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Stress, coping and personal strengths and difficulties in internationally adopted children in Spain

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ABSTRACT

This study analyses the types of coping strategies used by internationally adopted children, and explores the relation between these strategies and personal strengths and difficulties. The Kidcope checklist (Spirito, Stark, & Williams, 1998) and the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) were administered to a sample of 35 Spanish adoptees (25.7% boys and 74.3% girls, aged 8–12 years) and their parents. Self-reported problems were categorised and their relation with coping strategies and psychological adjustment was explored. Results indicated that adopted children report problems of interpersonal nature. The content of the problems mainly refers to relationships and health, illness, or accidents. Parents reported that children were generally well-adjusted and they had no problems outside the normal range. International adoptees used mainly control-oriented coping strategies. Escape-oriented coping was linked to parents' ratings of total difficulties, with self-criticism accounting for the highest percentage of the variance.

1. Introduction

Rates of international adoption are increasing steadily, with more than 45,000 children being placed worldwide each year. Traditionally, the United States has been the largest recipient of children for adoption, but many European countries also receive substantial number of children during the last decade. With 12.4 international adoptions per 1000 births, Spain reached the world's second highest ratio of adopted foreign children (Selman, 2006). Major changes occurred in this country and, while domestic adoption remained constant, intercountry adoption consistently increased (Palacios & Amorós, 2006). Between 2003 and 2007, a total of 23,035 children arrived in Spain and they mainly came from China, Russia Federation, Ethiopia and Colombia. However, this trend has been reversed and the number of intercountry adoptions has declined significantly in the recent years, especially in Spain (Selman, 2009). The children come from backgrounds often characterised by inadequate prenatal, perinatal and postnatal conditions: deprivation, malnutrition, lack of medical care, absence of sensory stimulation, poor social interactions or abuse and neglect (Gunnar & Kertes, 2005). Once placed in their new homes, international adoptees may feel out of place in another national, cultural or ethnic environment. As a result, they are assumed to be at increased risk for developing psychological problems in comparison to their nonadopted counterparts (Brodzinsky, 1990; Wierzbicki, 1993). International adoptees may also suffer from impaired or delayed development, attachment and behavioural problems, learning difficulties, language disorders, and they may not be able to meet the academic standards of their school (e.g., Johnson, 2002; Van IJzendoorn, Bakermans-Kranenburg, & Juffer, 2007; Van IJzendoorn, Juffer, & Klein Poelhuis, 2005; Verhulst, Althaus, & Versluis-den Bieman, 1990).

Internationally adopted children, then, have to cope with a wide range of potential stressors. The role of stress and coping has been widely recognized in mediating physical and psychological well-being (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001; Garmezy & Rutter, 1983; Lazarus & Folkman, 1984; Stark, Spirito, Williams, & Guevremont, 1989). Within this framework, Brodzinsky (1990) presented a stress and coping model of adoption adjustment. A core assumption of this model is that adoption always involves loss (of birthparents, origins, stability in relationships, and so on), which creates stress for the child and increases their vulnerability to psychological problems. The model also postulates that children's adjustment to adoption is mediated by their appraisal of the adoption experience and by their efforts to cope with adoption-related stress. A host of personal, biological and environmental variables are assumed to affect the whole process. The ability to manage stress successfully depends on the individual's repertoire of coping strategies. Research on children's coping indicates that they typically use more than one strategy in response to stress (for a review, see Donaldson, Prinstein, Danovsky, & Spirito, 2000). Although no one pattern of coping is necessarily associated with healthier adjustment, research generally

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suggests that the use of emotion-focused or avoidant strategies is related to poorer adjustment, whereas the use of problem-focused or approaching strategies is associated with more positive adaptation (for a review, see Compas et al., 2001).

The same findings are found in internationally adopted children, but studies in this population have examined only the way they deal with adoption-related stress: either overall (Smith & Brodzinsky, 1994), or considering one specific aspect of the adoption experience, such as the loss of birthparents (Smith & Brodzinsky, 2002). But, with reference to a particular stressful situation (for example, the fact of being adopted), all responses focus exclusively on this specific circumstance and little is known about the coping strategies that internationally adopted children use to deal with other stressful events. Since internationally adopted children's outcomes are influenced by the healthy use of coping strategies, the matter deserves special attention in this population.

In this context, it is often debated whether international adoptees are well-adjusted, given their pre-adoption history and the potential stressors they may have to face, but also given the positive opportunities for healthy development in the adoptive family and in the wider environment. Empirical studies have often provided inconsistent results. Wierzbicki's (1993) meta-analysis found that adoptees were significantly overrepresented in clinical populations and had significantly higher levels of maladjustment (more externalising disorders and academic problems) than nonadoptees. Recently, Juffer and Van IJzendoorn conducted two meta-analyses on behaviour problems and mental health referrals (Juffer & Van IJzendoorn, 2005) and self-esteem (Juffer & Van IJzendoorn, 2007) in international adoptees. The first one showed that, even though the subjects had more total, externalising and internalising problems and they were referred to mental health services more often than nonadopted controls, the majority were well-adjusted. The second one examined a specific adaptational aspect, self-esteem, finding that adopted children showed normative levels.

A great deal of attention has been paid to the problems of adoptees, but not much is known about their competences. Some studies found that, in relation to nonadopted children, adoptees show higher levels of prosocial behaviour (Sharma, McGue, & Benson, 1996), fewer social problems and withdrawn behaviours (Sharma, McGue, & Benson, 1998), more peer group popularity (Stams, Juffer, Rispens, & Hoksbergen, 2000) and more competence in sports and non-sports activities (Verhulst et al., 1990). These qualities play a central role in children's adjustment, moderating their reaction to stressful situations and promoting resilient outcomes (Rutter, 1987; Werner, 2000).

In sum, the current study examines the psychological adjustment of internationally adopted children using the stress and coping model. Although the outcomes of internationally adopted children have been widely studied, little is known about the relationship of these outcomes either with the coping strategies that the children use to face daily life stressors or with their personal strengths. The aims of the present study are as follows: first, to study the kind of problems that internationally adopted children report when asked about the most stressful event they had to face; second, to analyse their coping strategies as well as personal strengths and weaknesses; and third, to investigate the relationship between children's coping strategies and their overall psychological adjustment.

2. Method

2.1. Participants

Thirty-five internationally adopted children (9 boys and 26 girls) between the ages of 8 and 12 years ($M = 9.9$ years; $SD = 1.50$) and their parents (31 men and 35 women) participated in the study. Fourteen children (40%) were adopted from Central and South America (Bolivia, Brazil, Colombia, El Salvador, Dominican Republic, Guatemala, Mexico, Nicaragua and Peru), twelve (34%) from Asia (China), six (17%) from Eastern Europe (Romania, Russia and Ukraine) and three (9%) from Africa (Madagascar and Morocco). Eighty-five per cent came from orphanages and 15% from foster care families. Children arrived in Catalonia (Spain) at an average age of 2.6 years (range 2 months to 7 years), and they were studied after an average of 7.2 years ($SD = 2.1$) with their adoptive families. Slightly under a quarter (23%) of the adoptees were only children whereas 77% had at least one brother or sister, who had also been adopted in 62% of cases.

As regards the adopters, 89% were two-parent families and 11% single-mother families. Mean ages were 47.7 years for adoptive mothers and 48.0 years for adoptive fathers. All were white Caucasians. More than half of the parents (59%) had a university degree, 32% had secondary education (high-school or vocational training) and 9% had lower educational qualifications. The families were predominantly from middle-class or upper middle-class backgrounds. Ethical approval was sought and granted from both the university's department through which the research was conducted and the adoptive families' associations with whom the adoptive parents were registered.

2.2. Procedure

As a community-based sample was sought, researchers made contact with two adoptive families' associations. Stamped recruitment letters were forwarded to the adoptive parents by the associations. Families were invited to participate in the study on a volunteer basis and to contact the investigator by telephone or e-mail. Scheduled appointments were made at the family's convenience at the Clinical Psychology Centre of the University of Barcelona. Families were initially seen together and parents were asked for consent for their own and their child's participation. A comprehensive assessment protocol was then administered, including, among other measures, the Kidcope and the SDQ. The Kidcope was administered to the child individually while parents filled out the SDQ in another room. The comprehensive assessment protocol took between 1 h and two and a half hours to complete, and all the meetings were conducted by the first author.

2.3. Measures

2.3.1. Kidcope

The Kidcope checklist (Spirito, Stark, & Williams, 1988) is a brief screening measure of coping strategies for children and adolescents. The younger version, for 7–12-year-olds, analyses ten coping strategies: distraction, social withdrawal, wishful thinking, self-criticism, blaming others, problem solving, emotional regulation (relaxation and explosion), cognitive restructuring, social support and resignation. Spanish data from primary school, immigrant and after-school social care children are also available (Caqueo & Forns, 2004; Pereda, Forns, Kirchner, & Muñoz, 2009). In this study the bilingual Spanish–Catalan version was administered (Pereda et al., 2009). Children were required to describe the most stressful event in their lives and to indicate the use (yes/no) and the perceived efficacy (not at all, a little, a lot) of the corresponding coping strategies.

This scale has been used in a wide variety of settings and applications, including paediatric patients and healthy children and adolescents. Spirito et al. (1988) reported variable test–retest reliability depending on the test–retest interval. Moderate to fairly high correlations were obtained for short periods while longer intervals yielded lower correlations. Concurrent validity has been demonstrated by moderate to high correlations with other coping scales, such as the Coping Strategies Inventory (CSI) (Tobin, Holroyd, & Reynolds, 1984) and the Adolescent Coping Orientation for Problem (A-COPE) (Patterson & McCubbin, 1987). Factor analyses have

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revealed two main strategies: control-oriented coping and escape-oriented coping (Cheng & Chan, 2003). In the present study, the two-factor structure found in an *ad hoc* factor analysis conducted by the authors on a sample of 186 Spanish primary school children was utilized. The first factor explained 13% of variance and reproduced very closely the control-oriented coping. The second factor explained 11% of variance and reproduced very closely the escape-oriented coping. Values for Cronbach's alpha were not very high (.50, .46, respectively) probably due to the low number of items and the low number of categories defined for each item (Preston & Colman, 2000).

2.3.2. Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is a short screening questionnaire for assessing the psychological adjustment of children and youths. It is available in both parent/teacher report (for ages 4–16) and self-report (for ages 11–16) formats. The questionnaire asks about 25 attributes, some positive and others negative, organized into five scales: emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial behaviour. Each item is scored on a 3-point Likert scale (0 = not true, 1 = somewhat true and 2 = certainly true), the possible scores for each of the subscales ranging from 0 to 10. Higher scores on the prosocial behaviour subscale reflect strengths, whereas higher scores on the other four subscales reflect difficulties. A total difficulties score can also be obtained by adding the scores for all but the prosocial behaviour scale (range 0–40). Items and subscales are based on current nosological concepts as well as on previous factor analyses (Goodman, 2001). Extended versions of the SDQ include an impact supplement which asks whether the respondent thinks that the young person has difficulties in one or more areas such as emotions, concentration, behaviour or being able to get on well with other people (the perceived difficulties item) and if so, enquires further about chronicity, distress, social incapacity and burden for others (Goodman, 1999). Each item is scored on a 4-point scale and an overall impact score is computed by adding the scores on the distress and social incapacity items (range 0–10). In our study, the Spanish and Catalan versions of the questionnaire were administered (www.sdqinfo.org).

The SDQ has been used in many countries (e.g. Achenbach et al., 2008; Marzocchi et al., 2007), including Spain (Rodríguez et al., 2007). It has been used both in clinical contexts and research (for a review, see Vostanis, 2006), in children in care (e.g. Goodman, Ford, Corbin, & Meltzer, 2004; McCarthy & Geddes, 2003; Richards, Wood, & Ruiz-Calzada, 2006) and also in adopted children. Vorria et al. (2006) compared 61 four-year-old adopted children who had been institutionalised with 39 children raised from birth in their own families; both groups of children were well-adjusted and no significant differences were found between groups in terms of mothers' SDQ ratings. Golombok, MacCallum, and Goodman (2001) compared psychological well-being in forty-nine adopted children, thirty-four children conceived by in vitro fertilisation, and thirty-eight naturally conceived children at age 11. No significant differences were found in mothers' and teachers' scores between groups and the results showed that the children were well within the normal range of functioning.

Goodman (2001) reports that the SDQ shows satisfactory internal consistency, satisfactory test–retest stability and moderated interrater agreement. High correlations have been found between the SDQ and other established questionnaires such as the Achenbach System of Empirically Based Assessment (Achenbach et al., 2008) and the Rutter Scales (Elander & Rutter, 1995). The SDQ also distinguishes well between non-clinical and clinical cases, especially when multi-informant data are considered (Goodman, Ford, Simmons, Gatward, & Meltzer, 2003). Data on parental agreement on the SDQ have also been provided (Davé, Nazareth, Senior, & Sherr, 2008). Factor analyses have generally supported the five-factor structure of the questionnaire, although discrepancies emerged in recent confirmatory factor analyses (Acremont & Van der Linden, 2008; Percy, McCrystal, & Higgins, 2008).

2.4. Data analysis

First, the problems reported by children were analysed using the Coding System Problems Reported (Forns et al., 2004). Two coding categories were used: nature of the problem (which identifies who suffered the problem) and content of the problem (which identifies the type of the problem) (Table 1). Two independent psychologists classified the children's problems for this study. The kappa index was $k = .70$ for nature of the problem and $k = .81$ for content of the problem, which are generally considered as satisfactory (Gardner, 1995). Disagreements on problems were resolved via discussion between raters. Chi-Square Tests were used to examine differences according to gender, age and country of origin in the problems reported. When required, Chi-Square unbiased values were computed by means of a Monte Carlo sampling method based on 10,000 contingency tables. Second, types of coping used and their efficacy were analysed; thus, percentages of the strategies identified with the Kidcope were obtained. Third, coping strategies were grouped according to the two factors that emerged and a *t*-test was conducted to compare both means. Fourth, descriptive data for each SDQ scale and for impact supplement items were computed. Data drawn from previous research (Rodríguez et al., 2007) was used as a comparison group. Pearson's correlations and mean differences were calculated to compare mothers' and fathers' ratings. Scale scores were also categorised into "normal", "borderline" and "clinical" range, following the recommendations of Goodman (1999), and category percentages were obtained. Chi-Square Tests were used to compare mothers' and fathers' chronicity and burden ratings. Finally, an ANOVA was conducted to determine the effect of coping strategies on parent SDQ ratings. As the distribution of the P–P plot test was normal, parametric methods were used to analyse the data. Statistical significance was set at the 95% confidence level ($p \leq .05$). The Statistical Package for Social Sciences (SPSS 14.00) was used for statistical analyses.

3. Results

3.1. Internationally adopted children's problems

The 77% of the sample reported interpersonal problems, 17% reported personal problems and 6% reported problems related to others (Table 1). As regards content, 31% of the children expressed relationship problems, 26% problems referring health, illness or accidents, 14% conflicts with norms and rules, 14% victimization, 6% academic performance and 9% other problems. They didn't report any problem related to moving house/changing school, death/suicide, money/economy/work, addictions, or sports/leisure/holidays. None of the problems mentioned was related to the adoption experience, except in one case ("My brother is living in my country of origin. It's a very poor area. I miss him and I want him here with me").

As shown in Table 2, there were no significant differences in the problems reported according to gender, age or country of origin. Only marginally significant gender differences in the content of the problem were found, with girls showing more relationship problems and fewer conflicts with norms and rules than boys.

3.2. Type of the coping strategies used

The frequency with which children used each of the 10 coping strategies identified by Kidcope is shown in Table 3. The coping strategies most frequently used were wishful thinking, emotional regulation, social support, distraction and problem solving (used by over 75% of the children), followed by social withdrawal and cognitive

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Table 1
Classification of problems reported by children.

Category	Definition	Subcategories	Sub-definition	Frequency *n* (%)
Nature of the problem	Identifies who has the problem	Personal "I failed math"	The problem has happened to the child, without the intervention of other persons *(to me)*	6 (17)
		Interpersonal "Last Thursday I fought with my friend"	The problem is related to the relationship of the child with others *(me + others)*	27 (77)
		Related to others "My grandfather is at the hospital"	The problem has happened to other person or persons, who can be related to the child *(others)*	2 (6)
Content of the problem	Identifies the topic of the problem: facts, circumstances, characteristics or events related to the problem	Relationship "My mother told me off hitting my brother"	The problem appears in the relationship between: the child and his/her family, the child and his/her peers, and the child and his/her teachers or school authorities	11 (31)
		Health, illness or accidents "My father had a car crash last year"	The problem appears as a consequence of: physical/mental illness, poor health, and suffering an accident by the child or acquaintances	9 (26)
		Conflict with norms and rules "I stole some money from my father's bag"	The problem is related to breaking norms or rules by the child	5 (14)
		Victimization "My friend hit me"	The problem is related to physical/psychological aggression or abuse suffered by the child	5 (14)
		Academic performance "I failed most of my exams"	The problem is related to school achievement	2 (6)
		Moving house, changing school "I don't like my new neighbourhood"	The problem appears as a consequence of moving home or changing the school.	0 (0)
		Death, suicide "My grandmother died and we went to the funeral"	The problem is related to the death or suicide of a child's friend, relative or pet	0 (0)
		Money, economy, work "My mother has lost her job"	The problem is related to economical or labour problems	0 (0)
		Addictions "My father drinks a lot"	The problem is related to drugs, gambling, etc.	0 (0)
		Sports, leisure, holidays "I cannot play basketball any more"	The problem is related to the inability to play any sport or to go away on vacation	0 (0)
		Others "I lost my glasses"	The content of the problem doesn't belong to any of the previous categories.	3 (9)

Note. Adapted from Coding System Problems Reported by Forns et al. (2004).

restructuring (54%). Self-criticism (29%), blaming others (23%) and resignation (3%) were the least used. No significant differences were found in the use of these strategies according to gender, age or country of origin. Likewise, it was found that children used significantly more control-oriented coping ($M = .7$) than escape-oriented coping ($M = .4$), ($t = 3.59$, $df = 34$, $p < .01$). The influence of gender, age and country of origin on the coping scales did not reveal any significant differences.

3.3. Efficacy of the coping strategies used

Seven of the 10 strategies (distraction, cognitive restructuring, problem solving, emotional regulation, wishful thinking, social support and resignation) were rated as moderately or very effective ("a little" or "a lot" on the scales) by over 75% of users (Table 3). However, the efficacy of the resignation strategy should be considered with caution in view of its low rate of use.

Table 2
Effects of international adoptee's gender, age and country of origin on the nature and content of the problems reported.

	N	X^2	*gl*	Monte Carlo sig. (2-sided)
Gender				
Nature	35	3.59	2	.16
Content	35	10.23	5	.07
Age				
Nature	35	.45	2	.83
Content	35	4.27	5	.60
Country				
Nature	35	2.13	6	.94
Content	35	18.08	15	.26

3.4. Symptoms and positive attributes rated by parents

Most of the scores obtained from mothers and fathers on the SDQ fell within the normal band; only parental ratings of conduct problems slightly exceeded the cut-off point (Table 4). Likewise, the *t*-test for unpaired means showed no significant differences between the parental ratings obtained here and those presented by Rodríguez et al. (2007) in a Spanish control group. Mothers reported significantly more deviant behaviours than fathers for emotional symptoms ($p = .03$) and, marginally more for total difficulties scale ($p < .07$). Mothers' and fathers' ratings were positively and significantly correlated (*rs* from .41 to .86, $p < .05$) except for the emotional symptoms scale. The highest correlation values were for hyperactivity ($r = .86$), total difficulties ($r = .78$) and conduct problems scales ($r = .75$).

As presented in Table 5, over 60% of internationally adopted children were reported to be functioning well within the normal range in all the SDQ scales. The highest percentage was for the prosocial behaviour scale (about 94% for both mothers and fathers).

Table 3
Percentages of use and perceived efficacy of coping strategies according to the Kidcope.

Coping strategy	Use		Efficacy	
	n	%	*n*	%
Distraction	28	80	21	75
Social withdrawal	19	54	9	47
Cognitive restructuring	19	54	17	90
Self-criticism	10	29	4	40
Blaming others	8	23	4	50
Problem solving	27	77	24	89
Emotional regulation	30	86	26	87
Wishful thinking	32	91	24	75
Social support	29	83	26	90
Resignation	1	3	1	100

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The percentages of children rated as showing clinical behaviours ranged from 3% for emotional symptoms to 29% for hyperactivity.

3.5. Impact supplement: appraisal of the problem, distress and social incapacity

Twenty-seven mothers and twenty-three fathers reported that their child had at least "minor difficulties" (Table 4). Parents' ratings were strongly correlated ($r=.78$, $p<.01$), but mothers reported significantly more perceived difficulties ($p=.03$) than did fathers. Overall impact scores did not exceed the cut-off point, although they fell within the borderline range. Mothers' and fathers' impact scores were very strongly correlated ($r=.82$, $p<.01$) and no significant differences were found between them.

Children were reported to have long term problems (nearly "over 1-year" duration), but they were considered "only a slight" burden on the family (Table 4). There was a significant relationship between mothers' and fathers' chronicity ratings (χ^2 (3, $N=21$) = 21.00; $p<.01$; $T^2=.58$) with the highest agreement (81%; 17 families) being found in considering their child's difficulties to have lasted "over 1-year". A non-significant relationship was found between parents' ratings of burden (χ^2 (9, $N=21$) = 12.03; $p=.23$; $T^2=.19$).

3.6. Relationship between coping strategies and adjustment

Parents' ratings on prosocial behaviour and on total difficulties scale scores were correlated with control-oriented and escape-oriented factors. Control-oriented coping did not show any significant correlation with adjustment scales. Escape-oriented coping was significantly correlated with the total difficulties scale, for both mothers ($r=.52$, $p<.01$) and fathers ($r=.44$, $p=.01$). An ANOVA was conducted to determine the effect of each escape-oriented coping strategy on parents' total difficulties ratings. Statistically significant differences were found in self-criticism, both for mothers ($F=9.71$, $p<.01$, $\eta^2_p=.27$) and fathers ($F=5.72$, $p<.05$, $\eta^2_p=.20$). Higher total difficulties scores were found in those children who used self-criticism than in those who didn't use it.

4. Discussion

Extensive research has been conducted on the psychological adjustment of internationally adopted children. Spain has recently become one of the major receiving states of international adoptees in the world, but studies in this country are still scarce in the English scientific literature. In this sense, the study reported in this paper contributes to a better understanding of the outcomes for internationally adopted children in Spain. Likewise, not much research on this topic has included a sample of international adoptees aged between 8 and 12, although this is an important developmental period in children's lives that needs to be considered. Similarly, while previous studies have primarily focused on parental reports about their child's problems and difficulties, the present study considers their strengths and coping strategies as well. Special emphasis is given to the adoptees' perspective, thus providing a more comprehensive view of the adoption phenomenon.

When analysing what internationally adopted children find stressful, we found they mention daily life stressors. They mainly reported interpersonal problems, regardless of gender, age or country of origin. Similar results were obtained in Spanish children (Caqueo & Forns, 2004). The content of the problems generally referred to "relationships" and "health, illness or accidents" topics. These findings are consistent with Caqueo, and Forns (2004), Forns et al. (2004) and Pereda et al. (2009). As in the last two studies, girls tended to express more relationship problems while boys tended to report more conflicts with norms and rules. It has been suggested that girls may invest more in interpersonal relationships (Roecker, Dubow, & Donaldson, 1996; Stark et al., 1989) whereas boys are more likely to show deviant behaviours (McMahon, Wells, & Kotler, 2006). No differences were found in terms of age or country of origin.

It is noteworthy that just one child reported a problem related to the "adoption experience". It may be that at the ages examined, when the concrete operational cognitive stage is predominant (Piaget, 1954), problems are viewed as specific circumstances and not as situations affecting the subject's life in general. For this reason, they seldom consider adoption as a problem in itself; although it does not mean that adoption is not relevant to them. Likewise, the latency period may prevent them from appraising and talking about the subject. Finally, these findings may also indicate that, for the majority of children, "adoption" is not a problem, but a solution. Thus, the present findings are a reminder that although these children are international adoptees, they are children first. And that they worry about and have to deal with the usual things that children worry

Table 5
Percentages of parental reports classifying children's behaviour as normal, borderline or clinical.

SDQ scales	Normal range		Borderline		Clinical	
	Mothers	Fathers	Mothers	Fathers	Mothers	Fathers
Emotional symptoms	63	71	23	26	14	3
Conduct problems	66	68	17	16	17	16
Hyperactivity	66	65	6	10	29	26
Peer problems	60	74	29	19	11	6
Prosocial behaviour	94	94	0	3	6	3
Total difficulties	60	71	23	16	17	13

Note. Classification was made according to the banding of SDQ scores proposed by Goodman (1997).

Table 4
Means, *SD*, *t*-test differences and parents' correlations for SDQ scales and for impact items.

SDQ	Mean scores (*SD*)				Normal range	Parents' contrasts			Parents' correlations	
	Mothers ($n=35$)		Fathers ($n=31$)			*t*	*df*	*p*	*r*	*p*
Scales										
Emotional symptoms	3.0	(1.85)	2.2	(1.52)	0–3	−2.27	30	.03	.24	.20
Conduct problems	2.3	(1.93)	2.2	(2.25)	0–2	−.47	30	.65	.75	<.01
Hyperactivity	4.4	(3.15)	4.5	(3.09)	0–5	−.21	30	.83	.86	<.01
Peer problems	1.9	(1.45)	1.7	(1.25)	0–2	−1.32	30	.20	.41	.02
Prosocial behaviour	8.3	(1.62)	8.3	(1.95)	6–10	−.45	30	.65	.62	<.01
Total difficulties	11.6	(6.18)	10.5	(6.02)	0–13	−1.89	30	.07	.78	<.01
Impact supplement										
Perceived difficulties	1.4	(.97)	1.2	(.90)	0–2	−2.28	30	.03	.78	<.01
Impact score	1.9	(2.48)	1.8	(2.45)	0–2	−1.20	30	.24	.82	<.01
Chonicity[a]	3.7	(.71)	3.8	(.58)	0–2					
Burden[a]	1.1	(.85)	1.1	(.82)	0–2					

[a] Twenty-seven mothers and twenty-three fathers answered these items.

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about. Adoption is not an irrelevant issue, but is not necessarily a problematic one either.

In common with most of the literature (for a review, see Donaldson et al., 2000), this study reveals that internationally adopted children use a wide-ranging coping repertoire, which they perceive as highly effective. They reported frequent use of wishful thinking, emotional regulation, social support, distraction and problem solving. Self-criticism, blaming others and resignation were the least used strategies, suggesting that these children do not tend to attribute the cause of their problems either to themselves or to others. As in other studies (Caqueo & Forns, 2004; Donaldson et al., 2000; Pereda et al., 2009), resignation was scarcely used by children; perhaps, since internationally adopted children use problem solving and social support frequently and effectively, there is no need for resignation. The coping pattern used by international adoptees, with more control-oriented coping rather than escape-oriented coping, suggests that they make healthy use of coping strategies. Furthermore, they show a healthy perception of coping strategies, as they consider the former as more effective than the latter.

A relevant finding within this research is that most internationally adopted children, in spite of all the potential risks, appear to develop normally. Parents reported that the majority of them, both boys and girls, were well-adjusted, although conduct problems were slightly more frequent than in the normative sample. No differences were found in terms of age or country of origin. These positive outcomes may be attributed in part to the protecting characteristics of the adoptive families and the social context, which foster resilience in the adoptee (Golombok et al., 2001; Juffer & Van IJzendoorn, 2005, 2007). It may be important to recognize this fact because there might be a stigma attached to adoption, with some people thinking developmental problems are inevitable. On the other hand, the slightly higher rate of behaviour problems may reflect children's attempts to manage the grieving process of adoption-related losses (Brodzinsky, 1990) and/or their struggle with identity issues (Juffer, & Van IJzendoorn, 2005).

Adoptees also showed higher levels of prosocial behaviour. Several factors may contribute to this finding (Sharma et al., 1996, 1998; Stams et al., 2000); firstly, adoptees, who have already experienced loss, may try to avoid future abandonment by strengthening their social abilities. Secondly, adoptive parents, who are assumed to be more prosocial due to their having adopted a child, may have conveyed this value to their children. Finally, it may also be that adoptees recognize the value of prosocial behaviour in their own adoption and act accordingly.

Despite the high interparental agreement on children's level of adjustment, mothers tended to give higher scores than fathers on emotional symptoms, total difficulties, and perceived difficulties. This finding may indicate that adoptive mothers are more sensitive to their children's problems. Or it may equally reflect differences in the ways children behave when interacting with their mothers and their fathers. Interestingly, even though parents coincided in reporting problems of long duration in their children, they did not consider that these difficulties placed a burden on the family. It may be that their willingness to become parents and to care for their children strengthens them against difficulties and protects the children's development.

Finally, the findings also revealed an association between children's coping strategies and their psychological well-being. Escape-oriented coping was related to greater maladjustment, which is usually reported in the coping literature (Compas et al., 2001) and among adopted children (Smith & Brodzinsky, 2002). Self-criticism was the coping strategy that accounted for the highest percentage of the variation for parents' rated total difficulties. This coping strategy is believed to be associated with symptoms of a wide range of psychological disorders and psychological distress. Individuals high in self-criticism are extremely sensitive to stressors and they are also more likely to make global negative self-judgments. Conversely, the use of control-oriented coping, which is traditionally considered to serve a protective function, was not associated with health outcomes in the present study. Certainly, this question deserves further exploration.

Limitations to our work are obvious. The group size was small and diverse, which may affect the generalisation of results. However, at the same time, this heterogeneity reflects the wide variability existing inside this population. Another drawback is the cross-sectional nature of the study. Adoption is not a one-time event but a lifelong process, and child's and parents' well-being may change over time. Hence, further studies in larger samples and with prospective designs are necessary before firm conclusions can be drawn.

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