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The perceptions of young adult adoptees in India on their emotional well-being

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Abstract
This article presents the findings of a study of 46 adults adopted at very young ages in India and now aged between 20 and 30 years. The results suggest that the majority of respondents were physically healthy and well adjusted. However, 40% scored below the norm for social functioning, suggesting some underlying issues associated with poor well-being in their current phase of life. The mental health issues affecting the young people were associated more with anxiety and stress than depression. However, none of the variables investigated proved to be strong predictors of mental health difficulties. The results are discussed in the context of Indian culture and psychosocial development during early adulthood and include implications for practice.

Keywords
Adoption, emerging adulthood, health, well-being, mental health, India

Introduction

Adoption has a special significance for the study of child development because it facilitates the exploration of growth outside the context of the biological family. Historically and in many cultures, adoption or fostering by strangers is seen as unnatural, although adoption is

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increasingly viewed across the world as an effective way of providing for orphaned, abandoned or surrendered children by offering a combination of legal stability and a family context auspicious for healthy development (see van IJzendoorn and Juffer, 2006). However, while it is well established that adoption meets children's physical and material needs, the evidence about its effects on emotional and psychological well-being, especially at the time of emerging adulthood, is more equivocal. This article discusses findings from a study of the perceptions and well-being of 46 young adults adopted domestically as children in India – a moderately prosperous and traditionally patriarchal country – and now aged between 20 and 30 years of age. All the respondents had been aware of their adoption history from an early age.

Literature review

Research findings on the relationship between adoption and adult mental health are difficult to interpret as samples differ and it is hard to compare like with like cases. Many studies focus on the well-being of adoptees early in their life cycle while others comprise adults recalling events retrospectively. Moreover, outcomes vary in different areas of people's lives and are rarely wholly good or bad, and there may be contrasts between the results for different groups, such as those adopted domestically and intercountry. In addition, many published studies are based on adoptions within or into high-resource countries and focus on placements in white middle-class families in North America or Europe.

The main conclusions that can be drawn from all this research are that adoption is a varied experience and there are differences between sub-groups of children, such as domestic and intercountry adoptions or the placement of infants as opposed to older children in care. In addition, although much of the literature has focused on the age at adoption as a predictor of outcomes, a growing body of research emphasises the significance of the length and type of pre-adoptive adversity (Groza and Ryan, 2002), especially periods spent in institutional care (Cederblad, et al., 1999; Hawk, et al., 2013). Yet, despite all this evidence, there are very few studies of domestic adoptions in less economically developed and relatively poor societies, which are typical of most countries in the world. This article helps to fill this gap.

Indian culture, socialisation and adoption

In India, and particularly in the Hindu tradition (80% of the Indian population is Hindu, Census, 2011), children are perceived as being born innocent and pure, almost divine (Saraswathi and Ganapathy, 2002). Adoption is as old as Hindu law (Chowdhry, 1980) and is rooted in Hindu epics and mythological stories. Traditionally, adoptions were kept secret and were essentially intra-familial affairs (Bhargava, 2005; Stiles, et al., 2001) but they were documented in the histories of kings (Baig and Gopinath, 1976). In these accounts, adoption is neither uniformly accepted nor stigmatised. For instance, Mehta (2002: 198) refers to adoption in India as a 'beautiful way of building families' and Bhargava, writing about the policy framework for adoption in India, indicates that 'Adoption has always been considered as a wonderful opportunity to provide a child with home and parents' (Bhargava, 2005: 1). Yet for some Indians, there is a preference for fertility-assisted technologies or surrogacy rather than adoption (Bharadwaj, 2003) because the latter is seen as accentuating infertility. Social stigma is most likely to occur when adoption is chosen as a second choice for building a family. However, it must always be noted that India, with more than 5000

years of history, is a diverse and pluralistic country and general statements must be hedged with caution.

Since the independence of India from British rule in 1947, child welfare has been undergoing reform. The country has been a signatory to the Hague Convention 1993 since 2003. Adoptions have been occurring formally through the legal system and in the last four years approximately 21,000 adoptions occurred, 95% of them domestic arrangements (CARA, undated). Children are placed for adoption through a centrally recognised agency, the Central Adoption Resource Authority (CARA) in New Delhi, under the Hindu Adoption and Maintenance Act 1956 and recently a more secular and child centric Juvenile Justice Act of 2000 with a 2006 amendment, previously linked to the Guardianship and Wards Act of 1890. A large proportion (exact numbers are not known) of the children have been abandoned, voluntarily relinquished or surrendered because of the stigma of being born to a single mother (Baig and Gopinath, 1976), but in some instances the reasons are poverty or the death of parents.

There have been a few studies of adoption in India. In 2001, the children's charity Bharatiya Samaj Seva Kendra (BSSK) conducted a study of domestic adoptions to chart current practice using interviews and surveys of parents who had adopted their children through the agency (Groza, Kalyanvala and BSSK Research Team, 2003; Groza, et al., 2003). At the time of the study, the children's ages ranged from less than 12 months to 21 years, the average being 7.3 years. The average age at placement was eight months and the children had been in their respective placements for an average of 6.6 years. Families evaluated the agency's practice positively and the adoption outcomes were generally good. Most of the children were developmentally normal and few had health problems, or sensory or behaviour difficulties. Parents reported good parent–child relations and the placements were highly stable.

The main issue for the families concerned was when and how to discuss adoption with their child. Many talked openly about their struggles with broaching the subject and some believed that if it was mentioned when the child was young, there would be no need to raise it again. What emerged from the interviews was a clear indication that for many families dealing with adoption issues, including reference to the birth family, was a continual struggle. Also, as there were no formal supports available, many felt isolated and trapped in a unique situation. The support that was available came informally from their relatives and friends, despite the fact that the respondents expressed a wish for informal social contacts with other adoptive families.

In 2005, Bhargava studied 63 parent–child relationships (45 families) using quasi-ethnographic and survey field research as well as gathering personal and professional experiences. The ages of the adoptees, both at the adoption and at follow-up, varied and as in the research just described, she found that domestic adoptions were largely successful. She discusses several perspectives relevant to understanding adoption in India. The first is that self-identity among Indians is heavily influenced by the Indian kinship system that consists of caste, class and religious identity. Depending on when the adopted person learned about their history and how the parents handled this information, the children held distinct views on adoption and displayed different comfort levels regarding their identity. Bhargava found that some children were aware of their status from an early age and talked openly about their situation, whereas some parents had given their child minimal or false information or had kept everything secret, arguing that this was best for their children as there were so few other supports available to them.

In an earlier study with the same sample, Groza and colleagues reported that most adoptees (93%) were told about their history by their parents, on average at the age of 9.8 years (Groza, et al., 2014). Half (53%) said that they often thought about their birth families, particularly their mother, but 20% of those who did so explained that they felt this was disloyal to their adoptive parents. All of these studies focused on outcomes while the adoptees were still young and little is known about what happened later in their lives.

When charting children's well-being, it is important to understand the context of macro socio-cultural influences as well as subjective individual experience. Research to date supports the notion that parenting socialisation practices and beliefs are influenced by cultural values (Bornstein and Cheah, 2006). Thus, factors that affect development trajectories in one society may be different in another. Traditionally, Indians follow a patriarchal pattern with multiple generations living in the same household (Jambunathan and Counselman, 2002) or being closely connected by an extended family network described as 'jointness' (Saraswathi, 2012). This multiple family system has been a major influence on the socialisation process of children (Roopnarine and Hossain, 1992) and Asian Indians emphasise bloodlines, familial bonds and loyalty to the family (Kakar, 1978). Choudhary and Sharma (2012) confirm the pivotal role of the family in socialisation, noting that the single most important factor that characterises Indian children is their 'constant pull toward the family ethos that encourages them to place individual needs secondary to family needs, and subjugate their decisions to those made by the family to maintain cohesiveness' (p. 449). Today, due to modernisation, Indian families no longer depend on their children for material prosperity, but are still psychologically interdependent and closely integrated in the culture of relatedness, as described by Kâğıtçıbaşı (2005) in her description of traditional cultures in transition.

Asian Indian parents also place a high value on filial piety (Rao, McHale and Pearson, 2003), academic achievement (Bhugra and Mastrogianni, 2004; Verma, Sharma and Larson, 2002), family interdependence and respect and compliance (Dasgupta, 1989; Helwig and Helwig, 1980; Wakil, Siddique and Wakil, 1981). Demuth, Chaudhary and Keller (2011), in their qualitative study in which German and Indian students aged 18–41 years recollect their lives trans-generationally, describe the prevalence of social appropriateness, 'proper demeanour' and compliance, even in adolescence and early adulthood. Negatively constructed positive evaluations of self, such as 'I never let my family down', are typical of Indian culture (Demuth, Chaudhary and Keller, 2011: 45). But it is also common practice for Indian parents to use other adults as socialising agents, such as when middle-class Indian families employ nannies to take care of the children, with the result that kinship terms are commonly invoked in interactions with people who are not biologically related (p. 68). In the Indian context, the exercise of agency is not seen as desirable as the culture values well-being and loyalty with the family. The construct of the self is essentially relational, developed in relation to fulfilling a norm – or rather not violating one – and perceived through the eyes of others. Children are therefore socialised to recognise the needs of others (Paiva, 2008) and raised with the goal of developing an identity rooted within their family (Meyer, 2009).

Emerging adulthood and adoption

Emerging adulthood is a new conception of development in the period from the late teens to the mid-20s (Arnett, 2000; 2004), clearly a period of profound changes and independent explorations. When adults later recall the most important events in their lives, they most often identify episodes that took place during late adolescence and early adulthood

(Martin and Smyer, 1990). Arnett argues that emerging adulthood is neither adolescence nor young adulthood but is theoretically and empirically distinct from them.

In the Indian context, Saraswathi and Oke (2013) remark that among the urban middle classes, the years following adolescence but preceding adulthood lend credence to the phase 'emerging adulthood', a period characterised by exposure to modern ways of living, the availability of new media and communication technologies, completing higher education and preparing for specialised employment, all of which have delayed the traditional age of marriage. In the Hindu life stages this time is referred to as a stage of apprenticeship to acquire the skills, competencies and knowledge needed for becoming a responsible household provider (Saraswathi, 2012). In practice, parents continue to be a source of support during and beyond their children's early adulthood (Sandhu and Kaur, 2012).

Outcomes for the maturing adults can be positive or negative. Hawkins and colleagues (2009) have developed a multidimensional model of positive development during this transition period that identifies five important domains: social competence; life satisfaction; trust and tolerance of others; trust in authorities; and civic engagement in social institutions. However, this formulation is mostly based on young adults who grow up in birth families and less is known about those who have been adopted. Unlike children in foster care, about whom there is more evidence, many adoptees have been brought up in middle- and high-income families and prosperous communities. Even less is known about the pattern of adult transition for those adopted in India.

In India the non-biological component of the adoptive parent–child relationship is especially important. In cultures that reflect values of mutual social responsibility and obligation, adoptees may perceive being adopted as a psychological burden. This produces a different context for processes such as life story work, life narratives and searching for birth relatives, which are used successfully in western societies.

The research study

Drawing on data from the larger research project (Groza, Park and Oke, 2012), this article asks the following questions:

- What is the self-reported health and mental health status of domestically placed Indian adoptees?
- What predicts their mental health and well-being outcomes?

Methodology

Sampling strategy. Bearing in mind the sensitive nature of the study and the fact that adoptees may not know about their adoptive status, contact with potential participants was made via their parents. They received a letter introducing the research project and completed a consent form. The letter and the parent survey were written in English and Marathi, the language of most inhabitants from Pune (Poona), a satellite town of Mumbai in western India. A reminder was sent six weeks later to those who did not respond.

We deliberated on how to minimise the risks posed for the respondents. In stage two, only adoptees whose parents acknowledged that they knew about their history were included. We then asked them about their preferred method of participation, for example, via a postal survey, Skype, phone or face-to-face interviews in a location of their choice. The Indian

interviewing team were professionals working with BSSK but did not provide a service to the adoptee or parents. They were trained in basic interviewing skills and in the project protocol, including confidentiality and safeguarding.

Measures. The four criteria used to select the measures utilised in the study were that they would: (1) answer the research questions; (2) be easily obtained or publicly available; (3) not require any expenditure; and (4) be perceived by Indian colleagues as valid and feasible for use with Indian adoptees. The adult adoptee questionnaire included the Health Survey Short Forms (SF-36) (Ware and Gandek, 1994) and the Brief Screen for Depression (BSD) (Hakstian and McLean, 1989), as well as parent and adoptee questionnaires developed by the research team to supplement the standardised instruments.

The SF-36, Version 2, has been widely used (Turner-Bower, Bartley and Ware, 2002) and assesses respondents' specific health problems and level of general health in order to produce an overall profile of functional health. It is a generic health measure as opposed to one that targets a specific age, disease or treatment group. Norms are based on a sample (n = 6742) of non-institutional adults in the general US population in 1998 but there are none established for India. Thirty-six items measure eight health dimensions: physical functioning (PF), social functioning (SF), role limitations due to physical problems (RP), role limitations due to emotional problems (RE), mental health (MH), energy/vitality (VT), bodily pain (BP) and general health perceptions (GH). All scores are summed and linearly transformed to a 0–100 scale (SF-36 Manual). The scores are also calculated into norm-based scores with an average of 50 and a standard deviation of 10. They are summarised into two major scales: Physical Component (PC) and Mental Component (MC). The PC is composed of PF, RP, BP and GH. The MC comprises MH, RE, SF and VT. The Cronbach's alpha, as a measure for reliability for each scale, were as follows: PF (.87), RP (.74), BP (.76), GH (.74), VT (.64), SF (.68), RE (.49) and MH (.67). The BSD screens for depression and contains four questions; the alpha for depressed people was .65 and for non-depressed people .63 with good test-retest reliability (Hakstian and McLean, 1989).

Response rate

Initially 387 families were identified as possible candidates. This was derived from a census of all adoptions by families living in India whose children had turned 18 by 1 January 2010. After the initial mailing, no correct address was found for 30% (n = 116) of those approached, five per cent (n = 20) said they had not disclosed the adoption and 0.8% (n = 2) of parents and 2.1% (n = 8) of children had died. In addition, 0.8% (n = 2) had adopted a child with a disability that prevented participation and 2.8% (n = 11) refused to allow the researchers to have contact with the child, although they all claimed that their children knew about their histories. This left 227 adoptive families for consideration.

From this group of 227, 76 families responded – a rate of 34%. There are several reasons for this low figure. First, these adoptions occurred some 20 to 30 years ago and many families had moved during this period and not informed the agency. Second, at the time of the adoptions there was no age restriction on applicants, so those who were over 50 at the time of the adoption were now in their 70s or 80s and were likely either to be dead or to feel too old to participate.

The protocol for the study specified that the adoptees had to be aware of their adoption history and only 59 young people met this criterion, 46 of whom participated.

Most (80%, n = 37) were interviewed face-to-face, others by Skype (6.5%, n = 3), post (4%, n = 2) or phone (8.7%, n = 4). An analysis of demographic characteristics showed no relationship with the methods used.

A comparison was then made between the adoptees who participated and those who did not. The ages of young people in the two groups at the time of the study were not significantly different (t = 1.9, df = 57, p = .06, equal variances not assumed) with means of 24.5 and 23.6 respectively. Neither was the age at adoption statistically significant (t = 1.8, df = 56.4, p = .08, equal variances not assumed). However, there was a significant difference for gender (chi-square = 6.6, p = 01).

Respondents' background characteristics

As reported, 46 adult adoptees took part in the study, the majority of whom (63%, n = 29) were female. Their ages at the time of study ranged from 20 to 32 years with an average of 23.6 for men and 24.2 years for women. Age at the time of adoption ranged from two to 60 months; the average was 12.2 months (25% placed under six months, 50% under five months and 75% under 18 months), again with no significant differences between men and women. Interestingly, many adoptees were college graduates (43%) or had a master's degree or above (26%).

Respondents were asked about their general feelings around being adopted. The majority (82.6%, n = 38) reported that they felt positive about it, the rest (17.4%, n = 8) expressing neutral or mixed opinions. No one said that they felt negative. They were also asked how they felt about being placed for adoption and again, the majority (63.6%, n = 28) reported positive feelings with 31.8% (n = 14) expressing neutral or mixed opinions and 4.5% (n = 2) highly critical ones. Most adoptees felt a deep sense of gratitude towards their parents. In the words of one 25-year-old male: '... which other children could be as fortunate?' A 20-year-old female said that with adoption her life had been 'altered to her advantage'. Another 27-year-old male adoptee said that adoption had given him 'love, opportunities, family and security. It has given me a new life with a good family, education and neighbours.'

Table 1 presents results from the SF-36, Version 2, Health Survey. For each of the scales, the average scores based on the normed-based figures put the adoptees as a group near or slightly above the average for the general population.

Table 2 shows the percentage of the sample who were above, at or below the general population norms. The distribution of the results is wide but on 7 of the 10 measures, over half of the adoptees were above the norm. Problems, when they occurred, lay mostly in the areas of mental health and social functioning.

Mental health: depression

The results for the four questions that comprise the depression screening scale (Hakstian and McLean, 1989) are presented in Table 3. As a group, the score for the Indian adopted persons was statistically significantly lower than for those diagnosed with depression (DP), but statistically higher than the general population (TP) on which the score was normed in the USA, with the exception of one item.

For the item 'How many times during the last two days have you been preoccupied by thoughts of hopelessness, helplessness, pessimism, etc.?', Indian adoptees had significantly

Table 1. Results from the SF-36, Version 2, Health Survey.

	Normed-based scores (mean score on all scales = 50; σ = 10)
Physical functioning	52.8 (σ = 7.1)
Role limitations due to physical problems	53.5 (σ = 5.5)
Role limitations due to emotional problems	52.2 (σ = 5.8)
Social functioning	51.1 (σ = 7.4)
Mental health	50.5 (σ = 8.5)
Vitality	57.1 (σ = 8.0)
Bodily pain	53.8 (σ = 8.95)
General health	56.5 (σ = 8.2)

Table 2. Percentage of adoptees scoring above, at or below the norms on the SF-36 Health Survey*.

	Above norms	*At norms*	*Below norms*
Physical functioning	54%	8%	38%
Role limitations due to physical problems	58%	15%	27%
Role limitations due to emotional problems	60%	19%	21%
Social functioning	50%	10%	40%
Mental health	**31%**	**17%**	**52%**
Vitality	65%	8%	27%
Bodily pain	48%	15%	38%
General health	65%	10%	25%
Physical component	59%	11%	30%
Mental component	**35%**	**17%**	**48%**

*$p < .05$ for all bold numbers

lower scores than US citizens who were depressed ($F = 9.4$, $df = 55.8$, $p < .01$) but significantly higher scores than typical respondents ($F = -1.97$, $df = 56.1$, $p < .05$). For the item, 'How relaxed have you been during the last two days?', Indian adoptees again had significantly lower scores than the US depression sample ($F = 6.3$, $df = 54.6$ $p < .01$) but higher scores than the general population ($F = -2.2$, $df = 53.3$, $p < .05$). This result is repeated for the item, 'To what extent have you had difficulty starting and following through...?' Only for the question, 'How satisfied are you with your ability to perform your usual domestic duties?', did the Indian adoptees have significantly lower scores than the two other comparison groups, although these differences were not statistically significant ($F = -.65$, $df = 563.1$, $p = .5$). So, while the SF-36 indicates more mental health problems for half of the adoptees, the problem does not appear to be depression (a finding also supported by SF-36).

When the factors associated with mental health were further investigated, it was found that gender had no association with mental health ($t = -.07$, $df = 2$, $p = .94$, equal variances assumed); males had a mean score of 50.4 ($\sigma = 7.7$) and females 50.6 ($\sigma = 9.2$). Also

Table 3. Brief screen for depression items with means and standard deviations for depressed person, typical (normative) person and Indian adopted persons.

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

*$p < .05$

insignificant was meeting parents' educational expectations ($F = .56$, $p = .58$).[1] Similarly, parent satisfaction with adoptees' educational achievement had no association ($F = .89$, $p = .45$) with the mental health component.[2] Indeed, further analysis failed to find any factors that correlated with the Mental Health Component, including age at the time of the study ($r = .19$, $p = .19$), age at adoption (.01, $p = .92$) and age at adoption disclosure (.10, $p = .52$). In addition, being adopted or being placed for adoption yielded no significant results, even when the impact of outliers was taken into consideration.

Discussion

The results of this study show that most of the adoptees who were interviewed were doing well physically and few showed any discernable psychological disorders, thus substantiating suggestions about their general resilience. In the context of Indian culture, the family network is clearly a strong influence and in most cases a positive support. Nonetheless, the scores on some of the subscales of mental health and social functioning, where half of the adoptees scored below the norms, are worrying as they have implications for the adults' well-being. Interestingly, however, the mental health problems appeared to be related to anxiety and stress rather than depression, a feature of the Indian context noted elsewhere (Paralikar, personal communication, 2009; Sahoo and Khess, 2010).

It is possible that some of the issues faced by adult adoptees may have had less to do with adoption and emanated from the experience of emerging adulthood where the solidification of identity is an important process (Arnett, 2000). Of particular importance is the development of 'relatedness' and 'autonomy' (Kâğıtçıbaşı, 1996; 2005) and the dimensions labelled

by Bakan (1966) as 'communion' and 'agency'. The relationship between these factors is socio-culturally determined (Demuth, Chaudhary and Keller, 2011), so in the case of adoption, given the Indian stress on filial piety, there is an obligation to both the adoptive and birth families, even though the latter may be very little known to the adoptee. Although adoptees in India are clearly expected to fulfil ascribed roles and duties towards their adoptive parents, the study shows that many also thought about their birth families (Groza, et al., 2014), indicating that they may have had feelings about the circumstances of their earlier life. For some, these feelings had to be denied and the subtext that adoptees have to follow is to put their adoptive family's wishes before their own and not express their individual voice. When we examined the qualitative responses of the adoptees, a recurrent theme that emerged was their reluctance to speak about their birth families, although they had concerns and thoughts about them, especially their health and finances.

Indian parents struggle with discussing and telling their children about adoption (Groza, Kalyanvala and the BSSK Research Team, 2003) and are not always inclined to communicate openly and freely. Adoptees, therefore, often have to negotiate a healthy process of becoming relational-autonomous, whereas non-adopted young people usually receive some support during this transition. While 'relatedness' is traditionally emphasised in Indian culture, globalisation and modern living in India are demanding autonomous functioning and there is a growing tension between autonomy and relatedness. Thus, for adoptees, the process is especially difficult and further confounded by lack of knowledge about the circumstances of their birth as well as absence of opportunities to express their thoughts and feelings. This has implications for support services for adopted children and their parents, not only in the early stages of adoption but also later when thoughts and feelings related to the ghosts of the past emerge.

Limitations of the study

A limitation of this study is the small sample and associated questions about generalisability and statistical power. A second drawback is that the measures used were translated from English into Marathi but not back-translated for accuracy. This means that the physical and mental health data need to be interpreted with caution. A third problem is the disproportionate response of female respondents and the fact that only adoptees who knew their history and were comfortable about discussing their adoption took part.

Implications for practice

Although the study was small, it is one of the few that have been undertaken in India. Moreover, it focuses on a neglected group – adoptees moving into adulthood. Although their perceptions on their adoption were generally positive, evidence on their well-being indicates some underlying psychological and social problems. Adoptees, like other children in India, have strong family ties and their adoptive parents continue to relate with them well into adulthood. But in the context of adoption, some aspects such as answering 'when, how and why' questions related to adoption and dealing with thoughts about birth families remain a struggle.

In this transitional stage of 'emerging adulthood', agency staff may need to be sensitised to these difficulties and build more support into outreach services. Support groups that are confidential offer a valuable forum in which adoptees can speak openly about their thoughts,

feelings and longings. They can also provide a safe place for young people to share experiences with others in a similar situation. It is not necessary to make these issues into a pathology but to see them as a natural part of the adoptive family life cycle.

Indian adoptive families and agencies need continual public education to make them mindful of the dilemmas and issues discussed in this article and the fact that they are widespread and normal. The greater the awareness of these problems, the more likely it is that perceptions about the life-long process will change and informal supports strengthen. The plurality of Indian culture, coupled with rapid social and economic changes, makes it necessary to continually monitor the experiences of Indian adoptees and their families so that services can respond to the needs generated by new situations.

Notes

1. Here the scores were: met expectations ($\overline{X} = 51.3$, $\sigma = 7.4$), exceeded expectations ($\overline{X} = 53.9$, $\sigma = 4.2$) and did not meet expectations ($\overline{X} = 52.6$, $\sigma = 6.98$)
2. The scores here were extremely satisfied (mean = 52.4, $\sigma = 8.3$), very satisfied ($\overline{X} = 50.1$, $\sigma = 7.6$), satisfied ($\overline{X} = 52.4$, $\sigma = 4.8$) or very dissatisfied ($\overline{X} = 56.9$, $\sigma = 4.3$)

References

Arnett JJ (2000) Emerging adulthood: a theory of development from the late teens to the early twenties. *American Psychologist* 55(5): 469–480.

Arnett JJ (2004) *Emerging Adulthood: The winding road from the late teens through the twenties*. New York: Oxford University Press.

Baig IA and Gopinath C (1976) Adoption: the Indian scene. *The Indian Journal of Social Work* 37(2): 135–140.

Bakan D (1966) *The Duality of Human Existence: Isolation and communication in western man*. Chicago, IL: Rand McNally.

Bharadwaj A (2003) Why adoption is not an option in India: the visibility of infertility, the secrecy of donor insemination and other cultural complexities. *Social Sciences and Medicine* 56: 1867–1880.

Bhargava V (2005) *Adoption in India: Policies and experiences*. New Delhi/Thousand Oaks, CA: Sage Publications.

Bhugra D and Mastrogianni A (2004) Globalization and mental disorders. *British Journal of Psychiatry* 184: 10–20.

Bornstein MH and Cheah C (2006) The place of culture and parenting in the ecological contextual perspective on developmental science. In: Rubin KH and Chung OB (eds) *Parenting Beliefs and Parent Child Relations: A cross-cultural perspective*. New York: Psychology Press, pp. 3–33.

CARA (Central Adoption Resource Agency) (undated) *Adoption Statistics*. Available at: http://adoptionindia.nic.in/Resources/Adoption-Statistics.html.

Cederblad M, Höök B, Irhammar M and Mercke A (1999) Mental health in international adoptees as teenagers and young adults: an epidemiological study. *Journal of Child Psychology and Psychiatry* 40(8): 1239–1248.

Choudhary N and Sharma N (2012) India. In: Arnett JJ (ed.) *Adolescent Psychology around the World*. New York: Psychology Press, pp. 103–118.

Chowdhry DP (1980) *Child Welfare Development*. New Delhi: Atma Ram & Sons.

Dasgupta SS (1989) *On the Trail of an Uncertain Dream: Indian immigrant experiences in America*. New York: AMS.

Demuth C, Choudhary N and Keller H (2011) Memories of me: comparisons from Osnabrueck (Germany) and Delhi (India) students and their mothers. *Integrative Psychological Behaviour* 45(1): 48–67.

Groza V and Ryan S (2002) Pre-adoptive stress and its association with child behavior in domestic special needs and international adoptions. *Psychoneurendocrinology* 27(1): 181–197.

Groza V and Kalyanvala R (2003) BSSK Research Team. Indian families adopting Indian children. *Indian Journal of Social Work* 64(1): 93–113.

Groza V, Park H and Oke M (2012) *Report of a Study of Adoptees in India Placed Domestically through BSSK, Pune*. Cleveland, OH: Case Western Reserve University.

Groza V, Kalyanvala R, Boyer S and Nedelcu C (2003) Indian families adopting Indian children*:* the adoption process, birth family issues and post-placement services. *International Journal of Child & Family Welfare* 6(1-2): 4–17.

Groza V, Park H, Oke M, Kalyanvala R and Shetty M (2014) Adoption and birth family issues: adult adoptees in India placed through BSSK in Pune. *Indian Journal of Social Work* 75(2): 287–300.

Hakstian AR and McLean PD (1989) Brief screen for depression. *Psychological Assessment: A Journal of Consulting and Clinical Psychology* 1(2): 139–141.

Hawk B, McCall RB, Groark CJ, Muhamedrahimov RJ, Palmov OI and Nikiforaova NV (2013) Age at adoption: a measure of time in the orphanage or child-specific factors? *Adoption Quarterly* 15(1): 18–34.

Hawkins M, Letcher P, Sanson A, Smart D and Toumbourou J (2009) Positive development in emerging adulthood. *Australian Journal of Psychology* 61(2): 89–99.

Helwig AW and Helwig UM (1980) *An Immigrant Success Story: East Indians in America*. Philadelphia, PA: University of Pennsylvania Press.

Jambunathan S and Counselman K (2002) Parenting attitudes of Asian Indian mothers living in the United States and in India. *Early Child Development and Care* 172(6): 657–662.

Kâğıtçıbaşı C (1996) *Family and Human Development Across Cultures: A view from the other side*. New York: Psychology Press.

Kâğıtçıbaşı C (2005) Autonomy and relatedness in cultural context: implications for self and family. *Journal of Cross-Cultural Psychology* 36(4): 403–422.

Kakar S (1978) *The Inner Worlds: A psycho-analytic study of childhood and society in India*. New Delhi: Oxford University Press.

Martin P and Stayer MA (1990) The experience of micro- and macro-events: a life span analysis. *Research on Aging* 12(3): 294–310.

Mehta N (2002) An overview of child adoption in India: background, current scenario and future challenges. Paper presented at the *Fourth International Conference on Adoption,* New Delhi, October.

Meyer EJ (2009) *Gender, Bullying and Harassment: Strategies to end sexism and homophobia in schools*. New York: Teachers College Press.

Paiva ND (2008) South Asian parents' constructions of praising their children. *Clinical Child Psychology and Psychiatry* 13(2): 191–207.

Rao N, McHale JP and Pearson E (2003) Links between socialization goals and child-rearing practices in Chinese and Indian mothers. *Infant and Child Development* 12(5): 475–492.

Roopnarine JL and Hossain Z (1992) Parent–child interactions in urban Indian families in New Delhi: Are they changing? In: Roopnarine JL and Carter DB (eds) *Annual Advances in Applied Developmental Psychology*, Volume 5. New Jersey, NJ: Ablex Publishing Corporation, pp. 1–17.

Sahoo S and Khess CR (2010) Prevalence of depression, anxiety and stress among young male adults in India: a dimensional and categorical diagnoses based study. *Journal of Nervous and Mental Disease* 198(12): 901–904.

Sandhu D and Kaur D (2012) Adolescent problem behaviour in relation to emotional autonomy and parent child relationship. *Canadian Social Science* 8(1): 29–35.

Saraswathi TS (2012) Ecology of adolescence. In: Kapur M, Koot HM and Lamb M (eds) *Developmental Psychology and Education*. New Delhi: Manek Publications, pp. 188–201.

Saraswathi TS and Ganapathy H (2002) Indian parents' ethnotheories as reflections of the Hindu scheme of child and human development. In: Keller H, Poortinga YH and Scholmerich A (eds)

Between Culture and Biology: Perspectives on ontogenetic development. Cambridge: Cambridge University Press, pp. 79–88.

Saraswathi TS and Oke M (2013) Ecology of adolescence in India: implications for policy and practice. *Psychological Studies* 58(4): 353–364.

Stiles CF, dela Rosa R, Dharmaraksa D, Goldner T and Kalyanvala R (2001) Families for children: international strategies to build in-country capacity in the Philippines, Thailand, Romania and India. *Child Welfare* 80(5): 645–655.

Turner-Bower DM, Bartley BJ and Ware JE (2002) *SF-36[R] Health Survey and 'SF' Bibliography: Third edition (1988–2000)*. Lincoln, RI: Quality Metric Inc.

van IJzendoorn MH and Juffer F (2006) The Emanuel Miller memorial lecture 2006: adoption as intervention: meta-analytic evidence for massive catch-up and plasticity in physical, socio-emotional, and cognitive development. *Journal of Child Psychology and Psychiatry* 47(12): 1228–1245.

Verma S, Sharma D and Larson RW (2002) School stress in India: effects on time and daily emotions. *International Journal of Behavioural Development* 26(6): 500–508.

Wakil SP, Siddique CM and Wakil FA (1981) Between two cultures: a study of socialization of children of immigrants. *Journal of Marriage and the Family* 43(4): 929–940.

Ware J and Gandek B (1994) the IQOLA Project Group. The SF-36 Health Survey: development and use in mental health research and the IQOLA Project. *International Journal of Mental Health* 23(2): 49–73.

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