

**RESILIENCE IN ADOLESCENTS ADOPTED
FROM ROMANIAN ORPHANAGES:
A MULTIPLE CASE STUDY ANALYSIS**

by
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ABSTRACT

This study describes resilience (and non-resilience) processes in nine adolescents adopted between 9.5 and 24 months of age from Romanian orphanages between 1990 and 1991. The study was carried out using a qualitative case study methodology incorporating data from assessments at four time periods—at 11 months post-adoption, age 4.5, age 10.5, and age 16.5. The data were analyzed using a code and sort procedure similar to the one described by Bogdan and Biklen (1992). Case studies regarding the participants' pathways to resilience (or non-resilience) were categorized according to the ecological framework (Ungar, Lee, Callaghan, & Boothroyd, 2005; Ungar & the International Resilience Project Team, 2006) that guides this study. This framework includes: Individual factors, Relationships factors, Community contexts, Cultural factors, and Physical ecology factors. Findings indicate that participants' pathways to resilience were influenced by: (1) Individual factors, including pro-social character traits (e.g., being caring, thoughtful, and sensitive to others' feelings), positive self-esteem, and a sense of 'well-roundedness' that manifested itself in a variety of interests including academic, athletic, musical, and social pursuits; (2) Relationship factors, including early positive attachments with adoptive parents, consistent caregiving by stay-at-home parents in the early childhood years, family structure whereby participants received a lot of individual attention, low levels of parenting stress, and positive peer relationships; (3) Community factors, including services that met the families' needs, part-time employment opportunities that fostered a sense of responsibility and confidence in one's abilities, and positive school environments whereby individual needs were met; and (4) Cultural factors, including a sense of 'ease' with adoption history, and religious affiliation. Relationship factors seemed to be the most important influence in the participants' pathways to resilience; and physical ecology factors the least important. Individual variation was considered throughout the analyses in order to not lose sight of the complexity of resilience processes.

This dissertation is dedicated to the children, parents, and teachers who kindly agreed to participate in the Romanian Adoption project and contribute to our understandings of child development and resilience processes.

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INTRODUCTION

Within the field of psychology there has long been interest in discerning how children's early experiences affect their later development. This is understandable given the established links between poor adult outcomes and childhood experiences. For example, children of alcoholic parents are more likely to abuse alcohol themselves (Merline, Jager, & Schulenberg, 2008), poverty often begets poverty (McLeod & Shanahan, 1996), and poor parent-child relationships tend to lead to a pattern of conflicted relationships (An & Cooney, 2006). Researchers know a great deal about these typical paths—those that begin with adversity and end up with detrimental and undesirable outcomes. Much less is known about the more atypical path—the path of children who in the face of adversity seem to develop into well-functioning adolescents and/or adults (Schonert-Reichl, 2008). These individuals seem to thrive despite the odds stacked against them. They demonstrate 'resilience'—a dynamic process that leads to positive adaptation, even in the context of adversity (Luthar, 2003).

The present study examines processes of resilience in a group of children adopted from Romanian orphanages into Canadian families. These children experienced severe deprivation in these institutions prior to their adoptions. A multiple case study analysis approach is utilized which best captures the unique differences and varying developmental pathways demonstrated by these children.

History of Resilience

Compared to the long-standing emphasis on psychopathology and poor outcomes in psychological research, interest in resilience is a relatively recent phenomenon, dating back less than 50 years.

Since the late 1960s, researchers interested in children who develop well in the context of significant adversity have attempted to clarify the processes that result in healthy development, and to inform preventive interventions and policies that could enhance the lives of vulnerable children, families, and communities (Cicchetti & Garmezy, 1993). Although it is difficult to identify exactly when the upsurge in resilience research began, Rutter (1990) identifies several key research initiatives that likely played important roles. First, there was consistency in findings that there was marked variation in the outcomes of children raised by mentally ill parents (i.e., some children seemed relatively unaffected by this adverse rearing environment) (Rutter, 1966). Second, temperament research led by Thomas and Chess (1977) demonstrated that children's behavioural styles influenced their responses to stressful situations. Third, Lazarus and Folkman's (1984) concept of 'coping with stress' concentrated on the adaptations necessary for responding to a personal crisis. Accordingly, researchers gradually shifted their focus from 'risk variables' to the process of 'negotiating risk situations' (Rutter, 1990). It is in that context that attention shifted to protective mechanisms.

A pervasive curiosity remains in the 21st Century regarding what makes an individual survive and even thrive, while another succumbs to life's challenges. This is demonstrated by the unwavering popularity of literary accounts of resilience in lives

lived—Anne Frank’s (1952) *Diary of a Young Girl* or, more recently, Frank McCourt’s (1996) Pulitzer prize-winning novel *Angela’s Ashes* (Ungar, 2004a). In addition, recent large-scale global research projects, such as the International Resilience Project (Ungar & the International Resilience Project Team, 2006) have set out to elucidate potential factors inherent in resilience across cultures. Simultaneously, educators strive to promote ‘resilience-building’ in schools (Doll, Zucker, & Brchm, 2004; Thomsen, 2002; Waxman, Padron, & Gray, 2004), and policy-makers focus on investing in families and communities in an effort to foster resilience (Matten, Schellenbach, Leadbeater, & Solarz, 2004).

It is not surprising that the phenomenon of resilience has captured the attention of both researchers and practitioners alike. Wang and Haertel (1995) argue that resilience is an emerging psychological construct that provides a conceptual base for an intervention that calls for responsive familial, school, and community environments. In other words, the study of resilience is a hopeful endeavour; it inspires efforts to improve challenging life circumstances based upon the lived experiences of others (Masten, Best, & Garmezy, 1990).

Defining Resilience

The concept of resilience has strong intuitive appeal. When we see someone conquer a strongly negative circumstance, it is not uncommon to feel that something special or intrinsic to that person was responsible. This type of determinative model is pervasive in the way we view events, even those involving non-sentient organisms. If one tree in a grove resists a wind storm, we attribute a quality of strength to the tree.

Therefore, the concept of resilience is present in almost all explanatory models of behaviour, ranging from the biological to the social (Glantz & Sloboda, 1999). However:

while the stresses and the qualities that determine the endurance of an inanimate object are often tangible, consensually agreed on, fairly constant over time and circumstances and probably measurable, the same is rarely true in attempts to understand human behaviour. (p. 110)

Herein lies some of the difficulty in defining the concept of resilience.

In reviewing the literature on resilience, it is evident that there is a large degree of variability in how the concept is defined. Some definitions have focused exclusively on individual traits. This is evident in Cohler's (1987) comments about the nature of resilience; he argues that it is primarily the personal characteristics of children that enable them to cope with adversity (i.e., parents with mental illness):

In sum, the children of psychiatrically ill parents who are better able to cope with the adversity of unreliable and often emotionally inaccessible caretakers have innate ego-strength, creative abilities, and increased personal and physical attractiveness; these traits enable these children to continue to reach out to others for support. (p. 395)

Schonert-Reichl (2008) discusses how other descriptions of resilience have focused on invulnerability, or a sense that some children seemed to be "untouched" by the adverse life events they encounter. However, she goes on to describe how research advancements in the field of resilience have demonstrated that few children exhibit such complete immunity in the presence of stressors. Most children are distressed by adversity in some way, but not all become 'disordered' or 'incapacitated' by it. In other words, resilience is not an all-or-none phenomenon.

Other researchers acknowledge that resilience is not only related to internal characteristics (e.g., self-confidence and an optimistic outlook) but also to external

supports in the environment (e.g., a significant relationship with a supportive adult; community involvement) (Donnon, Charles, & Hammond, 2003). Furthermore, it is recognized that these factors do not operate in isolation, but instead interact with one another to help individuals avoid negative consequences. In this way, resilience can be thought of as a 'process' or 'fit' between an individual's capacity to cope, the risks he/she faces, and the context in which adaptation take place . Ungar (2004b and, with the International Resilience Project Team, 2006) incorporates these ideas in his comprehensive definition of resilience:

Resilience is both an individual's capacity to navigate to health-promoting resources and a condition of the individual's family, community, and culture to provide those resources in meaningful ways. (Ungar, 2008, p. 5)

Viewed this way, Ungar (2004b and, with the International Resilience Project Team, 2006) argues that individuals who experience adversity adapt and thrive to the extent that their environments provide them with what they need. In other words, a person is resilient only to the extent that he/she finds among his family, community, and culture, the resources he/she needs to experience positive growth or outcomes. Thus, taking a multi-dimensional perspective in conceptualizing resilience is important.

An Ecological Model of Resilience

From a multi-dimensional perspective, resilience is related to a constellation of factors including: (a) individual factors, (b) relationship factors, c) community contexts, d) cultural factors, and e) physical ecology factors. These five aspects together create an 'ecological model' within which to consider resilience in youth. Ungar (2008) outlines the resilience factors in this model as follows.

Individual Resilience Factors

Individual resilience factors refer to an individual's personal traits and resources that allow them to navigate under stress to well-being. These individual traits include, but are not limited to, such characteristics as: assertiveness; the ability to solve problems; self-efficacy; being able to live with uncertainty; self-awareness; perceived social support; positive outlook; having empathy for others; having goals and aspirations; showing a balance between independence and dependence on others; the appropriate use of, or abstinence from, substances like alcohol and drugs; a sense of humour, and a sense of duty (to others or self, depending on the culture).

Relationships Resilience Factors

Relationships resilience factors include, but are not limited to, parenting that meets the child's needs, appropriate emotional expression and parental monitoring within the family; social competence; presence of positive mentors and role models; meaningful relationships with others at school and home; perceived social support; and peer group acceptance.

Community Resilience Factors

Community resilience factors include, but are not limited to, opportunities for age-appropriate work; avoidance of exposure to violence in one's family, community, and among peers; government provisions for the safety of youth; recreation, housing, and job opportunities; meaningful rights of passage with appropriate amounts of risk; tolerance of high-risk and problem behaviour; safety and security; perceived social equity; and access to school and education, information, and learning resources.

Cultural Resilience Factors

Cultural resilience factors include, but are not limited to, affiliation with a religious organization; tolerance of differing ideologies and beliefs; adequate management of cultural dislocation and changes or shifts in values; self-betterment; having a life philosophy; cultural and/or spiritual identification; and being culturally grounded by knowing where you come from and being part of a cultural tradition that is expressed through daily activities.

Physical Ecology Resilience Factors

Physical ecology resilience factors include access to a healthy environment, security in one's community, and access to recreational spaces, sustainable resources, and ecological diversity.

In the present study resilience is conceptualized from such an ecological perspective. Viewed in this process-oriented way, salient developmental factors are also taken into account. Schonert-Reichl (2008) describes how children and adolescents might have different vulnerabilities and protective systems during different developmental phases. For example, during the earliest stage of development, because of the total dependence on caregivers, infants are highly vulnerable to the consequences of mistreatment by caregivers. Furthermore, as children grow and move beyond the family into the larger arenas of school and community, they are exposed to a wider range of potential risk factors (e.g., negative peer influences) and potential protective factors (e.g., 'mentoring' teachers). Resilience should therefore not be considered a 'fixed' or 'static' phenomenon—children and adolescents may be quite resilient to specific adversities, but vulnerable to others. For example, a child of alcoholic parent(s) may demonstrate high

levels of adaptation at home, as evidenced by taking care of younger siblings, making meals, and shopping for the family's needs. However, at school this same child may struggle with peer relationships and failing grades.

On a related note, it is important to re-emphasize that individuals can only be considered resilient if they have experienced adversity of some kind. Ungar (2008) discusses how the concept of resilience is often confused in the literature. A common reason for this is that 'developmental strengths' and resilience factors are often used interchangeably when they mean slightly different things: "When we talk about strengths we are referring to a population wide roster of internal and external assets" (p. 2). Research shows that in general, the more strengths or assets children have during their growing-up years, the more likely they are to succeed in adulthood in culturally approved ways. For example, work by the Search Institute (2007) describes 40 developmental assets that group under eight categories. These include external assets such as: Support (e.g., family support, caring neighbourhood); empowerment (e.g., community values youth, service to others); boundaries and expectations (e.g., family boundaries, school boundaries); constructive use of time (e.g., involvement in youth programs, creative activities); and internal assets such as: Commitment to learning (e.g., achievement motivation, school engagement); positive values (e.g., responsibility, equality and social justice); social competencies (e.g., interpersonal competence, cultural competence); and positive identity (e.g., self-esteem, optimism about personal future). Many of these assets overlap with the resilience factors described above in the ecological model. The difference is the condition of adversity. While many children from stable, well-resourced, non-violent homes enjoy the external assets of a supportive home and school

environment, and the internal asset of positive self-esteem, we would only say they have 'developmental strengths', not resilience. The adversities they face are minimal.

Ungar (2008) stresses that none of this takes away the importance of service providers implementing population-wide prevention strategies such as subsidies for maternity and paternity leaves, well-baby clinics, and quality day-cares. These interventions can prevent future problems across a population, and the compounding effect of risk factors piling up in children's lives.

In sum, although definitional controversy surrounds the notion of resilience, it is most sensible to incorporate salient contextual factors in our understandings of the concept. Ungar's and the International Resilience Project Team's (2006) ecological model provides a comprehensive framework of individual, relational, community, cultural, and physical ecology factors that should be considered when examining the processes of adaptation and negotiation that occur in a child's development. Finally, we must keep in mind two important points: (a) Resilience is not static, and therefore must not be considered 'fixed' at any point in time, and (b) having experienced adversity is an essential precursor before any discussion of resilience can take place.

The latter point leads to an important question -What kinds of adversities are relevant in a study of resilience? Examining research that has been conducted on resilience is helpful in illustrating the varied forms of adversities experienced by children and youth.

Research on Resilience

As one might imagine, research on resilience that incorporates an ecological perspective makes for complex investigations. While there is a growing amount of research on developmental strengths/assets and positive youth development (Scales, Benson, Leffert, & Blyth, 2000; Scales, Benson, Roehikepartain, Sesma, & van Dulman (2005); Donnon & Hammond, 2007), comprehensive research on resilience is still limited. Two seminal studies that incorporate contextual factors in studying resilience are the Kauai Longitudinal Study (Werner & Smith, 1982, 1992, 2001, 2005) and the International Resilience Project (2006).

One of the first researchers to coin the term ‘resilience’ in her research was Emmy Werner, who began the Kauai Longitudinal study approximately 50 years ago. The Kauai Longitudinal Study traced the developmental paths of a group of children who had been subjected to conditions widely believed to be predictive of poor outcomes. These adversities included peri-natal stress, poverty, parental psychopathology, disruptions of the family unit (e.g., divorce), and low parental education levels (i.e., Grade 8 or less). The 698 individuals whose lives were followed longitudinally from the prenatal period to adulthood were born in 1955 on the island of Kauai (Werner & Smith, 2005). A mixture of ethnic groups was represented, including Japanese, Filipino, and Hawaiian. “Their parents or grandparents came from Southeast Asia to work on the sugar and pineapple plantations on the island—with the dream of a better life for their children” (Werner & Smith, 1992, p. 1). Many intermarried with the local Hawaiians; the majority was raised by parents who were unskilled labourers.

The study has monitored the impact of a variety of biological and psychological risk factors, stressful life events, and protective factors on the developmental outcomes of these individuals. Quantitative and qualitative assessments were conducted by a team of mental health workers, pediatricians, social workers and public health nurses when the participants were ages 1, 2, 10, 18, 32, and 40. These ages were chosen because they represent important time periods in the lifespan that are critical for the development of trust, autonomy, industry, identity, intimacy, and generativity.

Results showed that the majority of ‘high risk’ children who had experienced four or more of the risk factors (described above) by age two developed learning or behavioural problems by age 10 or had delinquency records and/or mental health problems by age 18. Interestingly, one-third of these children deemed ‘high risk’ developed into competent, confident, and caring adults by age 32 (Werner & Smith, 1992). By the time they reached age 40, the same third were still doing very well—not one of them was unemployed, none had been in trouble with the law, and none had to rely on social services. In addition, many of the participants who were previously considered “troubled teens” were staging a ‘recovery’ in mid-life. Many that were struggling in adolescence were responsible members of the community, holding stable jobs, and in satisfying relationships at age 40. This ‘recovery’ was true for the majority of troubled teens, but more so for the female participants. It was found that the female participants relied more frequently on informal sources of support than the men (e.g., eliciting the advice of peers) and this likely contributed to their ability to cope with challenges more effectively than the males.

The authors concluded that the ‘resilient’ participants in the study (i.e., those with more positive outcomes in adulthood) were protected by three clusters of resilience factors—protective factors in the individual, protective factors in the family, and protective factors in the community.

Protective factors in the individual included: Temperament characteristics, the development of specific skills or talents, positive self-esteem, and an ‘other-oriented’ outlook. Even in the first few years of life, the ‘resilient’ participants tended to be described as good-natured, cuddly, affectionate, agreeable, sociable, and happy. By middle childhood these children had developed good problem solving skills and often had a special talent that gave them a sense of pride (e.g., music, sports). Furthermore, in adolescence they had developed a belief in their own effectiveness. Throughout their development these youth appeared to demonstrate empathy and willingly assisted others who needed help.

Protective factors in the family included the opportunity early on to establish an attachment with at least one competent, emotionally-stable person who was sensitive to their needs. In many cases this nurturing came from substitute caregivers, grandparents, aunts, uncles, or older siblings. Emotional expression was encouraged and reliable support was available in families of resilient participants. In addition, these families tended to hold religious beliefs that provided some stability and meaning in their lives (Werner & Smith, 2005).

Protective factors in the community centred on relationships with positive role models in the youths’ communities. Such role models included: favourite teachers, youth group leaders, older peers, caring neighbours, members in their church, or parents of

boyfriends or girlfriends. These role models were sought out for advice and emotional support in times of crisis.

As mentioned previously, many of the participants who were described as ‘non-resilient’ in their teen years had staged a ‘recovery’ in adulthood (by the age 32 or age 40 assessment). Werner and Smith describe several turning points in the lives of these individuals:

Among the most potent forces for positive change for these youth in adulthood were continuing education at community colleges, and adult high schools, educational and vocational skills acquired during service in the armed forces, marriage to a stable partner, conversion to a religion that demanded active participation in a community of faith, recovery from a life-threatening illness or accident, and, to a much lesser extent, psychotherapy. (p. 2)

Furthermore, when links were examined between individual characteristics and external sources of support in the family and community, it was discovered that the resilient participants were not passively reacting to the constraints of negative circumstances. Conversely, they actively sought out the people and opportunities that helped to facilitate a positive turnaround in their lives. The youth who made a successful adaptation in adulthood despite their adversity experiences relied on social support in their families and communities that increased their life skills and self-esteem, decreased the number of difficult life events they subsequently encountered, and opened up new opportunities for them (Werner & Smith, 2005).

The Kauai longitudinal study certainly demonstrates the importance of looking at the many possible factors that may contribute to resilience. Being the only study of its kind to continue into middle adulthood, it teaches valuable lessons about the pathways to

resilience, and reminds us that individuals can demonstrate resilience at some points in time and not others.

Similar to the Kauai project, the International Resilience Project (IRP; Ungar & the International Resilience Project Team, 2006) is comprehensive in its design, and emphasizes both the individual's role in creating health and the relational factors that must be present to create that health when facing multiple risks. The international scope of the IRP addresses a frequently described shortcoming of resilience research—the challenge of accounting for the cultural context in which resilience occurs. The goal of the project was to examine, within, and between sites, differences regarding aspects of resilience that were most relevant to youth in various cultural and geographical contexts.

The IRP includes 14 research sites on 5 continents. Each participating research site was selected for the diversity it brings to understanding youth in high-risk environments. Ungar with the International Resilience Project Team (2006) argues that each context poses its own risks for youth living there. Furthermore, the IRP purposefully chose to set up research sites in both 'western' (e.g., Southern Canada, Southern USA) and 'non-western' (e.g., Tanzania, India, Columbia) communities.

At least 60 youth participated from each research site, and all youth participants had experienced at least three culturally significant risk factors including, but not limited to, adversities of poverty, war, social dislocation, cultural disintegration or genocide, violence, marginalization, drug and alcohol addiction, family breakdown, mental illness of the child or parent, or early pregnancy.

Both quantitative and qualitative forms of data collection were used in the IRP. The Child and Youth Resilience Measure (CYRM)—a 58-item questionnaire was

administered to all participating youth. This questionnaire includes questions encompassing the five categories of resilience factors in Ungar's and the International Resilience Project Team's (2006) ecological model discussed earlier. For example, questions were asked pertaining to individual traits (e.g., Do you strive to finish what you start?), relationship factors (e.g., Do you feel supported by your friends?), community contexts (e.g., Are you treated fairly in your community?), cultural factors (e.g., I am proud of my ethnic background), and physical ecology factors (e.g., How safe do you consider your neighbourhood to be?).

Qualitative interviews were also conducted with some of the youth from each site that were considered 'high risk', but were deemed by their communities to be doing 'well'. Some of the following questions were asked: *How do you describe youth who grow up well here despite the many problems that they face? What do you do when you face difficulties in your life? What do you do, and others you know do, to keep healthy, mentally, physically, emotionally, and spiritually? Can you share with me a story about a child who grew up well in this community despite facing many challenges?* Adults in each community, identified as having something important to say about resilience (e.g., health care professionals, spiritual leaders, parents, etc.), were also interviewed and/or took part in focus groups where they could talk about their lives and how they understood the challenges facing youth in their communities.

Results from the IRP show that although global aspects of resilience can be identified, culturally diverse groups of youth show patterns in how resilience is understood and manifested. The data gathered also suggest seven 'tensions' that youth negotiate in order to thrive despite adversities. These tensions include: (a) access to

material resources (i.e., availability of medical, financial, educational, and employment assistance and/or opportunities as well as access to food, clothing, and shelter), (b) relationships (i.e., bonds with significant others, peers, and adults in one's community or family), (c) identity (i.e., personal and collective sense of purpose; self-appraisal of strengths and weaknesses, aspirations, beliefs and values, including spiritual and religious identification), (d) power and control (i.e., experiences of caring for oneself and others; the ability to affect change in one's social and physical environment), (e) cultural adherence (i.e., adherence to one's local and/or global cultural practices, values, and beliefs), (f) social justice (i.e., experiences related to finding a meaningful role in community and social equality), and (g) cohesion (i.e., balancing one's personal interests with a sense of responsibility to the greater good; feeling a part of something larger than oneself socially and spiritually).

Ungar and the International Resilience Project Team (2006) describe how youth who were seen by their communities as resilient were those who successfully worked their way through these tensions (each in her/his own way, and according to the strengths and resources available to the individual within her/his family, community, and culture). Several in-depth case studies conducted as part of the IRP further supported the notion that pathways to resilience take varied forms, and individuals are unique in the ways they adapt to and negotiate challenges in their lives. The case studies showed that it is also important to recognize that the seven tensions influence and inform one another. Thus, resilience should always be understood as a dynamic process, never permanent, always in motion. Consider, for example, Ungar's and the International Resilience Project Team's (2006) description of the case of Miguel.

Miguel is a 20-year-old male who grew up outside of Medellin, Columbia. Miguel's broader context, the industrial capital of Columbia, is well known for housing some of the most sophisticated drug trafficking operations since the 1970's and is considered one of the most violent and dangerous cities in the world. Key adversities experienced by youth in Columbia include family violence, poverty, inadequate health and social support, drug addiction, warfare, and lack of security. Miguel had experienced many of these adversities. His parents divorced when he was two years old; the marital relationship was one of domestic violence and alcohol abuse on the part of his father. Following the divorce he and his mother moved in with "a bunch of uncles and my grandfather." There was a steady theme of the importance of relationships with family members, neighbours, peers, and even religion throughout his narrative. (p. 21)

Certain excerpts from Miguel's narrative help to illustrate the importance of relationships in his life. He spoke positively of the relationship with his mother, and described his mother's reaction when he was photographed by a magazine to promote education. *"I felt very well about the pride that my mom felt when she saw it. She still has those magazines and it has been almost 9 years since that happened"* (p.21). When describing relationships with his peers he said:

What I believe that helped me (was) the social environment that I developed in the street. When I began the fifth grade of elementary, there was a group of friends with whom I grew who (were) very different to me, because they had families and they maintained doing wickedness, wanted to be laughing all the time and things like that. I grew with them and...I was the judicious one of all, but not the boring one. I laughed with them, although at the beginning it was difficult to get into the group. (p. 21)

Miguel also reflected on one of the negative relationships in his life—describing abuse experienced at the hands of an uncle:

...and it was there, at that time, when the family began to be dissolved...that was one of the causes for the family to separate, because the family felt a lot of fear from him, and so did I, obviously...I arrived home with my head down, I passed beside him with fear. It was very uncomfortable...He yelled at me every day, hit me, from time to time slaps on my head...but the moral abuse was impressive (p. 21)

Finally, a central theme in Miguel's life was his belief in God. He stated, "*I choose the side of God,*" and elaborated by saying that he had been buffered, not from negative experiences, but from negative outcomes, due to "*that 'bubble' that God put around me.*" While his Catholic beliefs were consistent with indigenous culture, it appeared that he did not regularly practice his faith within a church, which counters local traditions (Ungar & the International Resilience Project Team, 2006).

It is evident from this case study that some of Miguel's relationships were supportive and loving while others were abusive and demeaning; both ends of the continuum reinforcing a continued involvement with others in ways that held meaning for Miguel. While relationships were centrally important in Miguel's ability to adapt to adversity, other youth painted different pictures of their pathways to resilience, with community and cultural factors playing a more pivotal role.

The International Resilience Project provides no evidence that one pathway of negotiating challenges is better than another. Rather, in the qualitative interviews youth spoke of the unique ways in which they had navigated these tensions and succeeded when faced with adversity. This project therefore highlights the importance of examining individual differences in studies of resilience, which can be studied most effectively with qualitative approaches incorporating case studies.

Both the Kauai Longitudinal Study and the International Resilience Project highlight the importance of examining resilience from an ecological perspective with consideration of individual, relational, and community resilience factors. A major strength of the Kauai study is that it is longitudinal in design, extending into middle adulthood. The findings showing 'recovery' of many of the non-resilient teens in

adulthood illustrate that resilience is a dynamic process—never ‘fixed’ at any point in time. The International Resilience Project adds the dimension of cultural context, and highlights the importance of individual differences in the process of resilience; multiple pathways exist but none of them are necessarily better than another. Both studies include participants who experienced multiple risk factors. Many of these adversities were prolonged stressors (e.g., poverty, alcoholism, abuse by a family member, marital conflicts, mental illness of a parent, violence). While it is important to study the effects of such prolonged adversities in resilience research, it is also valuable to research the impact of severe adversity that is later followed by a radical change in rearing environment. Such is the experience of thousands of children who spent their early months and years of life in orphanages in Romania prior to their adoptions by families in western nations.

A Case of Severe Adversity

In order to understand why the case of thousands of Romanian ‘orphans’ is one of severe adversity, attention must be given to the political and societal context within which their early rearing took place.

Strong family ties have been an integral component of Romanian life for centuries. However, a quarter of a century of rule under totalitarian dictator Nicolae Ceausescu decimated this once flourishing European culture and impoverished an entire people (Gilberg, 1990). Central to Ceausescu’s economic plan were specific pronatal policies to increase the population from 23 to 30 million people. Contrary to other European countries that provided positive pronatal incentives, Ceausescu implemented

negative constraints (Johnson & Edwards, 1993). Abortion was outlawed and doctors violating the law were jailed. Sex education was non-existent and birth control methods were banned. Women younger than age 45 were expected to have five children.

‘Systemization’, another one of Ceausescu’s policies, eliminated rural villages and thousands of families were forced to move to crowded high-rise apartments. These accommodations were unsuitable to house large numbers of children (Johnson & Edwards, 1993).

Romania’s ‘full employment’ policy was a further detriment to family caregiving. Women were required to return to work after 3 to 6 months of maternity leave. In addition, elderly persons who traditionally functioned as caregivers were often refused essential medical treatment because health care was targeted at only those who could contribute to the economic productivity of the country. Thus, many elderly relatives were not physically able to care for children. Many parents were forced to turn over their children to the state, which operated a large network of institutions for children up to 18 years of age (Marcovitch, Cesaroni, Roberts, & Swanson, 1995). By 1989 experts estimate that there were approximately 200,000 Romanian children living in institutions.

The rearing conditions in these orphanages represented an extreme of deprivation—the children were under-stimulated and malnourished. Most were characterized as uninterested or unresponsive, spending most of their days lying or sitting immobile in their cribs (McMullan & Fisher, 1992). Child-to-caregiver ratios ranged from 10:1 to 20:1, allowing for minimal personal interactions, and limited opportunities for reinforcement or praise. Self-stimulatory activities such as rocking were a central and repetitive activity for many of these children simply because there was nothing else for

them to do. Caregiving was conducted in an assembly line fashion (Ames & Carter, 1992).

Ceausescu's communist regime was overthrown late in 1989. Within a month, pictures of rooms full of children, apparently starving and emotionless, flooded television screens around the world (Ames, 1997). When Westerners saw these television images of the appalling conditions in Romanian orphanages, many were motivated to 'save' these children, and rushed to take action. Some prospective-adoptive parents flew to Romania without completed home studies, visas, or documentation. However, thousands of adoptive parents from the United States, Canada, Europe, and other countries ultimately succeeded in adopting children between 1990 and 1991.

The simultaneous adoptions of so many Romanian orphans provided social science researchers with a unique opportunity to study the impact of early deprivation on later development. Such "experiments in nature" allow an examination of developmental processes when conditions are so severe as to impede normal development (MacLean, 2003). Furthermore, the profound intervention of adoption following such severe early adversity was a rare and unique situation in psychology and offered the potential to also examine ameliorative factors in the post-adoption environment.

Much research has been conducted on samples of these children over the last two decades (e.g., Carlson & Earls, 1997; Groze & Ileana, 1996; Kaler & Freeman, 1994; Marcovitch, Goldberg, Gold, Washington, Wasson, Krekewich et al., 1997). However, two influential studies are longitudinal in nature and ongoing, and have contributed the most to our understandings of the children's development post-adoption. These are the

Romanian Adoption Project in Canada (i.e., the larger project of which the present study is a part), and the English and Romanian Adoptees Study in the UK.

Both the Romanian Adoption Project (RAP; Ames, 1997) and the English and Romanian Adoptees Study (ERA Study; Rutter & the ERA Study Team, 1998) utilized comparison groups in their designs and examined children at several time-points. The RAP comprised an initial sample of 46 Romanian orphans (RO group) who had spent at least 8 months in institutions (range 8 to 53 months) prior to their adoption to Canada. The two comparison groups were the 29 early-adopted Romanian children (EA group) who would have ended up in orphanages had they not been adopted prior to 4 months of age from maternity hospitals or families; and 46 Canadian-born non-adopted, never-institutionalized children (CB group) who were individually matched on demographic characteristics to children in the orphanage group (Ames, 1997). The ERA study comprised an initial sample of 165 children adopted to the UK from Romania between birth and 42 months of age. These children were compared to a sample of 52 domestically adopted children (adopted within the UK), who were less than six months of age at the time of adoption. To date the Romanian Adoption Project has conducted four assessments—when the children were 11 months post-adoption, age 4.5, age 10.5, and age 16.5. The English and Romanian Adoptees Study have also conducted four assessments—at ages 4, 6, 11, and 15 years.

Results from both studies are similar across time and are by and large consistent with other research on post-institutionalized children. In general, post-institutionalized children tend to have a higher incidence of attachment difficulties (Chisholm, 1998; Fernyhough, 2003; O'Connor, Rutter, & the English and Romanian Adoptees Study

Team, 2000) and perform more poorly in school than their non-adopted peers (Kurytnik, 2003; O'Connor, Rutter, Beckett, Kreppner, & Keaveney, & the English and Romanian Adoptees Study Team, 2000; Morison, 1998). In addition, at every assessment they have shown a higher incidence of problem behaviour and attention difficulties (Audet, 2003; Audet, Kurytnik, & Le Mare, 2006; Kreppner, O'Connor, Rutter, & the English and Romanian Adoptees Study Team, 2001; Rutter, Anderson-Wood, Beckett, Bredenkamp, Castle, Groothues et al., 1999). The challenges are not isolated to the children themselves; their adoptive parents have also experienced higher levels of parenting stress and marital breakdowns than the comparison group families (Croft, O'Connor, Keaveney, Groothues, Rutter, & the English and Romanian Adoptees Study Team, 2001; Groothues, Beckett, & O'Connor, 1999; Le Mare & Kurytnik, 2002, 2004).

An important finding that has emerged in both the RAP and the ERA study is that, in general, the children who spent more than 6 months in an institution prior to adoption have demonstrated significant and lasting challenges whereas those who were adopted earlier in life are faring much better (MacLean, 2003). Interestingly, however, this was not true in all cases. Despite many obvious struggles in the children with extensive institutional experience, a considerable amount of variability in outcomes has been documented (Ames, 1997; Kreppner et al., 2007; MacLean, 2003) with some post-institutionalized adoptees doing much better than others. Therefore, it must *not* be assumed that severe and lengthy early adversity always 'dooms' a child to psychopathology.

Findings on these post-institutionalized samples have helped to delineate the effects of early deprivation and elucidate potential outcomes for other populations that

experience early adverse life events. In addition, such research has contributed much to theory in developmental psychology, and has been helpful for adoptive parents (and prospective adoptive-parents) and adoption policy-makers. What has been lacking; however, is particular attention and research efforts directed towards clarifying the reasons for the variability in outcomes. That is, why do some post-institutionalized children do *better* than others? Is it individual traits that the children possess that make a difference? Are there certain factors in the adoptive family that account for the variation? Do community supports play a role?

It should be mentioned that these questions have not been entirely ignored in previous research. Resilience-related constructs have been examined in relation to child outcomes and some interesting findings have emerged. For example, the Romanian Adoption Project examined relationships between parenting stress and child behaviour, as well as access to needed services and child outcomes when the children were 10.5 years of age (Le Mare, Audet, & Kurytnik, 2007; Le Mare & Kurytnik, 2002). Factors comprising the construct of parenting stress overlap with some of the relationship resilience factors, including parent support and parent expectations. In addition, access to services relates to the community resilience factors, including community support.

Le Mare and Kurytnik (2002) found that when the children were 10.5 years old, parenting stress was related to problematic externalizing child behaviour, such as aggression, delinquency, and hyperactivity. Furthermore, Le Mare et al. (2007) found that service utilization, such as academic help and counselling support, was an important factor in predicting academic and behavioural challenges. In comparing functioning of children with and without unmet service needs they found that those with unmet needs

suffered greater challenges than those whose service needs were met. While these studies are suggestive of what resilience factors might play a role in explaining variability in outcomes, they are limited in that they did not make use of a resilience framework or measures deriving from such a framework. In addition, because the research was primarily quantitative in nature, results could not capture some of the individual differences in adaptation that may have existed. The present study complements the current research on these post-institutionalized samples of children by examining data for the first time using a resilience framework with a qualitative case study approach.

The Present Study

The present study comprises 9 case studies of youth from the Romanian Adoption Project who were selected from the RO group (the group that had experienced at least 8 months in orphanage). Five 'resilient' adolescents and four 'non-resilient' adolescents were selected for inclusion in the study based on comprehensive assessments of adaptive functioning at Time 4 (when the children were approximately 16.5 years of age). The selection process is described in greater detail in the method section, but it should be noted that participants were classified as resilient or non-resilient based on available data at Time 4. This does not mean that they have always displayed resilience (or lack thereof), nor that their resilience status will remain stable into the future. As demonstrated earlier by findings from the Kauai Longitudinal Study, resilience is a dynamic process that cannot be considered absolute at any point in time. A case study approach was deemed to be the most efficacious way of studying this dynamic process.

Yin (2003) argues that the case study method is appropriate when researchers desire to: (a) define research topics broadly and not narrowly, (b) to cover contextual or complex multivariate conditions and not just isolated variables, and (c) to rely on multiple and not singular sources of evidence. The study of resilience, framed from an ecological perspective, is well suited to such an approach.

**Case Study Method for Studying Resilience:
Defining Research Topics Broadly**

Viewed in the context of an ecological model, resilience is a capacity that develops over time in the context of person-environment interactions (Egeland, Carlson, & Sroufe, 1993; Ungar, 2008). Defining resilience in such broad terms allows the researcher to examine many factors in development that could reveal insights regarding processes of adaptation. The use of qualitative case study methodology in the present study allows for a more detailed understanding of both person-based and environmental variables associated with resilience in these youth than has been possible in previously conducted studies. For example, difficult questions can be addressed in a comprehensive manner, such as: What do the interactions look like between the child and his/her environment? Who is the primary influences on her/his development? What is the role of the community in the child's development of adaptive processes? These kinds of questions will be addressed in the present study.

**Case Study Method for Studying Resilience:
Covering Contextual or Complex Multivariate Conditions**

As discussed earlier, resilience understood from an ecological perspective, involves a complexity of interactions between an individual and his/her environment over

time. Thus, the study of resilience must be conducted in a way that takes into account such contextual factors (e.g., community supports; cultural traditions).

Case studies offer a way to take seriously the influence context has on resilience. The method allows a process analysis of the multivariate, interacting forces by which behaviour may be explained (Liddle, 1994). Not only can informants in a study tell us if they felt, believed, or acted in a certain way, but they can also describe *why*—what the influences were on their feelings, beliefs, or decisions, and the limits inherent in their situations. The International Resilience Project (Ungar & the International Resilience Project Team, 2006) demonstrated that the case study method is ideally suited to clarifying some of the potential ‘pathways’ to resilience because it allows a systemic in-depth look at the level of the individual.

Case Study Method for Studying Resilience: Relying on Multiple Sources of Evidence

In order to gain a comprehensive understanding of resilience processes in development, multiple sources of evidence should be used. This allows for different viewpoints to be expressed about the phenomenon of interest, often resulting in more detailed descriptive information. These various sources can be cross-checked to validate observations. This method has been called ‘triangulation of sources’ (Orum, Feagin, & Sjoberg, 1991). The present study, as part of the larger Romanian Adoption Project, has multiple sources of evidence that can be considered over time in each case study. These include: reports from the children themselves, parent reports and interviews, teacher reports, and interviewer observations. This will allow for triangulation of data.

In summary, the case study method is the most appropriate and efficacious way to capture resilience processes in this post-institutionalized sample of children at the level of the individual. The qualitative analysis will complement existing quantitative analyses on the development of these children, and enable rich new insights into the various processes of adaptation following adversity. In addition, it is hoped that utilization of this method will provide direction to future research endeavours. As Orum et al. (1991) argues, the study of the single case or a collection of several cases is indispensable to the progress of research in the social sciences. If we are able to gain an understanding of how individuals “beat the odds” and navigate through stressful circumstances successfully, processes of adaptation can be recognized that will potentially guide interventions with others at risk. Rutter (1979) emphasizes the importance of such a research endeavour:

There is a regrettable tendency to focus gloomily on the ills of mankind and on all mankind and on all that can and does go wrong...The potential for prevention surely lies in increasing our knowledge and understanding of the reason why some children are not damaged by deprivation.... (p.49)

METHOD

This section is comprised of four parts. Given that the participants were selected from the larger Romanian Adoption Project (RAP), the numbers of participants at each phase of the RAP will be described. Second, the process of selection of participants for the present study is explained, and each of the 9 participants is introduced. Third, the data sources, both quantitative and qualitative, are described. Finally, the process of analyzing the data is explained.

Participants

The Romanian Adoption Project began in 1991, when the 43 Romanian Orphanage children (RO children—those that had spent at least 9 months in orphanage prior to their adoption) had been in their adoptive homes for 11 months. Data were also collected for a Canadian born (CB) non-adopted, non-institutionalized comparison group ($n = 43$), and an Early-adopted (EA) comparison group ($n = 22$) individually matched to the youngest RO and CB children. The EA children, also from Romania, were adopted prior to 4 months of age and came from hospitals, orphanages, or their biological parents. These children share similar birth family histories and pre- and peri-natal care with the RO children and would have been raised in orphanages similar to those from which the RO children were adopted had they not been adopted early in life.

At Phase 2, when the children were on average 4.5 years of age there were 43 RO children, 43 CB children and 26 EA Children. At Phase 2, three RO children could not be located so three new RO children were added. Within the CB group two participants

declined to participate at Phase 2 and a third could not be included due to being inadvertently tested one year too early. Three new CB children were added to serve as matches for the three new RO families. Four additional EA children were added at Phase 2 to serve as matches for two RO families who did not have an EA match at Phase 1 and two of the new RO families. No EA children were lost at this phase.

At Phase 3, when the children were on average 10.5 years of age, there were 36 RO children, 42 CB children and 25 EA children. Attrition from Phase 2 to Phase 3 occurred for a number of reasons. Some families declined to take part in Phase 3 because they no longer felt the research was of assistance to them. One family dropped out because a parent was gravely ill while another family chose not to participate because the parents had not told their child she was adopted. Some families had moved to other cities or countries and were not accessible for this phase of assessment, while we were unable to locate others. In all, 11 RO families, 5 CB families, and 5 EA families who participated at Phase 2 did not take part in Phase 3. Five new CB families were added in Phase 3 in order to provide matches for EA children who did not have RO matches.

At Phase 4, the most recent time point, data were analyzed for 22 RO children, 33 CB children, and 15 EA children. There were more Canadian born children than Romanian orphans because although some RO families chose not to participate in this phase of the study, the Canadian born children were needed as matches for the Early-adopted group. Attrition from Phase 3 to Phase 4 also occurred for a number of reasons. The main reason for RO families declining to participate was because their children were no longer in their care. Several of the RO parents found themselves unable to care for the growing demands of their adopted children or found that it was no longer safe to either

themselves or other children in their home to keep their children at home. Other reasons included family conflict such as divorce and parents reporting that the children would not be able to complete any questionnaires on their own as they were too low functioning.

Selection of participants for the present study was based on Time 4 data, collected when the children were age 16.5 years. Given that the experience of adversity is a precursor for studying resilience processes, youth were chosen only from the Romanian Orphanage (RO) group—those who had experienced at least 8 months deprivation experience in an orphanage prior to adoption.

Two researchers (i.e., the Principal Investigator of the Romanian Adoption Project and myself) independently examined all RO participant files from Time 4, and categorized them into two piles—those teens who seemed to be doing well and those who were not. Categorization was based on three main factors: (a) parent reports on the Child Behaviour Checklist (Achenbach, 1991), our best overall measure of adaptive functioning at Time 4; (b) parents' written reports of their child's strengths and challenges; and (c) an overall impression of how the teens were doing based on written comments by parents regarding academic, behavioural, and emotional functioning, as well as their child's current interests and activities.

Given that selection of participants was based solely on data from Time 4 (age 16.5), factors such as the amount of time spent in orphanage, number of developmental delays at adoption, and IQ were not considered until after selection had taken place.

Based on these considerations, five participants were chosen as the clearest cases of 'resilient' teens and 4 participants were chosen as the clearest cases of 'non-resilient'

teens. These 9 participants are introduced next (by pseudonyms), and the specific criteria upon which each participant was selected is described.

Resilient Participants at Age 16.5

Liam

Liam lives in a suburban community on the lower mainland of British Columbia. His total score on the Child Behavior Checklist (CBCL) was 2, indicating that he had very few behavioural and emotional difficulties at Time 4. Some of his strengths, as reported by his parents, included: “his sense of himself,” his academic and musical ability, and the fact that “he’s just a nice guy.” He was also described as being sensitive, caring, a great conversationalist, trustworthy, well-rounded, anti-drugs, and anti-alcohol. He excelled in art and music, and was part of the jazz band at his school. He also enjoyed skiing. He was doing very well academically and worked part-time at a grocery store. Other parent comments were: “He is a great kid—he is the kid at school whom other kids seek advice. He has long time friendships with kids from his Grade 6 French immersion class.” When his parents were asked about Liam’s challenges, the only thing mentioned was normal teenage behaviour—being slow in the morning and spending a lot of time on the phone with his girlfriend of two years.

Cole

Cole lives in a rural community in the Okanagan region of British Columbia. He had a total CBCL score of 0, indicating no behavioural or emotional difficulties at Time 4. Parent reports indicated that his strengths included: being warm, friendly, interested in others, willing to learn, musical, and technical. He was also described as follows: “He has

a great smile, appreciates his family, loves God, and has some very nice friends.” He played the cello and piano very well, and sang in choirs at school and in church. He also enjoyed sports and was particularly good at volleyball. In school Cole performed at average levels in all school subjects, except music history where he was at the top of his class. He also worked part-time in construction (mostly in the summer months), and enjoyed taking care of animals (e.g., horses, chickens). When asked about Cole’s challenges, his parents voiced that “he may have trouble knowing what to do for his life’s work, but he has a lot going for him.”

Heather (Twin of Cole)

Heather, Cole’s twin, also lives in a rural community in the Okanagan region of British Columbia. She had a total CBCL score of 0, indicating no behavioural or emotional difficulties at Time 4. Her parents reported that her strengths include: maturity, responsibility, warmth, and well-roundedness. She “thinks things through carefully and is strong in her beliefs.” She was also described as being loving, smart, caring, and well-behaved. She excelled in violin and choir and enjoyed skating, volleyball, baseball, horseback-riding and church youth group activities. She appeared to be performing at ‘average’ levels in all school subjects. She babysat a lot in her free time. When asked about Heather’s challenges, her parents had no concerns. Other parent comments were:

We think our children (referring to both Cole and Heather) are well on their way to be able to launch out and be helpful members of society. We enjoy each other immensely and are blessed. Our children are a joy to us. We look forward to our grandchildren someday!

Mitch

Mitch lives in a suburban community on Vancouver Island in British Columbia. He had a total CBCL score of 2, indicating virtually no behavioural or emotional difficulties at Time 4. His parents reported his strengths to be as follows: very musical, a good listener, focused on school work, devoted to his family, and very grateful and loving. He was also described as being “a hard worker in everything he does.” He excelled in both sports and music including: basketball, volleyball, badminton, tennis, piano, saxophone, and singing. He did very well in school and was taking a heavy load (i.e., chemistry, physics, calculus) as he desired to go to medical school. He worked part-time as a lifeguard at a nearby university and volunteered as a referee for volleyball and basketball games. He was also on the grad executive at school. When asked about Mitch’s challenges, his parents had no concerns. Other parent comments were: “He can play the piano beautifully and has never had any lessons”; and “I love my son—he is great to talk to about serious problems or concerns.”

Lauren

Lauren lives in a suburban community in Washington State. She had a total CBCL score of 9, indicating very few behavioural and emotional difficulties at Time 4. Some of her strengths included: showing leadership, responsibility, and empathy for others. She was also described as being loving, smart, caring, and well-behaved. She excelled in music (i.e., she played drums and guitar in the school band) and was adept at American Sign Language. She also played softball and golf. She appeared to be doing very well academically and would graduate from high school with a 2 year college diploma because she had taken additional credits on her own time. She also worked part-

time as a coffee-shop barista. Other parent comments were: “She’s a great kid—we are blessed.” When her parents were asked about Lauren’s challenges, the only thing mentioned was the fact that she is a lesbian. Lauren had told her parents two years prior (at age 14), and despite the fact that her parents were “less than thrilled about it,” they really liked her current partner and were trying to be very supportive.

Non-resilient Participants at Age 16.5

Alison

Alison lives in an urban community on the lower mainland of British Columbia. She had a CBCL score of 86, indicating many behavioural and emotional difficulties at Time 4. Some of these problems included: stealing at home, being unhappy, sad or depressed much of the time, screaming a lot, being secretive, withdrawing from others, hyperactivity and restlessness, and often feeling worthless and inferior. She also demanded a lot of attention, argued a lot, was easily jealous, and did not seem to feel guilty after misbehaving. In school, Alison was on a modified program and had a teaching assistant for every subject. She was performing ‘below average’ in every school subject, except for math where she was performing at ‘average’ levels. Parents reported that she had Attention Deficit Hyperactivity Disorder, and was also diagnosed recently with chronic depression. She did not pursue any hobbies or participate in any extra-curricular activities, although her mom reported that she knows Alison has ‘potential’ to be quite musical. Other parent comments are as follows: “She will not join in with her peers on any social level”; and “she wants nothing to do with her family.” Her mother was concerned about her post-secondary commitment, as she did not believe her daughter had potential to go further in school, and Alison “doesn’t see value in having a job.”

Jenna

Jenna lives in a suburban community on the lower mainland of British Columbia. She had a CBCL score of 26, indicating some behavioural and emotional difficulties at Time 4. Some of these problems included: acting too young for her age, frequent obsessive thoughts, compulsive behaviours (e.g., saying words over and over), staring blankly, and being very self-conscious and easily embarrassed. She also struggled with her social skills and often “says things in a way that may challenge or offend.” Jenna had a teaching assistant for every school subject, and was performing ‘below average’ academically. She had been diagnosed with Obsessive-Compulsive Disorder (OCD), and had experienced bullying in school related to her OCD tendencies. Her parents reported that despite her social challenges, she was very caring about others and tried her best at everything she attempted. She enjoyed crocheting and swimming. Her parents were very concerned about her future and her ability to be independent. They know it will be a challenge to “find an employer who will accommodate her learning curve.”

Cory

Cory lives in an urban community on Vancouver Island. He had a total CBCL score of 74, indicating many behavioural and emotional difficulties at Time 4. Some of these problems included: acting too young for his age, arguing, clinging to adults (i.e., being too dependent), difficulty concentrating, disobedience at school, perfectionistic tendencies, secrecy, anxiety, impulsivity, and stealing both at home and outside of home. Cory was failing at every subject in school and was required to repeat the 9th grade due to not passing any of the core subjects. He had been diagnosed with ADHD, and his parents were most concerned about his very low self-esteem and social immaturity. He enjoyed

playing soccer, but did not have any other hobbies or interests, and no paid employment. He was living with foster parents who commented that “he frequently engages in impulsive behaviour leading to poor choices.”

Micah

Micah lives in a mid-sized suburban community on Vancouver Island. He had a total CBCL score of 76, indicating many behavioural and emotional difficulties at Time 4. Some of these problems included: lying and cheating, alcohol/drug use, impulsive acts, stealing liquor and money both at home and outside of home, and lack of remorse for his actions. He was also reported to argue a lot, brag and boast, be unable to concentrate for long, and frequently steal female clothing. Micah attended an alternate school after previously dropping out of regular school, and had to repeat Grade 10. He was performing “below average” in all school subjects, and skipped school regularly. Parents reported that he has always had difficulty completing assignments and paying attention at school. He seemed to “beat to his own drum with no regard for others or consequences of his actions.” His strengths included his musical and athletic ability—he enjoyed soccer, drums, and guitar. He did not have any paid employment.

Data Sources

Given the longitudinal nature of the Romanian Adoption Project, the data sources that were analyzed in the present study stemmed from data collection that occurred at four time periods—when the participants were 11 months post-adoption, at age 4.5, age 10.5, and age 16.5. The assessments at each phase were comprehensive; data were collected pertaining to development across many domains—physical, intellectual,

behavioural, and emotional, including relationships with parents and peers. Data related to family functioning were also collected, including: parenting stress, parenting practices, stimulation in the home environment, and services utilized. Information on cultural aspects of development were collected through questionnaires that included items regarding cultural identity and feelings about being adopted.

Multiple informants were used at each phase of assessment, including reports from the children themselves, their parents, teachers, and observations made by researchers. Furthermore, data collected was both quantitative (e.g., questionnaires, standardized assessments) and qualitative (e.g., parent interviews, open-ended questions on questionnaires, observational notes) in nature. Both quantitative and qualitative data sources from multiple informants allowed for triangulation of data to occur (Orum et al., 1991).

The specific data sources used in the case study analyses will be described in order of when the raw data were collected. Keep in mind that some measures were administered at several time points (which will be indicated) and therefore are not described more than once. For a quick reference of data collected at each phase of assessment (see Table 1).

Table 1. Data Sources

	Time 1	Time 2	Time 3	Time 4
Physical	Denver Parent Interview	Parent Interview	Parent Interview	Health Questionnaire
Intellectual	Gesell	Stanford-Binet	Stanford-Binet Canada QUIET Parent report of Education Teacher report of Education Child self-report of Education	Parent report of Education CBCL Strengths and Challenges
Behavioural/ Emotional	Parent Interview	CBCL Parent Interview	CBCL CBQ Parent Interview SDQ	CBCL Strengths and Challenges
Parent Child Relationship	Parent Interview Researcher observations	Parent Interview Researcher Observations	Parent Interview Researcher Observations	IPPA
Relations with Peers	Parent Interview	Parent Interview	RPLQ Parent Report of Peer Activities Parent Interview	RPLQ Parent Report of Peer Activities Romantic Relationships
Family Structure/ Functioning	Demographic Parent Interview Researcher Observations	Demographic HOME PSI Parent Interview Researcher Observations	Demographic PSI Parenting Practices Parent Interview Researcher Observations	Demographic PSI Parenting Practices Service Use Researcher Observations
Cultural/ Gender Identity	n/a	n/a	n/a	Adoption Sex-role CYRM

Note. **Intellectual:** Strengths and Challenges refers to any strengths or challenges mentioned by parents that pertained to intellectual domain (e.g., "My daughter will graduate from high school with a 2-year college diploma; she has always been very strong academically").

Behavioural/Emotional: Strengths and Challenges refers to any strengths or challenges mentioned by parents that pertained to behavioural/emotional domain (e.g., attention/hyperactivity problems).

Parent Child Relationship: Researcher observations refers to observations by researchers regarding attachment (e.g., Child is clearly discriminately attached to parent, discriminate attachment is somewhat evident, or attachment is clearly indiscriminate).

Family Structure/Functioning: Researcher observations refers to researchers' descriptions of the family/home environment (e.g., does it seem harmonious, happy, or 'chaotic').

Time 1

Demographic Information

The parent interview at Time 1 started with questions pertaining to demographic information. This included their child's age at adoption, and length of time spent in orphanage prior to being adopted. Parents' ages, amount of education completed, current employment situation, marital status, family income, and sibling information (i.e., how many other children were living in the household—either biological or adopted) was also obtained. Parents were asked details about the adoption—why they chose to adopt in the first place, how long they had stayed in Romania, what the conditions were like in the institutions from which they adopted their child, and if they were able to meet the birth parents/families. Demographic information such as this was also obtained at Times 2, 3, and 4 (see Appendix A).

Parent Interview

During the Time 1 interviews, parents were asked questions regarding problems they experienced since bringing their child home, which included specific probes pertaining to: health (e.g., eating, sleeping, problematic illnesses or diseases) and behaviour (e.g., stereotyped behaviour; problems with siblings). Parents were also asked questions pertaining to indiscriminately friendly behaviour (i.e., lack of wariness toward strangers), attachment security, and services they may have obtained to help with their child's difficulties. An extensive parent interview was also conducted at Time 2 and 3. Any additional information (to that described above) collected at those later time points is discussed in their respective sections. A sample of questions asked on the parent interview is included in Appendix B.

Revised Denver Prescreening Developmental Questionnaire (R-DPDQ; Frankenburg, 1986)

The R-DPDQ was designed as a first step screening device to evaluate developmental progress in children aged 3 weeks to 6 years. The questionnaire is made up of 105 tasks or items within the range of accomplishments of children in the age span. Items are arranged in chronological order according to the age at which 90% of children in the standardization sample could accomplish them. Items are categorized in four domains: (1) Personal-Social, (2) Fine Motor-Adaptive, (3) Language, and (4) Gross Motor. Parent reports of the number of delays the RO children exhibited at adoption was used in this study.

Gesell Developmental Observation

The Gesell Developmental Observation (GDO; Amatruda, Bates-Ames, Castner, Gesell, Halverson, Ilg, & Thompson, 1940) is a standard procedure for direct observation of a child's growth and development. This assessment is conducted by a trained examiner who makes discriminating observations of a child's behaviour and then evaluates these observations by comparison with normative patterns developed for each developmental age. Behaviour is described in four areas: personal-social behaviour, neurological-motor growth, language development, and overall adaptive behaviour. Adaptive behaviour includes the child's ability to profit by past experience and to apply it to new situations. It reflects the child's capacity to integrate all the areas of growth (i.e., putting knowledge into action). The GDO was administered by trained professionals at Child Development Centres located near the participants' homes as part of an infant development program utilized by 7 of the 9 participants.

Researcher Observations

After each visit to the home of a participant, researchers recorded observations including general impressions of the child's development and the adoptive home environment. Researchers also reported on whether attachment to parent(s) seemed indiscriminate, somewhat discriminate, or clearly discriminate. They noted the child's reaction to the interviewer(s) to see if the child displayed indiscriminately friendly behaviour. Researcher observations such as these were also conducted at Times 2 and 3.

Time 2

Parent Interview

In addition to asking about the same information that was obtained in the parent interview at Time 1, in the interview at Time 2 parents were asked to give five adjectives describing their child. Questions were also asked pertaining to the children's peer relationships and school readiness, family religious practices, and how things had been going since Time 1 (e.g., if prior problems were ongoing or had been resolved and if new problems were evident). In addition to inquiring about which services participants' used, parents were asked if there were services they needed but could not access (and, if so, what those services were). This question was also asked in the Time 3 interview.

The Home Observation for Measurement of the Environment Inventory (HOME; Caldwell & Bradley, 1984)

The HOME Inventory is designed to assess the quality of stimulation and support available to a child in the home environment. At Time 2 the Preschool version was used with the 4.5-year-old children. The Preschool version contains 55 items clustered into eight subscales: (a) toys and learning materials, (b) language stimulation, (c) physical

environment, (d) pride and affection, (e) stimulation of academic behaviour, (f) encouragement of maturity, (g) variety of stimulation, and (h) acceptance (use of punishment). Internal consistency and inter-observer agreement have been shown to be high (Bradley, 1989). Internal consistency was .89 for the total HOME and averaged .70 for the eight subscales.

Child Behavior Checklist/4-18 (CBCL; Achenbach, 1991)

The Child Behavior Checklist (CBCL) is a measure on which parents or other individuals who know the child well rate a child's problem behaviours and competencies. This instrument can either be self-administered or administered through an interview. The CBCL can also be used to measure a child's change in behaviour over time or following a treatment. The first section of the questionnaire consists of 20 competence items and the second section consists of 120 items on behaviour or emotional problems during the past 6 months. Two versions of this instrument exist: one for children ages 1.5 to 5 and another for ages 6 to 18. The 1.5 to 5 version was used at Time 2, and Total CBCL scores were considered. Competence indices (e.g., in school and with peers) were also considered, as were parents' descriptive comments regarding their children's strengths, sports interests, extracurricular activities, hobbies, and any concerns they had. The CBCL (6 to 18) version was used at Times 3 and 4.

CBCL norms for girls and boys are available, along with clinical and borderline cutoffs. A total score of 70 or above is considered to be in the clinical range, with 98% of children generally scoring below this number, and scores from 67 to 69 in the clinical borderline range.

The CBCL has high validity and reliability. Achenbach and Edelbrock (1981) have documented that clinically-referred children obtain higher scores on the Problem Scales than non-referred children. The inter-rater and test-retest reliabilities of the CBCL item scores are supported by correlations in the .90s (Achenbach, 1991). Inter-parent agreement is also high, and over 1- and 2-year periods, the mean score changes are not significant (Achenbach, Phares, Howell, Rauh, & Nurcombe, 1990).

Parenting Stress Index (PSI; Abidin, 1990)

This 120-item self-report questionnaire yields 13 subscale scores, which are further grouped into a Child Domain, Parent Domain, and Total Stress score. High scores in the child domain are associated with children who display qualities that make it difficult for parents to fulfil their parenting roles. High scores on the parent domain suggest stress due to aspects of parental functioning (e.g., isolation and depression). The Parenting Stress Index was also used at Times 3 and 4.

The PSI has been empirically validated to predict observed parenting behaviour, and children's current and future behavioural and emotional adjustment, not only in a variety of U.S. populations but in a variety of international populations. The transcultural research has involved populations as diverse as Chinese, Portuguese, French Canadian, Italian, Korean, etc. These studies demonstrated comparable statistical characteristics to those reported in the PSI Manual, suggesting that the PSI is a robust diagnostic measure that maintains its validity with diverse non-English-speaking cultures. This ability to effectively survive translation and demonstrate its usefulness as a diagnostic tool with non-English-speaking populations suggests that it is likely to maintain its validity with a variety of different U.S. populations (Abidin, 2005).

Stanford-Binet Intelligence Scale, 4th Edition (SB4; Thorndike, Hagen, & Sattler, 1986)

The SB4 was used to assess the overall intellectual development of the children. It is well standardized, and has good internal reliability (Thorndike, Thorndike, Cunningham, & Hagen, 1991). The SB4 can be used to evaluate children from 2 to 23 years of age. Vocabulary and Comprehension subscales were used to assess concept formation and language development. Memories for Sentences, Bead Memory and Quantitative subscales were used to assess concentration abilities and short-term memory. Pattern Analysis, Copying and Matrices were used to assess abstract and visual reasoning. A composite score, along with subscale scores in Verbal Reasoning, Abstract-Visual Reasoning, Quantitative Reasoning and Short-Term Memory can be derived for the age range of the sample in this study. All tasks were introduced using the standard procedures provided in the test manual. Composite scores were considered in this study at Times 2 and 3.

Time 3

Parent Interview

In addition to the same information that was obtained at Times 1 and 2, at Time 3 parents were asked about prior problems (from Time 2) and whether or not they were ongoing or had been resolved. They were also asked about problems their children were currently experiencing, and services being used to deal with them. At the end of the interview parents were asked the question, “Given what you now know about being a parent to your child, if you could do the whole thing over again, how likely would you be to repeat the experience?”

Canada Quick Individual Educational Test (Canada QUIET; Wormeli & Carter, 1990)

The Canada QUIET is a standardized test that measures the academic achievement of students from Grades 2 to 12. It consists of four subtests; spelling, arithmetic, word identification and passage comprehension. The Canada QUIET is considered a valid measure of the achievement of students instructed in English (Wormeli & Carter, 1990). It was normed on students who were enrolled in English instructed schools across Canada, has good reliability for screening achievement in that population and was built from materials used in language arts and arithmetic instruction in Canadian programs (Wormeli & Carter, 1990).

School Questionnaire (NLSCY; Statistics Canada, 1997)

Children completed a questionnaire from the National Longitudinal Survey of Children and Youth (NLSCY) regarding how much they liked school, the importance they attached to academic achievement, and the support they perceived from parents and teachers concerning their schoolwork. Examples of items include 'How well do you think you are doing in your schoolwork?'

Child's Education (NLSYC; Statistics Canada, 1997)

Parents completed a questionnaire from the NLSCY that includes items concerning involvement in their child's education, the importance they place on academic achievement, and how much their child enjoys school. Examples of items include: 'Based on your knowledge of your child's schoolwork, including his/her report card, how is your child doing in mathematics (or various other subjects)?'; 'How is your child doing overall?'; How satisfied are you with your child's performance? Parents reported on

their level of satisfaction with their child's quality of schooling, and their expectations regarding how far their child would go in school. Information on grade retention was also obtained. This questionnaire was also completed at Time 4.

Student's Education (NLSYC; Statistics Canada, 1997)

Teachers completed a questionnaire from the NLSCY on children's academic achievement in reading, math, and written work. Examples of items include: 'How would you rate this student's current academic achievement in written work (i.e., spelling and composition)?; How would you rate this student's current academic achievement across all areas of instruction?' Teachers were also asked about how students were doing socially in the classroom—if they were helpful with their peers, etc.

The Self-Description Questionnaire (SDQ-1; Marsh, Smith, & Barnes, 1983; Marsh, 1988)

This is a widely used multidimensional measure of children's self-concept designed for use with middle to later elementary school children. It is a 56-item self-report measure that assesses a child's self-concept in five domains: academic, athletic, appearance, relations with peers, and relations with parents. It also has a separate subscale that assesses feelings of general self-worth.

The SDQ-1 has excellent psychometric properties of reliability, validity (construct, convergent, and discriminative) and utility with the age group in the present study. The construct validity of the measure has been checked across various studies and verified by confirmatory factor analysis (Byrne & Schneider, 1988; Marsh & MacDonald-Holmes, 1990). Marsh and MacDonald-Holmes provided support for convergent and discriminative validity by using multi-trait, multi-method analyses. The

SDQ-1 scales have high internal consistency (coefficient alpha = .82 to .93) and high test-retest reliability (Hymel, Ditner, Le Mare, & Woody, 1999).

The Children's Behaviour Questionnaire

The Children's Behaviour Questionnaire (CBQ) was used to examine temperament at Time 3. It is a 195-item measure developed by Mary Rothbart and her colleagues. The CBQ assesses 16 dimensions of temperament that factor analytic studies (e.g., Ahadi, Rothbart, & Ye, 1993) have indicated load on three factors: Negative Affect, Extroversion/Surgency, and Effortful Control. Negative Affect refers to characteristics such as sadness, fear, anxiety, and frustration. Extroversion/Surgency refers to characteristics such as impulsivity, high activity level, frequent smiling/laughter, and lack of shyness. Effortful Control refers to characteristics such as perceptual sensitivity, inhibitory control, and attentional control.

Internal consistency estimates of the CBQ scales have been reported in a number of studies. Ahadi, Rothbart, and Ye (1993) presented internal consistency coefficients for CBQ scales administered to a sample of 262 parents in the northwest region of the United States. Coefficients for the CBQ scales ranged from .67 to .94, with a mean internal consistency estimate of .77 across all 15 scales. Kochanska, DeVet, Goldman, Murray, and Putnam (1994) obtained similar reliability estimates for the CBQ scales in a study of temperament that included parent reports on 171 children. They obtained internal consistency estimates ranging from .69 to .93, with a mean reliability estimate of .78 across the 15 scales.

Relational Provisions and Loneliness Questionnaire

The 28-item Relational Provisions and Loneliness Questionnaire (RPLQ, Hayden-Thomsen, 1989), is a self report measure yielding scores for: (a) perceived social support from the peer group, and (b) perceived social support from close friends. The psychometric properties of the RPLQ are documented (Hayden-Thomsen, 1989) with considerable support for its construct validity and high internal and test-retest reliability shown. Internal consistency estimates ranged from .78 to .82. It was also completed at Time 4.

Parent Report of Peer Activities

Parents completed a short questionnaire regarding their children's peer activities. Questions were asked such as: (a) How often does your child do things with friends?; (b) How often do friends telephone your child?; (c) How often does your child telephone other kids?; and (d) During the past 6 months how well has your child 'gotten along' with friends and classmates? This questionnaire was developed specifically for the Romanian Adoption Project and was also completed at Time 4.

Parenting Practices

Parenting Practices were assessed with the Parenting Practices Questionnaire (Robinson, Mandelco, & Olsen, 1995), a 62-item self- and spousal-report instrument that yields scores for mothers and fathers based on Baumrind's Authoritative, Authoritarian, and Permissive parenting styles. Factor analyses of more than 1300 parents (both mothers and fathers) consistently yielded the three main factors. The alphas for fathers for the Authoritative, Authoritarian, and Permissive styles were .92, .87, and .63, and the alphas

for each of the styles for mothers were .84, .80, and .56, respectively (Robinson et al., 1995). This measure was also used at Time 4.

Time 4

Strengths and Challenges

Parents were asked the following two questions: (a) What do you consider to be your child's greatest strengths?; and (b) What do you consider to be your child's greatest challenges? Parents responded with written descriptions. This questionnaire was developed specifically for the Time 4 assessment of the Romanian Adoption Project.

Adoption Questionnaire

This self-report questionnaire asked teens to identify feelings surrounding their adoption (e.g., how they feel when they think about their birth mother, father, etc.?). It also solicited information regarding participants' knowledge of Romania, if they had any interest in learning more about their birth country or visiting it, and how comfortable they were talking about their adoption. This questionnaire was developed specifically for Time 4 of the Romanian Adoption Project (see Appendix C).

Inventory of Parent and Peer Attachment

The Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenburg, 1987) was used to measure the participants' perceived attachments to their parents. The teens filled out separate forms regarding their relationship with their mother and their father. Examples of questions included: "My mother respects my feelings"; and "I tell my father about my problems and troubles." Participants responded to each item on a Likert scale, with 1 being "Almost never or never true," and 5 being "Almost always or always

true.” Using two samples of undergraduate students who ranged in age from 16-20 years, Armsden and Greenburg (1987) reported good internal consistency for the IPPA with Chronbach’s Alpha coefficients ranging between .72 and .91 for the subscales across both the parent and peer scales. Good test-retest reliability for a sample of 18-20 year-olds over a three-week period was also reported with correlation coefficients ranging between .86 for peer attachment and .93 for parent attachment.

Romantic Relationships

This self-report measure included questions pertaining to the participants’ romantic relationships, including sexual orientation, dating experiences, and sexual experiences (e.g., Do you consider yourself to be sexually active now? If yes, please indicate which sexual activities you have been involved in with your partner). This questionnaire was developed for the Time 4 assessment of the Romanian Adoption Project (see Appendix D).

Health Questionnaire

This parent report included questions pertaining to the teens’ health, including physical and mental health conditions and diagnoses. In addition there was a section on services that had been obtained and whether they had been helpful. Participants were again asked if there were services they had needed but were unable to access, and if so, what those services were. This questionnaire was developed specifically for the Time 4 assessment of the Romanian Adoption Project (see Appendix E).

Sex-role Orientation

This questionnaire was aimed at gathering information regarding the teens' sex-role orientations. It was a self- and parent report (both teens and their parents filled it out independently) with questions such as: "I prefer (or your child prefers) to do things that boys typically do"; "I prefer to wear makeup"; and "I like action or war movies." Participants responded with: "No, not at all true"; "Sort of"; or "Yes, very true." This questionnaire was developed for the Time 4 assessment of the Romanian Adoption Project (see Appendix F).

Child and Youth Resilience Measure (CYRM; Ungar, 2003)

The CYRM is a 30-item self-report questionnaire that is grouped into four subscales (resiliency factors)—individual, relationship, community and culture, as well as a total score. An iterative research design process was used to develop this culturally and contextually relevant measure of resilience. As part of the International Resilience Project (Ungar & the International Resilience Project Team, 2006) the CYRM was piloted in 14 sites across 11 countries (in both western and non-western settings) and was administered to 1451 youth. Findings suggested the CYRM was a reliable measure of resilience factors across the entire sample, as well as distinguished unique subpopulations with culturally specific response patterns (see Appendix G).

Phone Conversation Notes with Parents

Given that formal parent interviews were not conducted at Time 4, detailed notes were kept regarding any phone conversations researchers had with parents or teens. Parents were telephoned on several occasions for various reasons (e.g., to ask if they

wanted to participate in the study, to see if they had any questions regarding completing the package of questionnaires, and to remind them to complete the questionnaires and mail them in as soon as possible). Many parents used these phone calls as an opportunity to talk about their teens and how things were going with them. These notes provided additional information regarding how the participants were doing in adolescence.

Analytic Strategy

To begin the process of analysis, I first created case record files (Merriam, 1988) for each of the 9 participants. These files included all data, both quantitative and qualitative, that were collected at each Time of assessment (i.e., at 11 months post-adoption, age 4.5, age 10.5, and age 16.5).

Then I strategically examined each case record file, starting with data collected at Time 1, and moving in consecutive order through Time 2, 3, and 4 data. I kept detailed notes in a separate journal regarding each participant. Extensive notes were recorded regarding the children's development at each phase of assessment. Qualitative interviews, parents' written descriptions on open-ended questions, and researcher observations were particularly useful in providing descriptive information regarding children's adaptive functioning—the majority of descriptive notes recorded in my journal stemmed from these sources. All quantitative assessments were examined as well, but fewer notes pertained to these sources. They were used more or less as a method of triangulating data to see if similar information existed.

I used a code and sort procedure similar to that described by Bogdan and Biklen (1992) to identify and organize the information obtained. This process involved

identifying emergent qualitative codes, and then organizing the coded data. This process is described below.

Throughout the case record analyses, when I sensed a larger thematic idea emerging or a pattern of some kind, I recorded it in ink of a different colour in my journal so it would stand out from my other notes. These 'qualitative codes' were mostly interpretive in nature, and revealed what seemed to be some of the underlying feelings, values, and perspectives of the various informants in the study. I went through the 9 case record files multiple times, adding to my journal each time something new emerged. When I felt I had 'exhausted' the process, and found that I had no more information to record, I moved on to the next stage of analysis.

The next steps involved developing a series of large charts in order to sort the coded data. The first chart enabled me to visually look across participants to see if similar themes were evident. In this chart I recorded all the 'potential' themes in the left hand column. In the adjacent columns (one for each of the 9 participants) I indicated if each theme applied to each participant and, if so, how it was manifested.

I then constructed a second chart to categorize the themes into an overarching framework. Given that I was conceptualizing resilience within an ecological framework (Ungar & the International Resilience Project Team, 2006), it made sense to sort the themes into the categories of resilience factors comprising this model. These included: Individual factors, Relationships factors, Community contexts, Cultural factors, and Physical ecology factors.

Finally, a third series of charts was completed in order to address the temporal dimension of resilience. It was important to gain a sense of how the themes varied across

the four time points in which assessments took place. This was a critical step in examining individual differences in the various ‘pathways’ to resilience—if there were certain turning points or significant times in which difficulties were exacerbated or resolved. A separate chart was constructed for each participant. Themes (in their respective categories according to the ecological model) were recorded at Time 1, Time 2, Time 3, and Time 4, for each participant.

Throughout the analyses, I triangulated data originating from multiple sources in an attempt to identify similarities and contradictions in my data and my interpretations of them. As themes emerged from the data I assessed the weight and sources of the supporting evidence and entertained other plausible explanations. The following kinds of questions were considered during this process (Neufeld, 1999): “Is there enough evidence here to support this assertion?”; “Can evidence supporting this assertion be found in more than one place?”; “Is there evidence that contradicts this position?”; and “Are there other plausible explanations of these data?” The process of triangulation gave me increased confidence in making assertions about the participants’ pathways to resilience.

Finally, given that there were approximately equal numbers of ‘resilient’ and ‘non-resilient’ participants, the way I undertook analysis and charting allowed me to examine group differences in a qualitative sense—identifying themes that were particularly evident in the ‘resilient; or ‘non-resilient’ groups. The advantage of the multiple case study design is that I could simultaneously look at such similarities and differences within and between groups, while also identifying unique individual variations that were occurring in the participants developmental’ pathways.

RESULTS AND DISCUSSION

In this section I first present a characterization of the participants at Time 1 (11 months post-adoption) in relation to their later development at Time 4 (age 16.5). Following this I provide detailed descriptions of patterns and themes that were evident in my case study analyses. These themes are organized according to the ecological framework of resilience (Ungar & the International Resilience Project Team, 2006) described earlier. Next, I summarize the general findings including descriptions of some of the ‘interactions’ among resilience factors, and overarching ideas regarding why the various themes may contribute to resilience or non-resilience processes in participants’ lives. Two cases in particular, ‘the case of Lauren’, and ‘the case of Cory’, will be highlighted in order to illustrate these points. Finally, conclusions are presented regarding the importance of this research, and directions for future research are suggested.

Characterization at Time 1

Despite clear differences between teens in the resilient and non-resilient groups at Time 4, at the outset of the study the two groups were not readily distinguishable. Examination of developmental indices, parent reports, and researcher observations at Time 1 revealed that every child had experienced adversity in an orphanage and had multiple challenges in a variety of domains. It must be emphasized that early challenges were not restricted to the participants who were classified as ‘non-resilient’ at Phase 4.

Time in Institution

Parent reports of their child's age at adoption revealed that all had spent at least 9.5 months (range 9.5 to 24 months) in an orphanage prior to being adopted. The 'resilient' participants actually spent longer in institutions (range 16 to 24 months) than the 'non-resilient' participants (range 9.5 to 15 months; see Table 2). The parents of all 9 children described orphanage conditions as 'poor' with inadequate staffing and marginal nutritional provisions. For example, Alison's mom mentioned how there were 20 toddlers in the room Alison was in with only one caregiver in sight. She went on to say that "in her room all the kids were lying flat on their backs and seemed to have given up on life; they wouldn't even make eye contact with you." Heather's mom described how toileting of the children seemed to take forever. Toddlers were lined up on potties and forced to sit there for an hour. Lauren's mother mentioned that her daughter's meals consisted only of "watered down soups." Only Liam's mother mentioned that there were a couple of pictures on the walls, and a bit of sunlight entering the room he was in.

Developmental Delays at Adoption

On the Denver Developmental Questionnaire (Frankenburg, 1986), which provides an assessment of gross motor, fine motor, personal-social, and language skills, the number of delays evident at the time of adoption was not a variable that distinguished the 'resilient' from the 'non-resilient' participants. Delays varied from 0 to 4 in the 'resilient' group, and 0 to 3 in the 'non-resilient' group (see Table 2). For example, Cole, who appeared resilient at age 16.5 displayed delays in gross-motor, personal-social, and adaptive functioning when adopted. In contrast, Cory, who was non-resilient at age 16.5 had primarily language delays at the time of his adoption.

Table 2. Participant Profiles at Time 1

	<i>Resilient Participants</i>					<i>Non-resilient Participants</i>			
	<i>Liam</i>	<i>Cole</i>	<i>Heather</i>	<i>Mitch</i>	<i>Lauren</i>	<i>Alison</i>	<i>Jenna</i>	<i>Cory</i>	<i>Micah</i>
Age at Adoption (months)	17	22	22	24	16	15	12	14	9.5
Number of Dev Delays (Denver)	4	1	3	1	0	3	2	1	0
Number of Delays on Gesell Test	n/a	3	4	1	1	n/a	3	1	0
Stanford-Binet IQ scores	115	85	84	99	116	86	73	93	89
Yearly Family Income (in thousands)	70-80	30-40	30-40	100	80-90	50	70-80	50-60	50-60
Parents' Ages at Adoption	36, 37	33, 38	33, 38	46, 47	43, 48	36, 40	29, 30	33, 35	38, 38
Parents' Education	Coll	Coll	Coll	Univ Grad	Univ	Coll	Coll	Univ Grad	Coll
Reason for Adoption	Inf	Inf	Inf	Rel	Inf	Inf	Hum	Hum	Inf

Note. **Parents' Education:**
 Coll = Some College Training;
 Univ = Some University Training;
 Univ Grad = University Graduate.
Reasons for Adoption:
 Inf = Infertility;
 Rel = Religious/Spiritual;
 Hum = Humanitarian.

The Gesell Developmental Schedule scores (Amatruda et al., 1940) corroborated to a large extent with the scores on the Denver. Of those participants with available Gesell data (2 were not given the test), all experienced delays of some kind, and delays were not restricted to the non-resilient group (see Table 2). For example, at the time of his adoption at 2 years of age, Mitch's parents reported that he only had a 5-word vocabulary. This was also reflected in his Gesell scores which indicated that he had both receptive and expressive language delays.

Intelligence

IQ was not measured until the children were age 4.5, but given the fact that IQ is generally considered to be stable across time it is relevant to mention it here to get a

sense of the cognitive abilities of the children at a young age. The Stanford-Binet (Thorndike et al., 1986) IQ scores varied a fair amount in both groups. In the 'resilient' group scores ranged between 84 and 115, and in the 'non-resilient' group scores ranged between 73 and 93. Thus, it is clear that not all the resilient participants were highly intelligent and not all the non-resilient participants were intellectually challenged as one might expect (see Table 2).

Family Demographic Factors

Family Demographic factors did not differ widely between groups at Time 1. There was some minor variation in family income, with a wider range of earnings found in the resilient group. Yearly income in the resilient group ranged between \$35,000 and \$100,000, and in the non-resilient group income ranged between \$50,000 and \$80,000. Parents' ages at adoption ranged between 33 and 48 (average was 39) in the resilient group and 29 to 40 (average was 35) in the non-resilient group. Parents' education levels were also similar. In both groups all parents' had spent some time in post-secondary training (i.e., college diploma and/or or some university training); and 2 families (one in the resilient group and one in the non-resilient group) had parents who had graduated from university.

Reason for Adoption

There were some differences between groups in terms of the reasons for adopting a child from Romania. Four of the five families in the resilient group chose to adopt due to infertility reasons. The other family cited religious/spiritual reasons. In the non-resilient group, two of four families chose to adopt for humanitarian reasons (i.e.,

wanting to ‘save’ or ‘rescue’ a child from the deplorable conditions in orphanage), while the other two families cited infertility as the reason.

Based on this review of participant characteristics at Time 1, it is clear that there was considerable variability in both the resilient and non-resilient groups at the outset of the study. Therefore, on the basis of the Time 1 data one would not likely have predicted the Time 4 outcomes that were observed.

Themes from the Case-Study Analyses

Themes that emerged from the case studies regarding the participants’ potential pathways to resilience (or non-resilience) were categorized, and are discussed below, according to the ecological framework (Ungar & the International Resilience Project Team, 2006) that guides this study; this includes Individual, Relational, Community, Cultural, and Physical Ecology factors. It must be noted that some themes overlap in more than one category (e.g., a theme may relate to both individual factors and relational factors), but are not described more than once. Finally, although generalizations are made regarding themes, individual variation is considered throughout each section in order to not lose sight of the complexity of resilience processes.

Individual Factors

Temperament

Temperament was considered in three domains—Extroversion/Surgency, Effortful Control, and Negative Affect. Scores for the participants in each of these domains are found in Table 3. In general, temperament characteristics did not vary much between the resilient and non-resilient youth. Certain problematic temperament

characteristics, such as high levels of extroversion/surgency and low levels of effortful control, were not restricted to youth in the ‘non-resilient’ group. These temperament characteristics can be associated with overly friendly behaviour (i.e., lack of stranger wariness), impulsivity, and attention difficulties. For example, at Time 3 in the resilient group, both Mitch and Cole’s parents mentioned difficulties that were related to attentional focusing and impulsivity. Mitch was described as being “hard to settle down” much of the time, and Cole’s mother said that any difficulties she had with her child were related to his difficulty with focusing.

Table 3. *Temperament*

		Extroversion/Surgency	Effortful Control	Negative Affect
Resilient participants	<i>Liam</i>	230	210	127
	<i>Cole</i>	n/a	n/a	n/a
	<i>Heather</i>	133	166	90
	<i>Mitch</i>	195	178	26
	<i>Lauren</i>	225	228	142
Non-resilient participants	<i>Alison</i>	278	119	107
	<i>Jenna</i>	200	194	103
	<i>Cory</i>	290	147	37
	<i>Micah</i>	220	102	107

Descriptive Adjectives

Descriptive adjectives that parents used to describe their children were somewhat different in the resilient and non-resilient groups. There were a higher number of empathy related ‘other - oriented’ adjectives listed by parents of resilient youth. Even at the young age of 4.5, descriptions of the resilient children typically included adjectives such as: caring, loving, sensitive, warm, gentle-hearted, thoughtful, and kind. These types of adjectives continued to be used by parents at later time-points. For example, at age 10.5

Heather was described by her mother as “very gentle-hearted and caring—she is very sensitive to the feelings of others.”

The use of ‘negative’ adjectives was restricted to parents of the non-resilient children. Parents of all four of these children used at least one ‘negative’ descriptor of their child including: aggressive, argumentative, self-doubting, self-destructive, bully, stubborn, and impulsive. Negative adjectives were typically used at either the Time 3 (age 10.5) or Time 4 (age 16.5) assessments. For example, at age 10.5 Cory’s mom expressed her concerns about her son’s self-destructive tendencies. “He sniffs nail polish, glue, and sucks back toothpaste; rides his bike on purpose into parked vehicles; and is trying to teach the dog to bite him.” Adjectives used by parents of children in the non-resilient group at earlier phases tended to focus on traits relating to energy levels (e.g., energetic, active, lively, vivacious, etc.). These descriptors were also used by parents of children in the resilient group, but to a lesser extent.

Interests

Several patterns emerged when examining the interests/activities of the participants. A sense of ‘well-roundedness’ was evident in all 5 of the resilient participants. These youth tended to be interested in a variety of activities, including sports and music of some kind. In addition, they participated in both solitary activities (e.g., reading, art, individual sports), and social pursuits (e.g., team sports, community or school bands). By the time they were 16.5, all had developed a special talent and passion for a particular activity (or, in some cases, several activities) and spent a lot of time at it. These talents included: piano, singing, cello, volleyball, basketball, saxophone, guitar,

music composition, and tennis. For example, by age 16.5 Lauren had developed a special talent for writing her own music and would then play her compositions on her guitar.

The non-resilient youth also participated in a variety of activities up to age 10.5, including music and sports, but by age 16.5 all four seemed to have a marked decrease in participation in extracurricular pursuits. Cory and Alison's parents reported that their teens did not have any hobbies or interests. Jenna's mother stated that her daughter participated only in solitary activities such as reading, video games, and swimming. Micah's father said his son enjoyed soccer and was good at it, but was currently not being allowed to play due to poor school performance and behaviour problems.

Self-esteem

At age 4.5 and 10.5, struggles with self-esteem were evident in the children from both the resilient and non-resilient groups. For example, in the resilient group, Cole had a tendency to exaggerate often which his parents attributed to his low self-esteem. Also, Heather needed a lot of encouragement from researchers during the Time 3 assessment (age 10.5) because she was afraid of not performing perfectly. She teared up several times during the academic assessments when questions got too difficult for her because she didn't want to get them wrong. Her parents commented that this type of behaviour was fairly typical of her and believed it related to her feelings about herself "deep inside."

In the non-resilient group, Jenna's mother described how she was always "full of self-doubt." She explained that "Whenever she is starting something new she has immediate doubts before she even tries it. If the teacher says 'tomorrow we'll start learning multiplication', Jenna would come home crying." Other struggles with self-esteem in participants from the non-resilient group were present early on in their peer

relationships. For example, at age 10.5 Cory's mom described how "he will do anything his friends tell him to do—whether it's kicking someone, biting, or things like that." In other words, he was easily swayed by peers and didn't seem to have a sense of himself or his values.

By age 16.5, all of the resilient teens seemed to have developed positive self-perceptions. This was evident in questionnaires pertaining to self-concept and parent reports. For example, Liam's mom described how "His strengths are just who he is. He's just a great kid. He doesn't bow to peer pressure." Conversely, in adolescence all the teens in the non-resilient group were struggling with self-esteem more than ever. Direct statements regarding this were evident. For example, Cory's foster parent voiced that his biggest concern about Cory was his low self-esteem. Given that Cory had problems with criminality, drugs, and alcohol abuse, it was interesting that self-esteem was highlighted. This is likely because the parent realized that such problem behaviours stemmed, at least in part, from low self-esteem.

Strengths

When asked about their child's strengths at Time 4, the parents of resilient youth tended to focus primarily on attributes related to character, whereas parents of children in the non-resilient group tended to focus on attributes related to abilities and competencies. Furthermore, similar to earlier findings related to descriptive adjectives, the character traits described for the resilient teens tended to focus on 'other-oriented' attributes. For example, Lauren's mother said, "I think she is just an extraordinary girl. She's very smart. She's friendly, noble, and loving, and she's very caring about other people. She has a big heart; she's not one that wants to hurt other people." Mitch's mother also

commented that “He is very caring, very loving, and very loyal to his family and friends”; and Cole’s parent mentioned that “Cole sees a positive side to everything—he shows his love to others and brings a lot of life into our home.”

In the non-resilient group, parents described the following ability related strengths: musical ability, soccer and lacrosse ability, and sports agility. Other strengths were mentioned with qualifiers attached. For example, Cory’s mom said “he’s smart but he doesn’t work hard.” An obvious exception was Jenna. Her strengths were clearly character-oriented and included: being kind to other people, and being caring, happy, helpful, and hard-working.

Challenges

Challenges were reported by all parents at Time 1. All of the children required an extra measure of care and individual attention immediately after adoption due to various developmental delays. By age 4.5, challenges related to hyperactivity, inattention, and impulsivity were reported by families of two of the resilient participants and three of the non-resilient participants. These same issues were brought up at the age 10.5 assessments for all five of these participants, but the nature of them had changed. For the two resilient teens, the attention issues were still concerning parents, but they seemed to have developed coping strategies. For example, Mitch’s mom commented:

Sometimes Mitch has difficulty focusing. In the morning he has certain things he has to do and sometimes he’s blanked right out and he doesn’t hear me tell him unless I get the eye contact. I find that eye contact is really important for him. I also don’t give him long lists of things to do. I keep it simple and manageable. He also loses privileges if he doesn’t do as he is asked.

Conversely, in the non-resilient group, the problems related to attention issues seemed to have exacerbated by age 10.5. All three of these teens had been diagnosed with ADHD, and parents seemed to be struggling to manage it. For example, Alison's mother commented:

The ADHD is a nightmare. She's quick to steal, and quick to do pranks. She beats up her sister. You can't leave her alone. You can't get her to focus on anything but TV and that is sometimes my babysitter.

At the Time 4 assessment (age 16.5), challenges mentioned by parents of non-resilient teens seemed to be more serious in nature compared to the 'normal' teenage challenges mentioned by the other parents. For example, both Jenna and Alison's parents' were concerned about their daughters' ability to be independent. Learning disabilities and poor social skills were challenges for both girls, therefore their parents were concerned about the girls' abilities to pursue further education and/or find employment. Cory and Micah's struggles with impulsivity had increased and were manifesting as deviant and/or criminal behaviours in adolescence (e.g., stealing, lying, self-destructive behaviours). Both boys' parents' made comments regarding their sons' inability to understand consequences related to actions.

In the resilient group, challenges at age 16.5 seemed like more 'normal' teenage behaviour. Liam's parent complained that he spent too much time talking to his girlfriend on the phone every night and was slightly worried that he wasn't eating a balanced diet because he had recently "become a vegetarian to make his girlfriend happy"; and Cole's mother thought he might have a hard time choosing his career path after high school, but followed it up by saying "he has a lot going for him though."

Behaviour Problems

Parents of resilient children reported very few behaviour problems on the Child Behaviour Checklist (at all time points assessed). On the other hand, parent reports of behaviour problems in the non-resilient group generally increased over time, and were in the clinical range for three of the participants by Time 3 (and again at Time 4). Problems were both internalizing and externalizing in nature. For example, at age 10.5 Cory’s mother described how Cory “seems to enjoy vandalizing vehicles—he smashes rocks through the windshield.” At age 16.5, Alison’s mother mentioned that her daughter was withdrawn much of the time and ‘afraid’ to engage with her peers. “She also steals at home and is very secretive” (see Table 4).

Jenna was an exception in the non-resilient group. Her parents reported only moderate levels of problem behaviours that were associated with her Obsessive-Compulsive Disorder, such as repeating words and sentences over and over; and “listening to the ‘tone’ of her voice so she doesn’t say things in a way that offends others.”

Table 4. *Scores on the Child Behavior Checklist*

		Time 2 (age 4.5)	Time 3 (age 10.5)	Time 4 (age 16.5)
Resilient participants	<i>Liam</i>	5	26	2
	<i>Cole</i>	58	25	0
	<i>Heather</i>	55	28	0
	<i>Mitch</i>	5	2	2
	<i>Lauren</i>	31	10	9
Non-resilient participants	<i>Alison</i>	n/a	79	86
	<i>Jenna</i>	18	22	26
	<i>Cory</i>	88	137	74
	<i>Micah</i>	25	47	76

Academic Performance

At Time 3 (age 10.5) school performance was in the ‘average’ range for three of the participants in the resilient group and also for three of the participants in the non-resilient group. The two other resilient teens were performing very well, near the top of their classes; and the one other non-resilient teen was doing very poorly. By age 16.5, three of the resilient teens were performing at the top of their classes (while the other two were still at ‘average’ levels). Conversely, all four non-resilient teens were performing at ‘well-below average’ or ‘failing’ levels in adolescence.

Diagnoses

Parents of all participants were asked if their child had received any diagnoses by a healthcare professional. Only one of the resilient individuals, Lauren, was reported to have received any diagnoses. Lauren struggled with and was treated for depression and anxiety in her early teen years. In contrast, every one of the non-resilient teens had been labelled with one or more diagnoses by the time they were 10.5; and in two cases they had additional diagnoses by age 16.5. Examples included: ADHD (3 cases), Depression (2 cases), Learning Disabilities (2 cases), Anxiety, Developmentally Delayed, Obsessive-Compulsive Disorder, Attachment Disorder, and Conduct Disorder (related to criminal activity).

Relationship Factors

Attachment

According to researcher observations, attachment with primary caregivers was ‘clearly discriminate’ by age 4.5 for all the participants in the resilient group. Conversely,

attachment at the same age was described as 'indiscriminate' for 3 out of 4 of the non-resilient participants at the same age, and 'somewhat discriminate' for the fourth child.

These observations were consistent with comments made by parents regarding the bond they had with their children. For example, in the resilient group Liam's mom described (at Time 1) that "it felt like Liam was our own child immediately." On the other hand, in the non-resilient group, Alison's mom stated that "Alison did not accept her father for 4 months."

Furthermore, comments made by early childhood professionals during Infant Development Program assessments (IDPs) seemed to show that forming an attachment was taking place at an early age in the resilient group. For example, at Heather's 32 month IDP assessment the following written comment was made: "Heather is managing well in her new household, and is becoming increasingly more outgoing and more secure. She appears to have bonded well with her adoptive mother."

Indiscriminate friendly behaviour, which is often related to attachment difficulties, also persisted for longer in the non-resilient group. The majority of participants demonstrated some indiscriminate behaviour during earlier phases of the study, but such behaviour had resolved by age 10.5 in all the resilient participants yet continued into adolescence for all the non-resilient participants. For example, at age 10.5 Alison's mother described how her daughter still lacked stranger wariness and feared she would go off with anyone easily. "I enrolled her twice in a stranger program and I think it may have helped a little, but I still don't completely trust her."

Primary Caregiver

There were distinct patterns in each of the groups regarding childcare arrangements. In the resilient group, all five participants were primarily cared for by their mothers. These mothers stayed at home full-time with their children in the early years—from the time they were adopted until they reached school age. Furthermore, when their children entered school, the moms who returned to work arranged their work schedules around school hours. For example, Liam’s mother described how she started her own housecleaning business because she knew she could organize her hours to work only while her son was in school.

In the non-resilient group, parents generally returned to work after their parental leave employment benefits had ended (which was typically several months). Thus by time 1 (11 months post-adoption), all of the adoptive parents in the non-resilient group were working either part-time or full-time, and children were looked after by others. Two of the children, Micah and Alison, were enrolled in full-time day-care. Cory was cared for by various in-home nannies. Cory’s family cycled through several caregivers because they “didn’t last long.” His mom said he was very difficult to care for and babysitters would quit because they were tired of dealing with his aggressive behaviours (e.g., hitting, kicking, and biting). She tried hard to place Cory in special needs day-care, but was unable to secure a place. In Jenna’s case, her mom worked part time before Jenna entered school so she was cared for only part-time by babysitters.

Family Structure

There were a variety of family structures represented in the various case studies. In the resilient group, there was a pattern of family makeup that seemed to enable the

youth to experience a lot of individual attention. For example, Liam and Lauren were both the only child in their families, and they each had full-time stay-at-home mothers. Heather and Cole (the twins) had one sibling (their parents' biological daughter), who was five years their elder. The twins were home schooled while their older sister attended public school, so this gave them a lot of undivided attention from their mother. Mitch's family had a very interesting structure. Prior to adopting Mitch, the family had adopted 8 other children (all from the foster care system), in addition to having 3 biological children. Therefore, Mitch was the youngest of 12 children, with the next oldest being several years his elder. As the 'baby' in his family, he was given a lot of individual attention from his older siblings and his parents.

In the non-resilient group, in 3 out of 4 cases, parents were busy caring for biological children (that were fairly close in age to their adopted Romanian children) or other adopted Romanian children. For example, Jenna had two older sisters (who were 3 and 5 years older), and Cory had a sister who was 3 years older. Alison's parents had adopted another Romanian child at the same time as her. She was younger (by a few months) than Alison and had special needs, both physical and mental, which required a lot of care. Her physical disabilities necessitated that she be in a wheel chair. The exception in the non-resilient group was Micah. He was the only child in his family.

Marriage Status

Marital breakdowns post-adoption occurred to the same extent in families from both the resilient (2 cases) and non-resilient (2 cases) groups. However, there appeared to be differences in how the divorces were handled between groups. In the resilient participants' families, the break-ups seemed to be handled in a way that put the needs of

the children first; whereas in the non-resilient participants' families, the divorces involved a lot of obvious conflict. For example, when Liam's parents split up (when he was 4 years old) his parents came to an agreement regarding joint custody, whereby Liam saw his father every weekend. He shared many similar interests with his father (e.g, skiing, golf, movies) and maintained a positive relationship with him through adolescence. His parents (including stepparents) all seemed to get along amicably following the divorce. This was mentioned at several time points by Liam's mother, and also observed by researchers who commented: "This strikes me as a very happy and well adjusted family despite the fact that the parents divorced." The marriage breakdown in Lauren's family (when she was 4) wasn't nearly as amicable initially. Her father decided he didn't want to pay child support, and therefore argued that he was never really Lauren's father (i.e., that the adoption wasn't valid). Lauren's mother did her very best to protect Lauren from feelings of abandonment and told her that "the court had taken away his Daddy job." Lauren's mom remarried several years later and she got along very well with her stepfather. Lauren's tomboyish personality was embraced by her new father, and they shared many sports interests.

In the non-resilient group, the two marriage breakdowns were much more conflicted. Alison's parents divorced when she was 11; however it was evident at earlier time-points that her mother had felt like a single parent well before the divorce occurred. The marriage breakdown seemed to exacerbate her mother's feelings of aloneness and desperation. She struggled very much as a single parent, both financially and emotionally, and spoke of her frustration with her ex-husband freely and in front of her children when interviewed.

Cory's parents divorced when he was 3.5. His mom said it was because his father had been abusive to her. After the divorce, Cory still saw his father once in a while but he didn't get along very well with him. His mother remarried when Cory was 9, and at the Time 3 assessment (age 10.5) researchers reported that it seemed he had a poor relationship with his step-dad.

Peer relationships

At age 4.5 some peer difficulties were evident in both the resilient and non-resilient groups. These tended to involve troubles with sharing, shy and withdrawing behaviour, and/or aggressive behaviour. However, by age 10.5 the peer problems had resolved in the resilient group and exacerbated in the non-resilient group.

At age 10.5 and age 16.5 resilient participants' tended to show leadership abilities among their peers, and were not swayed by peer pressure. For example, Mitch's mom described how he "stays away from kids that are rough around the edges"; and Liam's mother provided another example of disregard for peer pressure at age 10.5:

He's not swayed by peer pressure yet. Every year for his birthday I wrap up his lunch in wrapping paper and send him off....he opens it at school and of course everyone says "goo goo gaa gaa." He came home and said a couple of comments were made—positive comments—and I said 'Oh I don't know how many years I'm going to get away with doing this, because you know the kids might start laughing at you', and he said 'Well I guess I'll just be laughing right along with them, cause I don't want you to stop'. So he's, yeah, a real individual.

At later ages the non-resilient youth tended to show extremes in their peer relationships. By the time they reached adolescence, both of the girls were shy and withdrawing, and tended to only pursue solitary activities. The boys, on the other hand,

were aggressive and domineering, and frequently were getting into trouble with their peers.

Romantic Relationships

At age 16.5, two of the participants in the resilient group and two of the participants in the non-resilient group mentioned that they had no experience with romantic relationships yet. This seemed to be a deliberate choice for the resilient youth (Cole and Heather) and was likely related to parental values regarding ‘appropriate’ ages to begin dating. For the non-resilient youth—Jenna and Alison—their lack of experience with romantic relationships was likely related to their shy and withdrawing social behaviour.

Of the teens that had experience with romantic relationships, those in the resilient group seemed to have fairly ‘normal’ relationships. Liam and Lauren had been dating their partners for 1 to 2 years, and Mitch had dated several girls in the past couple of years. Conversely, in the non-resilient group, Cory and Micah demonstrated a pattern of unhealthy romantic relations. Cory frequently spied on his older sister while she was dressing and made sexual comments towards her; and Micah had an obsession with stealing female undergarments.

Parenting Stress

There was a clear pattern of low levels of parenting stress in the resilient group and high levels of parenting stress in the non-resilient group. The exception was Jenna’s parents, who reported moderate levels of stress (i.e., higher than the resilient group, but lower than for the parents of the three other non-resilient youth).

It seemed the stress was primarily related to two factors—children’s behaviour issues (and other developmental needs), and lack of supports in place to help parents deal with their children’s challenges. For example, Alison’s mother described how she was “disowned by my parents for what I had done.” Her parents did not agree with her decision to adopt children from Romania in the first place, and when difficulties emerged they became uninvolved in the family. She also felt her husband was unsupportive (as described earlier - they later divorced), and so she felt isolated as she parented two daughters with multiple challenges. Cory’s mother seemed perpetually stressed by the ‘system’ and its inability to help her with her son’s issues. She fought to get respite care, but was denied because Cory’s challenges were not deemed severe enough to qualify for this service. By the time Cory was 16.5, he was being cared for by foster parents. Perhaps this was partly related to his mothers’ clinical levels of parenting stress.

Parenting Practices

Two patterns emerged when examining parenting practices in the resilient group. First, parents were consistent over time in their parenting approach (and spouses seemed to be consistent with one another in their parenting). Secondly, it was evident that parents were sensitive to their children’s emergent needs over time, and adapted their parenting as necessary. For example, at a young age Heather was extremely shy and found it really hard to be around groups of people. At the Time 2 assessment, her mother described how she “arranged her schedule around what Heather can cope with.” Cole’s challenges (Heather’s twin) were quite the opposite in social situations—his inattention and impulsivity became greater obstacles for him when he entered Kindergarten. After much deliberation, the twins’ parents decided that homeschooling was the best approach for

their children's unique needs, and started this at Grade 1. By age 10.5, it was clear that both children were thriving with this approach. They weren't stellar students by any means (their performance was consistently 'average'), but they seemed to have much greater confidence in their abilities and improved self-esteem.

Mitch's mother also demonstrated adaptation and sensitivity in her parenting. Having raised 11 other children she was accustomed to certain discipline approaches, but seemed to recognize what was most appropriate for Mitch. This was illustrated by written comments made by the Infant Development Program specialist (when Mitch was 32 months old):

Mitch's family is very sensitive to his needs and provides him with experiences to encourage development in a natural and loving manner. His mother has excellent parenting skills. She recognized that using isolation as a discipline technique was inappropriate for this child.

Lauren's mother showed sensitivity in regard to Lauren's tomboyish tendencies. At Time 2 she described how Lauren often "cried because she wasn't a boy." She consulted a psychologist regarding her daughter's behaviour and followed the advice to 'not make a big deal out of it'. She allowed Lauren to dress in whatever way she chose, and wear her hair in a short 'boyish cut'.

In the non-resilient group, the parents of Jenna and Micah seemed united in their parenting approach, and appeared to deal as sensitively as possible with their children's challenges. However, this was not the case for Alison or Cory. Both children's parents divorced and their fathers were essentially uninvolved in the children's lives and/or their involvement did not support the mothers' efforts. The lack of sensitivity in parenting was evident in parent interviews and comments made by researchers. For example, at the

Time 3 assessment, the researcher commented that Cory's mother seemed "lacking in care and affection for her son." She discussed his challenges with a sense of resignation and lack of emotion. The researcher who visited Alison's home also felt uncomfortable with how Alison was regarded by her mother. She commented that: "her mother doesn't seem harsh, but not nurturing either. There is far too much talking about the kids in front of them."

Parental 'Outlook'

In general, parents of resilient participants displayed an optimistic attitude toward their children's development and this was evident early on in the study. Certain annoying behaviours exhibited by their children were 'normalized' to a greater extent in this group. For example, in a parent interview with Mitch's mom at Time 3, she commented, "he is often immature, but so are all 10-year-old boys." Furthermore, on the Parenting Stress Index she added written comments expressing her feelings that the measure itself was "too negative." She added: "We've been parenting for almost 30 years. This little boy we got in Romania has been a delight for us. He is enriching our lives. I am learning so much from him." Liam's mom also commented, "If I'd written a list to God and said this is what I want—well, that's what I got. He's definitely not perfect, but he's wonderful in so many ways."

In the non-resilient group, a sense of optimism seldom permeated any of the parent reports or questionnaires. Parents of Micah and Jenna came across as fairly neutral in the attitudes towards their children's development—not overly optimistic or pessimistic. However, there was a clear sense of parental exasperation and desperation in Alison and Cory's families. For example, when asked about what had been the most

troublesome problem at Time 2, Alison's mom responded "life in general—there are so many challenges." Every parent was also asked the question, "Given what you now know about being a parent to your child, if you could do the whole thing over again, how likely would you be to repeat the experience?" Alison's mother was the only parent in the non-resilient group to answer "definitely not—the combination (referring to the adoption of both girls from Romania) has been horrible and hard." Her extreme frustration and desperation was also evident when she commented on the challenges of dealing with Alison's ADHD. She stated: "It was either she goes on Ritalin or we give her away."

Cory's mom also displayed a pessimistic outlook. At Time 1, she stated that she believed "it's harder to bond with an adopted child than a biological child." By the time Cory was 10.5, a sense of hopelessness was evident in many of her comments. For example, she said: "I know something is going to happen, but it's not my fault. I'm fully prepared that he will be arrested someday...he's not changing...he'll never change. To have low expectations is the best thing and just be prepared."

Community Contexts

Service Needs

Reports of services utilized at Time 1 and Time 2 indicated that most families (i.e., 7 participants) had utilized Infant Development Programs (IDPs) at local Child Development Centres. These programs were aimed at assessing developmental delays, providing advice for parents on how best to help the children 'catch up', and tracking progress. Children were followed until the age of 3, with the exception of Jenna. Her parents took her for one assessment, and decided they no longer needed the services because they were not very concerned about her development (even though delays were

likely still evident as Jenna was labelled “Developmentally Delayed” when she entered school). The two participants who were not in infant development programs were Liam and Alison. Liam’s mother did not feel he needed the services as he was displaying ‘catch-up’ immediately upon arrival in Canada; Alison’s mom was unable to obtain access to the IDP services (for reasons unknown).

With the exception of Lauren’s service use for depression in adolescence, none of the other resilient participants accessed any psychological services after the IDPs. However, in the non-resilient group there was a consistent pattern over time of accessing services to help with the children’s difficulties as well as an inability to access needed services. A variety of services were used including: psychologists, psychiatrists, teacher’s aides, and residential treatment programs. All four of the families of non-resilient youth had unmet service needs. The services they wanted but could not get included: speech therapists, special needs day-cares, respite care, and educational help—primarily teachers’ aides.

Employment

At age 16.5, every one of the resilient participants had paid employment experiences. These included: working at a grocery store, at a coffee shop, in construction, care-giving for elders and/or children, lifeguarding, and paper routes. Conversely, only two of the participants in the non-resilient group had employment experiences (both in fast food restaurants). Micah’s job had only lasted one month, but it wasn’t clear why it ended. Cory had just started a job at the time of the assessment.

School Environment

By age 10.5, school environments were generally positive for all of the resilient participants. Students attended one school consistently and parents had few complaints. On the other hand, school environments for the non-resilient youth were generally negative. All parents reported being 'dissatisfied' with their school's ability to meet their child's needs. For example, at age 10.5, Alison's mother described how "even though she is in a special school with small class sizes, her teachers seem to have a hard time complying with her special learning needs." In two cases families had switched schools in order to find a more positive environment for their child.

Cultural Factors

Adoption

In the resilient group all of the youth seemed 'at ease' with the fact that they were adopted. This was evident in parent descriptions and the teens' self-reports on the adoption questionnaire. Three of the resilient participants had maintained contact of some kind with their biological parents in Romania. Cole and Heather exchanged letters occasionally with their birth mother, and they felt that that was 'just the right amount of contact'. Lauren had visited Romania on two separate occasions, when she was 8 and 13 years old, and had been lovingly embraced by her biological mother and siblings. This experience of being connected with her birth culture/family was so meaningful to her that she chose to change her name (back to her original Romanian name) after she returned from her first visit. Lauren's mother described how when they visited Lauren's biological mother in Romania there was a prominent display of photos of her daughter that she had mailed over the years. "It was like a shrine for Lauren and made her feel really loved by

her family on the other side of the world.” Given that many of Mitch’s older siblings had been adopted, it was not an issue for him. His mom expressed that being adopted “is just part of who he is.”

Conversely, in the non-resilient group, there seemed to be some unresolved issues surrounding being adopted. On the self-report questionnaire, 3 participants reported that they “feel their adoptive parents’ feelings might be hurt if they talk about their birth parents.” This was not the case for any of the resilient participants. Furthermore, all four of the non-resilient teens had no contact with their birth families and expressed mixed feelings towards them. When asked how they felt when they thought about their birth mothers and/or fathers, responses included anger, hurt, and/or confused feelings.

Religion/Spirituality

Religion/spirituality seemed to be an integral part of the lives of three of the resilient participants. At earlier time-points it manifested itself more as a family value, and by age 16.5 it was evident that religion was important to the teens themselves. For example, in Mitch’s case his parents had adopted him for ‘religious/spiritual’ reasons. He was enrolled in Christian school, and attended church with his family. By age 16.5, he was very involved in youth group and missions activities with his church, and volunteered for church events on a regular basis. His dad commented that: “Mitch is a very religious young man who devotes much of his time to church activities.”

Religion was clearly valued in the twins’ (Heather and Cole) family as well. Their parents mentioned on several occasions that their ‘church family’ had been incredibly supportive to them throughout both the pre and post-adoptive periods. In their teen years, both Heather and Cole were very involved in their church’s music ministry.

Finally, when asked on a self-report measure if 'spiritual beliefs are a source of strength for you'; Mitch, Heather, and Cole all responded that the statement "describes me a lot."

Religion/spirituality was not reported as being important for the other two resilient participants, and none of the non-resilient participants.

Physical Ecology Factors

Orphanage Conditions

As mentioned earlier, the orphanage conditions for all nine participants were described as very poor by parents. The only positive detail mentioned was by Liam's mother, who said that there were some pictures on the walls and some sunlight entering the room he was in.

Adoptive Family Living Environment

Reports on the HOME Inventory (i.e., Home Observation for Measurement of the Environment) at age 4.5 were fairly positive regarding appropriate stimulation (e.g., books, toys, learning experiences, etc.) in the home environments of all the participants. However, at age 10.5, researcher observations related to physical environments revealed some concerns pertaining to two of the resilient youths' environments and two of the non-resilient youths' environments.

For example, in the resilient group, there were some concerns about the location of Cole and Heather's home. It was situated in an extremely rural setting set apart from any other housing developments. Researchers were concerned that this may hinder the children's access to informal social opportunities with other children.

In the non-resilient group, concerns about Alison’s and Cory’s living spaces centred on a general sense of disorder and messiness in the houses. Researchers visiting both homes found it hard to ‘clear’ an area where they could do the assessments with children because of an extreme amount of clutter littering all potential work spaces. After leaving Cory’s house, the interviewer noted that she was so relieved to leave because she was feeling claustrophobic in the house related to the “stuff everywhere and chaotic environment.”

Resilience Scores

Although resilience scores on the Child and Youth Resilience Measure (CYRM) do not reflect resilience factors pertaining solely to the physical environment, they give a general sense of the participants’ self-perceptions of the various resilience factors operating in their lives. Results on the CYRM showed that all of the participants in the resilient group had higher total resilience scores than participants in the non-resilient group (see Table 5). This is what would be expected after examining the themes that emerged in the various categories of the ecological model.

Table 5. Scores on the Child and Youth Resilience Measure

Scores on the Child and Youth Resilience Measure (CYRM)		
Resilient participants	<i>Liam</i>	120
	<i>Cole</i>	121
	<i>Heather</i>	134
	<i>Mitch</i>	132
	<i>Lauren</i>	115
Non-resilient participants	<i>Alison</i>	103
	<i>Jenna</i>	n/a
	<i>Cory</i>	103
	<i>Micah</i>	112

Discussion of General Findings and Overarching Themes

A particularly salient finding in this research, which should be emphasized at the outset, is the fact that all nine of the participants did not vary much at the start of the study. Interestingly, the participants who were classified as ‘resilient’ at age 16.5 had actually spent longer in orphanages than the ‘non-resilient’ participants. Developmental delays were also fairly equivalent at the time of adoption and in the early months following it. Furthermore, demographic variables such as parents’ ages, family income, and parent levels of education did not appear to differ widely among participants. In fact, the participants in the lowest income family (i.e., \$35,000/yr) were in the resilient group. Thus, it does not appear that such factors played a significant role in promoting resilience or non-resilience.

In addition, the findings in the present study provided support for the notion that, although IQ may play an important role for some children, it is not an absolute predictor of resilience or non-resilience. Two of the participants in the resilient group had fairly high IQ’s (i.e., 115 and 116). However, two other participants in the resilient group had IQ scores which were a full standard deviation below the mean (i.e., 85), and lower than the IQ’s of several of the non-resilient participants. Such findings highlight the fact that deprivation does not ‘doom’ a child to psychopathology. Therefore, it is critically important not to focus solely on early life experiences when examining later development. In this study, many factors in the post-adoptive family environments were likely instrumental in the participants’ pathways to resilience.

There were some general patterns that emerged regarding changes in the participants’ development over time. In the resilient group, the pattern was generally

improvement over time. While all had early delays and struggles of varying degrees, they tended to improve with age, and by adolescence all five of these teens were thriving. This is not to say that there were no struggles along the way (e.g., parents' divorces, difficulty concentrating in school, gender identity issues), but challenges were worked through over time with supports in place to help them.

In the non-resilient group, struggles tended to intensify over time. At various transitional times in their lives (e.g., entering school, entering adolescence) the participants generally experienced more behavioural difficulties, and an increase in mental health diagnoses. However, it should be noted that there were exceptions to these patterns. Over time, difficulties experienced by some of the youth were showing signs of improvement. For example, with school supports in place and a clear understanding of her disorder, Jenna and her family were starting to get better at managing her obsessive-compulsive tendencies during adolescence.

With these general patterns in mind, it makes sense to look specifically at a multitude of factors and experiences in the post-adoptive environment that may have contributed to processes of resilience according to the ecological model that provides the framework for this study. These include: individual factors, relationship factors, community contexts, cultural factors, and physical ecology factors.

Individual resilience factors that seemed most central in the teens' resilience were pro-social character traits (e.g., being caring, thoughtful, and sensitive to others' feelings), positive self-esteem, and a sense of 'well-roundedness' that manifested itself in a variety of interests including academic, athletic, musical, and social pursuits. By

adolescence, resilient participants also seemed to have developed special athletic and/or musical talents.

Relationship factors stood out as being particularly important in the participants' pathways to resilience. Discriminate attachment with parents was evident at an early age (i.e., by age 4.5), and parents described a strong bond with their children being present immediately following adoption. The resilient teens also had a stay-at home parent during their early years, and once they reached school age these parents' organized their work schedules around their children's school hours. The families of resilient participants were also structured such that the children received a lot of individual attention. Some were the only child in the family, while others had siblings old enough to 'dote' on them, rather than compete for attention. Parenting stress in these families was generally low and parenting practices were consistent between spouses. When marriage breakdowns occurred, the child's best interests were paramount and parents' strived to maintain consistency, sensitivity, and adaptability in their parenting practices. Relationships with peers and romantic relationships were also generally positive, and resilient participants didn't seem negatively influenced by peer pressures.

Community factors that seemed important in the resilient participants' lives were services that met the families' needs (e.g., primarily infant development programs accessed in the early years following adoption), part-time employment opportunities that fostered a sense of responsibility and confidence in one's abilities, and positive school environments whereby individual needs were met.

An important cultural factor that stood out for the resilient participants was a sense of 'ease' with their adoption history. Participants seemed to have open

communication with their adoptive parents regarding their adoption, and in some cases, had contact with their birth parents through letters or visits. Feelings toward birth parents were positive and there was an absence of angry and confused feelings. Religion was also a source of strength for several of the resilient participants and their families.

Physical ecology factors did not stand out as being particularly important in the participants' pathways to resilience. There were some concerns noted by researchers that two of the children were living in too isolated an environment (i.e., in an extremely rural setting), and that this would hamper their social development. This did not appear to be the case. Researcher observations for the other resilient participants' environments were generally positive—they lived in non-chaotic, seemingly organized homes in urban or suburban settings.

Several of the specific themes that emerged in these case studies supports research findings on resilience in the Kauai study (Werner & Smith, 2005) and the International Resilience Project (Ungar & the International Resilience Project Team, 2006) that were discussed earlier. For example, the findings relating to 'other-oriented' character traits, the development of special talents, self-esteem, and access to services supports findings in the Kauai study. Furthermore, similar to findings in the International Resilience Project (IRP), cultural factors stood out as being important in this sample of post-institutionalized adopted children. But perhaps the most important link between the IRP and the present study is the finding that resilience factors in this study seemed to inform and influence each other as they did in the IRP. The case analyses in this study revealed such interactions in several regards.

Interactions Among Resilience Factors

There were likely several interactions among factors in the participants' lives that contributed to patterns of resilience or non-resilience. For example, in two of the cases in the non-resilient group, parents adopted for 'humanitarian' reasons. Essentially, they sought to 'save' a child from the horrific conditions in Romanian orphanages that were being broadcast by media. This was an admirable act of humanitarianism as these parents likely did save the children's lives. Many children who remained in orphanages died from their lack of basic needs being met. After adoption, however, parents who adopted for humanitarian reasons may have had a sense that their children would be in such a drastically improved environment that they wouldn't require too much special attention. Perhaps they may even, possibly in an unconscious sense, felt that their children 'owed' them something for their efforts to rescue them. This may have coloured their outlook post-adoption, such that the children's behavioural and emotional problems were a surprise to them and they felt unprepared to deal with them. Non-resilient participant families tended to have difficult marriages, unmet service needs, unsupportive extended families, and negative school environments. Therefore, without stable supports in place to assist them in coping with the challenges their children had their levels of stress increased. Over time, increased stressors as their children grew older likely fuelled their sense of pessimism, hopelessness, and desperation.

Furthermore, diagnoses were likely sought more readily by frustrated parents of non-resilient participants for certain 'problematic' temperament characteristics (e.g., inattention and hyperactivity). This is completely understandable as these parents likely desperately needed to receive necessary services and supports that were missing in their

lives. In contrast, parents of resilient participants were more likely to ‘normalize’ their children’s challenges because they had a greater number of informal supports in place to help them do this (e.g, positive marriage partners, friends from church, etc.). Having been ‘labelled’ with a diagnosis, which was typically followed by more diagnoses over time may have impacted the non-resilient participants’ self-esteem and furthered their sense that they were ‘different’.

Parents’ frustration levels and lack of supports and coping mechanisms seemed to exacerbate over time in the families of non-resilient participants. This may have contributed to an intensification of negative relationships patterns with their children. In a way, it seemed to be a vicious cycle. With time, parental frustration levels seemed to increase as did children’s challenges. It is hard to say which influenced which more strongly, but regardless of the direction of effect it is clear that important parent-child relationships were stressed.

These interactions among resilience factors all seemed to, in one way or another, centre around relationships. In fact, in all of the case studies, relationships with parents and others consistently emerged as seminal factors in participants’ pathways to resilience or non-resilience.

The Importance of Relationships

As mentioned earlier, relationship factors seemed to be the most widely mentioned, and likely the most important category of resilience factors in the case study analyses of the participants in this study. In particular, as was found in the Kauai study (Werner & Smith, 2005) and the IRP (Ungar & the International Resilience Project

Team, 2006), the importance of a stable and emotionally supportive caregiver with whom the children formed an attachment in their early years was likely one of the most important factors contributing to their resilience.

Attachment to a primary caregiver has been given much attention in psychological literature, and consistently emerges as an important factor in later development. Given that attachment is generally believed to happen in the 2nd-half of the 1st-year (Bowlby, 1969), all of the participants in this study had missed the 'window' of time in which this important bond is likely to occur. Therefore, it was particularly important for these children, who spent their early years in socially/emotionally depriving orphanages, to have an extra measure of time, attention, and sensitivity from their parents in order to try and facilitate attachment at a later age.

Once adopted, the resilient participants had the distinct advantage of having a parent at home full-time to provide sensitive and nurturing care-giving. Between 1990 and 1991 (when these adoptions took place), most parents did not have the luxury of the paid maternity or parental leaves that are currently available in Canadian society. Thus parents of the resilient children seemed particularly 'invested' in them to the extent that they made career and financial sacrifices to provide their adopted children with as much individual attention as possible. All of the children needed a lot of special help in the early years post-adoption. Developmental assessments, at-home therapy to assist with physical and cognitive delays, frequent doctors' appointments, and other special attention were needed to help these children adjust to their new environments and facilitate developmental catch-up. This extra measure of time and attention, coupled with the

adaptive/sensitive parenting exhibited in the families of resilient participants' likely helped attachment to develop by age 4.5.

Attachment has been described as a 'blueprint' for future relationships (Schaeffer, 1993). In other words, the development of early trusting relationships provides a schema on which one develops a set of expectations for how later relationships will be; thereby future relationships are typically viewed in a positive light by securely attached individuals and they generally do not shy away from engaging in positive relationships with others. Thus, the secure attachments between resilient participants' and their parents may help to explain some of their other later positive findings. Relationally, they had a distinct advantage over the non-resilient participants, which likely assisted them as they developed later relationships with peers, teachers, and romantic partners. Interactions involving these relationships likely facilitated their continued development on a pathway to resilience, as was the case of Miguel described in the introduction. Just as Miguel's positive relationships with his mother, friends, and faith were fundamental to his resilience, relationships in general seemed to serve a central role in the post-institutionalized children's pathways to resilience in the present study. Certain aspects in the development of one of the resilient participants, Lauren, and one of the non-resilient participants, Cory, will be highlighted to further illustrate the importance of relationships.

The Case of Lauren

Lauren was adopted at the age of 16 months and had an above average IQ of 115. A general theme of positive relationships seemed to play a pivotal role in Lauren's resilience at several 'turning points' and tough times in her life. Immediately following adoption, Lauren's mother left work to stay home with her until she reached school age.

Discriminate attachment was evident between Lauren and her mother at an early age, and that sense of emotional security seemed to help facilitate a trusting pattern of open communication between mother and daughter; which in turn helped her navigate certain challenging times in her life.

Lauren's parents divorced when she was 4 years old. Her relationship with her mother was especially helpful in protecting her from undue emotional stress. Her adoptive father did not want to pay child support, and therefore wanted nothing to do with Lauren after the divorce. Rather than allow Lauren to feel abandoned by her dad, Lauren's mother did not talk negatively about him and thus protected her from feelings of abandonment as best she could. Later, when Lauren's mom remarried, her step-dad became another positive influence in her life. Lauren's tomboyish nature was especially appreciated by her stepfather, and they bonded by sharing similar recreational interests.

Lauren and her mother also had open communication about her adoption. Her mother felt it was important that Lauren have the opportunity to meet her biological parents in Romania and therefore took her there on two occasions, at the ages of 8 and 13. Her biological parents and siblings warmly embraced her and she knew without doubt that she had another family on the other side of the world that loved her. This connection to her 'roots' was so important to Lauren that she decided she wanted to change her adoptive name back to her original Romanian name—a change her adoptive mother accepted and helped her to adjust to. Teachers and peers were also supportive of her Romanian identity and name change and this helped her feel accepted for who she was.

It was evident that her positive relationship with her mother also contributed to her resilience when she struggled with depression and anxiety in her early teen years. Her

mother seemed to recognize her distress immediately and elicited professional help in the early stages. She received the help she needed and recovered within a relatively short time frame. Furthermore, when Lauren struggled with gender identity issues in childhood (i.e., wanting to be a boy), and in her teens confided to her parents that she was a lesbian, her parents supported her as best they knew how, and were accepting and welcoming towards her romantic partner.

It is clear that Lauren's path was certainly not an easy one. She navigated many challenges that could potentially have resulted in negative developmental outcomes—parents' marriage breakdown, adjustment to a stepparent, gender identity struggles, mental health issues, and the process of 'coming out' as a lesbian. However, her secure attachment with her mother, and positive subsequent relationships with her step-father, birth parents, peers, and teachers were very likely the most important factors in her ability to thrive in adolescence.

Similar to Lauren, relationships seemed to be particularly salient in Cory's development. However, in his case, unfavourable relationships and a pattern of lack of necessary supports seemed to be contributing factors to his pathway of non-resilience.

The Case of Cory

Cory was adopted at 14 months and had an IQ of 93. His parents returned to work soon after they adopted him and he was looked after by various babysitters. There was no evidence that he developed strong attachments with any of his caregivers, likely because none of them were with him for more than a few months as they were exasperated by his behaviour. His mother described how, "None of them lasted long because they couldn't

handle it” (i.e., referring to Cory’s hyperactive and aggressive behaviours). Cory’s mother tried to enrol him in a ‘special needs’ day-care on several occasions, but he didn’t qualify.

A further detriment for Cory was his relationship with his adoptive father. His father had a history of emotionally abusive behaviour with his adoptive mother and their marriage was conflict-ridden. By the time Cory was three his parents were divorced, and he visited his father infrequently. His mother said his father was “not really interested in Cory” after the divorce. She remarried shortly after and it appears his stepfather also did not have much interest in a relationship with Cory. The parenting seemed to fall entirely on Cory’s mother, who seemed increasingly frustrated at each assessment. She tried to get respite care but was told she didn’t qualify because Cory’s difficulties were primarily behavioural in nature.

As he entered school and adolescence, Cory’s relationships with his teachers and peers were negative. He caved in to peer pressures and was frequently in trouble with his teachers. His mother described him as ‘bright’ but said that sitting still to concentrate on school work was of no interest to him. Although diagnosed with ADHD it seemed he never had the adequate supports in place at school or at home to manage it. The interviewers described his home environment as seemingly “chaotic” and “disorganized”, which likely did not help him to cope with his attention and impulsivity difficulties. His behaviours became increasingly self-destructive and criminal and his relationships with the opposite sex (including his older sister) were perverted.

Cory’s mother seemed to have almost given up on her son. She was clearly exasperated by his behaviours and felt hopeless. This was evident in several comments

she made at the Time 3 (age 10.5) assessment. For example, at one point in the interview she mentioned that:

he is in the principal's office at least four times per week, but there's not much you can do about it. No matter what you try to do with him it doesn't stop him from doing it. He's not changing....he'll never change.

By the Time 4 assessment, Cory was living in foster care and had visits with his adoptive mother once per month. Notes from phone conversations with his mother didn't reveal any signs of improvement in his relationship with her. She said that "he doesn't like coming to see me, and when he does come it is so he can steal money from me."

Cory likely would have benefited greatly from consistent caregiving in his early years post-adoption. If he had had a chance to bond with one primary caregiver and that caregiver was able to find support in dealing with his attention and behaviour difficulties at an early age he might have been able to cope better in school and in subsequent relationships. Thus, a combination of relational instability and lack of necessary supports to cope with his challenges seemed to be the main contributing factors to his struggles in adolescence.

Conceptual Implications

The model of resilience described by Ungar (2004b, & the International Resilience Project Team, 2006) provided the conceptual framework for this study. Of the various factors outlined in that model, relationship factors emerged as being most central to the resilience (or lack thereof) of the participants in the present research. The implications of this finding for Ungar's model require consideration. Is it the case, as Ungar has argued, that a multidimensional ecological perspective is necessary to

understanding resilience, or can we more parsimoniously understand resilience by simply focusing on relationships, particularly those between children and their caregivers?

Although relationships were found to be the most salient factor in the cases of the youth studied here, the multidimensional model highlighted how other factors (e.g., individual, cultural, and community) interacted with relationship factors to influence developmental outcomes, providing a richer understanding of the process of resilience (or non-resilience). One example of this from the present study concerns the links between cultural and relationship factors. It was found here that resilient teens tended to have stronger knowledge of and ties to their Romanian culture of origin than did the non-resilient teens, suggesting that being culturally grounded by knowing where you come from and being part of a cultural tradition is indeed part of resilience, as argued by Ungar (2004b). But there was also evidence that relationship factors influenced the degree to which teens were willing or able to connect with their culture of origin. This was seen in the finding that the majority of non-resilient teens felt that their adoptive parents' feelings would be hurt if they talked about their biological parents and demonstrates how positive and secure parent-child relationships can 'underpin' access to and a sense of cultural identification.

With this in mind, it might be sensible to conceptualize the various factors in Ungar's (2004b) model as a hierarchy, similar to Maslow's (Maslow, 1962) hierarchy of needs, with relationship factors forming the foundation. If relationship factors are not positive, then the other factors become less important in distinguishing resilient from non-resilient individuals. If relationship factors are positive (i.e., that need is met) then the other factors start to come more into play in explaining outcomes.

Consistent with this conceptualization, it may have been the case that relationship factors were found to be so important for the participants in this study because they were so deprived in that regard in their early lives. Different findings may have emerged if another population of 'at-risk' youth had been studied, for example, a group of youth orphaned by HIV/AIDS. Such individuals would likely have experienced good early care and relationships prior to their parents becoming ill and eventually dying. Perhaps for these youths, factors such as community supports and cultural factors would have emerged as more important in differentiating the resilient from the non-resilient individuals.

That being said, Ungar's multidimensional conceptualization of resilience was very valuable in conducting this study. It was advantageous to commence the research from a broad perspective, with examination of a multitude of potential factors relating to resilience. If, at the outset, the investigation had been limited to solely relational factors, the very real structural constraints that were present in children's lives (e.g., unmet services) would have been missed as would have the links between such factors and relationship factors. For example, Cory's mother might have had a more positive experience parenting (and hence, in her relationship with her son) if she had had access to more services. Ungar's model goes beyond linear combinations of predictors and outcomes, and recognizes the fact that the resilience factors do not operate in isolation, but rather influence one another to help individuals avoid negative consequences.

Conclusions

Although general themes were evident in this study regarding the participants' pathways to resilience or non-resilience, it is clear that much individual variation was also present. Therefore, as Ungar and the International Resilience Project Team (2006) suggest it is important to always keep in mind the complexity of resilience processes, and the fact that there are multiple pathways that can be taken. The case study approach utilized in this study was particularly helpful in capturing some of the unique aspects of individual's pathways.

Several themes centred on the need for positive external supports following adoption—both informal (e.g., supportive friends, extended family, spouses) and professional (e.g., community services such as access to school supports, developmental assessments, counselling, respite care) in nature. Therefore, it is important that prospective adoptive parents be aware that they will need a support system in place to help them navigate the various challenges they may encounter. Simultaneously, policy-makers and service providers need to be aware of the unique challenges faced by these children and their families and the services they may require.

This study also highlights the importance of parents of post-institutionalized children providing extra measures of time and sensitivity to their children in order to help compensate for their early adversities and assist in the development of secure attachments. Given the severe social-emotional deprivation that occurred in orphanage settings, this subsequent investment of nurturing and one-on-one attention seemed especially important for these children. Discriminate attachment occurred at a later age in all five of the resilient teens—an especially salient finding considering that attachment

typically occurs in the first year of life. Such positive attachments likely permeated all of the children's future relationships, thus contributing to a continued pattern of resilience throughout their development. This has implications not only for children adopted from overseas orphanages but also for thousands of foster care children or other children who may have experienced a lack of consistent, emotionally-sensitive care-giving in their early years. It may not be 'too late' to provide the type of nurturance needed to help these youth develop the positive relationships which can ultimately change the course of their lives.

Finally, it must be noted that the present study was limited in that it did not examine resilience processes beyond adolescence. It may be possible for the non-resilient participants to show 'recovery' in adulthood like some of the participants in the Kauai study (Werner & Smith, 2005). There were glimmers of hope in the non-resilient kids in this sample. For example, many of Jenna's difficulties pertained to her cognitive limitations and obsessive-compulsive tendencies rather than anti-social or deviant behaviours. As her mother had hoped, if "she can find an employer who will accommodate her learning curve" and succeed at a job, it may increase her confidence levels and social skills to promote her independence in adulthood. Also, even Cory, with his history of challenging and deviant behaviour, had recently succeeded in obtaining a part time job at age 16.5. His success at such a pursuit might foster a needed sense of responsibility and maturity which carries forward into other aspects of his 'adult' life. Given that resilience is not a static concept, future research is needed to see how the participants' pathways continue into the future.

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APPENDICES

Appendix A. Demographic QuestionnaireRomanian Adoption Project
Demographic Questionnaire—Phase 4

1. 1. Parent's name:
 - a. Mother _____
 - b. Father _____
 - c. Step-mother _____
 - d. Step-father _____

2. Mother's date of birth _____

3. Father's date of birth _____

4. Mother's ethnicity:
 - a. Caucasian
 - b. Black
 - c. Asian
 - d. Indian (South Asian)
 - e. Aboriginal
 - f. Other _____

5. Father's ethnicity:
 - a. Caucasian
 - b. Black
 - c. Asian
 - d. Indian (South Asian)
 - e. Aboriginal
 - f. Other _____

6. Child's name: _____

7. ID Number: _____

8. Sex: male _____ female _____

9. Date of birth: _____

10. Date of adoption: _____

11. Age at adoption: _____

12. Prior to adoption, where was your child living?
- Orphanage state-run _____ church-run _____
 - Hospital
 - Birth parents
 - Foster home
 - Other relatives
 - Other
13. How would you describe the care your child was receiving prior to adoption?
(1=very poor; 10=excellent)
- Caregiver-child ratio _____
 - Quality of caregiving (warmth/nurturance) _____
 - Nutrition _____
 - Hygiene _____
 - Access to age appropriate toys and activities _____
14. Your reason for adopting:
- infertility _____
 - humanitarian _____
 - religious/spiritual _____
 - add to family _____
 - other _____
15. Why did you choose to adopt from Romania, rather than from somewhere else?
16. Parent's marital status:
- Never married or never common-law
 - Married or common-law _____ Since when? _____
 - Separated _____ Since when? _____
 - Divorced _____ Since when? _____
 - Re-married or common-law _____ Since when? _____
17. Names of siblings Date of birth or adoption Age
- _____
 - _____
 - _____
 - _____
 - _____
18. Names of step-siblings Age
- _____
 - _____
 - _____
 - _____

19. Have there been changes in your family composition since your child was adopted? **If no, go to #19**; if yes please describe the change and when (month & year) it occurred (e.g., birth, death, adoption, separation, divorce, marriage).
- a. _____ date: _____
 b. _____ date: _____
 c. _____ date: _____
 d. _____ date: _____
20. Mother's highest level of education
- elementary school
 - some high school
 - high school completion
 - vocational or some college/university
 - college or university graduate
 - graduate or professional school
21. Mother's employment outside the home: Yes No **If no, go to #23**
22. Mother's occupation _____
23. Is mother's employment: full-time _____ part-time _____
24. Father's highest level of education
- elementary school
 - some high school
 - high school completion
 - vocational or some college/university
 - college or university graduate
 - graduate or professional school
25. Father's employment outside the home: Yes No **If no, go to #27**
26. Father's occupation _____
27. Is father's employment: full-time _____ part-time _____
28. Please estimate your gross annual family income
- Less than \$20,000
 - 20—30,000
 - 30—40,000
 - 40—50,000
 - 50—60,000
 - 60—70,000
 - 70—80,000
 - 80—90,000
 - 90—100,000
 - above 100,000
-

29. How would you describe where you currently reside?

- a. Urban _____
- b. Suburban _____
- c. Rural _____

Appendix B. Sample Questions from Parent Interview

1. Have you experienced any problems with your child's sleeping?
2. Have you experienced any problems with your child's eating?
3. Has your child had any difficulties with peer relationships? Sibling relationships?
4. Would you describe your child as being indiscriminately friendly (e.g., would go off with strangers easily)?
5. Would your child be willing to let an unfamiliar person put him/her to bed?
6. Does your child exhibit any stereotyped behaviour (e.g., rocking, head banging, etc.)?
7. What has been the most troublesome problem you have experienced?
8. Please describe the best things about your child.
9. What services have you accessed to deal with your child's difficulties?
10. Were there any services you needed but were unable to access? Describe.
11. Have the challenges you described at previous phases of the study exacerbated or resolved? (each previous difficulty is asked about separately).
12. Please give 5 adjectives to describe your child.

Appendix C. Adoption Questionnaire

1. How comfortable are you talking about your adoption?
 - a. Not at all comfortable
 - b. Somewhat comfortable
 - c. Completely comfortable

2. How comfortable are you talking about your background in Romania?
 - a. Not at all comfortable
 - b. Somewhat comfortable
 - c. Completely comfortable

3. How comfortable are you talking about your birth mother?
 - a. Not at all comfortable
 - b. Somewhat comfortable
 - c. Completely comfortable

4. How comfortable are you talking about your birth father?
 - a. Not at all comfortable
 - b. Somewhat comfortable
 - c. Completely comfortable

5. How comfortable are your parents talking about your adoption?
 - a. Not at all comfortable
 - b. Somewhat comfortable
 - c. Completely comfortable

6. How comfortable are your parents talking about your background in Romania?
 - a. Not at all comfortable
 - b. Somewhat comfortable
 - c. Completely comfortable

7. How comfortable are your parents talking about your birth mother?
 - a. Not at all comfortable
 - b. Somewhat comfortable
 - c. Completely comfortable

8. How comfortable are your parents talking about your birth father?
 - a. Not at all comfortable
 - b. Somewhat comfortable
 - c. Completely comfortable

9. When you talk about adoption at home, who usually starts the conversation?
 - a. You
 - b. Your mother
 - c. Your father
 - d. Your brother or sister
 - e. Someone else

10. In terms of the amount of discussion you have at home about your adoption, is it
 - a. Not enough
 - b. About right
 - c. Too much

11. Do you ever talk to people outside your family about being adopted?

12. If yes, please indicate to who:
 - a. friend(s)
 - b. boyfriend or girlfriend
 - c. teacher
 - d. or
 - e. other (please specify)

13. Do you ever have contact with other young people adopted from Romania?
 - a. No
 - b. Yes, occasionally
 - c. Yes, regularly

14. If yes, do you talk about adoption with them?
 - a. Yes
 - b. No

15. If yes, do you find it helpful?
 - a. Yes
 - b. No

16. How familiar are you with Romanian culture?
 - a. Not at all
 - b. Somewhat
 - c. Very familiar

17. Please indicate if and how much you have done any of the following:

	A little	Somewhat	A lot
Read books on Romania			
Attended Romanian cultural events			
Joined a Romanian cultural group			
Discussed Romanian culture with parents			
Learned Romanian language			
Learned Romanian songs/stories, etc.			

18. Are you interested in finding out more about Romania?

- a. Yes
- b. No

19. Have you ever visited Romania?

- a. Yes
- b. No

20. If yes:

- a. at what age(s) did you go to Romania?
 - b. Who did you go with?
 - i. By myself
 - ii. With my parents and/or family
 - iii. With friends
 - iv. Other (please specify)
 - c. What did you do there?
 - i. Holiday only
 - ii. Visited friends
 - iii. Went to an orphanage
 - iv. Visited my birth place (town or village)
 - v. Met my birth parent(s) or family
 - d. Did you enjoy the visit?
 - i. No
 - ii. Sort of
 - iii. Yes
 - e. Would you like to visit Romania again?
 - i. Yes
 - ii. No
 - iii. I'm not sure
 - f. If yes, what would you like to do there?
 - i. Holiday only
 - ii. Visit friends
 - iii. Go to an orphanage
 - iv. Visit my birth place (town or village)
 - v. Meet my birth parent(s) or family
 - vi. Other (please specify)
-

21. If no, would you like to visit Romania?
- a. Yes
 - b. No
 - c. Not sure
22. Do you have any contact with your birth mother?
- a. If no, would you like to have contact with your birth mother?
 - i. Yes
 - ii. No
 - iii. Not sure
 - b. If yes, what kind of contact do you have?
 - i. The occasional letter
 - ii. Regular letters
 - iii. Occasional phone call
 - iv. Regular phone calls
 - c. Would you like more or less contact with your birth mother?
 - i. More
 - ii. Less
 - iii. The same
 - iv. Not sure
23. Do you have any contact with your birth father?
- a. If no, would you like to have contact with your birth father?
 - i. Yes
 - ii. No
 - iii. Not sure
 - b. If yes, what kind of contact do you have?
 - i. The occasional letter
 - ii. Regular letters
 - iii. Occasional phone call
 - iv. Regular phone calls
 - c. Would you like more or less contact with your birth father?
 - i. More
 - ii. Less
 - iii. The same
 - iv. not sure
-

24. Do you have any contact with your birth siblings?
- a. If no, would you like to have contact with your birth siblings?
 - i. Yes
 - ii. No
 - iii. Not sure
 - b. If yes, what kind of contact do you have?
 - i. The occasional letter
 - ii. Regular letters
 - iii. Occasional phone call
 - iv. Regular phone calls
 - c. Would you like more or less contact with your birth siblings?
 - i. More
 - ii. Less
 - iii. The same
 - iv. Not sure
25. Do you have any contact with any other birth relatives?
- a. If no, would you like to have contact with other birth relatives?
 - i. Yes
 - ii. No
 - iii. Not sure
 - b. If yes, what kind of contact do you have?
 - i. The occasional letter
 - ii. Regular letters
 - iii. Occasional phone call
 - iv. Regular phone calls
 - c. Would you like more or less contact with other birth relatives?
 - i. More
 - ii. Less
 - iii. The same
 - iv. Not sure
26. How often do you think about your birth mother?
- a. Never
 - b. Rarely (once a year or less)
 - c. More than every year but less than every month
 - d. More than every month but less than every week
 - e. Every week or more

27. When you think about your birth mother, how do you feel?

	Not at all	A little	A lot
Anger			
Sadness			
Understanding			
Love			
Respect			
Confusion			
Nothing			
Curious			
Hurt			
Other (please specify)			

28. How often do you think about your birth father?

- a. Never
- b. Rarely (once a year or less)
- c. More than every year but less than every month
- d. More than every month but less than every week
- e. Every week or more

29. When you think about your birth father, how do you feel?

	Not at all	A little	A lot
Anger			
Sadness			
Understanding			
Love			
Respect			
Confusion			
Nothing			
Curious			
Hurt			
Other (please specify)			

30. How often do you think about your birth sibling(s)?

- a. Never
- b. Rarely (once a year or less)
- c. More than every year but less than every month
- d. More than every month but less than every week
- e. Every week or more

31. When you think about your birth sibling(s), how do you feel?

	Not at all	A little	A lot
Anger			
Sadness			
Understanding			
Love			
Respect			
Confusion			
Nothing			
Curious			
Hurt			
Other (please specify)			

32. How often do you think about other birth relatives?

- a. Never
- b. Rarely (once a year or less)
- c. More than every year but less than every month
- d. More than every month but less than every week
- e. Every week or more

33. When you think about other birth relatives, how do you feel?

	Not at all	A little	A lot
Anger			
Sadness			
Understanding			
Love			
Respect			
Confusion			
Nothing			
Curious			
Hurt			
Other (please specify)			

34. Do you think it would hurt your parents' feelings if they knew you were thinking about your birth parents?

- a. No
- b. Maybe
- c. Probably
- d. Yes, definitely

35. How do you feel about your birth parents having placed you for adoption?

	Not at all	A little	A lot
Angry			
Sad			
Understanding			
Respectful			
Confused			
Happy			
Thankful			
Hurt			
Other (please specify)			

36. In general, how do you feel about being adopted?

	Not at all	A little	A lot
Angry			
Sad			
Understanding			
Respectful			
Confused			
Happy			
Hurt			
Thankful			
Other (please specify)			

Appendix D. Romantic Relationships

1. I feel romantically attracted to people of the opposite sex
2. I feel romantically attracted to people of the same sex
3. I am interested in dating
4. I have experience dating
5. Do you currently have a boyfriend/girlfriend?
 - a. If yes:
 - i. Is your partner a boy or girl
 - ii. How old is she/he?
 - iii. How often do you see him/her?
 - b. If no:
 - i. Would you like to have a boyfriend/girlfriend?
6. Have you ever had a boyfriend/girlfriend?
 - a. If yes:
 - i. Was your partner a boy or girl
 - ii. How old were you?
 - iii. How old was she/he?
 - iv. How often did you see him/her?
7. Do you consider yourself to be sexually active now?
 - a. If yes, please indicate which sexual activities you engage in with a partner
 - i. Kissing
 - ii. Sexual touching above the waist
 - iii. Sexual touching below the waist
 - iv. Sexual intercourse
 - v. Oral sex
8. Have you been sexually active in the past?
 - a. If yes, please indicate which sexual activities you have engaged in with a partner
 - i. Kissing
 - ii. Sexual touching above the waist
 - iii. Sexual touching below the waist
 - iv. Sexual intercourse
 - v. Oral sex
 - b. How old were you when you became sexually active?

If you have any other comments that you would like to share about your romantic relationships, feel free to use the space below.

Appendix E. Health Questionnaire

Phase 4 Health Questionnaire

Ph. 4 ID _____

1. In general, how would you say your child's physical health is?
 - a. Excellent
 - b. Very good
 - c. Good
 - d. Fair
 - e. Poor

2. Over the past few months how often has your child been in good physical health?
 - a. Almost all the time
 - b. Often
 - c. About half the time
 - d. Sometimes
 - e. Almost never

3. What is your child's current height? _____ feet _____ inches OR _____ cm

4. What is your child's current weight? _____ lbs. OR _____ kg

5. Has your child ever had asthma that was diagnosed by a health professional?
 - a. Yes
 - b. No _____ **If no, go to question #8**

6. Does your child's asthma prevent or limit his/her participation in any activities (e.g., school, sports, work)?
 - a. Yes
 - b. No

7. Has your child had an attack of asthma in the past 12 months?
 - a. Yes
 - b. No

The following question refers to long-term physical conditions that have lasted or are expected to last 6 months or more.

8. Does your child have any of the following long-term conditions that have been diagnosed by a health professional?
 - a. Allergies (please specify) _____
 - b. Bronchitis
 - c. Heart condition or disease
 - d. Epilepsy
 - e. Cerebral palsy
 - f. Kidney condition or disease
 - g. Other (please specify) _____
-

9. Does your child have any physical conditions or health problems that limit his/her participation in activities normal for his/her age?
- Yes (please specify _____)
 - No
10. Does your child take any of the following prescribed medications on a regular basis for a physical health condition?
- Ventolin or other inhalant(s)
 - Anti-convulsants or anti-epileptic medication
 - Other (please specify medication and the condition it is for)

The following questions concern pubertal development in boys and girls.

11. Would you say your child's underarm and pubic hair:
- has not yet started growing
 - has barely started growing
 - growth of body hair is definitely underway
 - growth of body hair seems nearly complete
12. What was your child's age when you first noticed the growth of his/her underarm and/or pubic hair? _____

For parents of girls:

13. How would you describe your daughter's breast development?
- Breasts have not yet started to develop.
 - Breasts have barely started to develop
 - Breast development is definitely underway
 - Breast development seems nearly complete
14. At what age was your daughter when you first noticed her breasts beginning to develop? _____
15. Has your daughter begun to menstruate? Yes No
16. If yes, at what age did she begin to menstruate? _____

For parents of boys:

17. How would you describe the changing of your sons voice?
- Voice has not started changing
 - Voice has barely started changing
 - Voice is definitely changing
 - Voice change seems complete
-

18. At what age was your son when you first noticed his voice starting to change?

19. How would you describe your son's growth of facial hair?

- a. Facial hair has not yet started growing
- b. Facial hair has barely started growing
- c. Facial hair growth is definitely underway
- d. Facial growth seems nearly complete

20. How old was your son when you first noticed his facial hair growth? _____

21. **For families who are participating in this study for the first time:**

- a. What was your child's birth weight? _____ lbs _____ ounces OR
_____ kg
- b. What was your child's weight at adoption? _____ lbs _____ ounces OR
_____ kg
- c. Please list any medical/physical conditions your child had at the time of adoption.
 - i. _____
 - ii. _____
 - iii. _____
 - iv. _____
 - v. _____
- d. At the time of his/her adoption, in general, how would you say your child's physical health was?
 - i. Excellent
 - ii. Fair
 - iii. Very good
 - iv. Good
 - v. Poor

The following questions are for all participants

22. In general, how would you say your child's mental/emotional health is?

- a. Excellent
- b. Very good
- c. Good
- d. Fair
- e. Poor

23. Over the past few months how often has your child been in good mental/emotional health?
- a. Almost all the time
 - b. Often
 - c. About half the time
 - d. Sometimes
 - e. Almost never
24. Would you describe your child as being usually
- a. Happy and interested in life
 - b. Somewhat happy
 - c. Somewhat unhappy
 - d. Unhappy with little interest in life
 - e. So unhappy that life is not worthwhile
25. Has your child been diagnosed by a health or mental health professional for any of the following conditions?
- a. Learning disability
 - b. Depression
 - c. Bi-polar disorder
 - d. Anxiety disorder
 - e. Phobia
 - f. Obsessive compulsive disorder
 - g. Eating disorder (please specify) _____
 - h. Borderline personality disorder
 - i. Attention deficit disorder
 - j. Attention deficit with hyperactivity disorder
 - k. Fetal alcohol spectrum disorder
 - l. Autism
 - m. Aspergers syndrome
 - n. Psychosis
 - o. Tourette's syndrome
 - p. Attachment disorder
 - q. Gender identity disorder
 - r. Other (please specify) _____
26. Does your child have any mental health or emotional conditions that limit his/her participation in activities normal for his/her age?
- a. Yes (please specify _____)
 - b. No
-

27. Does your child take any of the following prescribed medications on a regular basis?

- a. Ritalin or other medication for ADD or ADHD
- b. Anti-depressant medication
- c. Anti-anxiety medication
- d. Anti-psychotic medication
- e. Other (please specify medication and condition it is for: _____)

SERVICE USE: The following section asks about your use of services for help and support with situations, conditions and difficulties that your child and family may have experienced.

28. Have you received help for difficulties related to your child's academic learning?

- a. Yes (if yes, please go to #29)
- b. No (if no, please go to #30)

29. What was/is the nature of your child's **academic** difficulty(s)?

a. From whom did you receive help and how useful were/are their services?

i. _____

1. extremely useful
2. very useful
3. somewhat useful
4. not very useful
5. not at all useful

ii. _____

1. extremely useful
2. very useful
3. somewhat useful
4. not very useful
5. not at all useful

iii. _____

1. extremely useful
2. very useful
3. somewhat useful
4. not very useful
5. not at all useful

30. Have you received help for difficulties related to your child's physical health?

- a. Yes (if yes, please go to #31)
- b. No (if no, please go to #32)

31. What was/is the nature of your child's **physical health** difficulty(s)?

a. From whom did you receive help and how useful were/are their services?

i. _____

1. extremely useful
2. very useful
3. somewhat useful
4. not very useful
5. not at all useful

ii. _____

1. extremely useful
2. very useful
3. somewhat useful
4. not very useful
5. not at all useful

iii. _____

1. extremely useful
2. very useful
3. somewhat useful
4. not very useful
5. not at all useful

32. Have you received help for difficulties related to your child's mental health?

- a. Yes (if yes, please go to #33)
- b. No (if no, please go to #34)

33. What was/is the nature of your child's **mental health** difficulty(s)?

a. From whom did you receive help and how useful were/are their services?

i. _____

1. extremely useful
2. very useful
3. somewhat useful
4. not very useful
5. not at all useful

ii. _____

1. extremely useful
2. very useful
3. somewhat useful
4. not very useful
5. not at all useful

- iii. _____
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

34. Have you received help for difficulties related to your child's speech?
- a. Yes (if yes, please go to #35)
 - b. No (if no, please go to #36)

35. What was/is the nature of your child's **speech** difficulty(s)?

- _____
- a. From whom did you receive help and how useful were/are their services?

- i. _____
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

- ii. _____
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

- iii. _____
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

36. Have you received help for difficulties related to your child's peer relationships?
- a. Yes (if yes, please go to #37)
 - b. No (if no, please go to #38)
- _____

37. What was/is the nature of your child's **peer relationship** difficulty(s)?

a. From whom did you receive help and how useful were/are their services?

i.

-
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

ii.

-
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

iii.

-
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

38. Have you received help for difficulties related to your child's attachment?

- a. Yes (if yes, please go to #39)
- b. No (if no, please go to #40)

39. What was/is the nature of your child's **attachment** difficulty(s)?

a. From whom did you receive help and how useful were/are their services?

i.

-
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

ii.

-
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

- iii. _____
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

40. Have you received help for difficulties related to parenting your child?

- a. Yes (if yes, please go to #41)
- b. No (if no, please go to #42)

41. What was/is the nature of your parenting difficulty(s)?

- _____
- a. From whom did you receive help and how useful were/are their services?
- i. _____
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful
- ii. _____
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful
- iii. _____
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

42. Have you received help for any difficulties that we have not yet mentioned?

- a. Yes (if yes, go to #43)
- b. No (if no, go to #44)

43. What was/is the nature of your child's **additional** difficulty(s)?

a. From whom did you receive help and how useful were/are their services?

i.

-
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

ii.

-
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

iii.

-
1. extremely useful
 2. very useful
 3. somewhat useful
 4. not very useful
 5. not at all useful

44. Are there any services you have wanted but have been unable to access or obtain?

- a. Yes (go to #45)
- b. No (go to #46)

45. Please identify the service(s) you wanted, the problem it was for, and the reason you were unable to obtain this service.

- a. Service: _____
- b. Problem: _____
- c. Reason for lack of access:
 - i. Service unavailable in my community
 - ii. Lengthy waiting list
 - iii. Problem dismissed by a professional
 - iv. Couldn't afford this service
 - v. Didn't qualify (please explain _____)
 - vi. Other (please specify _____)

- d. Service: _____
- e. Problem: _____
- f. Reason for lack of access:
- i. Service unavailable in my community
 - ii. Lengthy waiting list
 - iii. Problem dismissed by a professional
 - iv. Couldn't afford this service
 - v. Didn't qualify (please explain _____)
 - vi. Other (please specify _____)
- g. Service: _____
- h. Problem: _____
- i. Reason for lack of access:
- i. Service unavailable in my community
 - ii. Lengthy waiting list
 - iii. Problem dismissed by a professional
 - iv. Couldn't afford this service
 - v. Didn't qualify (please explain _____)
 - vi. Other (please specify _____)
- j. Service: _____
- k. Problem: _____
- l. Reason for lack of access:
- i. Service unavailable in my community
 - ii. Lengthy waiting list
 - iii. Problem dismissed by a professional
 - iv. Couldn't afford this service
 - v. Didn't qualify (please explain _____)
 - vi. Other (please specify _____)

Appendix F. Sex-role Questionnaire

Please answer: 1. No, not at all true. 2. Sort of 3. Yes, very true.

1. I prefer to do things that boys typically do.
2. I prefer to do things that girls typically do.
3. I prefer to wear my hair short.
4. I prefer to wear my hair long.
5. I like to wear makeup.
6. I am interested in fashion and clothing.
7. I prefer being friends with boys.
8. I prefer being friends with girls.
9. I am romantically interested in boys.
10. I am romantically interested in girls.
11. Competitive sports are one of my favourite activities.
12. I enjoy talking about people and relationships.
13. I would like to be the opposite sex.
14. I'm really interested in how things are made and how they work.
15. I love babies and small children.
16. I like to cook and bake.
17. I like playing electronic games, for example, on the computer, X-Box, or PlayStation.
18. I prefer boy's clothes for everyday wear.
19. I prefer girl's clothes for everyday wear.
20. I like romantic or dramatic movies.
21. I like action or war movies.

