fine spun gold
Gently nestling us to the fold
Like silken thread it holds us fast
Bonds like this are meant to last.

And though at times a thread may break
A new one forms in its wake
To bind us closer and keep us strong
In a special world, where we belong.

- Sheelagh Lennon –

1.1 Attachment

The mechanism of attachment, particularly between mothers and their babies, has been richly debated and investigated by developmental theorists. In the past, both Sigmund Freud and learning theorists believed that infants became attached because attachment was linked to the fulfilment of primary biological needs, for example hunger and thirst. They believed that infants that were well attached to their parents were infants that had their biological needs fulfilled by their parents (Dworetsky, 1995). However, during the last 30 to 40 years, the theoretical understanding of attachment has changed. Research has shown that children seem to need a lot more from their caregivers than having their biological needs fulfilled, for example love and affection (e.g. Harlow & Suomi, 1970, Ainsworth et al.,1978).

Accounts of disordered attachment first appeared almost 70 years ago when a number of scholars observed the unhealthy consequences of raising children in institutions (Levy, 1937, Spitz, 1946). Some have argued, furthermore, that it was the movies of Rene Spitz about infants in institutions that called attention to the problem in a way that publications in professional journals during the preceding 50 years had not. The large numbers of European children who had been separated from their parents or actually orphaned by World War II led the World Health Organization to commission John Bowlby to prepare a report on the mental health needs of homeless children. *Maternal Care and Mental Health* was published in 1951, and it summarized the observations of Spitz (1946) and other clinicians about the harmful effects of institutionalization. It also contained the foundation of Bowlby's ideas about attachment that evolved into ethological attachment theory (Bowlby,1969/1982).

Bowlby (1951) began to write about the undesirable influence of insufficient maternal care on development and called attention to the severe distress that young children seemed to experience after being separated from their primary caregivers. This distress was viewed as a fundamental human response, and Bowlby claimed that a close mother-infant relationship was necessary for socio-emotional adjustment: ”the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute – one person who steadily mothers him) in which both find satisfaction and enjoyment” (Bowby, 1953, p.11). This belief of Bowlby sounds, in fact, sensible but interestingly it marks the transition from observational studies of distress to suggestions about the meaning of a child’s desire to avoid such

distress.

At the same time that research findings about children raised in institutions were building up (e.g. Tizard & Hodges, 1978; Tizard & Rees, 1974,), case reports of children raised in extremely abusive and depriving environments continued to appear (e.g. Curtiss, 1977; Koluchova, 1972; Skuse, 1984), and social characteristics of maltreated children were delineated (Aber & Allen, 1987; Gaensbauer& Sands, 1979; Mueller & Silverman, 1989).

Bowlby (1969) argued that an infant's early attachment to his/her parents might constitute the basis of all later social relationships. Contrary to the existing views of the time, he hypothesized that these early attachments were not just a passing phase of little long-term significance, but rather that they were crucial for later psychological development. Bowlby (1969) argued for an attachment-model in which an individual is seen as progressing along one or other of an array of potential developmental pathways. He offered a dynamic view of development that could proceed along a variety of different pathways, each of which is influenced by later, as well as by early experiences, and with none as universally optimal in all circumstances.

Since then, the idea has been taken much further, and over the last 50 years researchers have been discovering interesting things in relation to how infants and children react to separation from their caregivers. By using controlled experiments researchers have identified types of secure and insecure attachment (Ainsworth, 1979), and have followed that work with predictions about how children classified as being securely or insecurely attached as babies will behave and feel later in life. Furthermore, even adults are now being classified according to attachment types (Main & Hesse, 1992) and insecure attachment has been linked to damaging affects, such as anxiety, withdrawn behaviour (Aoki, Xeanah, Sherryl, Heller, Bakshi, 2002), problematic relationship with mother (Waters, Wippman, Sroufe, 1979), problematic relations with teachers (Sroufe, 1983) and pre-school-behaviour problems (Hubs-Tait et al., 1991).

1.2. The purpose of this thesis

Considering the negative affects that have been linked to the lack of healthy attachment I want to look more closely at the concept of attachment and ascertain the way in which the creation of attachment seems to be important for healthy development in children. I will especially focus on disturbances and disorders of attachment in internationally adopted children, children adopted

from foreign countries. I choose this group of children because research has shown that internationally adopted children appear to be the highest risk group diagnosed with some kind of an attachment disorder (e.g. O'Connor, Bredenkamp, Rutter & the ERA Study Team, 1999, O'Connor, Rutter & the ERA Study Team, 2000, & Zeanah, 2000). Furthermore, the two diagnostic manuals of mental disorders, DSM-IV (American Psychiatric Association (APA), 1994) and ICD-10 (World Health Organization, 1992), link attachment disorder, or so-called *reactive attachment disorder* (RAD), to the extremes of caregiving such as that given to children who have been raised in institutions. Clinicians have even been urged to be cautious in making diagnosis without evidence of abuse or neglect (World Health Organization, 1992).

Thus, internationally adopted children and especially those that have been living in institutions or orphanages before adoption are considered to be in the highest risk group with attachment problems and being diagnosed with reactive attachment disorder. However, the fact that DSM-IV and ICD-10 lay great emphasis on the fact that maltreatment is a necessary factor to make a diagnosis, has been criticised. Clinical experience and research suggest that disturbances in attachment can be found in children living in institutions though not having experienced abuse or neglect and not having been deprived of adequate physical care or opportunities for social interaction with peers and caregivers. They have, in fact, been living in stable, even though unhealthy relationships (e.g.Tizard & Rees, 1975, O'Connor, Bredenkamp & Rutter, 1999). Thus, disorders of attachment seem to exist beyond RAD, and the question arises as to the cause of attachment problems in children that have not been living in deprived situations and have not been seriously abused or neglected. Perhaps we will find the answer if we go approximately 40 years back in time and look at what John Bowlby and his associate Mary Ainsworth had to say about the subject.

As has been described, attachment theory is a developmental theory, not a theory of pathology. However, Bowlby stresses in his theory of development the importance of selective attachments (Bowlby, 1969). In fact, long-term mental health is strongly connected to early social-emotional development, and particularly to secure early-attachment relationships (Ainsworth, 1979, Bowlby, 1969). Disturbances in attachment are then linked to poor mental health consequences and negative behavioural outcomes (Ainsworth, 1979). Because of this, disturbances in attachment should be more likely to happen if caregivers are not available and not responsive to the needs of children. That would, in my mind, be a conclusion well in accordance

with attachment theory, rather than the conclusion that maltreatment or institutionalization as such cause attachment disturbances in children.

Because of this discrepancy between the two nosologies DSM-IV and ICD-10 (American Psychiatric Association (APA), 1994, World Health Organization, 1992) and what can be drawn from attachment theory about the likely causes of disturbances in attachment, I think it is important to investigate better what really lies behind disorders of attachment. I especially want to investigate whether the lack of selective attachment - the lack of a relationship with a responsive caregiver - can be considered the primary cause of disturbances of attachment in internationally adopted children.

I want to investigate this issue because here we have a group of children that really needs help with their problems and by better identifying the cause of their perceived problems, one can hopefully find better ways to help them. Also, it is important in my mind to understand better which children, with what kind of background etc., are at most risk for developing attachment disorder. By detecting that one can, for example, try to improve the environment they are living in whilst still in institutions or orphanages. Furthermore, it is important that adoption agencies and those considering adoption are aware of the risk factors so they can prepare themselves for receiving a child that very likely needs special attention.

What is more, studies have shown that some internationally adopted children are dealing with serious psychological and physical problems after living in institutions (e.g. Dalen & Rygvold, 1999, Mehlbye, 2005). It is possible that not all adoptive parents are ready for the challenge of raising a child with severe special needs. Therefore, it is important that the information held by adoption agencies and others working in this field is accurate. Adoptive parents should be able to know what to expect, should receive help to prepare themselves if they choose to adopt, and then get further support after they have received the child.

1.3. The structure of this thesis

In the first chapter of this paper I will discuss early theories of attachment, look at early research in the area and discuss what Freud, the Learning theorists, Harry Harlow, John Bowlby and, last but not least, Mary Ainsworth believed about the attachment process.

In the second chapter I will look at the concept of reactive attachment disorder (RAD) and how it has been linked to internationally adopted children. I will look closely at the two manuals, DSM-IV and ICD-10, and discuss their criteria for reactive attachment disorder. Furthermore, I will discuss criticism on the two nosologies and finally try to understand better what risk factors actually appear to lie behind this disorder.

In the third chapter of the paper I will then start a discussion about the adoption process. The main focus will be on the selection of adoptive parents. I will reflect on issues that should be considered in relation to this selection, discuss adoption laws and how they seem to have been working, especially in Denmark and Iceland.

In the fourth chapter I will further the discussion about the adoption process, now focusing on international adoption per se and the selection of children. I will reflect on the history of international adoption and look into which risk factors have been connected to psychological and physical problems in internationally adopted children, with emphasis on problems of attachment.

After having discussed the risk factors for disturbances in attachment I will then, in the fifth chapter, discuss what can be done to reduce or avoid the occurrence of such disturbances. I will examine what research has to say about what can be done in institutions or orphanages, and what can be done to help these children and their families after adoption.

Finally, in the conclusion, I will try to answer the main question of this paper, which was expressed here above on page four, viz., whether "the lack of selective attachment - the lack of a relationship with a responsive caregiver - can be considered the primary cause of disturbances of attachment in internationally adopted children."

2. Attachment theory

2.1. Early theories of attachment

As mentioned in the introduction, both Freud and the behaviourists argued that because nursing satisfied an infant's biological needs strong attachments are established between infant and a mother. They believed that infants became attached because attachment was linked to the fulfilment of primary biological needs and that the infants that were well attached to their parents were the same infants that had their biological needs fulfilled by their parents (Dworetsky, 1995). This was at the time when behaviourism was very popular in mainstream academic psychology. Behaviourists assumed that the mind was a black box; mind, thoughts, and emotion could not be studied because they could not be observed.

At the same time the psychologist Harry Harlow wanted to study love. He thought that love mattered, that it was important to development. Harlow's interest was in the way love developed between mother and child, and the effects of that relationship on later responses to affection. He then got the idea for his experiments when he noticed that baby monkeys separated from their mothers developed emotional attachments to gauze cloths used to keep their cages clean. When the cloths were removed, the monkeys would often throw temper tantrums until they were returned. Harlow wondered if the cloths might be being used as surrogate mothers (Harlow & Suomi, 1970).

In the experiment Harlow separated rhesus monkeys from their mothers at an early age and placed them with artificial surrogate mothers. There were two surrogates, one made of wire, and the other made of terry cloth and possessing a more monkey-looking face (see figure 1). Both "mothers" could be equipped with a baby bottle placed in a hole in their chest for nursing to take place. No matter which mother provided food, the baby monkey spent as much time as possible cuddling and hugging the cloth mother. Even baby monkeys that were fed only by the wire mother seemed to form stronger attachments to the cloth mother and spent most of their time hugging her (Harlow & Suomi, 1970).

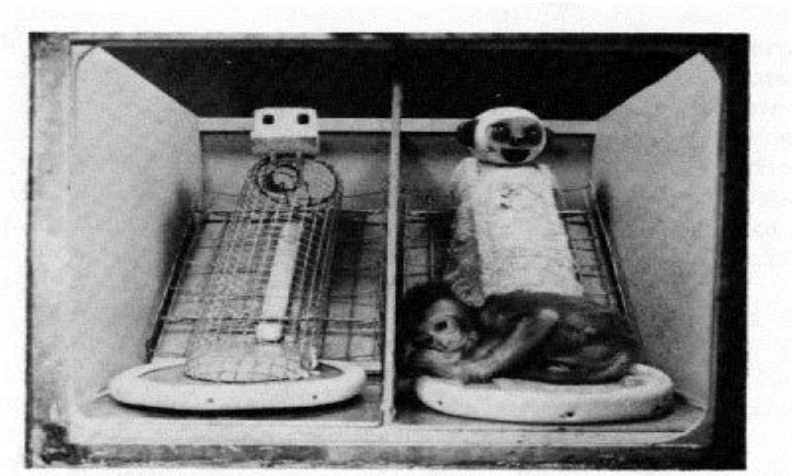

Figure 4. Wire and cloth mother surrogates.

Figure 1.

Following these results, many researchers concluded that cloth feels better than wire and that "contact comfort" was more important than nursing in the formation of attachments. However, Harlow did not agree with that interpretation. He went further in his experiments and discovered that the baby rhesus monkeys were frightened of so-called "cooties," plastic toy insects. These insects were the same size as a baby monkey and looked scary. Harlow discovered that when a baby rhesus monkey was placed in a room with a cootie and a cloth surrogate mother, the monkey would run to the surrogate mother and cling to her. The baby monkey would then appear relaxed and calm. Henceforth, the monkey would often begin to use the surrogate mother as a safe base; he would explore the environment and then run back to her. Harlow set up a number of experiments in this fashion. In one he positioned the cootie between the monkey and the surrogate mother, an experiment which led to interesting results and showed the power of attachment. The terrified monkey ran straight toward the cootie, jumped over it, and landed directly on the surrogate mother, where it then relaxed and seemed to feel protected. Interestingly, the baby monkeys did not show such attachment to just a soft piece of cloth left lying on the floor (Harlow & Suomi, 1970).

However, without early attachment to a mother, surrogate or real, an attachment did not occur. In those instances, baby monkeys did not run to the surrogate mother when afraid of the cootie but simply curled up and shook with fear or tried to run as far away as possible. Early attachments in rhesus monkeys seem to be formed rapidly and are long-lasting. Monkeys raised

with cloth mothers and then separated from them for 6 months will respond readily the moment they are reunited, running to the mother and clinging to her (Harlow & Suomi, 1970).

As can be imagined, the results of this study challenged the view of both Freud and the behaviourists. Could it be that children did not become attached to their mothers because they were the ones that usually feed them? In other words, was attachment related to something else than food? Could it be that infants' needs were also more complex than simple hunger? Would they react in similar ways? This study made people start wondering about what infants really need from their caregivers, especially their mothers. Interestingly, observations on human infants have since shown that infants can indeed become attached to family members who seldom if ever feed them, including fathers, siblings and grandparents (see e.g., Shaffer & Emerson, 1964). Furthermore, a study was made that offered an interesting similarity to Harlow's and Suomi's. The study involved108 preschool children and showed that toddlers that sleep alone and experience frequent daytime separations from their parents sometimes develop a strong emotional tie to a soft, cuddly toy or blanket. These objects of attachment are effective sources of security that seem to substitute for special people when such people are not available (Passman, 1987). This happens despite the fact that the object or objects have never played an important role in feeding.

2.2. An innate need for love?

Today, developmental researchers do not all agree on one view of infant attachment. However, attachment theory is now largely built on John Bowlby's paradigm. According to Bowlby, in humans there is an innate drive to form attachments that is as strong as the motivational forces of mating and eating (Bowlby, 1969). In tune with this perspective Bowlby offered a framework for understanding risk and protective factors in social and emotional development during the first 3 years of human life. Bowlby (1951), in his monograph, *Maternal Care and Mental Health,* reviewed the world literature on maternal deprivation and claimed that emotionally available caregiving was essential for infant development and mental health.

According to Bowlby (1969), human beings are innately equipped with attachment and caregiving behavioural systems, among other important behavioural systems (e.g., exploration, sexuality). Bowlby (1969) theorizes that the reason for this is that during evolution it was

essential to become emotionally attached to caregivers. Caregiving for dependent or injured individuals increased the chances of survival, reproduction, and successful parenting and protected a person from danger by assuring that he or she maintained proximity to caring and supportive others (attachment figures) who provided protection, support, and relief in times of adversity (Bowlby, 1969). In other words, dependence on a parent is a fact of life for all children. Humans, by nature, have the longest period of dependence of any animal and simply do not survive without the caregiving of their parents. Attachment to a caring parent means survival.

According to this view there are a number of behavioural systems that are species-characteristic and that have evolved because their usual consequences have contributed substantially to species survival. A long period of immaturity implies a long period of vulnerability during which the child must somehow be protected. Bowlby argued that infants must be equipped with a relatively stable behavioural system that operates to promote sufficient proximity to the primary caregiver, usually the mother figure, so that parental protection is facilitated. Several behaviours may be classed together as serving a given behavioural system, because they often have a common outcome. They may be grouped together because each is an essential component of a series of behaviours that lead to the outcome. Bowlby refers to the outcome as "predictable," to imply that once the system is activated the outcome in question usually occurs. If the outcome does not occur repeatedly, and in enough individuals, the survival of the species can be at stake. The predictable outcome of a child's attachment behaviour is to bring the child into closer proximity with other people, especially with the individual who is primarily responsible for his care. Bowlby refers to this individual as the "mother figure," and in fact, for humans as well as other related species, this individual is usually the biological mother (Ainsworth, Blehar, Waters & Wall, 1978).

Some behavioural components of the attachment system are signalling behaviours, such as crying, calling, or smiling. These behaviours seem to have the purpose of attracting a caregiver to approach his child or to remain in proximity once closeness has been achieved (Ainsworth, et al., 1978). However, according to Bowlby, attachment is not merely an outward manifestation of a learned or gained behaviour pattern. Attachment is dependent on an internal, or intraorganismic, organization, hence the infant is biologically organized, or ready, to form attachments to caregivers (Bowlby, 1969). There can be many reasons for this intraorganismic organization. For one thing, it can be because of the fact that living beings who are innately predisposed to forming

attachments to caregivers are more likely to survive than those who are not predisposed to forming such attachments. Another reason can be that children quite simply need to be loved and cared for, not only for survival but also for emotional development.

We can also discuss the research done by Harlow and associates (1970) on rhesus monkeys in this respect. As Harlow continued doing his experiments on monkeys, his experiments in fact grew "darker." He began to design surrogate mothers that he called "Iron Maidens." These were mothers with all the comfortable features of the cloth mothers, but who also had the ability to turn evil. Without warning, they would prod their babies with metal spikes or blow cold air against them so hard that they were pushed against the side of the cage. Despite the cruelty of his "Iron Maidens," Harlow noticed something interesting. No matter how abusive the evil mothers were, the baby monkeys always came back and displayed affection towards them. Even in the face of abuse, the need for love seemed to be overpowering. The monkeys could not be without it, in fact the worse the mothers abused their "children," the needier those children became. Removing love from the monkeys simply damaged them (Slater, 2004).

Harlow's experiments, while sometimes dark and without doubt unethical to many people, seem to tell us something important, perhaps a basic truth about the human being: the human being needs love for a healthy development. The human being is engaged in more then just a mindless search for fulfilment of its biological needs. Indeed we have interesting results which indicate that the human being is in fact much more complex than both the learning theorists and Freud believed at the time. For a child to grow into a healthy individual it is not enough that it gets its physical needs fulfilled. A child needs a lot more.

2.3. The mother-child relationship

Research has shown that there are many attributes apparent in infants that seem to help the infant and its mother to form an attachment relationship. For example, the infant is able to cry which helps him to get attention and fulfilment of a basic need, e.g. nourishment. Also, the infant is sensitive to touch (Dworetsky, 1985), which is shown to promote close physical contact. Furthermore, the infant is attracted to faces (Fantz, 1961), engages in “conversations” with caregivers (Rosenthal, 1982) and vocalizes more when eye contact is made (Keller & Scholmerich, 1987). This seems to stimulate mutual interest between the infant and the caregiver

and facilitates social communication.

Early on in his training Bowlby believed that analysts, in their preoccupation with a child's fantasy life, were paying too little attention to actual events in the child's real life. He became more aware of the impact that parents have on the development of a child's personality, and of the ways in which this interaction is influenced by a parent's early experiences with his or her own parents (Bowlby, 1969).

Bowlby's first systematic research began with a comparison of 44 juvenile thieves with a matched control group. The results showed that long-lasting experiences of mother-child separation or deprivation of maternal care were much more common among the thieves than in the control group, and that such experiences were especially linked to children diagnosed as affectionless (Bowlby, 1944).

Bowlby, convinced of the significance of real life events on the course of child development, then chose to focus on the effects of early separation from the mother. He did this first and foremost because separation was an event on record, unlike disturbed family interaction, of which, in those days, there were no adequate records (Bowlby & Ainsworth, 1991). Bowlby began delving into the ethological literature, and Konrad Lorenz's work on imprinting. He found the descriptions of separation distress and proximity- seeking of precocial birds, which had become imprinted on the mother, strikingly similar to those of young children. He also noticed the evidence that a strong social bond could be formed without oral gratification and was amazed at the fact that ethological research began with field observations of the animal in its natural environment, a starting point analogous to that of a clinician (Bowlby & Ainsworth, 1991).

Before Bowlby's work, most researchers who studied attachment focused on a few specific behaviours, such as how long a child cried after his mother left the room. Such behaviours were counted and from time to time monitored for change over a period of years. Bowlby, on the other hand, did not look at attachment as a few behaviours that can be counted and measured in the laboratory. He believed that attachment was an entire way of interacting with other people, featuring a lot of different behaviours at different times and argued that it was necessary to examine a wide range of attachment behaviours in each person that was studied (Dworetsky, 1985).

Bowlby furthermore believed that the attachment system becomes well organized sometime during the second half of an infant's first year of life. By then the attachment system is starting to build on previous behaviours (Bowlby, 1969). For example, shortly after birth infants do specific things that can be seen as helping to promote attachment, such as crying, touching and following their parents with their eyes. Later, they may show these behaviours as part of an actual attachment by smiling, touching or particularly looking at a familiar person rather than just anyone (Brooks-Gunn & Lewis, 1981). Furthermore, when children are able to crawl, they usually make an active attempt to maintain closeness to the person they have become attached to (Bell, 1970). Here, children may have developed so-called internal working models of the relationships between themselves and their caregivers. These internal working models consist of the child's memories of the attachment relationship. The child then uses the memories to decide what he or she can expect from caregivers (primarily the mother) in situations that it faces. For example, if a child is abused or rejected by its parents when seeking security and comfort, the child is likely to develop an internal working model of its parents' rejection as well as its unworthiness of love and affection (Ainsworth et al., 1978).

2.4. The strange situation

Although researchers have shown that most children will become attached by the second half of their first year of life, it is interesting that the nature and quality of this relationship differs greatly from child to child. Some infants are especially relaxed and secure in the presence of their caregiver, other seem more anxious and uncertain. The questions arise: How do we classify different attachment behaviours and how do we measure them accurately? Mary Ainsworth, who trained with John Bowlby, tried to come up with answers to those questions. She developed a measure to study the factors that influence attachment and its impact on later development. The method is known as The Strange Situation and is the most widely used technique for measuring the quality of attachment between 1 and 2 years of age. The Strange Situation takes infants through eight short episodes during which separations from, and reunions with, the parent, usually the birth mother, occur. By observing the responses of infants to these episodes, researchers have identified a secure attachment pattern and two patterns of insecure attachment (Ainsworth et al., 1978).

In the year 1963, Ainsworth located a sample of 15 mothers each with an infant through paediatricians in private practice. Visits were made to the families every 3 weeks from 3 to 54 weeks after the baby's birth. Each visit lasted for approximately 4 hours, resulting in about 72 hours of observation altogether for each case. Direct observation of behaviour was accompanied by information yielded in informal conversations with the mother. At the end of the baby's first year, baby and mother were introduced to a 20-minute laboratory situation, called the *strange situation* (Ainsworth et al., 1978).

The strange situation is intended to demonstrate individual differences in the quality of attachment and to be an assessment of the variables that determine the quality of infant attachment. It is a research on to what goes on between an infant and its mother, the creation of the strong bond between them, and the affects on personality development by absence or interruption on the creation process (Bowlby & Ainsworth, 1991).

The strange situation is arranged as follows: A mother and her young child (approximately 1 year old) are followed into an experiment room. The mother places her child on a small chair surrounded by toys and then takes a seat on the other side of the room. After a short period of time a stranger enters the room. He sits quietly for a moment but then tries to engage in the child's play. At that time, the mother quickly leaves the room. After a short while the mother enters the room again and plays with her child, and the stranger leaves. Then the mother leaves once more, and now abandons the child alone in the room for 3 minutes. The stranger returns after 3 minutes and a few minutes later the mother returns and the stranger leaves (Ainsworth et al., 1978). Table 1 can clarify better the sequence of events. Everything that occurs during these sessions is recorded by an observer sitting behind a one-way mirror.

Table 1. The strange situation

Episode	Actors present in room	Action
1	Child, mother	Mother and child enter room
2	Child, mother, stranger	Stranger enters
3	Child, stranger	Mother exits
4	Child, mother	Mother returns and stranger exits
5	Child, alone	Mother exits
6	Child, stranger	Stranger returns
7	Child, mother	Mother returns and stranger exits

One advantage of the strange situation is that it allows observers to quantify many ways in which an infant can demonstrate attachment, instead of measuring only proximity. In relation to this we can, for example, consider a 1-year old child who expresses avoidance in the strange situation by turning away from its mother and then continues to show avoidance at 1 ½ years old by giving little attention to its mother when she returns. If researchers only examine one kind of behaviour (for example turning away) they will miss the continuity which is offered in examining the purpose of the behaviour instead of just the behaviour.

The strange situation has turned out to provide a relatively quick method of assessment of infant-mother attachment. It has become widely used, but unfortunately not always wisely and well, which has in many ways overshadowed the findings of the research project. However, the longitudinal home visit data, (which include information about how a mother's behaviour is linked to the course of infant development) and the strange situation together have given important information about the development of attachment in infancy (Ainsworth & Bowlby, 1991). Ainsworth and her colleagues concentrated on the infant's reaction to the return of the mother. By using a number of observational techniques, they could identify three contradictory attachments reactions. The first, *secure attachment* was the most common. It accounted for about 65 to 70% of children studied. Babies that showed this response gave their returning mothers happy greetings and approached them or stayed near them for a time. These mothers are shown to

respond consistently rather quickly to infant crying early-on and to have infants who by the end of the first year cry relatively little and seem to be securely attached. These mothers are also sensitively and appropriately responsive to infant signals in general, including feeding signals, which seem to foster secure infant-mother attachment (Ainsworth, et al., 1978). The second group accounted for about 10 to 15% of children, a group called *anxious/resistant attachment*. These are infants who approach their mothers, cry to be picked up, but then squirm or fight to get free from their mothers. The third group is then called *anxious/avoidant attachment* and accounted for about 20% of infants. These infants did not approach their mothers or actively avoided them. The infants, who seemed to be very insecure at home, showing frequent separation protest or crying a lot in general, were actually indifferent to their mothers' departure in the strange situation and avoided them upon reunion. Ainsworth's interpretation was that under the increased stress of the unfamiliar situation a defensive process is activated, similar to the detachment that develops in young children undergoing major separations (Ainsworth et al., 1978). Although the avoidant infants had themselves experienced no major separations, their mothers had tended to be rejecting at home during the first year, especially when their babies sought contact, as well as being generally insensitive to infant signals.

The strange situation procedure highlighted the distinction between secure and insecure infants. It is assumed that anxious/avoidant attachments and anxious/resistant attachments are weak attachments while secure attachments are strong attachments (Dworetsky, 1985).

2.5. The strength of attachment

Although the results of Ainsworth et al., (1978) are interesting the study itself has received criticism. For example, it has been criticised for having too few participants. The sample of participants (26 infant-mother pairs) was small compared to the number of variables. A sample of 26 infants is rather small to be divided up into 3 groups. That alone could affect the validity of the study. However, in defence of ethological attachment theory, it has to be said that it has generated much research focused on understanding the social, emotional, and interpersonal development of children. In addition, there is substantial empirical evidence that supports the existence of the core elements of attachment theory which we are going to look at further in this paper.

Thus, despite criticism it can be said that what is seen in the strange situation is the strength of an attachment, an attachment that is sometimes strong but also weak. Discovering that all children do not seem to be securely attached to their mothers is of course something that makes researchers in the area wonder about. What lies behind this outcome? Are children that show anxious/avoidant or anxious/resistant behaviour treated in any different way by their mothers than children that show securely attached behaviour? Is there something in the environment of these children that triggers the behaviour? Studies show that that seems to be the case. The behaviour of the mother is correlated with her child's behaviour. Studies have, for example, shown that mothers of *anxious/avoidant* infants tend to respond poorly to their children's cries and demands. Often they simply ignore their children. They also appear to be less sensitive than other mothers to their babies' needs (Smith & Pedersen, 1988) and frequently state they dislike physical contact with their children (Ainsworth et al., 1978). *Anxious/resistant attachment* on the other hand appears not to be related to rejection but rather to inconsistency by the mother during the infant's first year of life (Ainsworth, et. al., 1978). These infants may react the way they do plainly because they do not know what to expect because the adult's behaviour has been so inconsistent and unreliable in the past. What supports this idea is, for example, the observation that anxious/resistant infants engage in social referencing more than secure or anxious/avoidant infants (Dworetsky, 1985).

In the past it was argued that if children were pampered or hugged whenever they cried or showed emotion they would become dependent. Today, however, studies have shown that securely attached babies require less proximity and physical contact as they grow older than insecurely attached children (in Dworetsky, 1985). The reason for this might be that securely attached children have learned to trust and count on the adult who has responded correctly and quickly in the past to their needs or desires. They have learned that their parent loves them and is responsible.

Children with secure attachments furthermore seem to feel that their caregivers are physically and emotionally available to them. They have generally better developmental outcomes and lower rates of psychopathology than children with insecure or disorganized attachments. Secure attachments appear to provide a "secure base" with the caregiver that fosters safe exploration and learning (Zilberstein, 2006). Research has in fact shown that mothers that are accessible, consistent, and sensitive and that respond to their infants' cries and signals are likely to

have securely attached children (Isabella, Belsky, & von Eye, 1989). They also seem to enjoy their babies more than mothers with less securely attached children.

On the other hand, insecure attachment appears to result from a child's attempt to maintain proximity to a caregiver who is emotionally unavailable or only occasionally responsive. In this group, insecure children, there are *anxious-avoidant* and *anxious-resistant* (the two groups from the strange situation) but also there is another group called *disorganized attachments*. This group of insecure children was found to exist much later than the former two groups which Ainsworth noticed in her experiments. These children have therefore not been previously discussed in this paper despite being an important part of the group *insecurely attached* children.

The fact of the matter is that about 20 years ago, researchers began to concentrate their investigations on high-risk families and found out that the behaviour of some babies did not fit into the previously described patterns. These infants acted in unpredictable ways and did not seem to have any consistent strategy for dealing with stress and attachment. The classification systems then began to recognize the levels as *secure, anxious-avoidant, anxious-resistant/ambivalent, or disorganized* (Carlson, 1998;[1])

Disorganized children seem to be caught between craving proximity and fearing to approach the caregiver. They often seem to exhibit disorganized or contradictory behaviour, such as freezing, stilling, or apprehension toward their attachment figures (Main & Solomon, 1990). Of all three types of attachments, disorganized children tend to be at the highest risk for later behavioural and emotional difficulties (Zilberstein, 2006).

2.6. The significance of attachment

Overall, studies of attachment have supported the central thesis of Bowlby's framework and today attachment research has been moving increasingly into the preschool years, adolescence, and adulthood. The attachment system appears to be most evident during infancy and childhood but continues to be important across the life span. Its innate parameters are gradually shaped and altered by social experiences with attachment figures. This results in fairly stable individual differences in attachment style, a systematic pattern of relational expectations, emotions, and behaviours that arise from a particular attachment history (Fraley & Shaver, 2000;

[1] http://www.visi.com/~jlb/thesis.html

Hazan & Shaver, 1987).

Researcher L. Alan Sroufe (1983) carried out one of the more detailed investigations on personal competence and peer approval among children in an effort to discover how the type of attachment that a child shows in infancy affects later social relationships. The study was known as the Minnesota preschool Project. Sroufe and his associates designed a rating scale of "social competence" by subtracting the amount of inappropriate and negative social-emotional interactions demonstrated by each child from the number of appropriate and positive interactions. The investigation revealed that children that had been described by the researchers as securely attached at 15 months of age tended to have the highest scores and by the age of 3 ½ years they were more likely to be peer leaders in the preschool. This group of children was likely to be involved in social relationships and actively engaged in their environments. Furthermore, they were often well liked by their peers and likely to enjoy sharing good feelings and thoughts with others. Low-ranked children on the other hand were often not liked by their peers and the teachers referred to them as unpredictable, outsiders and even "chronic whiners."

Research done by Aoki, Zeanah, Sherryl, Heller, and Bakshi, (2002) on infant–parent relationship adaptation furthermore revealed that observations of only 10 minutes of free play between mothers and their infants at 20 months of age predicted subsequent mother–infant interaction at 24 months and child internalizing symptomatology at age 24 months. Free play at 20 months predicted the child's compliance and positive relatedness with the mother at the age of 24 months. The scores at 20 months were significantly related to mothers' help and support at 24 months and the scores at 20 months were also predictive of infant compliance and marginally predictive of infant positive relatedness at 24 months. Compliance and relatedness are indeed the hallmarks of what Bowlby termed the 'goal-corrected partnership' of attachment (Bowlby, 1969). The findings of this study are therefore compatible with Bowlby's theory of attachment. Infants who are relating well to their mothers at 20 months are also relating well to them at 24 months and are showing fewer problem behaviours.

These findings indicate that infants who are able to take on new challenges enthusiastically (such as attempting to solve problems) but, at the same time, are able to accept help without conflict when help is needed, have achieved a balance between independence and dependence. In fact, attachment theory emphasizes this as the most salient index of mental health in the latter part of the second year of life. Conversely, infants who have problematic relationships with their

mothers early in the rapprochement phase and early in the goal-corrected partnership demonstrate more problems with regard to sad or anxious moods, withdrawn behaviour and less satisfying interactions with their mothers later in these same developmental phases. (Aoki, et al., 2002).

Developmental attachment research has indeed demonstrated that insecure attachment in infancy is associated with subsequent psychosocial maladaptation in preschool and middle childhood years (see e.g., Troy & Sroufe, 1987). Infants who are insecurely attached to their mothers at 1 year of age demonstrate more interactive disturbances with their mothers at home and in the laboratory (Matas, Arend, & Sroufe, 1978; Wippman, & Sroufe, 1979), less social competence with peers (Troy & Sroufe, 1987), and more problematic relationships with their teachers (Sroufe, 1983). Studies have furthermore suggested strong associations between disorganized attachment classifications and preschool behaviour problems (in Hubbs-Tait et al.,1994).

Furthermore, research has shown that securely attached children seem to be encouraged more by their mothers in a positive way to play and explore. This further encourages them to expand their experiences. Securely attached children are more likely than others to explore and experience new things which gives them more opportunity to be good at the things they encounter (Dworetsky, 1985). Research has shown that this competence has lasting benefits. These children are likely to be confident and persistent as they grow older, which has, for example, been reflected in the schoolwork of these children measured at the age of 12 years, many years after they were perceived as securely attached infants (Estrada, Arsenio, Hess & Holloway, 1987). Furthermore, securely attached children have been found to have superior cognitive functioning in adolescence (Jacobsen, Edelstein, & Hoffmann, 1994).

Insecurely attached children on the other hand seem to be dealing with several problems. Boys that are insecurely attached have, for example, been found to be more assertive, aggressive, controlling, disrupting, and attention seeking than more securely attached boys. Insecurely attached girls have been found to be more dependent and compliant than their securely attached peers (in Dworetsky, 1985).

However, we do have to bear in mind that all this data is correlational. We can state that high levels of positive behaviours and emotions are correlated with peer approval, acceptance, and early secure attachment, while less desired outcomes are associated with insecure forms of attachment. However, we cannot say without a doubt that secure or insecure attachment is the

cause of a particular outcome. There is the possibility that a third variable is causing both secure attachment and a positive outcome. Yet although we are talking about correlational outcomes, it can be said that there seems to be a strong relationship between attachment and children's behaviour and emotions. Children that appear to be securely attached to their parents, specifically to their mother, differ in behaviour and emotion, from children that appear to be insecurely attached to their mother. The observed difference between these two groups of children signifies the importance of secure attachment.

Also, even though we are talking about correlational relationships, we are often discussing case studies. Case studies, like the monkey experiments of Harry Harlow (Harlow & Suomi, 1970), and last but not the least the strange situation developed my Mary Ainsworth (Ainsworth, et al., 1978), have contributed extensively to the understanding of attachment and its development in human beings. Case studies are in the category "qualitative methods." Qualitative studies focus on the content, the nature and the meaning of the subject and are often connected to what anthropologists and sociologists call fieldwork, studying people in their natural surroundings (Vadel, 1981). A qualitative approach then gives the opportunity to watch events in their "wholeness," and can therefore give a better sense of the relevant variables. Secondly, it allows one to watch events that may not be easily or realistically captured in other ways, for example the verbal interactions between a child and a parent. Last but not the least it permits a record of events as they occur (Rosnow & Rosenthal,1998).

Therefore, one may not underestimate the results of well-designed case studies, especially not if the results have been replicated in many studies the last three decades or so. Although we cannot state that attachment is the cause, we can state that attachment seems to be a very important influential factor. We can therefore hopefully see the need to identify all the things that can help caregivers to establish a good and healthy relationship with their children and furthermore help caregivers to avoid doing things or saying things that can have a damaging affect on this relationship.

2.7. Discussion

Thus, children do not become attached to their caregivers, especially the mother, only because she fulfils their biological needs. Human beings seem to be innately equipped with attachment and caregiving systems. Perhaps this happened because becoming attached to a caregiver made one more likely to survive or, plain and simply, because of the fact that we need love for emotional development. Love and affection seem to be necessary ingredients for healthy human development. That is one thing we can draw from the studies discussed in this chapter. What is more, if infants are deprived of love and affection from their mothers, or if they develop weak attachments towards them, it seems to affect their development in negative ways. They are, for example, more anxious and withdrawn; they have problematic behaviours with their mothers and peers, and they are less confident than children with strong attachments. Building a strong attachment towards the primary caregiver (which is most often the mother) then seems to be very important for the healthy development of children. We have numerous studies that have repeatedly shown a strong connection between attachment and children's behaviour and emotions, and therefore we should be able to see the need to find out more about how we can help caregivers to build good and healthy relationships with their children. For this paper, it should furthermore be important to identify better how this factor, lack of attachment relationship with a primary caregiver, affects adopted children. Is this the factor that can be considered to be the primary cause of problems found within this group of children?

In the next chapter I will go more into the damaging affects that have been linked to insecure attachment. I will discuss research on disturbances in attachment and furthermore discuss the concept reactive attachment disorder, which has been linked to disturbances in attachment in infancy. I will look closely at the two manuals DSM-IV and ICD-10, discuss their criteria for reactive attachment disorder and review criticism on the two nosologies. It is my hope that this discussion will reveal better what risk factors actually appear to lie behind disturbances in attachment.

3. Disturbances in attachment

3.1. Reactive attachment disorder

Reactive attachment disorder (RAD) is one of the few diagnostic categories applicable to children under 3 years of age in standard nosologies of psychological disorders. The disorder first appeared in the *Diagnostic and Statistical Manual of Mental Disorders (*3rd ed.; *DSM-III;* American Psychiatric Association, 1980) 20 years ago. At the present time there has been a sudden increase of knowledge from developmental research on attachment that has not been included in criteria for diagnostic categories of attachment disorders. Because of this fact I feel that it is a good idea to look closer at the two manuals, DSM-IV and ICD-10, and discuss their criteria for attachment disorders.

As for the official nosologies, the *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed.; *DSM-II;* American Psychiatric Association, 1968) did not mention attachment disorders, although it illustrated "adjustment reaction of infancy" with the protest response of an infant separated from its mother. DSM-II described that response as "crying spells, loss of appetite, and severe social withdrawal (p. 49)." Attachment disorders were also not described in the ninth edition of the ICD (ICD-9; World Health Organization, 1978). The first appearance of attachment disorders was not until in 1980, in the DSM-III. At that time, reactive attachment disorder was connected with failure to thrive (Spitzer & Cantwell, 1980), with the requirement that onset of the disorder should occur before 8 months of age.

However, because selective attachments seem to occur between 6 and 9 months of age, infants were required to develop onset of a disordered attachment before they even had expressed a preferred attachment. Subsequently, criteria were changed in the third edition of the DSM *(DSMIIl- R;* American Psychiatric Association, 1987). A failure to thrive was dropped as a central feature of the disorder and age of onset was changed to within the first 5 years of life. Furthermore, two clinical types of "inhibited" and "disinhibited" attachment disorders were introduced, types that are still present in newer editions, viz. DSM-IV and ICD-10 (American Psychiatric Association (APA), 1994, & World Health Organization, 1992). Reliability of diagnosis of reactive attachment disorder seemed to improve greatly with these changes in criteria (see Zeanah, 1996).

3.2. Similarities and differences in the criteria of reactive attachment disorder in DSM-IV and ICD-10

Zeanah (1996) has widely written about and researched reactive attachment disorder. He is critical when he discusses the two nosologies, DSM-IV and ICD-10 and his discussion is, in my mind, worthy of note. He identifies features that the two systems have in common and also what they do not share, which is an important issue to discuss before starting criticism of the two systems. For example, according to Zeanah (1996) if one looks at the criteria of the DSM-IV and ICD-10 one can see considerable agreement on the major features of the disorders. In both nosologies, the disorders involve a persistent disturbance in the child's social relatedness that begins before age 5 and extends across social situations. Attachment disorders in both nosologies must furthermore be distinguished from pervasive developmental disorders. The two systems also agree in that there are two distinct clinical pictures of attachment disorders, inhibited and disinhibited. A child with inhibited RAD often shows ambivalent, inhibited, or hyper vigilant responses which are focused on one or more adults. On the other hand, a child with disinhibited RAD often shows indiscriminate oversociability and fails to show selective attachments. This child furthermore seems to be dealing with a lack of selectivity in relation to the individuals he or she wants to receive comfort from and very likely displays weakly adapted social interactions with unfamiliar people across a range of social situations (American Psychiatric Association (APA), 1994).

Both of these patterns have been observed in children raised in institutions and in maltreated children (Zeanah & Emde, 1994). Recent research has confirmed that these patterns may be identified in children in these two risk groups, using observational, interview, and questionnaire methods (O'Connor, Bredenkamp & Rutter, 1999; O'Connor & Rutter, 2000; Zeanah, Heller, Smyke, Scheeringa, Boris, & Trapani, 2004; Zeanah, Smyke, & Dumitrescu, 2002). Interestingly, the UK group of O'Connor and Rutter (O'Connor et al., 1999; O'Connor & Rutter, 2000) have identified these patterns in children adopted from institutions and followed with their new caregivers, while the U.S. group of Smyke and Zeanah have documented these patterns in children still residing in institutions (Zeanah, 1996). Inhibited reactions may be extremely vigilant, restrained or hesitant. An inhibited child may for example respond to its caregivers with mixtures of approach, avoidance, and resistance to comforting. Disinhibited

reactions on the other hand occur in a variety of social interactions and the child does not discriminate among people he or she chooses as attachment figures. This child will behave with inappropriate familiarity towards strangers (American Psychiatric Association (APA), 1994).

Furthermore, criteria in both nosologies, ICD-10 and DSM-IV, tie the disorders etiologically to parental abuse or neglect or to extremes of caregiving such as with children raised in institutions. According to Zeanah (1996), developers of DSM-IV, for example, decided to maintain a requirement from the DSM-III-R (American Psychiatric Association, 1987) that there be evidence of grossly pathogenic caregiving (e.g., frank neglect, harsh treatment) or repeated changes in caregivers. 1CD-10 also does not make explicit the requirement of parental maltreatment, although the syndrome is believed to result from "severe parental neglect, abuse or serious mishandling" (World Health Organization,1992, p. 279). What is more, clinicians are urged to use caution in making the diagnosis "in the absence of evidence of abuse or neglect" (World Health Organization, 1992, p. 281).

Despite similarities there are, however, also differences in criteria for attachment disorders in DSM-IV and ICD-10. According to Zeanah (1996) these differences are not as visible as the similarities. DSM-IV, for example, groups together two clinical pictures of RAD under a single category of RAD, whereas ICD-10 makes each of the clinical pictures into a distinctive type. In the ICD-10 criteria, the child must have the capacity for social responsiveness as shown in interactions with nondeviant adults. In contrast, the DSM-IV emphasizes abnormal social behaviour being apparent in most social contexts. Thus, criteria in both systems deemphasize the child's behaviour with the attachment figure, although the DSM-IV is more definite about a lack of relationship variability. Finally, the DSM-IV clearly excludes children with mental retardation from a diagnosis of reactive attachment disorder if any of the prominent symptoms are believed to be due to cognitive delays (American Psychiatric Association (APA), 1994). The ICD-10, on the other hand, makes no such exclusion, although the child with reactive attachment disorder must demonstrate elements of normal relatedness when interacting with responsive adults (World Health Organization, 1992).

3.3. The usefulness of DSM-IV and ICD-10 criteria for Reactive Attachment Disorder

According to Zeanah (1996), the emphasis of contemporary nosologies on attachment disorders as "reactive" appears to serve two functions. Firstly, it attempts to differentiate them from the pervasive developmental disorders, which also profoundly affect the social behaviour of young children. Secondly, it ties them etiologically to maltreatment. Important questions may be raised about the usefulness of this emphasis. The ICD-10 suggests that the attachment disorders may be distinguished from pervasive developmental disorders in a number of ways: (a) a normal capacity for social relatedness in reactive attachment disorder, (b) remission of social abnormalities in a normal rearing environment in reactive attachment disorder, (c) distinctive communicative and language abnormalities in pervasive developmental disorders, (d) cognitive deficits that improve with improvements in the caregiving environment only in reactive attachment disorder, and (e) persistently restricted, repetitive, and stereotyped patterns of behaviour, interests, and activities are features of pervasive developmental disorders but not attachment disorders (World Health Organization, 1992).

Thus, DSM-IV and ICD-10 distinguish attachment disorders from pervasive developmental disorders which seems to stem from the belief that the social behaviours in the two conditions are alike. It is assumed that similar appearing social behaviours may be the result of different mechanisms of pathogenesis. In relation to attachment disorders, children with intact central nervous systems who experience extremes of maltreatment and deprivation are believed to develop socially unresponsive and abnormal behaviours. On the other hand, in the case of pervasive developmental disorders, children are thought to have central nervous system abnormalities that are responsible for the socially abnormal behaviours (Zeanah, 1996). Thus, the DSM-IV clearly leaves out children with pervasive developmental disorders and the ICD-10 emphasizes the capacity for normal social interaction in children with attachment disorders.

The difficulty with this, however, is that today it is widely recognized that ongoing interactions between life events and brain neurochemistry play a role in the symptoms of affective disorders (Hirshneld & Goodwyn, 1988). Many psychiatric disorders are reactive in the way that their clinical picture represents a final common pathway of individual biology and psychology expressed in a social context. If it were possible to determine the etiology of a particular clinical picture of young children who exhibit problems with relatedness with certainty, the distinction

might be more valuable. It may not even be possible to make an etiologic determination at a given time of assessment. A child exhibiting symptomatic behaviour who has a reliable history of adequate caregiving with opportunities for attachment to one or two figures suggests a central nervous system abnormality. However, such a history is not always available in the clinical setting. Not uncommonly, a symptomatic child is referred for evaluation with a clinical picture of aberrant social behaviour and a history of foster care of unknown quality. If the child's symptoms improve significantly with changes in the caregiving context, attachment disorders are likely, but this, of course, cannot be known ahead of time (Zeanah, 1996).

The question arises whether distinctions can be made between the socially abnormal behaviours in pervasive developmental disorders and those in attachment disorders, as stated in the 1CD-10. There is not much data available that addresses this question directly. Children raised in institutions cannot be the sole source of data because it is not always clear what factors led parents to place the children there originally. If parents detected early signs of abnormal social behaviour in their infants, then one of the reasons for placement could have been the abnormalities they detected. A thorough examination of the characteristics of children with reactive attachment disorders, compared with those diagnosed with pervasive developmental disorders that live in stable, secure environments, could be a useful start for investigating this question further, says Zeanah (1996).

Another problem in relation to the label "reactive" according to Zeanah (1996) is that if a child has delays and problematic social behaviour, how can one be sure that the delay is the cause of the behaviour? In fact, as is known from children raised in impoverished institutions and in extremes of deprivation, significant cognitive impairments are likely to occur along with disordered attachments (Provence & Lipton, 1962; Rosenberg, Pajer, & Rancurello, 1992). The risk factors associated with RAD are in fact similar to the risk factors associated with developmental delay (e.g., profound neglect). Because of this it is likely that developmental delay frequently occurs simultaneously with RAD (Lieberman & Zeanah, 1995; Zeanah & Boris, 2000). It is also known that children in institutions that are more stimulating and developmentally sensitive have normal intelligence but disordered attachments (Tizard & Hodges, 1978). The DSM-IV criterion about cognitive delays then appears to limit attachment disorders to children with an intact central nervous system. The question arises as to the rationale behind this. What justifies the presumption that children with cognitive delays or mental retardation cannot also have

attachment disorders? Indeed, there seems to be little justification for presuming that children with cognitive delays or mental retardation cannot also have attachment disorders. These problems are more than likely to co-occur.

Another problem that Zeanah (1996) discusses in relation to both DSM-IV and ICD-10 criteria for disorders of attachment is that they describe the disorders in terms of socially abnormal behaviour in general rather than focusing more specifically on attachment behaviours per se. The DSM-IV emphasizes a failure to initiate or respond to social interactions across a range of relationships (American Psychiatric Association (APA), 1994), and the ICD-10 similarly focuses on contradictory or ambivalent social responses that extend across social situations (World Health Organization, 1992). There is little attention in the nosologies to the broad range of behaviours that might index disordered attachment relationships. The emphasis is rather on maltreatment. There are descriptions of general problems with deviant social behaviours rather than a more specific focus on attachment behaviours. Defining attachment disorders by using criteria that are drawn primarily from children who have been physically abused, suffered extremes of deprivation, and who have been deprived in institutions restricts the disorders to children in extreme situations and does not account for children who are in stable, even though unhealthy, relationships without evident abuse or neglect. Focusing on unusual social behaviours across a range of situations tends to restrict the diagnosis of the disorder to severely mistreated children (Zeanah, 1996).

Furthermore, although one can see that attachment influences development it is still uncertain how attachment theory can be applied to disordered attachments. As was discussed earlier in this paper, attachment theory is a theory of development; it is not a theory of pathology. Attachment theory never distinguishes between normal variations in attachment and a disorder. Additionally, psychopathology is frequently multidetermined, the result of many factors and where attachment is often just one of them. For example, although disorganized children are at high risk for later psychopathology, many of them never develop the disorder and when it does emerge it is more often predicted by multiple risk factors combined than by disorganized attachment alone (Zilberstein, 2006).

There are in fact many factors that have been shown to affect the development of attachment disorder. There are, for example, factors like temperament, medical conditions and other significant environmental factors and relationships, including trauma, which can affect the

development. Environments that promote problematic attachments often contain several deficits and risks other than attachment difficulties. Furthermore, there can be many aspects of primary relationships that fall outside the domain of attachment, for example playing and disciplining, which can influence development and self-regulation (in Zilberstein, 2006). Because of this fact it can be hard to determine the effects of disorganized attachment alone on attachment disorder. Development is a continuous and evolving process, and over time derivatives of attachment behaviour change and interact with other environmental and maturational factors, which makes it possible for them to appear different at different developmental stages (Zilberstein, 2006).

Finally, attachment theory makes it clear that early relationships are important to development. However, that knowledge does not alone help us to understand RAD. We have secure, insecure, and disorganized attachments and each one represents a different degree of risk. DSM-IV and ICD-10, (American Psychiatric Association, APA, 1994 & World Health Organization,1992) however, does not recognize variations in attachments or severity of attachment difficulties as part of RAD diagnosis. Insecurity and disorganization seem to be risk factors but not in themselves sufficient basis for diagnosis of RAD (Boris, Hinshaw-Fuselier, Smyke, Scheeringa, Heller, & Zeanah, 2004).

3.4. Research

Thus, DSM-IV and ICD-10 have received criticism. But what does research tell about the criteria of RAD? Does it indicate some lack of reliability or validity? We do not have much research on RAD but what we do have seems to indicate that there are some problems in relation to the definition of DSM-IV at least. For example, Boris, Zeanah, Larrius, Scheeringa, and Heller (1998) used an alternative set of criteria that were more focused on attachment behaviours rather than on social behaviour. Using that alternate set of criteria led interestingly to improvements in reliability. Four clinicians, experienced in the clinical evaluation of infants, reviewed records of young children referred to an outpatient clinic and applied alternative or DSM-IV criteria to the records (diagnoses had been removed). Reliability for the DSM-IV descriptors had a kappa of 0.46 (RAD-inhibited) and 0.36 (RAD-disinhibited), while the alternative criteria for Disordered Attachment with inhibition (corresponds with inhibited) received a kappa of 0.70, and Disordered Attachment with indiscriminate sociability (corresponds with indiscriminate) had a reliability

kappa of 0.81. Recent research in fact suggests that modifications in DSM-IV criteria and conceptualizations may be necessary. For example, cluster analyses of signs of attachment disorder in young children being raised in institutions and in maltreated young children placed in foster care have identified mixed patterns where signs of emotional withdrawal and signs of indiscriminate behaviour co-occur (Smyke, Dumitrescu, & Zeanah, 2002; Zeanah, Smyke, & Dumitrescu, 2002). If true, it suggests that these two types of RAD are orthogonal rather than on the opposite ends of the same continuum.

Other interesting research was done by Zeanah, Scheeringa, Boris, Smyke & Trapani (2004). They investigated the prevalence of RAD with American children. The children were 4 years old or younger and had all experienced violence, maltreatment or been in a foster care. The results of the study showed that by using the DSM-IV and ICD-10 criteria for RAD one could diagnose about 38 to 40% of the children with attachment disorder. As can be seen that is a very high proportion of the group that could be diagnosed with the disorder which, for example, raises the question of over-diagnosis. When using the criteria of DSM-IV all these children can be diagnosed with RAD. How can that be when one of the main arguments in the criteria states that RAD should be considered to be a very uncommon disorder? (American Psychiatric Association (APA), 1994). If it really is uncommon are we then looking at over- diagnosis in this group of children, caused by the diagnostic criteria? Or is the disorder more common than DSM-IV has considered it to be?

Also, the two different clinical descriptions for RAD, signs of emotional withdrawal and signs of indiscriminate behaviour seemed to co-occur, as in the research of Smyke and colleagues (2002). In fact 17% of the children meet the diagnostic criteria for both descriptions which strongly indicates again that these two types of RAD are much more connected than the descriptions in DSM-IV and ICD-10 say. If they were not connected they would not be likely to arise in such a high percentage of the group. Interestingly, indiscriminative behaviour and affectionate behaviour towards strangers was found with children that were specially attached to one adult as well as children that were not attached to anyone special. Furthermore, that kind of behaviour was also found in children that had also shown signs of emotional withdrawal. Because of these results the researchers concluded that perhaps there is a reason to think that the behaviour of these children is closely connected to an inability to discriminate between different people, for example between strangers and familiar people in social situations. If that is the case then one

could look at this as one symptom of RAD rather than a special type of RAD (Zeanah et al., 2004).

3.5. Symptom overlap

Despite the fact that DSM-Iv claims that RAD is a very uncommon disorder, Chaffin and associates (2006) conclude in their *"Report of the APSAC task force on Attachment therapy, Reactive attachment disorder and Attachment problems"* that accurate prevalence estimates for RAD are unavailable at present. Some have suggested that RAD may be quite prevalent because severe child maltreatment, which is known to increase RAD, is prevalent, and because children who are severely abused may exhibit behaviours similar to RAD behaviours. However, that argument is not without a flaw says Chaffin and associates (2006). It is firstly questionable to infer the prevalence of RAD based on the types of behaviour problems exhibited by children who are abused or neglected. Although RAD may be the cause of some behavioural problems with children that are severely maltreated there can be other common and treatable diagnoses that account for many of these difficulties. One must not fail to consider other diagnoses than RAD when dealing with maltreated children, and again one must remember the fact that RAD is presumed to be a very uncommon disorder (American Psychiatric Association (APA), 1994) despite its drawing much attention and interest at present (Chaffin et al., 2006).

Research on RAD however indicates that attachment disorder is more common than DSM-IV and ICD-10 have claimed it to be. For example in the research discussed above, Zeanah and associates (2004) found out by using the DSM-IV and ICD-10 criteria for RAD, that about 38 to 40% of the children in their group could be diagnosed with attachment disorder. Furthermore, in the same study, the prevalence of RAD was examined in 20 biological siblings. The results showed that in 75% of these cases both siblings could be diagnosed with RAD according to DSM-IV (Zeanah et al., 2004). Is this disorder then really uncommon? Or are we looking at over-diagnosis?

It seems to me, when I look over the RAD literature, that it is not that easy to diagnose RAD accurately. Firstly, there exist no standardized tools for assessing RAD (Zeanah, 1996). Secondly, it seems that some of the interview procedures that are used in assessing RAD lead to misdiagnosis (O'Connor, Rutter, in Zeanah, 1996). Furthermore, several other disorders share

considerable symptom overlaps with RAD, and as a consequence can be confused with RAD. For example, disorders such as conduct disorder, oppositional deviant disorder, and some of the anxiety disorders, including posttraumatic disorder (PTSD) and social phobia, all share some features with RAD (see in American Psychiatric Association (APA), 1994). Symptom overlap can lead to failure to diagnose RAD correctly when it is present, and to overdiagnose RAD when it is not present.

According to Chaffin and associates (2006) it is also important to bear in mind that RAD can be confused with several other neuropsychiatry disorders, such as autism spectrum disorders, pervasive developmental disorders, childhood schizophrenia, and some genetic syndromes. Furthermore, some children plainly have a temperament that can be confused with having RAD. Children can be extraordinarily social or they can be extremely shy and avoid other people without having RAD. Some children plainly and simply learn odd social habits because of living in institutions or other unnatural environments, and these behaviours may mimic psychiatric disorders. Furthermore, it should never be assumed that RAD underlies all or even most of the behavioural and emotional problems seen in foster children, adoptive children, or children who are maltreated. A history of maltreatment does not necessarily imply a disorder. Many children who are maltreated cope well. A lot of maltreated children emerge without any long-term mental disorder, let alone a disorder as severe as RAD. Resilience is a common and relatively normal human characteristic and maltreated children are as likely as other groups of human beings to possess that feature (Chaffin et al, 2006).

Resilience has indeed been studied in a wide variety of situations throughout the world and interestingly, for this paper, the two most widely reported predictors of resilience appear to be relationships with caring prosocial adults and good intellectual functioning. For example, a landmark study now spanning four decades was carried out on found children born on the Hawaiian Island of Kauai in 1955. The risk group (about 1/3 of the children) was defined by having four or more early risk factors that included poverty, prenatal stress, family conflict, and low parental education. The results showed that about 1/3 of these high-risk children developed well in terms of getting along with parents and peers, doing well in school, avoiding serious trouble, and having good mental health. The resilient group had more resources and fewer difficulties from an early age. They had good parenting, more appealing temperaments as babies, better intellectual skills, more connections with caring adults, fewer separations from caregivers,

and better physical health, etc. They were also more responsible, self-confident and motivated to achieve (Werner, 1993).

The most important protective factor for development was a strong relationship with a competent, caring, prosocial adult and good cognitive functioning. These assets are also associated with competence in normal development (Werner, 1993). Resilient children then do not appear to possess some unique qualities; rather, they hang on to important resources which represent basic protective systems in human development. Thus, if good parenting (by parent or others) and good cognitive development are supported, human development is robust even in the face of adversity (Werner, 1993).

If this is the case, that attachment with a competent caregiver is such a strong protective factor for developmental delay or other problems, one starts to speculate whether attachment problems or disorders could not indeed be strongly connected to the lack of a good relationship with a caregiver, and not be limited with RAD? Interestingly, in the light of limitations of the definition of RAD criteria some clinicians have begun to identify a broader group of novel attachment disorders. Zeanah and colleagues have, for example, started to describe a range of attachment disturbances including disorders of nonattachment, secure base distortions, and disorders of disrupted attachment (Zeanah & Boris, 2000). Indeed, it seems that in the absence of consensual and officially recognized diagnostic criteria, the term "attachment disorder" has been increasingly used by some clinicians to refer to a broader set of children whose behaviour is first and foremost affected by a lack of primary attachment figure, a seriously unhealthy attachment relationship with a primary caregiver, or a disrupted attachment relationship (Chaffin et al.,2006). As Zeanah and Boris (2000) argue, clinical experience suggests that disorders of attachment do exist beyond the confines of RAD. However, the exact parameters of the disorders are not yet established.

3.6. Potential misapplications of Reactive Attachment Disorder diagnosis

As has been discussed above, attachment disturbances in children may be underdiagnosed, overdiagnosed or both simultaneously. Uncommon conditions can, for example, be missed simply because of unfamiliarity among clinicians. The notion that a child has experienced pathogenic care or trauma cannot be taken as an indication of an attachment disorder or any other disorder.

There can always be other possibilities which have to be considered.

When considering a child entering into foster care, adoption or other settings, stress can, for example, be a factor that the child is experiencing at the time. Also, behaviour problems or relationship problems that arise during that stage do not automatically suggest any disorder. It is important to think about these issues when evaluating children in cross-cultural or international adoptions. Different cultures have different normative social behaviours which can, without doubt, be misunderstood as a disorder. For example, failure to make eye-contact is included on some checklists as a sign of attachment disorder. However, that may be a normative social behaviour in many cultures (Keating, 1976, in Chaffin et al., 2006).

According to Chaffin and his associates (2006), the danger of becoming fascinated by rare disorders should be recognised by clinicians. Unfortunately, in the field of psychology and other related fields there is a history of diagnostic fads. Uncommon or even mysterious diagnoses become fashionable and spread quickly through the practice world and even the popular press. These fads have even resulted in evident harm. For instance, in the history of child abuse there has been a rise and fall in popularity of diagnoses such as multiple personality disorder and concepts such as repressed memory. Although fashionable a few years ago, some scientists today question whether these phenomena actually exist at all, and it is now generally accepted that neither is nearly as common as supporters once suggested. Furthermore, both of these diagnostic fads seem to have harmed some patients (Darwick, 2004, in Schaffin et al., 2006).

As can be seen, it is important not to diagnose an uncommon disorder when the diagnosis of a common disorder fits better. Disorders like attention-deficit/hyperactivity disorder (ADHD), conduct disorder or even post traumatic stress disorder (PTSD) could, for example, be considered along with reactive attachment disorder (RAD) (Schaffin et al., 2006).

Another reason for caution among clinicians diagnosing RAD before considering other disorders or problems is that some controversial attachment therapies have in fact propagated fairly broad and non-specific lists of symptoms that are said to indicate whether a child has an attachment disorder. For example, Reber (1996) set up a table that lists "common" symptoms of RAD. The list includes problems or symptoms across many domains, social, emotional, behavioural and developmental. It ranges from DSM-IV criteria from RAD to non-specific behaviour problems including destructive behaviours, refusal to make eye contact, cruelty to animals and siblings, lack of cause and effect thinking, poor peer relationships, stealing, lying,

lack of conscience, poor impulse control, abnormal speech patterns, fighting for control, etc., etc. Other checklists have also been made that suggest that if, for example, an infant prefers dad to mom it can indicate attachment problems (Buenning, 1999, in Chaffin et al., 2006).

Evidently, these "checklists" extend far beyond the diagnostic criteria for RAD and beyond attachment relationship problems in general. They are non-specific and unfortunately because of this high rates of false positive diagnoses can occur. This danger affirms the fact that it is of great importance that clinicians, parents and others who believe a child has an attachment problem should also consider other possibilities. Although a child shows destructive behaviours and even steals and lies it does not have to mean that he has an attachment disorder. There are other possibilities and one should bear that in mind before starting the diagnostic process.

What is more, although maltreatment is probably one important contributor to some types of attachment disorders, it is neither necessary nor sufficient to make a diagnosis. Similarly, not all maltreated children will exhibit attachment disorders. According to Zeanah (1996), focusing on disordered attachment behaviours rather than on maltreatment avoids the problem of attempting to determine what constitutes emotional maltreatment; recognizes that attachment is only one among several possible sequela of maltreatment; and recognizes that maltreated children have diverse outcomes. It is not clear at present how the clinical picture is affected by, on the one hand, the main effect of central nervous system abnormalities and, on the other hand, environmental adversity alone. There could well be some ongoing interaction between the two.

3.7. Alternative Conceptualizations

Several alternative conceptualizations to disordered attachment have appeared besides those appearing in the official nosologies, DSM-IV and ICD-10. Greenspan and his colleagues, for example, (Greenspan & Lieberman, 1988) believed that attachment disorders were phase-specific disturbances within a developmental-structuralist framework. Call (1983), on the other hand, considered attachment disorders in relation to the psychodynamic perspective, that is the developmental processes of separation and individuation. These two approaches have in many ways provided alternative conceptualizations to the criteria in DSM-IV standard nosologies. They focus on disordered attachment more specifically and on the infant's behaviour with the primary attachment figure. Their attempt includes a broader focus than responses to maltreatment alone.

However, neither Greenspan nor Call incorporated findings from developmental attachment research in their definitions and in the criteria used to operationalize them. What is more, neither of these two approaches has had the reliability or validity of their criteria assessed, and neither has won widespread acceptance (Zeanah, 1996).

Contrary to these approaches, Lieberman and Pawl (1990) drew upon developmental attachment research in defining attachment disorders as secure base distortions. They described three patterns of disordered attachment. The first type they called recklessness and accident proneness. Here they described infants who failed to check back with their caregivers at times when their infant's attachment systems ought to have been aroused. The second type they called inhibition of exploration. Those infants were described as being unwilling to venture away from the secure base that their caregivers were to provide. Finally the third type, that of precocious competence in self-protection, in which infants seemed to have inverted the secure base so that they were excessively self-reliant and providing care and protection to the parent. This system of classifying attachment disorders, although not fully developed in the form of criteria, formed the foundation for the expanded system of classifying attachment disorders described by Lieberman and Zeanah (1995).

This most recent alternative system for classifying disordered attachment was also created from clinical observation but in addition with the attempt to fashion criteria for attachment disorders that incorporated the major findings of developmental attachment research. The system of classification identifies three different major types of disorders of nonattachment, disordered attachments, and disrupted attachment disorder. Nonattached attachment disorder describes infants who do not exhibit a preferred attachment to anyone, despite having attained a cognitive age of 10 to 12 months. There are two types, an emotionally withdrawn, inhibited subtype and an indiscriminately social subtype. These two subtypes are similar to the DSM-IV and ICD-10 descriptions of attachment disorders (Zeanah, 1996).

Disordered attachments, on the other hand, are distortions in the child's use of the caregiver as a secure base from which to explore the world and a safe haven to which to return in times of danger. What is characteristic of secure-base distortions is that the symptomatic behaviours are relationship-specific and confined to the disordered attachment relationship. The young child who is excessively clingy and extremely inhibited about exploring typifies an attachment disorder with inhibition. The child who moves away from the caregiver too easily without checking back even

in times of danger and who exhibits a pattern of reckless and dangerous behaviour characterizes attachment disorder with self-endangerment. Finally, if the attachment relationship is inverted so that the child takes care of and worries excessively about the emotional wellbeing of the attachment figure to a developmentally inappropriate degree, then disordered attachment with role reversal ought to be considered (Zeanah, 1996).

By drawing on clinical experience and developmental attachment research, Zeanah, Mammen & Lieberman (1993) have proposed several domains of child behaviour expressed toward caregivers that, in my mind, ought to be evaluated in considering disordered attachment. These include lack of affection or promiscuous affection; absent, odd, or ambivalent comfort-seeking from the caregiver; excessive dependence or failure to use the supportive presence of the caregiver when needed; noncompliance or overcompliance; excessively inhibited exploratory behaviour or exploration without checking back; oversolicitous and inappropriate caregiving with excessively bossy and punitive attempts by the child to control the parent's behaviour; and failure to re-establish affective contact after brief separations including ignoring, angry, or unaffectionate responses (see in Zeanah et al. 1993).

Although some of these behaviours are indices of insecure attachments, they become clinical indicators only at extremes of the normal distribution. When these behaviours represent extremes, and when they indicate together a pattern of the child's behaviour expressed toward attachment figures, these aspects of child behaviour may be useful in identifying disordered attachments (see case examples in Zeanah et al., 1993, & Lieberman & Zeanah, 1995).

According to Zeanah (1996) this system is more specifically focused on children’s attachment behaviours and attachment relationships rather than on social behaviours in a variety of contexts. Focusing on disordered attachment more specifically and on relationship disturbances between infants and parents and less specifically on abnormal social behaviour can mean that attachment disorders will become applicable to a larger number of symptomatic young children.

3.8. Discussion

If attachment disorders are defined by criteria derived from findings in attachment research as described above, they will without a doubt become applicable to a broader range of children in severely disturbed relationships with their primary caregivers, instead of just those children that have been physically abused or extremely deprived. Therefore, an alternative system of classification that takes findings from clinical observation and developmental research and tries to integrate them into criteria for attachment disorders should, in my mind, be considered. Although attachment theory has been the key theoretical foundation for research and clinical work on attachment problems, it has not been used as a basis for diagnosis in DSM-IV. DSM-IV strives to be atheoretical, so it does not base its criteria on attachment theory nor any other theory. At the same time, the theory's principles remain critical in understanding the components of attachment disorders which, in my mind, makes it hard for diagnostic manuals of attachment disorders to not base any criteria on the theory. Also, until now, both DSM-IV and ICD-10 tie attachment disorders strongly to parental abuse or neglect or to the extremes of caregiving such as children raised in institutions. By doing this, in both DSM-IV and ICD-10, the clinical usefulness is reduced by the restriction of the population to whom they can be usefully applied. However, by including research findings and definitions from developmental research, it should be possible to modify the criteria and to describe the clinical features of a larger group of children who are in attachment relationships, although disordered in some ways. Also, by focusing more on infant-caregiver attachment, the disorder is broadened to include not only children with no attachment relationships but also those with extremely disturbed attachment relationships with their caregivers. Furthermore, despite the fact that RAD may be the cause of some behavioural problems with children that have been severely maltreated there can be other common and treatable diagnoses that account for many of these difficulties. Although, maltreatment can be one important contributor to some types of attachment disorders, it is neither necessary nor sufficient to make a diagnosis. Not all maltreated children will exhibit attachment disorders. Focusing then on disordered attachment behaviours and on relationship disturbances between infants and parents and less on abnormal social behaviour can mean that attachment disorders may be applied to a larger number of symptomatic young children and will yield space by leaving out those maltreated children that do not have attachment disorder.

Clinical experience furthermore suggests that disorders of attachment do exist beyond RAD, and today the term "attachment disorder" is increasingly used to describe the behaviour of children whose behaviour is primarily affected by a lack of primary attachment figure or some disruption in the attachment relationship. Focusing on that instead of maltreatment gives an opportunity for considering attachment problems in a larger group of children, and in my mind it is built on much sounder grounds. As was expressed in the introduction to this paper, although attachment theory is not a theory of pathology Bowlby emphasizes the importance of selective attachments and perceived consequences of the failure to develop selective attachments relationships. Growing up with good mental health can therefore be linked directly to secure attachment relationships in infancy and childhood and disturbances in attachment can on the other hand be connected to poor mental health consequences and negative behavioural outcomes. In this way, attachment theory, although not a theory of pathology, stresses the importance of selective attachments for healthy emotional development and even connects insecure attachments to poor mental and behavioural outcomes. We can therefore use attachment theory to help us understand attachment disorders better. Even though it does not clearly distinguish between normal variations in attachment and a disorder, it pinpoints a big risk factor for psychopathology in later life, viz., insecure attachments. Of course, not all insecure attachments will develop into disorders but attachment theory considers them to be risk factors, especially disorganized attachment. However, because attachment theory is not a clinical theory we are not told when the risk factor has turned into a disorder. The question then remains: When does the risk factor become a case? To answer that question we then have to look to clinical experience, which indicates, as has been discussed above, that attachment problems become psychiatric disorders when emotions and behaviour displayed in attachment relationships are so disturbed as to indicate persistent distress or disability of the infant. This happens when insecure attachments become clinical indicators at extremes of the normal distribution.

To focus more on disordered attachments and on relationship disturbances between infants and parents than on maltreatment or the absence of a child-caregiver relationship is indeed in accordance with attachment theory which emphasizes that attachment disturbances would be more likely to take place if caregivers are not available and not responsive to the needs of children. Hopefully, this shift of focus will deepen the perspective on important clinical disorders. This is important with respect to the group of concern, viz. internationally adopted children, especially

those that have been adopted from institutions. Although attachment theory is not a theory of development it can be very useful in helping us understand better the development of attachment disorders, for example by considering better the risk factor, insecure attachment, and when it becomes a disorder.

I will investigate this issue further in this paper, and view new studies on the subject which hopefully will shed a light on what appear to be the most influential factors on disturbances in attachment. If we can better locate which children are at most risk, and in this case which internationally adopted children seem to be at highest risk, we can see better what can be helpful for children in these situations. However, the next step in this paper is to look further into the subject of international adoption. There are certain things that have affected countries in making decisions about adopting children from other countries or allowing their children to be adopted abroad. I will reflect on these points and then discuss how the situation has been in Denmark and Iceland specifically. After that I will discuss the selection of adoptive parents and look into adoption law. In my mind it is important that the selection of adoptive parents is satisfactory and, first and foremost, focused on what is in the best interests of the child concerned. As studies have shown, children need more than food to become healthy individuals. They need love and affection and a strong attachment to their caregivers. Children, plainly and simply, need good, healthy parents that are ready to take good care of them. However, when considering individuals that want to adopt there is the question of how to screen for good candidates for adoption and how to screen out those that are not as good. In the next chapter I will discuss the issue further, analysing the ways we can try to select good candidates for adoption, while focusing on the child's best interests.

4. International adoption

4.1. The starting countries in international adoption

The first countries that allowed international adoptions were The United States of America and Sweden. They were also the first nations that started investigating the subject by doing research on adoptions and adoptive children in the eighties (Dalen, 1999). Today, American citizens represent the majority of international adoptive parents. They are then followed by Europeans and people from other more developed countries. The people that adopt are often placed in two groups, on the one hand those that cannot have children, and on the other hand those that want to adopt a child because of a certain cause or a vision in life (Dalen, 1999). The former group has been significantly larger than the other, about 80 to 90% of the whole group (in Dalen, 1999). During the last 20 years the average age of children adopted has been going down and today the average age in most countries is around 1 year old (Dalen, 1999).

The United States of America started adopting children in substantial numbers after World War II (1939-1945). Many of the children that were adopted were European and Japanese War orphans. More adoptions followed after the Civil War in Greece (1946-1949), the Korean War (1950-1953), and, last but not the least, the war in Vietnam (1954-1975). However, concerns other than War have affected countries in allowing their children to be adopted abroad. Poverty and social disruption have, for example, been shown to be critical factors in the adoption of children from Latin America, the former Soviet Union and Eastern Europe over the last twenty years. In China government population control policies (one-child policy) has furthermore been shown to affect the decision of parents to abandon their daughters and has lead to overcrowded orphanages in China. These factors have without a doubt affected the Government's decision to make international adoptions available[2]. The most common countries for international adoption by parents in the United States were, in 2005: China, (7905), Russia, (4639), South Korea (4630) and Guatemala (3783). In the last five years most children have come from China and South-Korea. The majority of children from these countries are girls, or 60%. Furthermore, most of the children are under one year of age when adopted (also about 60%)[3].

[2] http://www.adoptioninstitute.org/FactOverview/international.html

[3] http://www.adoptivefamilies.com/internationaladoption.php

The first adoption act in Sweden was in 1917 and in 1959 adopted children became fully-fledged family members by law. Sweden started international adoptions in the sixties. Since then about 46,000 children have been adopted to Sweden from many different countries. About a thousand children are now adopted into Sweden every year and the majority of children in 2005 came from China (462), South-Korea (104), Colombia (54), South-Africa (56) and India (44). The children are mostly girls, or 65% in the year 2005, and most of the children were under one year of age when adopted (62%)[4].

4.2. International adoptions in Scandinavia

Adoptions to other Scandinavian countries than Sweden started in the seventies and today about 650,000 children have been adopted in those countries[5]. In Denmark and Iceland most adoptions are done through so-called Adoption agencies (e.g. DanAdopt & IsAdopt). About 600 children are adopted now into Denmark every year. On the whole (from 1970 until 2005) the majority of children adopted into Denmark have come from South-Korea, or 44% of all internationally adopted children. The next largest group has come from India, 13%, and then from Colombia, 11%. However, the situation seems to be changing rapidly after adoptions of children born in China started in Denmark in 1995. Today, the majority of internationally adopted children come from China, or nearly 30%. As in Sweden, about 60% of the children are girls[6]. (See also Table 2).

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[4] http://www.mia.eu/frameset.htm

[5] http://www.mia.eu/frameset.htm

[6] http://statistik.adoption.dk

Table 2. Internationally adopted children in Denmark in the years 2001-2005.

Country	2001	2002	2003	2004	2005	Total
China	134	145	178	164	207	828
India	115	93	65	100	65	438
Vietnam	62	75	19	13	72	241
Columbia	88	81	58	38	37	302
South-Korea	69	46	56	53	46	270
Ethiopia	22	20	40	41	30	153
South-Africa	0	8	13	26	46	93
Bolivia	17	23	14	20	30	104
Thailand	22	19	10	17	16	84
Check Republic	20	19	16	18	13	86
White-Russia	13	25	19	15	0	72
Other countries	69	55	34	22	24	204
Total	631	609	522	527	586	2875

Information gained from "Adoption og Samfund" (http://statistik.adoption.dk)

As was said earlier, the average age of children when adopted has been decreasing during the last twenty years and is now in most countries around 1 year (Dalen, 1999). From the year 2001 the majority of internationally adopted children in Denmark has indeed been under one year of age, or 45%. The next largest group has children that are somewhere in-between one year and two years. This group includes 34% of the population. In Table 3 one can see better the ages of internationally adopted children when they arrived in Denmark during the years 2001-2005.

Table 3. Children's age of adoption in Denmark in the years 2001-2005.

2001-2005	<one year	one-two years	two-three years	three-four years	four-five years	>five years	Total
China	44%	51%	2%	1%	1%		828
India	5%	63%	20%	5%	3%	5%	438
Vietnam	59%	31%	9%				241
Columbia	77%	11%	5%	3%	2%	3%	303
South-Korea	96%	4%					270
Ethiopia	68%	12%	8%	1%	5%	6%	153
South-Africa	51%	24%	20%	3%	2%	1%	123
Bolivia	74%	16%	10%				80
Other countries	41%	19%	11%	13%	8%	8%	294
Total	**45%**	**34%**	**10%**	**5%**	**3%**	**3%**	3128

Information gained from "Adoption og Samfund" (http://statistik.adoption.dk)

In Iceland, around 500 children have been adopted since 1978. Today, about 25 children are adopted every year. International adoptions have been increasing steadily since 1999. In the years 1996-1998 they were around 10 every year but since 1999 they have not gone under 20 a year. The majority of internationally adopted children in Iceland have come from India. In the years 1996-2004, 92 children came from India, or 51%. However, during the last five years the situation has been changing in ways similar to those in Sweden and Denmark. In the years 2001-2004 about 60% of internationally adopted children in Iceland came from China and 33% from India. As in Sweden and Denmark, the situation then appears to be changing with respect to country of origin. The majority of internationally adopted children in Iceland are girls, or more than 70% (Hagtíðindi, 2005). In Table 4, the number of internationally adopted children in Iceland can be seen, together with the country they came from, in the year 2001-2005.

Table 4. Internationally adopted children in Iceland in the years 2001-2004.

Country	2001	2002	2003	2004	Total
China	0	10	18	19	47
India	26	8	7	7	48
Rumenia	2	0	0	0	2
Other countries	1	2	2	1	6
Total	29	20	27	27	103

Information gained from "Hagstofa Íslands (http://hagstofa.is)

The average age of internationally adopted children in Iceland is, interestingly, higher than in Denmark. The majority of adopted children, or 54%, are between one and two years, not under the age of one year as in Denmark. This difference seems to emerge due to the fact that the majority of adopted children in Iceland come from China and they are, on average, older than one year at arrival. The percentage of Chinese adopted children is higher in Iceland than in Denmark, or 70% versus 30%. Thus, the fact that most adopted children in Iceland now come from China seems to be the reason for a higher average age in Iceland. Table 5 shows clearly the age of internationally adopted children at their arrival in Iceland in the years 2001-2004.

Table 5. Children's age of adoption in Iceland in the years 2001-2004.

2001-2005	<one year	one-two years	two-three years	three-four years	four-five years	>five years	Total
China	11%	91%					47
India	63%	37%					48
Rumenia			50%	50%			2
Other countries	17%	33%	17%		17%	17%	6
Total	**30%**	**54%**	**22%**	**17%**	**6%**	**6%**	103

Information gained from "Hagstofa Íslands (http://hagstofa.is)

Thus, the situation in Denmark and Iceland is not entirely the same. Although most international adopted children today come from China in both of these countries, the proportion of Chinese children in Iceland is much higher than in Denmark. Also, in Denmark adopted parents can choose from more than 10 countries to adopt from, and there is more distribution between those countries. In Iceland, more than 90% of adoptive parents adopt from China and India. Last but not the least the age difference of adopted children on arrival to the countries is interesting. In Iceland the children are older on average which is, without a doubt, explained by the fact that such a large proportion of adopted children comes from China.

4.3. The selection of parents

The selection of "good" adoptive parents is always an issue in international adoption. Both the adoption agencies and the birth country of the concerned child usually have some requirements about this. I would assume that it would be a generally held view that it is of great importance to find healthy and prosperous parents for the children concerned, parents that are able to take good

care of a child. Focusing on healthy, fully-functional or "good" parents can, however, create problems. Do we really know what constitutes a fully-functional parent or the best environment for a child to be brought up in? I doubt that everybody would agree on that issue, not even psychologists or other professionals. We do not have any psychological "cook book" about which parents are best or what kind of environment is the most favourable for children. However, we do have information about what kind of environment appears to be damaging for children to be raised up in and that information can be a good starting point when selecting parents for adoptive children.

We know, for example, that it can be damaging for children to be raised by alcohol-dependent or violent parents. We therefore do not wish children to be raised in such an environment. Sadly, too many children born in for example, Denmark and Iceland have parents that drink too much, are violent and even abusive. In the worst situations the social services even have to intervene, either with help and support for the family or by simply removing a child from its parents. However, the difference between those cases and adoption is that in real life we have no control over what kind of people decide to have children. No one has the right to forbid other people to reproduce. Concerning adoption, the situation is different, however. There we have the opportunity to think, first and foremost, about the child's best interests and we can set requirements that are thought to represent that concern. No one is permitted or forbidden to have his/her own children, but requirements are set for people that want to adopt somebody else's children. We would not want those who are not able to take care for a child to adopt, and we have to look out for signs that might indicate that people are not good candidates for adoption. For example, if there is a history of alcohol and/or drug abuse, financial difficulties, or even in the worst case, a history of violent or abusive behaviour, those things would have to be considered. The child's best interests must be born in mind when considering prospective parents. It is all about finding good parents for a child.

However, if we then face the fact that both adoption agencies and the countries where children are adopted from have the power to select adoptive parents, one would hope that the requirements set are fair and built on evidence. One requirement I would consider important after reading Bowlby's thoughts on attachment (Bowlby, 1969), considering the strange situation procedure by Ainsworth (Ainsworth, et al., 1979) and looking into the interesting study on Harlow's rhesus monkeys, is that children, plainly and simply, require love. Children need

parents that are able to love and care for them. However, we do not have any test that can tell us a person's capability for love and care of a child. Yet we can use information from studies on what appears to be damaging for children's development and the kind of environment that appears good for healthy development. By considering these factors we can establish some general requirements for adoptive parents, which are thought to be in the child's best interest as regards mental and physical development.

For example, studies have shown that it is important for children's development that they have a stable life, and for adopted children, stability is believed to be equally, if not more important, than for other children (e.g. Barth, Crea, John, Thoburns & Quinton, 2005). Stability is therefore, a variable that should affect the requirements that are set. It is thought to be in the child's best interest to find a stable family. Finding such a family might involve looking into past records to see how prospective adoptive parents have been living their lives. Do they have a history of divorce? Have they been moving a lot in the past? Are they in good and stable jobs? Do they have a history of alcoholism or anything else that could be considered non-stable and even damaging for children? It might also be wise to look into their financial background and consider their financial status today. In my mind, it is in the child's best interest that adoptive parents can financially afford supporting a family. Although love and affection is extremely important for a child's emotional development, parents also need to be able to afford food for the table, clothes, diapers, and kindergarten, amongst other things.

Of course it would be wonderful if one could screen for "damaging" parents in more thorough ways; if only there was a test that could distinguish between "fully-functional, healthy parents" and "dysfunctional, unhealthy parents." But while such a test does not exist, we have to use other means in trying to screen good candidates for parenthood. Hopefully, by having first and foremost the child's best interests in mind and by setting requirements in conjunction with that goal, good and healthy parents will be found for children that need them.

The next step in this paper is to look at the requirements in the United States, Denmark and Iceland. As one can imagine, the requirements necessary to start the process of international adoption vary widely. It can, for example, depend on which country the adoptive parents are applying from, which country the adoptive parents live in and the organization (adoption agency) through which people are applying. In this paper I only look into the three countries mentioned above to try to ascertain whether the adoption rules are similar and, last but not the least, to try to

find out if they seem to be working. By looking into this and considering research on how the requirements are working it is hoped that we will see whether these countries are doing their best in selecting good parents for internationally adopted children.

4.4. The adoption process

Adoption policies for each country can vary. Items such as the age of adoptive parents, financial status, marital status and history, number of children, sexual orientation, weight, and psychological health have been used by different countries to determine which parents are qualified to adopt from a particular country. Items such as the age of the child, fees and expenses can also vary from one country to another. Each country sets its own rules, timelines, and requirements in relation to adoption[7].

Normally, the first stage of the adoption process in the United States is to select an agency or facilitator to work with. Each agency or organization normally works with diverse countries although there are few that only focus on one particular country. There are also a few countries that allow independent adoption (not done through an agency) but it is rare that adoptive parents choose that way, especially with their first adoption[8]. In Denmark and Iceland the process is similar. Adoptive parents contact an agency which then helps them through the process[9].

The next step is normally the preparation work by the adoption agency on a dossier about the prospective adoptive parents. In the United States, this usually includes financial information, a background check, fingerprints, a home study review by a social worker and other supporting information[10]. However, the requirements can also vary from country to country. For example, in Denmark and Iceland the report usually includes a financial report, health report and another background checks but no fingerprints are needed. Furthermore, there are requirements as to the length of the relationship or marriage between the prospective adoptive parents and their age. Thus, information about these factors normally goes in the dossier[11].

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[7] http://en.wikipedia.org/wiki/International_adoption
[8] http://da.wikipedia.org/wiki/International_adoption
[9] http://www.danadopt.dk/adoptionsforl%C3%B8b/valg%20af%20organisation.aspx & http://www.isadopt.is/index.php?p=aettleid

[10] http://da.wikipedia.org/wiki/International_adoption
[11] http://www.danadopt.dk/adoptionsforl%C3%B8b/almindelige%20krav.aspx & http://www.aettleiding.is/index.php?option=com_content&task=view&id=31&Itemid=61

After the report is completed and the adoptive parents approved they are then matched to an eligible child. The parents receive information about the child, such as age, gender and history. At the same time parents are usually informed about when they may travel to meet the child and are asked to sign any additional paperwork. Often parents only need to make one trip and then escort the child to their home country. However, this as with other factors, depends on the country. In some countries parents need to make more than one trip overseas to complete the legal process and in other countries adoptive parents are not required to travel to the country of their adopted child. In those instances a child may be escorted to the adoptive parents' home country by someone else[12]. In Iceland and Denmark adoptive parents usually have to make a trip overseas and then escort the child to their home country. It is seldom that people have to make many trips or that someone else escorts a child to the adoptive parents' home country. The adoption process, from the date of application until the adoptive parents have received their child, usually takes between one and two years, both in Iceland and Denmark[13].

Finally, there are usually some requirements after the child has been brought home. For instance, there might be additional paperwork, to make the child a legal citizen in the parents' home country. Also, one or more follow up visits from a social worker may be required, either from the adoption agency or by the laws of the country from which the child was adopted[14].

4.5. Adoption laws

Adoption law can vary widely between countries. The countries that children are adopted from have their own law and the countries to which children are adopted have their law. Hence, although a particular country permits adoption in some situations this does not necessarily mean that it will happen. For example, in Denmark and Iceland individuals, gays and lesbians have permission to adopt which is not the case in many adoption countries. In Iceland, for example, the only country that individuals can adopt from is China. The laws in each country therefore do not tell the whole story about who can or cannot adopt. The law in the birth country of the child also

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[12] http://da.wikipedia.org/wiki/International_adoption
[13] http://www.danadopt.dk/adoptionsforl%C3%B8b/almindelige%20krav.aspx &

[14] http://en.wikipedia.org/wiki/International_adoption

has great impact.

However, if we look at Denmark we have, firstly, the general requirement for applicants, viz. that they be at least 25 years of age, with the age difference between a child and an adoptive parent being not more than 40 years. Another requirement is that applicants have been living together for at least two and a half years and that at the time when they have been approved for adoption they should be married. Unmarried singles do, however, have permission to adopt. Further requirements are that applicants are in good physical and psychological health, live in adequate accommodation and that they obtain the financial resources required for raising a child[15]. In Iceland there are similar requirements. Applicants should be at least 25 years old and not older than 45. Applicants should furthermore have been living together for at least three years, one year thereof in marriage. If unmarried, couples can, however, adopt but are required to have been living together for at least five years. Unmarried singles are allowed to adopt in Iceland. Lastly, applicants are supposed to have good physical and psychological health and must show that they can, without doubt, financially support a family[16].

It is of course debatable as to how much money adoptive parents really need to afford raising a child, and whether the criteria are fair in this regard. However, the criteria do not appear to be strict concerning this issue. It is not a question of a certain amount earned per year or some similar consideration, but rather it is a question of stability, an issue I discussed earlier. If one wants to think first and foremost about the adopted child's interests it is evident that it is important that a child be raised in a stable environment, having parents with stable incomes and living stable lives. The criterion concerning financial status therefore symbolizes that claim.

One can also raise a question concerning the requirement in Denmark that adoptive parents need to be married. In Iceland they do not need to be married. The requirement in Iceland for unmarried couples is that they have lived together for 5 years which is two years more than is required for married couples. So, although there is a difference, the rules in both countries illustrate a preference for married couples over unmarried. This indicates that the underlying reason for the rules is again related to stability. It is believed to be in the child's best interest to live in a stable environment and healthy married couples are assumed to be more likely than many

[15] http://adoptionsnaevnet.dk/regler/hvordan.htm#betingelser%20for%20at%20blive%20godkendt

[16] http://www.aettleiding.is/index.php?option=com_content&task=view&id=25&Itemid=48
http://www.hcch.net/index_en.php?act=conventions.pdf&cid=69

others to be able to provide that stability.

4.6. International law

International law has been created in an effort to protect those involved from corruption and the exploitation that sometimes goes together with the adoption process. The Hague Conference on Private International Law developed "the Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption." The convention was concluded on 29th May, 1993 and put into force 1st May, 1995. The main objectives of the Convention are to set up safeguards to ensure that international adoptions take place in the best interests of the child and with respect for his or her fundamental rights as recognised in international law. The Hague convention obligates the country, into which a child is born, to investigate whether the child can live with its biological family. If not, then the government of the country is required to try to find another family for the child in its home country. Only if that is not possible, can international adoption take place. The convention furthermore states that a system of co-operation amongst Contracting States should be established in an effort to ensure that the safeguards are respected and thereby to prevent the abduction, sale of, or traffic in children[17]. In the year 2005, this convention had been ratified by 64 countries. Several more countries are signatories to the Convention and are at different stages in taking steps to achieve full ratification[18]. Denmark and Iceland are among these 64 countries[19].

4.7. Stable environment

As I have expressed before, adoption rules should in my mind be set, first and foremost, with the interest of the adoptive child in mind. After having discussed my thoughts on setting requirements, and having considered the rules that have been set, for example in Denmark and Iceland, I now want to look into what research can tell us about the effectiveness of requirements and rules concerning international adoption. If the requirements for international adoption are

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[17] http://www.hcch.net/index_en.php?act=conventions.pdf&cid=69
[18] http://www.adoption.dk/jura/haager_konvention.htm
[19] http://www.althingi.is/lagas/nuna/1995160.html & http://www.adoption.dk/jura/haager_konvention.htm

satisfactory then I would think that the majority of internationally adopted children are raised in a stable and well-nurtured environment. Unfortunately, I did not find much research on the subject in Denmark and Iceland, but what I did find I will discuss. However, I also have studies from Norway, Sweden and the United States, which should in some ways represent what the likely outcome would be in Iceland and Denmark, because of the similarity in the adoption requirements and rules in these countries.

Firstly, McGuinnes & Pallanch (2000) studied families of 105 internationally adopted children in the United States of America. The children came from the Former Soviet Union. The results showed that 95% of the children were raised in a family with two caregivers, a father and a mother. The average length of marriage was 14 years. The adoptive parents furthermore had a socioeconomic advantage which, for example, was expressed by the fact that 71% of the parents had household incomes falling in the 51,000 to 70,000 dollar range. The adoptive parents were furthermore well educated, with both parents typically having completed at least a bachelor's degree. What is more, adoptive family environments were generally positive, with higher than average levels of cohesion and expressiveness, and lower levels of conflict. Thus, the findings of that study indicated that adoptive family environments were very positive for children.

Botvar (1995) also conducted a large study on internationally adopted children in Norway that were adopted from South-Korea. The results showed that 90% of the children lived with both of their parents and more than half of them met their grandparents every week. The majority of the children furthermore lived in good financial conditions and had a home in the suburbs or in small towns. Their parents rarely moved and the children had good access to playgrounds, and other similar facilities. Eighty percent of the children had one sibling or more and only 3% of the adopted children thought that their relationship with a sibling was worse than for other siblings.

A Swedish study on internationally adopted children then showed that 60% of the adopted children lived in good social and financial conditions. The same study showed that in the comparison group, "regular" Swedish children, only 30% lived in good social and financial conditions. The adoptive mothers were also older than other mothers and more educated. Their age could however, be a variable affecting the higher education level (Borczyskowski, Hjem, Lindblad, & Vinnerljung, 2006).

A Danish study, conducted by Skovmand-Madsen (1999) on 13 young adults internationally adopted from Asia, furthermore showed that the majority of adopted individuals had lived in good social and financial conditions. They had experienced close and deep contact with their parents and although at the time of study they had almost all moved out of the parental home they were still in contact with their parents almost every day, either by phone or by visiting them. Only two had experienced a parental divorce and all of the adoptive adults had siblings, either adopted or biological children of their adoptive parents. The majority of the adoptive adults had experienced close and warm relationship with a sibling. Lastly, most of these young people were happy about their lives, had friends, jobs and did not seem to be dealing with more problems in life than the average young Danish individual.

However, despite interesting results, one has to be aware that this is a very small study, with only 13 subjects. One should therefore be cautious in generalizing the results to the larger population of internationally adopted children in Denmark. Also, the study method was an interview, designed by the researcher. To my knowledge the validity and reliability of this interview is not known, which again should make people cautious in taking the results as evidence that most internationally adopted children in Denmark have experienced life in the same manner as these 13 young individuals.

Lastly, there is an interesting Icelandic study I would like to discuss. The subjects were 109 internationally adopted children aged one to 18 years, and their families. A questionnaire, designed by Dr. Dana Johnson, child psychiatrist, was send to adoptive parents. The questionnaire had formerly been used in large surveys on health and general well-being of adopted children in the United States. It was translated into Icelandic for this study. The subjects answered the questions and sent back the questionnaire to the researchers. The study showed that 90% of the adoptive parents were married, and that 61% of the mothers and 48% of the fathers had a University degree. More than 95% of these children got along well with their siblings and a similar amount of children got along well with their parents. Only 5% of the children had experienced a divorce, one child had experienced the loss of a parent and one child had experienced the loss of a sibling. About 26% of the children had had a new sibling in the home. More than 40% of the adopted children 6 years or older had practised one or more sport during the past year and 84% had participated in some kind of leisure activities outside of school (Hermannsdóttir & Oddsdóttir, 2006).

Thus, research indicates that the majority of adopted children are raised in a stable environment. Most of the children have a mother and a father, and in many instances the parents are well-educated. The adopted children also overall seem to be doing well in life, or at least in ways similar to other children, and even in some ways better. For example, the Swedish study showed that 60% of the adopted children lived in good social and financial conditions, while only 30% of "regular" Swedish children, lived in good social and financial conditions. Also, the studies discussed above show that only about 5 to 10% of the adopted children have experienced parental divorce and that the parents are in most instances well-educated. In my mind these results indicate that the conditions of adopted children are at least as good as those of other children, and are, with regard to certain issues, even better.

The results of these studies therefore indicate that the adoption rules of these countries seem to be working as they were intended to, viz. to find good parents and homes for these children. According to the research discussed, children internationally adopted by American and Scandinavian parents have been raised in a healthy and satisfying environment and do not differ in any negative way from other children. Of course, another factor might be affecting the relationship, for example, the fact that people who decide to adopt a child very likely to want to care for their child and really want to take on the parenting role. That could be a factor affecting the outcome and perhaps in some ways minimising the effects of each country's adoption rules. However, as has been discussed, it is necessary to have rules. We do not want the trafficking of children, and we do not want people to adopt that have a seriously unstable or alarming background. Therefore, in an effort to minimize that threat there are set requirements, background information checks, and so forth. In my mind it is necessary to have such rules, and fortunately they appear to work in the best interests of the children concerned. Internationally adopted children are, on average, doing well and appear to have been adopted by good people.

4.8. Mental health

Thus, the adoption process appears to be satisfying. Most internationally adopted children seem to be doing well. They are adopted by healthy parents and raised in a stable and good environment. However, although we agree that the environment they are raised in is, in most instances, satisfying, people have been concerned with another issue. Internationally adopted

children often look different from the standard citizen in the adoptive parents' home country and for that reason many investigators have been speculating whether "foreign-born" adoptees might have poorer mental health than "local-born," non-adopted individuals. The majority of internationally adopted children in the USA, Sweden, Denmark and Iceland have, for example, come from China, South-Korea, India, Colombia, and other countries in Asia and South America. I will now look at what research has to say about this concern.

Firstly, in an overview of studies of transracial adoptions the conclusion was that most transracial adopted children seemed to be well-adjusted and had similar developmental outcomes as same-race adopted children (Rushton & Minnis, 1997, in Cederblad, Höök & Mercke, 1999). Tizard (1991), for example, concluded that 75-80% of internationally adopted children were well adjusted. Furthermore, most studies on preschool and prepuberty school children have concluded that adopted children, whether internationally or same-race placements, develop well and do not differ in their adjustment from nonadopted children (e.g., Cederblad, 1981, Fisher, Ames, Chisholm, & Savoie, 1997).

A few years ago there was also a heated debate in the United States about adopting Afro-Americans or Native American children into Caucasian families. Critics claimed that adoptees could risk losing their ethnic identity, have difficulties with coping with racial discrimination, and be in danger of becoming racially confused. However, studies have shown that the majority of these children seem to be well adjusted (in Cederblad, et al., 1999). Furthermore, studies have been made on international, transracial adoptive children. Kim (1995), for example, summarized studies on Korean adopted children in the United States which showed that the children were well adjusted and had high self-esteem. He compared the findings on identity from the American studies, which showed that the children felt more American than Korean, with studies of Korean adopted children in Denmark, where they mostly felt Danish (Rørbech, 1989) and with studies of Korean adopted children in Germany, where they felt German (Kühl, 1985). Furthermore, Botvar (1995) concluded a study in Norway on internationally adopted children from South-Korea which revealed that the majority of children in the study felt Norwegian.

Another interesting study concerning the mental health of adopted children was done by Brand & Brinich (1999) in the United States of America. They used data from a large representative sample to examine whether adopted children were more likely to have had more mental health contacts or emotional or behavioural problems than non-adopted children. Age of

placement in the adoptive home was examined as a variable contributing to the adjustment of adopted children. The results showed that adopted children were more likely to have had mental health contacts. They were more likely to have received treatment than non-adopted children. Age of placement was significant in predicting the likelihood of a mental health contact. Children that had been placed in an adoptive home after 6 months of age were significantly more likely to have had mental health contact than children that had been adopted before 6 months of age.

However, the results were mixed regarding whether adopted children had had more behavioural problems than non-adopted children. When the researchers removed a small number of influential cases from the adoptee groups the "significant" differences in emotional and behavioural problems became insignificant. The researchers then saw that the distribution of scores on the behaviour problem scale showed that there was a small group of adopted children with very high scores. This small group of children then affected the differences between non-adopted and adopted children that were observed in the beginning. According to the researchers it is possible that this small group has been affecting the results of other studies and is the reason that adopted children have so often been over-represented in clinical samples. It is likely that these children are the ones that often end up in clinical samples and affect the large difference seen between adopted and non-adopted children (Brand & Brinich, 1999).

The researchers furthermore state that it would be a an error to interpret the differences as reported in the study as suggesting that adoption per se puts children at risk for behavioural problems. The results show that the majority of adopted children display patterns of behaviour problems that are very similar to those of non-adopted children. In this sample 88% of the adopted children had problem scale scores similar to those of non-adopted children (Brand & Brinich,1999). The results are then similar to the studies discussed above. The majority of internationally adopted children do not appear to differ in any way from other children. Their mental health is good and although one can notice some behavioural problems within a group of internationally adopted children, the children displaying those behaviours seem to be the rare exceptions.

However, it is of course important to investigate why we see these exceptions and to consider why some internationally adopted children have poor mental health, display behavioural difficulties and experience disturbances in physical and psychological development. Those children do exist and need help with their problems. They are perhaps overgeneralized in the

population, as the above study indicates, but despite that fact a number of studies on children adopted from, for example, institutions in Romania and Russia show that a large number of these children are dealing with considerable emotional and behavioural difficulties (e.g. Mehlbye, 2005, O'Connor, Bredenkamp & Rutter, 1999, Smyke, Dumitrescu & Zeanah, 2002, & McGuinnes & Pallanch, 2000). These and further studies will be discussed in the next chapter of this paper, which will reveal just what it is that affects the development of these children in such a negative way.

4.9. Discussion

Thus, although we cannot truly measure whether a certain individual will become a good and loving parent, we can, by looking into her/his history, get a clearer picture of what kind of person this is and make a decision from that information as to whether they are likely to be a good candidate for parenthood. Furthermore and pleasingly, this kind of investigation seems to be working well. The requirements set in the Scandinavian countries and the United States seem to be successful. Internationally adopted children in these countries appear to have been raised up in a healthy environment, and most often with two competent parents. Furthermore, the mental health of this group of children normally seems to be good and they most often do not differ in any negative ways from other children. So, the positive conclusion of this chapter is that the adoption rules appear to be working well, especially if we are concerned about them working in the adopted children's best interests. The majority of internationally adopted children are raised in healthy families and grow up to be healthy individuals themselves. However, as was discussed above, studies have found that children in this group appearing to be at risk for emotional and behavioural difficulties are perhaps only rare exceptions, but they are still reported in many studies. It is then important to understand better why these children develop difficulties and to ascertain the actual risk factors for developing attachment disturbances. If we want to know how we can help these children and their families, it is important to be able to pinpoint better the cause of their problems. Furthermore, people that are considering adoption should, in my mind, be informed about these risk factors. Parents should be informed about the status of the children they are considering adopting and if parents choose to adopt a child that is likely dealing with psychological or behavioural difficulties, they should be offered sufficient help and support after adoption. I will

discuss these and further issues in the next chapter. I will also look into the risk factors that have been connected to psychological and physical problems in internationally adopted children, and will especially consider factors connected to problems with attachment. Hopefully this discussion will give a clearer picture of the factors that parents and others should look out for when considering a child for adoption, and will help professionals to understand the issues so that they can better prepare adoptive parents who are adopting a child at risk for physical or psychological problems.

5. Internationally adopted children

5.1. The selection of children

It is not in the best interests of a child if a parent adopts him or her without knowing that there is a high risk for developmental problems. In my mind, adoptive parents should be informed about what kind of problems might arise and the likelihood of their occurrence, and they should be offered assistance in dealing with those problems. Just as a country can set rules and select parents to adopt, should not the same apply for adoptive parents? Should they not also be able to select a child and be able to choose whether they want a healthy child or a child that is in some way "damaged"? Again, if only with regard to the child's best interests, it is not good for a child with severe developmental problems to be adopted by a parent that is in no way ready to care for a child with special needs. It can create many problems for the child and the family as a whole if the parents are not informed about the health status of the child and the best way to take care of a child with special needs. For example, the child will not be taken care of as it should, which can further affect its development in negative ways. Also, the parents' reaction, after being prepared for receiving a healthy child and then receiving a child with severe problems, could be damaging for the child and the whole family. Will the parent feel anger or resentment towards the child? Does the parent feel betrayed, having got a "damaged" child instead of a healthy child? If so, if angry and hurt, towards whom will the parent show resentment? Towards the child or someone else?

Interestingly, studies have shown that adoptive parents have not always been correctly informed about the status of the child they have adopted. For example, a Danish study on internationally adopted children from Romania revealed that not all the adoptive parents had received information about the health status of their child. In fact only 10% of the 120 adoptive parents said that they had received all the information about the child's status before they got the child. About 25% said that they had received some information and about 50% of the parents that had received a child with severe psychological or physical problems had not received any information about those issues before they were given the child. Actually, 81 parents of children with physical or psychological disorders had either no information or a very small amount of information about the child's problems before adoption (Mehlbye, 2005).

Furthermore, only 22% of the parents in this study felt that they had received the help and support they needed after adoption, for example from the school, teachers, psychologists and doctors. In fact, 46% of the parents said they had been forced many times to fight for their child's needs to be met. Furthermore, when 15 parents in the study were asked more thoroughly about the adoption process and the effects of receiving a severely damaged child on their lives, many of them could remember scenes where they had been irritated and angry towards their child. For example, one mother had received a daughter that was seriously physically handicapped and had never learned to cry. Although she felt pain or hurt she did not cry. But then, after about half a year the mother was lying in bed with her daughter and then suddenly the girl started to cry. The mother lay in bed irritated and did not understand why her daughter was suddenly crying. In fact she said to herself that if anyone should cry it should be her, not her daughter; the daughter should be happy now that she had got this good life with her. These thoughts likely express the mother's frustration over receiving a child that is severely damaged. She never expected this and felt betrayed, angry and very tired (Mehlbye, 2005).

Thus, the information that adoptive parents receive before adoption does not always seem to be adequate. Also, the help and support after adoption is, according to the Danish parents in this study, not sufficient. The testimony of these parents is interesting and some valuable lessons can be learned. Parents should be informed about the status of the children they are considering adopting. Furthermore, if parents choose to adopt a child that likely is dealing with psychological or behavioural difficulties, they should be offered sufficient help and support after adoption. Interestingly, in the United States it is well known that adoptive parents want to adopt children with disabilities and turn to adoption agencies with that in mind. In that country there is apparently a long waiting list, even many years of waiting, for children with Down syndrome[20]. Not all people just want to adopt healthy babies; some want to adopt children with disabilities. For example, in relation to Down syndrome the people adopting have often had a family member or acquaintance with Down syndrome or they work with them in medical or school professions[21]. Thus, many people appear to be unafraid of adopting a child with disabilities and seem to be ready for the challenges this raises. Interestingly, in Iceland, adoptive parents can now consider

[20]http://specialchildren.about.com/gi/dynamic/offsite.htm?site=http://www.showmenews.com/2006/Feb/20060205News025.asp

adopting children with disabilities from China. They then know beforehand that the child they will adopt is in some way disabled. This is just starting in Iceland and it will be interesting to see how it will work[22].

Thus, it is important to investigate better the risk factors for attachment disorders and other difficulties to arise in internationally adopted children. Adoptive parents, people working at adoption agencies, and others concerned with this issue should be as well informed about the likely status of these children as possible.

5.2. Risk factors

As was discussed previously in this paper, the majority of internationally adopted children seem to be well-adjusted and to be happy with themselves. However, a number of internationally adopted children have experienced difficult situations that may have influenced their development. Some of the risk factors most investigated are connected to pregnancy, for example the drug abuse of the adopted child's mother, lack of nourishment in the womb and stress during pregnancy (Ornoy, Michailevskaya, Lukashov, Bar-Hamburger, & Harel, 1996). Other factors might be lack of attachment with a caregiver, abuse and emotional and physical violence (Carlson, 1998). Research done by Verhulst, Althaus, & Versluis-den Bieman (1992) showed that maltreatment, violence and movement between foster families or other places increased the likelihood of disturbances of attachment later in life for adopted children. Lastly, instability in parental care seems to have a negative effect on attachment (Roy, Rutter & Pickles, 2004).

Furthermore, a study on adopted children in Norway showed that behavioural problems were more common for adopted children that had been raised in institutions than for adopted children raised in a foster-family, before adoption (Dalen & Rygvold, 1999). Research has in fact linked institutionalization of children to such disturbances as attention hyperactivity disorder and reactive attachment disorder (e.g. Mehlbye, 2005). However, length of stay in an institution seems to matter. For example, a review of 29 studies and other information on children adopted from orphanages in Romania, Russia and China showed that the most consistent indicator of ongoing

[21]http://specialchildren.about.com/gi/dynamic/offsite.htm?site=http://www.showmenews.com/2006/Feb/20060205News025.asp
[22] http://www.isadopt.is/index.php

problems was the length of time spent in orphanage care. Researchers found that children in care a year or longer were at highest risk for cognitive delays and behavioural problems that may lead to academic difficulties (Meese, 2005).

Thus, length seems to matter. Of course, there are also other things to consider, for example the quality of the orphanages. Institutions are not all the same and some are better in quality than others. It may never be assumed that children adopted from institutions will be dealing with difficulties or disturbances. It is good to be aware of the risk factors but it is also necessary to realise, as has been discussed in this paper, that most internationally adopted children do not differ in any negative way from other children. Most of them do well.

However, many have suggested that difficulties found within internationally adopted children may be linked to institutional settings experienced by these children during sensitive developmental periods (Spake, 1998). Children may be malnourished, have diseases, be smaller and lighter than normal children, and display marked developmental delays. They may furthermore show behaviours such as lying quietly in bed without calling or trying to get up, withdrawal from other children, being overactive and distractible, inability to form deep or genuine attachments, being indiscriminately friendly, and difficulty in establishing peer relationships. Institutional settings or orphanage placement has furthermore been shown to put young children at increased risk of serious infectious illness, delayed language development and physical and sexual abuse (in Ames et al., 1997).

What is more, institutions or orphanages have been linked to attachment disorders, especially disinhibited (O'Connor, Rutter & the ERA Study Team, 2000), and defended/coercive atypical (Rutter & the ERA Study Team, 1998), insecure attachments that seem to continue for some years after adoption. Although these children seem to improve immediately and substantially upon adoption they also continue displaying indiscriminate friendliness, poor peer relations, behaviour problems, lower IQ at 41/2 years, poor school readiness, impulsive behaviour, smaller height and weight, more externalizing behaviour problems, frequent social problems, and more frequent need for specialized education (O'Connor, Rutter & the ERA Study Team, 2000).

Thus, in relation to institutional settings or orphanage care, studies have shown that children raised in institutions are at risk for a variety of social and behavioural problems, including disturbances of attachment (Zeanah, 2000). However, O'Connor et al., (2000) have suggested that these undesirable behavioural and mental health outcomes are not primarily a result of

malnutrition, physical and sexual abuse, lack of stimulation, cognitive impairment, and even the lack of reasonable care, but rather stem from the lack of a consistent and responsive caregiver. In my mind it is important to examine better the evidence for that conclusion.

5.3. Consistent and responsive caregiver

Perhaps the most important early study in this regard was Tizard's study of young children placed in residential nurseries in London in the 1960s (Tizard & Rees, 1975). She identified a group of 65 children placed in these nurseries at birth or soon thereafter. Between the ages of 2 and 4 years, 24 of the children were adopted, 15 of the children were returned to their birth families, and another 26 remained institutionalized. When the 26 still institutionalized children were assessed at age 4 years, eight (30.8%) were emotionally withdrawn and unresponsive, displaying unusual social behaviours and no evidence of discriminated attachments. Another 10 (38.4%) children were indiscriminate, approaching and seeking attention from relative strangers as readily as from familiar caregivers. The remaining eight (30.8%) children had managed to develop a preferred attachment to a caregiver at the nursery (Tizard & Rees, 1975).

In this study the basic physical needs of the children were met and they were provided adequate opportunities for social interaction, including interactions with sensitive caregivers and with peers. However, what they lacked was a specific consistent and responsive caregiver. Being deprived of a specific consistent and responsive caregiver then appeared to have affected these children's attachment behaviours. This conclusion is in conjunction with Bowlby's emphasis on selective attachments on the perceived consequences of the failure to develop selective attachments relationships (Bowlby, 1969). The root of long-term mental health is tied directly to early social-emotional development, especially to secure early-attachment relationships (e.g. Ainsworth et al., 1979, Bowlby, 1969). Secure attachment is then considered to be derived from socially-responsive and developmentally appropriate caregiving behaviours that are provided over a certain amount of time by a small number of caregivers. Effective behaviours for example include reciprocal exchange, nurturance, positive attitudes, and appropriate stimulation (Bowlby, 1969). Disturbances in the attachment relationship are then linked to poor mental health consequences and undesirable behavioural outcomes (e.g. Ainsworth et al., 1979). Attachment disturbances are more likely to take place if caregivers are not available and not responsive to the

needs of their children (e.g. Ainsworth et al., 1979, Bowlby, 1969).

Thus, the conclusion of Tizard's study (Tizard & Rees, 1975) is in concurrence with attachment theory, and in that way links the theory with clinical problems in children. As was discussed earlier in this paper, attachment theory is a theory of development; it is not a theory of pathology. Despite that fact, the theory appears to grasp a certain risk factor for an attachment disorder to arise. Attachment theory and Bowlby's ideas about attachment and disturbances in attachment can be linked to the real clinical world. In fact, the first two clusters of children in Tizard's study (Tizard & Rees, 1975) were an important basis for the criteria later used to define two clinical types of RAD, the emotionally withdrawn/inhibited type and the indiscriminately social/disinhibited type, which are described in both the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev. [DSM– IV–TR]; American Psychiatric Association, 2000) and The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines (World Health Organization, 1992).

5.4. The caregiver relationship

Other studies have replicated and extended the findings of Tizard (Tizard & Rees, 1975). For example O'Connor, Bredenkamp, & Rutter (1999) examined a sample of 111 children that had experienced institutional upbringing in Romania, where institutional settings have been very poor in quality, for example in relation to bad nutrition, lack of stimulation, lack of reasonable care, abuse and the lack of a consistent and responsive caregiver. These children were later adopted into the United Kingdom and examined in this study along with a comparison sample of 52 intracountry adopted children not exposed to early deprivation. All children were four years of age at the time of assessment. Information was gathered from a semistructured interview with the parent, questionnaires and direct assessment of the children.

The main results of the study were that attachment disorder was not correlated with previous or current indices of nutritional deprivation. That suggests, as in Tizard & Rees (1975), that deprivation may not play a key causal role. Furthermore, attachment disorder behaviours were observed despite adequate physical care and opportunities for social interactions with peers and care-givers. That is also in accordance with Tizard & Rees (1975). Lastly, cognitive impairment could be ruled out as a central causal variable because it was unrelated to attachment

disorder behaviours (O'Connor, Bredenkamp, & Rutter, 1999). A similar conclusion was indeed reached by Tizard and Rees (1975).

The results strongly indicated that the critical factor for attachment difficulties might be the lack of a consistent and responsive caregiver (or small number of caregivers), or the opportunity for the child to form selective attachments. Nutritional and social deprivations per se appeared not to play a primary causal role. The absence of an opportunity to form selective attachments should in fact be a significant challenge to a young child because, as Bowlby (1977) noted, attachment behaviour "is directed towards one or a few individuals" (p.203). These results are then in conjunction with previous reports and seem to outline some of the consequences of the failure to develop selective attachments relationships (Bowlby, 1969, Rutter, 1981).

On the other hand, the results also showed that all of the children who exhibited attachment disorder behaviours at age four showed relatively immediate signs of impairment at the time of entry to the United Kingdom. It is interesting that a large group of those children displayed indiscriminate approach at entry but displayed no sign of attachment disturbance at age four. It therefore appears that attachment disorder behaviours commonly result from very deprived rearing conditions, but do not persist in a substantial number of children. Recovery is then not only predicted by contact with a sensitive caregiver but also indirectly from the absence of other forms of deprivation. That explanation is consistent with the absence of short-term improvement reported in Romanian children studied by Ames (1997).

Smyke, Dumitrescu, and Zeanah (2002) studied signs of RAD in young children raised in a single, large institution in Bucharest, Romania. They found significantly more signs of both types of RAD in the institutionalized group compared to a never-institutionalized community group attending child care. More importantly, they also found that children from two different units in the same institution demonstrated differences in the frequency with which they showed signs of RAD. On the unit in which the total number of caregivers assigned to each child during one week was reduced from 17 to 4, children had significantly fewer signs of both emotionally withdrawn/inhibited and indiscriminately social/disinhibited RAD. That conclusion obviously supports once more Bowlby's emphasis on one or few caregivers for a child. Zeanah, Smyke, Koga, Carlson & the BEIP Core Group (2005) then studied attachment in another group of Rumanian children that had been living in an institution for the most part of their life. They compared the results for this group to a group of children that had never lived in an institution.

The outcome of the study was in agreement with the former study: the majority of children that had been living in institutions showed serious signs of disturbances in attachment while the children that had never lived in an institution did not show any signs whatsoever. However, as the institutional facilities had been poor one cannot claim that it is the variable "institutionalization" that is the primary reason for this difference. It could also be a question of how the children were nurtured and looked after while living in an institutional environment.

Roy, Rutter & Pickles, (2004) produced a study that shows very clearly the cause and effect relationship. They compared a group of children that had been raised in a foster family with another group of children that had been raised in an English orphanage. All children had been raised in the same place since before their first birthday. The results showed that the greatest difference between the groups seemed to exist because of environmental influences rather then biological influences. For example, social and psychological problems in biological parents were as common in both groups of children. However, lack of attachment towards a caregiver was more common in the group that had been raised in an orphanage. Twenty percent of children raised in the orphanage seemed to lack attachment to a caring adult while all of the children who had been raised in a foster family seemed to have developed an attachment towards their foster parents.

5.5. Poor quality

As in Rumenia, the negative effects of institutionalization have been reported in children adopted from the former Soviet Union. As in many Romenian orphanages, the institutional settings have been very poor in quality. Meeting the basic nutritional needs of children is problematic for many orphanages and according to some adoptive parents travelling to Russia, the orphanages were without heat and/or food during the winter of 1998-99 (McGuinnes & Pallanch, 2000). A human rights Watch report called the orphanages "gulags," citing physical, sexual and confinement abuse (Powell, 1998, in McGuinnes & Pallanch, 2000). The children were maltreated, both physically and mentally; were seriously sick and, in the worst cases, they had been physically and sexually abused (McGuinnes & Pallanch, 2000).

In the light of these reports McGuinnes & Pallanch (2000) studied families of 50 male and 55 female children adopted from the former Soviet Union, including independent republics of

Russia, Ukraine, Latvia, Belarus, Lithuania, Georgia, and the Central Asian Republics. Only children that had been living in their adoptive homes for at least two years were included in the study. Each adopted child was between six and nine years of age at the time of the investigation. Parents answered questionnaires and were interviewed by phone.

The main results of the study showed that length of time spent in an institution was negatively related to competence outcomes. The more time a child had spent in an institution the more likelihood there was for behavioural problems, problems with self-care, problems with socializing, difficulties with communication, including learning to read and write, and delayed development in motor skills. Maternal deprivation and discontinuity of care was particularly experienced by these children, together with a large amount of different caregivers. In this study, length of time in institutional settings was found to be the strongest predictive influence on competence.

However, it is likely that the length per se is not a cause for behavioural problems or other difficulties found in the study. Maternal deprivation and discontinuity of care should, for example, be considered important in this respect. As was mentioned above, institutions and orphanages in the former Soviet Union are not known for their good facilities or satisfactory care of children. Considering the circumstances that the children are likely to be living in, it is rational to assume that the longer a child spends in an orphanage in the former Soviet Union the longer he or she is deprived of maternal care with the likelihood of more subjection to many different caregivers and caregiving approaches. This fact has, without doubt, influenced the development of these children, along with maternal deprivation, the ratio of caregivers and discontinuity of care.

In this study, the experience of abuse and neglect did not have a statistically significant impact on competency scores. Still, that is not surprising in the light of the way in which the information was collected. Many parents did not know whether their children had experienced abuse or neglect and records of abuse or neglect were often incomplete, with information only being made available if the adoptive parents asked the adoption agency. The absence of significance could therefore be a systematic error. There is always the possibility that more children than reported in the study had experienced these things.

5.6. Age at adoption versus quality in care before adoption

Age at adoption has in many studies been associated with poorer mental health (e.g.Verhulst, Althaus, & Versluis-den Bieman, 1990). Howe (1997) studied adjustment problems during childhood and adolescence in adopted young adults through retrospective interviews with their parents. In that study it was possible to separate age at placement and satisfactory or adverse care for the child prior to adoption. He found that it was the quality of the preplacement situation that was important rather than the age at placement in itself. Hoksbergen (1997) also found that the risk of disruption increased if the child had lived in an orphanage before placement and had experienced several moves (In Cederblad et.al., 1999).

Juffer and Rosenboom (1997) then studied attachment in transracially adopted infants who came to their families in Holland before 6 months of age. They found the same rate of securely attached infants (74%) as in normative studies. Marcowitch et al. (1997), on the other hand, found less frequent secure attachment than expected in a group of Romanian children adopted by Canadian families. Age at adoption was much higher than in the previous study (below 6 months to 42 months of age at placement). Those who showed a secure attachment had fewer behavioural problems than insecurely attached children. The results of these studies then indicate that it is either the age at adoption that is a risk factor for attachment problems or, as has been discussed in this paper, the length of time spent in an institution and the experiences the children encounter during that time. Perhaps a study by Cederblad, Höök & Mercke (1999) will better illustrate the probable cause of this relationship.

Cederblad & associates (1999) made a study with regard to internationally adopted children in Sweden. Interestingly, the results showed that the situation before adoption seemed to have more impact than age of arrival in itself. The length of time children had been living in an institution, what they had experienced during that time and what they had been deprived of during that time are the things that seem to matter most. For example, if child had arrived at 1 year of age or earlier and had been 6 months or less in an orphanage/foster home, only 6% showed attachment problems. In the group where a child had arrived after 1 year of age and had been in an orphanage or foster home for more than 6 months, 23% showed attachment problems. In the middle group, where a child had either arrived after 1 year of age or been in an orphanage or foster home for more than 6 months, 11% showed attachment problems. Therefore, as in Howe (1997),

Hoksbergen et al., (1997) and other studies discussed above, the conclusion was that pre-adoption conditions increased the risk of later maladaptation rather than age at placement in itself. The rate of children that were diagnosed with poor attachment increased if a child had been in an orphanage or foster home for a longer time and therefore it can be assumed that preplacement situations that disturb the attachment process explain the association between age at placement and the rate of behaviour problems. (Cederblad et al., 1999).

Thus, we have the results of diverse studies that all highlight one important factor: length of time spent in an institution or an orphanage. That factor is then likely to contain other elements, such as maternal deprivation, discontinuity of care and a large amount of different caregivers. Also, abuse and neglect can be factors that seriously affect children's development. The next step in this paper is to look at two new and interesting studies on internationally adopted children in Iceland and Denmark. It is my hope that they can shed light on the risk factors that have been found to affect the lives of adopted children in these countries, with special attention to attachment. It will be interesting to see if the same factors will be found or whether the situation is somewhat different.

5.7. Studies in Denmark and Iceland

My discussion starts with a Danish study carried out by Mehlbye (2005). Mehlbye examined children internationally adopted from Romania to Denmark in the years 1990 to 2000. The researcher used questionnaires and telephone interviews with parents and other people that were connected to these cases, for example social workers and employees at the adoption agency. All parents that had adopted a child from Rumania in the years 1990 to 2000 were sent questionnaires. Seventy-five percent of the families answered, or 120 families.

As in other studies on Rumanian children discussed earlier in this paper, the children most often had been living in orphanages under bad circumstances before arriving to Denmark. They had, for example, been malnourished, had experienced poor hygiene and lacked emotional contact to an adult. The children were typically adopted when they were between the ages of two and four years. About 65% of the adopted children had some psychological or physical problems when they arrived in Denmark, according to their parents. Forty percent had been dealing with problems of attachment to their parents, and 18% with a considerable attachment problems.

Psychological and physical problems were associated with the child's age at arrival in Denmark. Fifty-six percent of children aged between zero and two years had some physical or psychological problems on arrival, and 68% of children in the ages between three and five years (Mehlbye, 2005).

In this study the children's parents were asked about the situation today as regards the psychological and physical health of their children, who had been adopted in the years 1990 to 2000. According to their testimony 36% of the children were without problems. Thirty-three percent were dealing with psychological problems, 9% with physical problems and 21% with both physical and psychological problems. The most common psychological diagnoses in this group of children were attention-hyperactivity disorder, lowness of spirits, fatal alcohol syndrome, tourette syndrome and post- traumatic stress disorder. Other common problems for this group of children were late development, hyperactivity, poor concentration, poor verbal ability, attachment problems towards parents, siblings and others. Many of the parents stated that their children were easily influenced by other people, had low self-esteem, were frightened of being alone and, finally, were uncritical in their choice of contact with other children and adults (Mehlbye, 2005).

As can be seen, in this group there is a high percentage of children dealing with problems, a considerably higher percentage than in most other studies on adopted children. The reason for this could be of course that the majority of children in the study were not adopted until the ages between two and four years. Age in itself is not necessarily a crucial factor but, as other studies have shown, the experiences the children have had before adoption and the length of time they have undergone these might be crucial. Also, it has to be remembered that these children come from orphanages in Rumania, where they have seriously lacked emotional and physical contact with caregivers and have very likely experienced physical and psychological abuse. Rumanian orphanages are, as has been discussed, not known for their good facilities or for applying the best emotional and physical care. This is something that must be considered.

It is also important at this point to remember what other studies on internationally adopted children in Denmark previously reported in this paper have shown. There we have results that state that the majority of adopted children have adapted well, have good mental health, have been raised in good families and feel as Danish as any other Danish citizen. It is important to remember that most internationally adopted children are healthy and what we are discussing here are the rare exemptions.

In comparison with the Danish study we have an Icelandic study on 109 internationally adopted children carried out by Hermannsdóttir & Oddsdóttir (2006). This is the first Icelandic study that explores how internationally adopted children seem to have adapted in Iceland and it looks at variables such as physical health, emotional health and other important factors that tell us about the status of this group compared with other groups of children. For example, researchers look into the question of whether difficulties after adoption could be linked to a child's experiences before adoption. It also explores the attitudes of the adopted child's parents to the services they have received and other significant factors.

The adopted children in the study do not come from institutions or orphanages in Rumania, so there we have an important factor that distinguishes between the groups of children in the Danish study and this one. The majority of the children came from China and India, the two countries most popular for international adoption in Iceland. The researchers used questionnaires. Forty percent of the families answered, or 109 families (Hermannsdóttir & Oddsdóttir, 2006).

The results of the study showed that 90% of the children were under 18 months of age at arrival and about 90% had been living in an institution in their home country before adoption. Twenty-two percent had been living in an institution for six months or less, 28% for seven to 12 months and 28% for 13 months or longer. In the study parents were asked about their ideas as to the environment their children were living in before adoption. The majority of parents, or 63%, believed that their child had been well taken care of and 37% believed that their child had been merely "OK" or badly taken care of. Forty-four percent of the parents believed that their child had in some ways lacked love and affection where he or she had been living prior to adoption (Hermannsdóttir & Oddsdóttir, 2006).

The most interesting result in my mind is that 80% of the parents stated that only a few days went by after the child's arrival in Iceland until the children started to attach to them. Twenty percent said that it took about one month. Furthermore, the majority of parents, or 94%, claimed that their children were well attached to them a year after arrival in Iceland. This high proportion of parents claiming that their adopted children are well attached to them after a year gives a picture totally different to the studies discussed previously (Hermannsdóttir & Oddsdóttir, 2006).

However, there are things that have to be considered in this perspective. Most of the children in the study come from India or China and were adopted before 18 months of age. They therefore had not been living in an institution for more than that time. In the Danish study above,

the group of children was very different. They had been living in institutional settings in Rumania, which has been linked repeatedly with bad results in physical and emotional development for internationally adopted children. China has also been linked in such a way, with poor care and high mortality rates in some state institutions, especially in the 1980s and the early 1990s. However, after intense international pressure for reform, the situation seems to be changing[23]. For example 94% of the parents in the Icelandic study went to their child's home country to take the child home, and according to their testimony 63% believed that their child had been well taken care of. That is a high percentage of parents in comparison with the Danish study above where the majority of children had experienced poor care, inadequate nutrition, bad hygiene and a lack of emotional contact with an adult before adoption. Furthermore, most of the children had been institutionalized for 2 to 4 years, which is a longer time than in the Icelandic study.

However, another variable could also be affecting the outcome. The parents in the Icelandic study were not asked in detail about being well attached to their children. Perhaps, if they had been asked more questions about this, for example, what kind of behaviours their children were showing or not showing and how their children communicated with them and with others we could have seen just how well attached the children actually were. In my mind it would be interesting to study that aspect in greater detail.

5.8. Difficulties with attachment

I am going to end my discussion about the risk factors for difficulties with attachment and reactive attachment disorder by going into the largest and most comprehensive study of attachment per se until today. My hope is that the conclusions of the study can help us to identify more clearly the most important factors in this perspective and enable us to see what results can arise when a child is deprived of attachment to a caregiver figure.

The study was conducted by Zeanah, Smyke, Koga & Carlson, (2005). They examined attachment in institutionalized and community children aged 12 – 31 months in Bucharest, Romania. The former group was a group of 95 children (Institutionalized Group) who had spent on average 90% of their lives in institutions in Bucharest, Romania. The second was a group of 50

[23] www.en. wikipedia.org

Romanian children who had never been institutionalized and who were recruited from paediatric clinics affiliated with the Institute of Maternal and Child Health in Bucharest. These 50 children served as a never- institutionalized community comparison group (Never Institutionalized Group). The children participating in the study were all considered cognitively capable of forming attachments. They were at least 12 months of age and had a cognitive age of at least 11 months (Zeanah, Smyke, Koga & Carlson, (2005). Attachment was assessed using ratings of attachment behaviours and ratings of caregiver descriptions in a structured interview. The behaviour was assessed by using the Strange situation procedure.

The results showed that Institutionalized children had significantly higher levels of RAD emotionally withdrawn/inhibited ratings than Never Institutionalized children. Institutionalized children also received higher RAD indiscriminately social/disinhibited ratings than children in the Never Institutionalized comparison group. Within the Institutionalized Group, there was no apparent relationship between length of institutionalization and signs of either RAD emotionally withdrawn/inhibited or RAD indiscriminately social/disinhibited. This is interesting because, as has been discussed in this paper, findings have been relating length of institutionalization to signs of RAD (e.g., O'Connor & Rutter, 2000, add more). However, those studies were done on children after they had moved from the institutional settings in which they were living. In this sample, the lack of relationship likely results from the fact that the children are still in the adverse caregiving environment (Zeanah, Smyke, Koga & Carlson, 2005).

Other results of the study were that only 22% of young children in institutions had organized attachment strategies in interactions with their ''favourite'' caregivers, whereas 78% of children living with their parents had organized attachments to their mothers. Fully 12.6% of the institutionalized group had so little attachment behaviour that it could not even be classified disorganized and instead received a designation of unclassifiable. The observed quality of caregiving was related to formation and organization of attachment in children living in institutions. The results held even when other variables, such as cognitive level, perceived competence, and quantitative interaction ratings, were controlled for. In contrast, there was no relationship between caregiving quality and attachment in the community setting (Zeanah, Smyke, Koga & Carlson, 2005).

Thus, most institutionalized children had failed to organize an attachment to a caregiver. Even when the children had apparent attachment patterns, the patterns appeared to be unusual or incompletely developed. The continuous ratings of attachment behaviours in the Strange Situation Procedure in the institutionalized children indicate a lack of fullness compared with the attachment behaviours of young children living with their families. The institutionalized children that were studied were in a constant state of deprivation in which the amount and quality of contact that they received was unlikely to change significantly, which is different from the situation of having been adopted from institutions, being released from the predicament, and gaining the possibility of building a relationship with a new caregiver. If these children were to be adopted one could anticipate that behaviours would become more robust over time and would change for the better.

The importance of quality caregiving for young children in extreme conditions of social deprivation is, however, clear. In institutional settings, a positive relationship with a caregiver does not always seem to be happening. It is of course possible, but if not, it appears to enhance the probability of formation of diverse developmental problems and less organized attachment styles. However, it has certainly to be considered that in this study the participants were Rumanian children, living in Romanian institutions. These institutions are characterized for the most part by their particularly poor caregiver to child ratios and may not be representative of some institutions in other countries.

In my mind, this study clearly brings to light how important it is for children to become attached to a caregiver. RAD in internationally adopted children is significantly related to having been deprived of attachment-building to an adult. The relation even held when other variables such as cognitive level, perceived competence, and quantitative interaction ratings, were controlled for. The result therefore strongly supports what other studies discussed in this chapter have been showing and what Bowlby and attachment theory emphasise: building attachment with one caregiver or few is a critical issue for the emotional development of children. One of the most important protective factors for healthy development appears to be a positive relationship with a competent adult.

Furthermore, as was discussed earlier, resilience is a common and normal human characteristic and studies have shown that a relationship with caring prosocial adults is strongly associated with competence in children's development (Werner, 1993). Resilience is therefore a factor that one should be aware of. As was discussed before in this paper, resilience is also,

interestingly, strongly linked to the relationship with a competent, caring, prosocial adult. In that way attachment to a caring adult appears to be a strong protecting factor for children's development. An influential factor that even protects children raised in extremely harsh environments. That finding in my mind indicates strongly that caregivers and the attachment relationships that develop between caregivers and children are fundamental to children's development.

5.9. Discussion

Thus, creating attachment appears to be a strong protecting factor in relation to maltreated children and their psychological and physical development in life. Institution then by itself or maltreatment is not necessarily a risk factor for problems to arise. It depends on other factors such as whether a child has been able to become attached to a caring adult despite difficult circumstances. It is also interesting that the main risk factor that has been found for developmental delays and behavioural problems for internationally adopted children actually appears to be the lack of a consistent and responsive caregiver. The variable "attachment to a caregiver" then seems to be strongly related to the issue, and furthermore has been linked to attachment problems and reactive attachment disorder.

There is therefore strong evidence in my mind that insecure attachment is an important risk factor for later developmental problems, including RAD. In the light of this it becomes important to find ways to help children that are or have been deprived of adequate caregiving, for example find out about what can be done in the institutions where children are living to help them to gain better emotional and physical health. Also, what can be done to help adoptive parents? What, according to the research, is beneficial? What appears to be the best intervention for adoptive parents and their children in establishing a close relationship and avoiding behavioural and developmental difficulties? I will endeavour to answer these and further questions in the next and final chapter of this paper.

6. Intervention

6.1. Improvements in early care in institutions

As has been discussed in this paper, previous studies have documented the potential harmful effects of inadequate institutional care, particularly when it is prolonged. What has been less well established is whether improvement in institutional care can be made via the systematic training of staff and the addition of resources, and, if so, how this could be accomplished. Furthermore, an investigation has not yet been made as to whether intervention can significantly improve a child's social-emotional and cognitive outcomes. In my mind these are important issues because many children are spending long periods of their young lives in institutional settings. As lack of adequate caregiving and attachment to a consistent and responsive caregiver has been connected to harmful consequences, it is important to ascertain whether the use of certain intervention methods in orphanages can ameliorate the situation. An investigation must be made to enable the quality of life for children in orphanages to be improved, despite institutional settings.

Furthermore, as has been discussed in this paper, traditional attachment theory states that caregiver qualities such as: environmental stability; parental sensitivity and responsiveness to children's physical and emotional needs; consistency; and a safe and predictable environment support the development of healthy attachment. Thus, not only from a clinical perspective but also from a theoretical perspective, improving the positive caregiver and environmental qualities should be an important element in the creation of attachment between child and caregiver, which will then hopefully affect the child's development in positive ways.

Not many studies have investigated this subject. However, there are three rather interesting studies on the matter that I will discuss, and hopefully the results of those studies can tell us more about the effect of intervention methods in orphanages. The first study that I will discuss was conducted in the years 1991 to 1994, by a group of Romanian and American colleagues (Sparling, Dragomir, Ramey & Florescu, 2005). They undertook an experimental and humanitarian effort to try to improve the quality of life, mental health, and developmental progress of 169 young children in a Romanian orphanage. The participants in the study resided in an orphanage in Iasi, Romania. The children in the study ranged from birth to 3 years of age and were divided into

control groups and experimental groups. No intervention was applied to the children in control groups. The intervention used in the studies was adapted from an intervention in childcare centers in the United States that had been proven effective in reducing intellectual decline in at-risk children. The adapted intervention included staff training, caregiving/intervention protocol, educational games and supervision. Staff-child ratio was furthermore set to one caregiver per four children, for a significant portion of the day

The results of the study are promising. The video-data revealed clear intervention – control group differences in relation to language development. Furthermore, additional training and supervision of the caregivers and the improved staff-child ratios in the experimental groups appeared to be a source of observable staff behaviour changes. The staff was more active, engaging with the children, playing and demonstrating interest towards the children. In most cases in the study, children treated with an educational intervention progressed about one developmental month per month of treatment while children in the control groups showed rates of development that were one fourth to two thirds this rate. However, the study also revealed that on average younger children benefited more from the intervention than older children. The older children had, as a rule, resided longer in the orphanage environment which could be affecting the result. As has been already discussed this can be a risk factor for physical and mental development in children, and could also be a factor affecting the response of older children to intervention. As the authors note, "birth is the only safe time to begin intervention" (p.141, Sparling, Dragomir, Ramey & Florescu, 2005).

The researchers furthermore decided to look at extreme cases in the experimental groups, in an effort to see more clearly what it is that typifies the children that seemed to gain the most from the intervention and the children that seemed to gain the least. The results of that investigation showed that the two extreme groups of four children were different in many ways before the intervention started. Despite the same chronological age, the children that gained the least developmentally were further behind in the beginning of the intervention. There was a developmental difference of at least 6 months. Health and physical growth was also different between the groups. Of the two low-change children, 2 were identified as HIV positive, and each of these had more than 40 days of illness during the intervention period. The other two in that group were very small for their age. On the other hand, of the high-change children, 2 had late admissions to the orphanage, resulting in a shorter total stay in the institutional setting. What is

more all of them had stable caregivers with whom minimal turnover or reassignment occurred, and two of them were described as "favourites" of the staff (Sparling, Dragomir, Ramey & Florescu, 2005).

In my mind the results of this study are very interesting. It shows that an effective intervention can be carried out in a residential institution for young children. Furthermore, the results indicate that an intervention like this can have a positive effect on the quality of life of these children by trying to support the establishment of normal development. However, the results also suggest that not all children are equally affected by this kind of intervention. The younger a child is, the shorter time it has been living in an institution and been connected to a stable caregiver, and these seem to be important factors. All this makes it imperative to start early on with children living in orphanages, in order to produce an even stronger positive affect on their lives.

Another study was done by Taneja, Aggarwal, Beri & Puliyel (2002) on all 30 children living in an orphanage in India, aged between 6 months and 2 ½ years. An intervention programme of structured play was implemented to stimulate the children. It was the hope of the researchers that the intervention would affect the psychosocial development in these otherwise healthy children.

The main results of the study showed that at the end of 3 months of the programme the motor, mental and social scores of the children had improved significantly. There was also an overall change in the atmosphere of the orphanage. The children were more playful, responsive and independent. Furthermore, contrary to what the caregivers had assumed, their workload decreased. The responsiveness in the children appears to have been awakened as a result of play, and this responsiveness acted as a positive feedback for caregivers to continue the play sessions. The results therefore show that even short daily sessions of play can significantly improve the development of children in institutional settings (Taneja, Aggarwal, Beri & Puliyel, 2002).

However, the children's development and the status of the programme was also reassessed one year later by the researchers. That investigation revealed sadly that the enthusiasm of the caregivers seemed to have waned over the year the programme was entrusted to them. The involvement of the caregivers had decreased gradually and they slowly returned to their previous mechanical routine of cleaning and feeding the children. What is more, there was a visible decline in the development of the children in the absence of the play programme. Because of this

observed difference, a full-time dedicated child development specialist was hired as a play therapist to revive the play programme in an effort to change things for the better in the orphanage (Taneja, Aggarwal, Beri, Puliyel, 2005).

Three monthly assessments were then done after the therapist had joined the project. The results interestingly showed that the children's motor and mental scores changed significantly and in positive ways within three months of restarting the programme (Taneja, Aggarwal, Beri, Puliyel, 2005). The results therefore indicate that this kind of intervention can accelerate the motor and mental development of children in orphanages. However, it seems to require a highly motivated and dedicated person to sustain the programme over long periods of time. As the results of the above study show, the benefits are to my mind very promising. They verify that an effective intervention can be carried out in a residential institution for young children. Furthermore, the results indicate that an intervention can have a positive effect on the motor and mental development of children living in orphanages. However, it seems to need a full-time motivated therapist joining the program.

Finally, the third study was done by the researchers Groark, Muhamedrahimov, Palmov, Nikiforova & Mccall (2005), on new-born to 4-year old children in an orphanage in Russia. In the study they attempted to promote positive social-emotional relationships and attachment between caregivers and children in orphanages in St. Petersburg, Russia. The children who live in these orphanages are usually between birth and 48 months of age, and about 50% of them have been diagnosed with disabilities. Approximately 60% of children living in these orphanages leave through foreign adoptions. In the beginning of the study, the orphanage caregivers showed a high level of anxiety and depression and were detached from the children, communicating little. Furthermore, throughout baseline observations, the children showed poor attachment behaviours, such as indiscriminate friendliness, aggression and impulsive behaviour. Two interventions were then carried out in the study. Firstly, a training of caregivers to provide warm, responsive caregiving and secondly, a staffing and structural alteration to support relationship building, especially increasing the consistency of caregivers. The orphanage used in the study displayed a reasonable environment in terms of cleanliness, toys, nutrition, and medical care.

The results showed that the interventions appeared to have been implemented successfully. For example after intervention caregivers were found to talk with all the children regardless of their age or disability. They also smiled and seemed to be especially enthusiastic when talking

with pride about the success of their children. They seemed to respond to their children's needs and set limits to their behaviour in a firm but kind manner. Toileting and diaper changing were used as opportunities for interaction by the caregivers towards the children. The children furthermore appeared to be happy, spirited and enthused. There were also fewer aggressive interactions with peers and more obvious signs of affection shown towards caregivers than before. The children appeared to want social interactions with caregivers, such as being picked up or having a two-way conversation. What is more, the older children responded more appropriately to strangers, with eye-contact and wariness. They engaged them appropriately without the indiscriminate friendliness of the past (Groark, Muhamedrahimov, Palmov, Nikiforova & Mccall, 2005).

In this study one of the important changes was the creation of a smaller and more stable set of caregivers for each child. Studies have shown that children in orphanages in Russia have been known to have had approximately 60 to 100 caregivers during the first two years of their life (Muhamedrahimov, Palmov, Nikiforuva, Groark, & McCall, 2005). That is of course a considerable amount of caregivers. As has been discussed in this paper, the lack of a consistent caregiver has been linked to negative outcomes in a child's development. Furthermore, from studies on the subject it has been assumed that a child needs stability and consistency of one or few caregivers, not many. In light of this it should not be surprising that the effects of institutionalization in Russia seem to be harmful for the children. In this inconsistent environment, with a lack of stimulation and affection, and a very high ratio of caregivers it is no wonder that the children have issues. It is also no wonder that intervention, as described above, can have dramatic affects on children's physical, mental and emotional development. Interestingly, the interventions also appear to have affected the caregivers' behaviour and attitudes. After intervention they had less traditional attitudes toward children, and less anxiety and depression (Groark, Muhamedrahimov, Palmov, Nikiforova & Mccall, 2005).

In my mind these early findings indicate that training can increase socially responsive caregiving behaviour in staff and improve the social interactions of the children. It is possible to change the social environment for children living in closed institutions and to provide more familial conditions. What is more, both caregivers and children seem to have benefited. Hopefully, we will see more studies of interventions carried out in institutions or orphanages in the future which can help us establish just what it is that brings about such a positive change in

children's development and mental health. An institution does not have to be a damaging place to live in. Things can be changed for the better.

6.2. Help for adoptive parents

Now we have discussed how intervention can change things for the better in orphanages. Studies have shown that, for example, training staff, supporting relationship-building, and establishing more play-time for children in orphanages can significantly affect their development in positive ways. The next question in my mind is: Can similar methods be used to help adoptive parents to become attached to their children so as to affect their children's development in positive ways?

Because attachment patterns develop within relationships, correcting attachment problems should, to my mind, require close attention to improving the stability and quality of the parent-child relationship. In fact, in a review of more than 70 studies of interventions designed to improve early childhood attachment, increased parental sensitivity was the most effective intervention in improving children's attachment security (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2003). In these types of interventions the focus was first and foremost on parental-child relationship and teaching positive parenting skills rather than on the individual child's pathology.

What is more, Bakermans-Kranenburg, Ijzendoorn, & Juffer, (2005) did a narrative review and quantitative meta-analysis of 15 preventive interventions in attachment disorganization. The results showed that the effective interventions started after 6 months of the child's age and were focused on sensitivity only. Interventions that also focused on support and a parent's mental representations were a lot less affective. The study then showed that disorganized attachment can change as a side effect of sensitivity-focused interventions.

Juffer, Bakermans-Kranenburg & van IJzendoorn (2005) furthermore conducted a randomized intervention study involving 130 families with 6-month-old adopted infants from Sri Lanka, South-Korea and Colombia. Two attachment-based intervention programmes were tested. In the first program, mothers were provided with a personal book and written information focusing on sensitive parenting and playful interactions. In the second programme, the mothers were provided with a personal book and three sessions of video feedback. The intervener showed the mother a video recording of herself interacting with the child, and commented on selected

fragments of the film. This intervention was implemented in two home visits at 6 months and 9 months. The intervener, in her comments, focused upon sensitive responsiveness, providing security by reacting sensitively to the child's attachment behaviour, and also offering a chance for the child's exploration behaviour. The third group did not receive any intervention (control group).

The results of this study revealed that the intervention with video-feedback and the personal book resulted in enhanced maternal sensitive responsiveness. The intervention affected in positive ways maternal sensitive responsiveness and infant attachment. These infants were significantly more often securely attached than the infants in the control group. In the group where the intervention was simply a personal book and in the control group, attachment security in infants did not increase during the intervention period. Furthermore, children of mothers who received this intervention were less likely to be classified as disorganized attached at the age of 12 months, and received lower scores on the rating scale for disorganized attached at the age of 12 months. In the book-only intervention group children showed lower disorganization ratings compared to the control group, but no effect on the number of infants with disorganized attachment classifications was found (Juffer, Bakermans-Kranenburg & van IJzendoorn, 2005).

This short-term preventive intervention in my mind verifies the importance of the caregiver relationship, the importance of sensitive responsiveness in relation to the development of attachment between a caregiver and a child. The use of video-feedback and the observed effect of this I also find interesting. It appears to help the intervener to focus the parent's attention on the child's actual behaviour and to coach parents in observing their child's behaviours in more accurate ways. Furthermore, by illustrating and repeating video fragments of the parent's sensitive behaviours the intervener can reinforce and encourage satisfactory response to the child's signals. In this way parents can learn to concentrate better on their child's behaviour, retain focus and be attentive to their child's needs in more constructive ways. Lastly, this study provides evidence that attachment disorganization may be influenced by nurture processes or environmental factors. Disorganization appears to have been decreased in children because of parental interventions. That is an interesting and positive result.

However, video-feedback is of course not the only effective treatment programme that has been studied. An interesting study on late-adopted and former institutionalized 5 year-old twins, for example, investigated the effects of Theraplay on increasing attachment and decreasing

problem behaviours (Mahan, 2001). The results of the study were positive. By intervening Theraplay, a short-term therapeutic approach that utilizes elements of play therapy and is designed to help parents and children build better attachment relationships through attachment-based play, the twins' attachment increased, and their problem behaviours decreased. While Theraplay needs further study, the findings suggest that Theraplay, can be an effective intervention with former institutionalized children that need to strengthen their attachment relationships. Interestingly, Theraplay is built on attachment theory and John Bowlby's theorisations on attachment[24]. The results of the study are furthermore in accordance with the studies discussed above conducted in orphanages. There, play between a caregiver and a child seemed to be an important ingredient in the positive effects of intervention.

Furthermore, in connection with the results of this study, a review of more than 70 studies of interventions designed to improve early childhood attachments showed that the interventions that most increased parental sensitivity were also the most effective in improving children's attachment security (Bakermans-Kranenburg, van Ijezendoorn, & Juffer, 2003). In these studies the focus was primarily on the parent-child relationship and teaching positive parental skills rather than on the individual's child's pathology. The results of the studies discussed in this chapter are, interestingly, in conjunction with the result of the meta-analysis. When the focus is on the caregiver-child or parent-child relationship the interventions seem to be working better.

Also in the same meta-analytic review by Bakermans-Kranenburg et al., (2003) some common characteristics were identified among more successful approaches, and shorter term, more focused, and goal-directed interventions were the main ingredients that yielded better results than broadly focused, longer term interventions. This was even true irrespective of the level of problems in the family, and regardless of whether the program was delivered to prevention or intervention populations. Interestingly, the interventions discussed above were both short-term and in my mind well focused. This is then also in accord with the review by Bakermans-Kranenburg et al., (2003) and shows furthermore that short-term interventions can be very affective. It is not necessary therefore to use an intervention that takes many months or years to bring about an increase in attachment and decrease in problematic behaviours.

[24] www.wikipedia.org

In the same review, other factors such as maintaining focus, being goal-directed, and using behavioural approach seemed to increase sensitive parental behaviours. In fact, a large number of these characteristics are the same characteristics that have been identified in many effective child interventions, such as parent skills training and behavioural focus (Patterson, Reid, & Eddy, 2002).

6.3. Discussion

Thus, interventions can indeed significantly improve children's development. Quality of life for children can be improved, and this can be seen in orphanages. Furthermore, the fact that intervention - first and foremost intended to strengthen the caregiver-child relationship - shows a positive result even in orphanages is a strong support for classical attachment theory. Methods focused on improving social interactions, more caregiving behaviour and sensitive responsiveness are the ones that seem to be the most successful. A calm, sensitive and nurturing approach toward children, where close attention is given to improving the stability and quality of the caregiver-child relationship and interaction, shows a positive result. This positive effect is in accordance with attachment theory, Bowlby's emphasis on maternal bonding to infant, and disorders of attachment. In 1951, John Bowlby laid great emphasis on the subject of attachment between caregiver and infant, and today we appear to have substantial evidence for the claim that children need more than just food to survive. The results of studies on children in orphanages and adopted children discussed in this paper are, in my mind, convincing verification of traditional attachment theory. Hopefully, we will see a lot more research on the subject. We need more research on different attachment therapies in an effort to see more clearly what it is that really helps children and their parents to bond with each other. In my mind efficacious services for children should be built on strong theoretical and evidential grounds. To achieve that goal we need to look at what the results of studies seem to be telling us and of course we should try to uphold information-sharing between professionals and researchers in the area. If the caregiver-child relationship is as important as studies have been indicating we have to take notice of it. If children's emotional development is so strongly associated to becoming attached or not becoming attached to one or few caregivers, as studies discussed in this paper indicate, we have to pay attention to those results. Children's lives are at risk. It is just that simple.

7. Conclusion

Then main question I wanted to find an answer to in this paper was whether the lack of selective attachment or the lack of a strong relationship with a responsive caregiver could be considered to be the primary cause for disturbances in attachment in internationally adopted children. In trying to find the answer to that question I then discussed early theories of attachment and reviewed numerous studies carried out on the subject the last four decades or so. In my mind, the findings of this investigation indicate that internationally adopted children that have been lacking a consistent and responsive caregiver, children that have not formed strong attachment to one or few caregivers, are in great danger of having to deal with disturbances in attachment and related difficulties. Studies have repeatedly shown that this factor is linked to negative development in internationally adopted children. Indeed there are other factors that have also been connected to developmental problems, negative behaviour and poor mental health, for example the length of stay in institutions or orphanages, and maltreatment. However, those and other factors also seem to be strongly connected to the fact that during the time of stay in an institution a substantial number of children do not develop selective attachment towards one or few caregivers. Even in institutions where the basic physical needs of children are met and they have been provided with adequate opportunities for social interaction, including interaction with sensitive caregivers and peers, they display unusual social behaviours, are emotionally withdrawn and show no evidence of discriminated attachments. What these children seem to have lacked, however, is the development of a relationship with a specific consistent and responsive caregiver. Being deprived of this relationship therefore appears to affect children's development in negative ways, and in my mind signifies the importance of selective attachment. The lack of selective attachment indeed appears to be the main causal factor for disturbances in attachment and behavioural and mental problems related to this.

That conclusion is furthermore in accordance with Bowlby's emphasis on selective attachments or perceived consequences of the failure to develop selective attachment relationships. According to Bowlby, long-term mental health is directly connected to early social-emotional development, especially to secure early-attachment relationships. Furthermore, as has been discussed in this paper, secure attachment has been connected to socially-responsive and developmentally appropriate caregiving behaviours that are provided over a certain amount of

time by a small number of caregivers. Disturbances in the attachment relationship are however connected to poor mental health consequences and undesirable behavioural outcomes. Therefore, disturbances in attachment should indeed be more likely to take place where caregivers are not available or unresponsive to the needs of children. In my mind, that is exactly what we see happening with internationally adopted children, especially those that have been living in institutions or orphanages. Even though they have been provided with adequate social interactions with caregivers and peers and have had their physical needs fulfilled, they still show negative signs in development. What they seem to have lacked is, plainly and simply, love and affection from one or few caregivers. They have not developed selective attachment. Furthermore, what seems to help these children the most, both by intervening while they are still living in orphanages and after they have been adopted, are methods that focus on improving the child-caregiver relationship, methods that take a calm, sensitive and nurturing approach toward children, and where close attention is given to strengthening the caregiver-child relationship and caregiver-child interactions. Interestingly, as discussed above, using those kinds of methods is in accordance with attachment theory.

Thus, in my mind we have strong support for the notion that the lack of selective attachment or the lack of a strong relationship with a responsive caregiver should be considered to be the primary cause for disturbances in attachment in internationally adopted children. If the rhesus monkeys of Harry Harlow needed love in order to thrive it follows that children must likewise receive love in order to develop properly.

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