

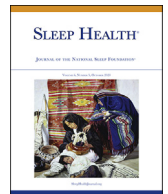


ELSEVIER

Contents lists available at ScienceDirect

Sleep Health

Journal of the National Sleep Foundation

journal homepage: sleephealthjournal.org

Sleep patterns and insomnia among internationally adopted adolescents

 Kristin Gärtner Askeland, PhD^{a,*}, Børge Sivertsen, PhD^{b,c,d}, Mari Hysing, PhD^{a,e}
^a Regional Centre for Child and Youth Mental Health and Child Welfare, NORCE Norwegian Research Centre, Bergen, Norway^b Department of Health Promotion, Norwegian Institute of Public Health, Bergen, Norway^c Department of Research & Innovation, Helse-Fonna HF, Haugesund, Norway^d Department of Mental Health, Norwegian University of Science and Technology, Trondheim, Norway^e Department of Psychosocial Science, Faculty of Psychology, University of Bergen, Bergen, Norway

ARTICLE INFO

Article history:

Received 2 October 2019

Received in revised form 17 January 2020

Accepted 12 February 2020

Keywords:

Sleep

Insomnia

Adolescence

Adoption

ABSTRACT

Objective: Sleep is essential for adolescent development. We aimed to investigate sleep patterns and insomnia among internationally adopted adolescents compared with their nonadopted peers.

Design: Cross-sectional.

Setting: Data stem from the population-based youth@hordaland-survey, conducted during winter/spring 2012, in Hordaland, Norway.

Participants: Of the 9846 adolescents who responded to the sleep measures in the youth@hordaland-survey, 44 were identified as international adoptees by linkage to the Central Adoption Registry.

Measures: The adolescents provided self-report information on demographic characteristics, mental health problems, and a range of sleep measures.

Results: There were no significant differences between the adoptees and nonadopted peers regarding how much time they spent in bed, but the internationally adopted adolescents reported significantly shorter sleep duration, both on weekdays ($d=0.37$, $P=.014$) and weekends ($d=0.37$, $P=.015$). The difference was due to the adoptees spending longer time awake after sleep onset ($d=0.78$, $P>.001$). Furthermore, 32% of the adopted adolescents fulfilled the DMS-5 criteria for insomnia, compared with 18% of their nonadopted peers (odds ratio 2.06, 95% CI: 1.09–3.90). However, this association was no longer significant after adjusting for symptoms of depression. Adolescents adopted after 12 months of age reported more sleep problems than those who were adopted earlier. **Conclusion:** The short sleep duration and high occurrence of insomnia among the internationally adopted adolescents suggest both a problem area that should receive more focus and a potential avenue for intervention. The results further suggest that assessing both mental health problems and sleep problems among internationally adopted adolescents who are experiencing difficulties could help target interventions.

© 2020 The Authors. Published by Elsevier Inc. on behalf of National Sleep Foundation. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Introduction

Sleep is a vital aspect of healthy adolescent development,¹ and insufficient sleep is associated with important functional outcomes, such as reduced academic performance^{2,3} and absence from school.⁴ During adolescence, sleep duration becomes shorter,^{5,6} although the sleep need remains stable and many adolescents sleep less than recommended.⁷ Adoles-

cent sleep is characterized by a long sleep-onset latency and a delayed sleep phase.^{8,9} Insomnia is also highly prevalent during adolescence,^{7,10} entailing difficulties with initiating or maintaining sleep and tiredness or sleepiness during the daytime that disturbs normal functioning.¹¹ Although sleep problems are common in the general population, they might be even more prevalent in at-risk populations, such as international adoptees.¹² Although international adoptees are known to have more sleep problems than their peers early in life, little is known about sleep problems in the adolescent years.

In the months immediately after adoption, sleep is one of the most commonly reported worries of adoptive parents, and about half of all

* Corresponding author: Kristin Gärtner Askeland, PhD, Regional Centre for Child and Youth Mental Health and Child Welfare, NORCE Norwegian Research Centre, Post-box 22 Nygårdstangen, 5838 Bergen, Norway.

E-mail address: Kristin.askeland@norce-research.no (K.G. Askeland).

newly adopted children are reported to have sleep difficulties.^{13,14} The most common difficulties include need of extensive help to fall asleep, displaying separation anxiety at bedtime, and frequent awakenings during the night.¹³ Studies indicate that these are also present later in childhood, although the extent of the problems identified varies between studies. A study comparing international adoptees to the norms on the Child Behavior Check List (CBCL) in young children (aged 2 to 6 years) found slightly more sleep problems among adoptees (effect size $d=0.12$).¹⁵ A small and uncontrolled pilot study of adopted children aged 2 to 10 years found that sleep difficulties, assessed with the Children's Sleep Habits Questionnaire, were present in 71% of the adoptees.¹⁶

There are several reasons why internationally adopted adolescents could experience sleep problems. First, international adoptees have experienced adverse life events that could disrupt sleep, including at least one change of primary caregiver early in life, and many experience stress, malnutrition, neglect, and being placed in institutions in the time before adoption.^{17–19} Adverse childhood experiences have been related to insomnia in adolescents,²⁰ poor sleep quality,²¹ and self-reported sleep problems²² in adults in the general population. Although there is seldom available information on the experiences of international adoptees in the time before adoption, age at adoption can be used as a proxy to indicate early adversity.¹⁹ Previous studies indicate that higher age at adoption is related to poorer cognitive development^{23,24} and increased mental health problems,²⁵ suggesting that such an effect could also be present with regard to sleep problems. Second, international adoptees report more depressive symptoms and internalizing problems in adolescence compared with their peers.^{26–28} Previous studies of adolescents in the general population suggest that depressive symptoms and mood disorders are related to both short sleep duration and insomnia.^{29,30} Indeed, sleep problems are a common symptom of depression in adolescence and are related to the severity of diagnosable depression.^{31,32} Thus, it is important to account for the presence of depressive symptoms when assessing sleep among internationally adopted adolescents.

Previous studies on sleep among international adoptees have assessed sleep problems with either a single item,¹⁴ a single item with follow-up questions,¹³ or the limited sleep items of the CBCL.¹⁵ To our knowledge, no previous studies have assessed this group using a more detailed and validated battery of sleep instruments, including both sleep patterns and symptoms of insomnia. Furthermore, many of the previous studies did not include a control group,^{13,14,16} and given the high rate of sleep problems in the general population, conclusions regarding additional risk for adopted children are therefore limited. It would be an important contribution to the literature to investigate sleep among adoptees using more detailed sleep measures, including specific sleep problems that are prevalent in adolescence, such as insomnia and short sleep duration.

Based on the aforementioned considerations, the aim of the present paper was to investigate sleep patterns in internationally adopted adolescents compared with their nonadopted peers. Furthermore, we aimed to investigate the proportion of adopted adolescents who fulfilled the diagnostic criteria for insomnia and the possible influence of depressive symptoms. We further aimed to investigate whether age at adoption was related to sleep problems in the group of international adoptees.

Participants and methods

Procedure

Data for the current article stem from the youth@hordaland-survey, conducted in the County of Hordaland, Western Norway during winter/spring 2012, in collaboration between the Regional Center for Child and Youth Mental Health and Child Welfare (RKBU Vest) and

Hordaland County Council. The main aim of the survey was to investigate mental health problems, lifestyle factors, and service use among adolescents. The questionnaire used in the survey covered information on demographic background factors, familial socioeconomic status, lifestyle factors, and several validated measures investigating mental health problems. Examples of included measures are the Short Moods and Feelings Questionnaire (SMFQ), the Strengths and Difficulties questionnaire (SDQ), the Adult ADHD Self-Report Scale (ASRS), and the Resilience Scale for Adolescents (READ).

All adolescents born between 1993 and 1995 who were residing in Hordaland at the time of the survey were invited to participate. For adolescents enrolled in school, information about the survey and a link to participation was sent to their school e-mail address. Adolescents not in school received the information by postal mail to their home address.

The schools allocated one school hour (approximately 45 minutes) for completion of the questionnaire. School personnel were present to organize the data collection and ensure confidentiality. Survey staff were available via telephone during the project period to answer questions by students or teachers. Adolescents who were not in the school on the day of the data collection could complete the questionnaire at their own convenience during the data collection period.

Sample

Of the 19 430 adolescents invited to participate in the youth@hordaland-survey, 10 257 (53%) responded to the questionnaire. The sample for the present study was limited to participants with valid answers on the sleep variables. Sleep variables were checked for validity by analyses identifying clearly erroneous answers including negative sleep duration and negative sleep efficiency. 374 participants were deleted because of invalid responses, and the remaining sample consisted of 9846 adolescents.

Adoption sample

The internationally adopted adolescents who responded to the youth@hordaland-survey were identified by linking the survey to the Norwegian Central Adoption Registry. The registry is administered by the Norwegian Directorate of Children, Youth and Family Affairs and contains information on all adoptions that have taken place in Norway since 1917. In addition to type of adoption (i.e. international, national, or stepchild adoption), the registry contains information on age at adoption and country of origin. Of the 9846 adolescents in the current sample, 44 were identified as internationally adopted.

Most of the adoption sample (54.6%) were adopted from Korea, whereas 31.8% were adopted from other Asian countries. Only 13.6% were adopted from countries in Africa and South America. These numbers deviate from the statistics of the total number of children born between 1993 and 1995 who were adopted to Hordaland in the period of interest, where 28% were adopted from Korea, 19% from other Asian countries, and 34% from Africa and South America. In addition, 19% of the children were adopted from countries not represented in the present sample (for instance Eastern European countries). Concerning age at adoption, a total of 61.4% of the adolescents in the present sample were younger than one year at the time of adoption, whereas 22.7% were aged between one and two years, and 16% were older than two years. These percentages also deviate from the statistics, where 42% of the children adopted to Hordaland were younger than one year at the time of adoption, 29% were adopted between one and two years of age, and 29% were adopted after they were two years old. Thus, the adoptees in the present sample were adopted at an earlier age compared with the available statistics on international adoptees in Hordaland. However, these numbers are

not directly comparable as the available statistics only include information on the children who were adopted into Hordaland county. We do not know whether they still resided in the county at the time of the survey.

Instruments

Demographic information

The age and gender of the participants were derived from the personal identification number from the Norwegian National Registry. The socioeconomic status (SES) of the family was assessed by parental education and perceived economic well-being. The adolescents were asked to report the education of their mother and father, with the response alternatives: 'primary school,' 'secondary school,' 'college or university: less than 4 years,' 'college or university: 4 years or more,' and 'do not know.' For the purpose of the present study, the two categories pertaining to college or university education were collapsed into one category. Perceived economic well-being was assessed by asking how well off the adolescents deemed their family to be compared to others, with the response alternatives: 'better than others,' 'equal to others,' and 'poorer than others.'

Sleep measures

Self-reported bedtime and rise time were reported separately for weekdays and weekends in hours and minutes using a scroll-down menu. Time in bed (TIB) was calculated by subtracting the bedtime from rise time. Sleep-onset latency (SOL) and wake after sleep onset (WASO) were similarly indicated in hours and minutes but not reported separately for weekdays and weekends. Sleep efficiency was calculated by subtracting SOL and WASO from TIB and calculating the percentage of the time in bed that was spent sleeping.

The adolescents responded to a statement that they had difficulties initiating and/or maintaining sleep (DIMS) rated on a three-point Likert-scale with the response alternatives 'not true,' 'sometimes true,' and 'certainly true.' If confirmed (i.e., 'somewhat true' or 'certainly true'), adolescents were asked how many days per week they experienced problems either initiating or maintaining sleep. Adolescents also provided information on the duration of DIMS.

The adolescents reported if they experienced daytime sleepiness or tiredness with the response alternatives 'not true,' 'somewhat true,' and 'certainly true.' If the adolescents confirmed tiredness or sleepiness by either of the two latter alternatives, they were asked to report the number of days per week they experienced these problems separately for tiredness and sleepiness.

In the present study, insomnia was operationalized according to the DSM-5 criteria.¹¹ The adolescents fulfilled these criteria if they experienced DIMS at least three nights per week, reported daytime sleepiness and/or tiredness at least three days a week, and had a duration of sleep problems of at least 3 months. This operationalization has been applied previously.⁷

Depression

Symptoms of depression were assessed by the Short Moods and Feelings Questionnaire (SMFQ).³³ The SMFQ consists of 13 items concerning the emotional and cognitive aspects related to depressive symptoms. Each item is rated on a 3-point Likert-scale pertaining to experiences during the past two weeks. The Norwegian translation of the response alternatives corresponds to the original wording: 'not true,' 'sometimes true,' and 'true.' The SMFQ has been found to have high internal consistency and strong unidimensionality both in early and late adolescence^{34,35} and in a study based on the sample from youth@hordaland.³⁶

As one of the SMFQ items is directly related to sleep problems ('I felt so tired I just sat around doing nothing'), the analysis was conducted both with and without this item included in the scale.

Statistical analyses

Differences between internationally adopted adolescents and their peers regarding demographic variables were investigated using the chi-square tests. The independent samples t-tests were used to examine differences in sleep patterns between the two groups and between international adoptees adopted before and after 12 months of age. Between-group effect sizes were calculated using the Cohen *d* formula. The effect sizes can be interpreted according to Cohen's guidelines,³⁷ with *d*'s of about 0.20 representing small effect sizes, *d*'s of about 0.50 medium effect sizes, and *d*'s greater than .80 representing large effect sizes. The proportion of internationally adopted and nonadopted adolescents who fulfilled the criteria for insomnia were investigated by a Pearson's chi-squared test. Logistic regression analyses were conducted to investigate differences in insomnia in adopted versus nonadopted adolescents and to what extent symptoms of depression could explain potential differences. Stata 15 was used for all analyses.³⁸ Results were considered statistically significant at the 0.05 level. Two-tailed tests were used for all analyses. Missing values were handled using listwise deletion.

Compliance with ethical standards

The study and the linkage between the youth@hordaland-study and the Norwegian central adoption registry were approved by the Regional Committee for Medical and Health Research Ethics in Western Norway. All participants gave their informed consent before their inclusion in the study. In accordance with Norwegian regulations, adolescents aged 16 years and older can make decisions regarding their own health (including participation in health studies), and thus gave consent themselves to participate.

Results

Study sample

Of the 9846 adolescents in the sample, 44 had been adopted internationally in childhood. There were no significant differences between the adoptees and the nonadopted adolescents regarding age, gender, or any of the variables measuring SES (see Table 1).

Sleep patterns

There were no significant differences between the internationally adopted adolescents and their nonadopted peers regarding how much time they spent in bed on neither weekdays nor weekends (see Table 2 for details). There was, however, a significant difference in the sleep duration of the two groups, with adoptees reporting a mean sleep duration of 5 hours and 48 minutes compared with 6 hours and 25 minutes among the nonadopted adolescents in the weekdays ($d=0.37$, $P=.014$). Both groups reported longer sleep duration on the weekends, but the difference between the groups remained; internationally adopted adolescents reported 41 minutes shorter sleep duration ($d=0.37$, $P=.015$).

SOL and WASO

The internationally adopted adolescents reported a slightly longer SOL of 55 minutes, compared with 47 minutes among the nonadopted adolescents, but the difference was not statistically significant ($d=0.13$, $P=.385$, see Table 2). In contrast, the adoptees reported

Table 1
Demographic characteristics in the youth@hordaland-survey

Demographic variables	Nonadopted N=9802 99.5%		Adopted N=44 0.5%		P-value
	N	%	N	%	
	Gender				
Girls	5228	53.3	24	54.5	
Age					.334
17	3936	40.2	13	29.6	
18	3416	34.9	19	43.2	
19	2450	25.0	12	27.3	
Maternal education					.373
Primary school	739	7.7	3	6.8	
Secondary school	3028	31.5	14	31.8	
College/university	3569	37.1	12	27.3	
Unknown	2292	23.8	15	34.1	
Paternal education					.330
Primary school	761	7.9	2	4.6	
Secondary school	3326	34.6	17	38.6	
College/university	3096	32.2	10	22.7	
Unknown	2422	25.2	15	34.1	
Perceived economic wellbeing					.131
Equal to others	6417	67.5	24	54.3	
Better than others	2422	25.5	17	38.6	
Poorer than others	673	7.0	3	6.8	
Adoption variables					
Age at adoption					
<1 year			27	61.4	
1-2 years			10	22.7	
2-7 years			7	15.9	
Country of origin					
Korea			24	54.5	
Other Asian countries			14	31.8	
Africa and South America			6	13.6	

P-values are derived from the chi-square tests.

being awake after sleep onset on average 44 minutes, compared with 14 minutes among the nonadopted adolescents ($P < .001$). The effect size for the difference was medium to large ($d = 0.78$).

Insomnia and depression

A greater proportion of internationally adopted adolescents fulfilled the DSM-5 criteria for an insomnia disorder compared with their nonadopted peers (32% compared with 18%, respectively, $\chi^2 = 5.20, P = .023$). Logistic regression analyses showed that internationally adopted adolescents had an odds ratio (OR) of insomnia of 2.06 compared with their nonadopted peers (95% CI: 1.09–3.90, $P = .026$). When symptoms of depression were included in the analysis (using the total SMFQ-score), the OR was attenuated and no longer

statistically significant (OR = 1.55, 95% CI: 0.75–3.18, $P = .234$). The results were similar when omitting the item assessing tiredness from the SMFQ (OR = 1.58, 95% CI: 0.77–3.22, $P = .213$).

The influence of age at adoption

Analyses of differences in sleep patterns between internationally adopted adolescents who were adopted before and after they were 12 months old are presented in Table 3. Adolescents who were adopted after 12 months of age reported significantly shorter sleep duration on weekdays, with a large effect size ($d = 1.25, P = .003$). There was no significant difference between the two groups regarding SOL ($d = 0.09, P = .758$), but the adolescents who were adopted after 12 months reported being awake after sleep onset significantly longer (1 hour and 39 minutes compared with 12 minutes, $P = .004, d = 1.38$).

A greater proportion of the adolescents who were adopted after 12 months of age fulfilled the DSM-5 criteria for an insomnia disorder compared with those who were adopted before 12 months (41% compared with 26%, respectively), but the difference was not statistically significant ($\chi^2 = 1.12, P = .290$).

Discussion

The present findings indicate that internationally adopted adolescents have shorter sleep duration both on weekdays and weekends compared with their nonadopted peers, although they spend similar lengths of time in bed. The differences were mainly related to the adoptees reporting longer WASO than their peers, with an average of 44 minutes wake time during the night. Furthermore, a greater proportion of the internationally adopted adolescents fulfilled the criteria for insomnia, which could partly be explained by the adopted adolescents also reporting higher levels of depressive symptoms. Adolescents who were adopted after they were 12 months old reported significantly more sleep problems compared with those adopted earlier.

The internationally adopted adolescents reported significantly shorter sleep duration than their nonadopted peers, although there was no difference between the groups regarding the time spent in bed. Although no previous studies have investigated the sleep duration of international adoptees, these findings are in line with studies of adoptive children indicating that many adoptees experience sleep difficulties.^{13,14,16} The short sleep duration of the international adoptees was mainly related to spending more time awake after they had fallen asleep, as there were no significant differences in sleep-onset latency or time spent in bed. This is consistent with parent-reported problems of adopted children, where frequent awakenings are one

Table 2
Sleep patterns of internationally adopted and nonadopted adolescents

Sleep characteristics	Nonadopted			N	Adopted		P-value	Cohen's d
	N	Mean	SD		Mean	SD		
Weekdays								
Time in bed	9374	7:29	1:01	43	7:30	1:03	.950	0.01
Sleep duration	9374	6:25	1:39	43	5:48	1:59	.014	0.37
Sleep efficiency	9374	85.31	17.68	43	76.27	22.10	.001	0.51
Weekends								
Time in bed	9349	9:41	1:22	43	9:38	1:28	.782	0.04
Sleep duration	9349	8:37	1:51	43	7:56	2:07	.015	0.37
Sleep efficiency	9349	88.74	13.69	43	81.75	16.26	.001	0.51
Weekdays/weekends								
Sleep-onset latency	9802	0:47	0:57	44	0:55	0:44	.385	0.13
Wake after sleep onset	9802	0:14	0:39	44	0:44	1:20	.000	0.78

P-values are based on the independent samples t-tests.

Table 3
Sleep patterns of internationally adopted adolescents adopted before and after they were 12 months old

Sleep characteristics	Adopted < 12 months			Adopted > 12 months			P-value	Cohen's d
	N	Mean	SD	N	Mean	SD		
Weekdays								
Time in bed	27	7:39	0:46	16	7:14	1:25	.284	0.30
Sleep duration	27	6:33	1:25	16	4:30	2:11	.003	1.25
Sleep efficiency	27	85.43	14.41	16	60.81	24.55	.001	1.31
Weekends								
Time in bed	27	9:31	1:21	16	9:50	1:40	.515	0.15
Sleep duration	27	8:25	1:52	16	7:07	2:20	.068	0.66
Sleep efficiency	27	88.00	11.74	16	71.21	17.7	.003	1.18
Weekdays/weekends								
Sleep-onset latency	27	0:53	0:49	17	0:57	0:38	.758	0.09
Wake after sleep onset	27	0:12	0:27	17	1:39	1:45	.004	1.38

P-values are based on independent samples t-tests.

of the most commonly reported problems.¹³ The mechanisms behind these sleep difficulties are likely different for the adolescent adoptees, but the present findings suggest that they still experience difficulties many years after adoption.

There is evidence from the general population of continuity of sleep problems in general³⁹ and sleep maintenance problems specifically⁴⁰ from childhood to adolescence. Although no previous studies have investigated the trajectories of sleep problems among international adoptees, a Dutch longitudinal study found that the impact of early adversities on mental health problems remained stable from childhood to adulthood.¹⁷ It is possible that a similar continuity is present for sleep problems, and this could be due to early adversity. As there are no differences regarding time spent in bed, it does not seem likely that different routines in adoptive families underlie the short sleep duration among the adoptees.

Nearly one in three of the internationally adopted adolescents fulfilled the DSM-5 criteria for insomnia in the present study, which was significantly more than the nonadopted peers. Although insomnia has not been investigated among international adoptees previously, a study of adopted children indicate that while many parents express concerns about minor sleep problems, few report more serious sleep problems (9%).¹⁴ It could be that international adoptees experience more severe sleep problems in adolescence than in childhood, in line with the developmental pattern of sleep problems in the general population.⁷

As the adoptees reported significantly longer WASO, but not SOL, compared with their nonadopted peers, they are more likely to experience sleep-maintenance insomnia than sleep-onset insomnia. Among adults with insomnia, those who reported adverse childhood experiences had more awakenings during the night and more movement arousals than those without such experiences.²¹ Thus, it is possible that problems with sleep maintenance could be related to adverse experiences in the time before adoption. This assumption is strengthened by the importance of depression for the increased rate of insomnia among the adoptees in the present study. Rumination and worrying are known risk factors for sleep disturbances⁴¹ and may be part of depressive symptomatology and more frequent among those who have experienced negative life events. This may be one route through which early adversities may inflict later sleep. Cortical hyper arousal may be the physiological mechanisms accounting for the nighttime awakenings,⁴² but this needs to be investigated in this specific group. Nightmares may be another reason underlying nighttime awakenings, and they are more common among children with early-life adversities.⁴³ This is an interesting avenue for future research.

The association between adoption status and insomnia was attenuated when accounting for depression. This could indicate that the

high levels of depressive symptoms among adopted adolescents²⁶ could be an important contributing factor for insomnia. Although this is the first study to investigate the association between insomnia and depressive symptoms among internationally adopted adolescents, the finding is in line with studies on the general adolescent population.^{29,30} It has also been suggested that sleep problems could be a precursor for depression,⁴¹ but analyses of the temporal association between sleep problems and depression are precluded in the present study because of its cross-sectional nature. The results could further indicate that sleep problems and depressive symptoms more often co-occur among international adoptees.

As both sleep problems and depression are related to functional impairment also in adolescence, it is important that such problems are detected and that treatment is available for those presenting with more severe difficulties. Because there were no significant differences regarding time in bed between international adoptees and their peers, and the problems seem to be related to being awake after sleep onset, it can be difficult for adoptive parents to detect these problems. It is therefore important that adoptive parents are given information about the increased risk of sleep problems in adolescence.

Interestingly, there were large differences according to age at adoption, where adolescents adopted after they were 12 months old reported more sleep problems than adolescents who were adopted earlier. This is in line with previous studies investigating other outcomes in international adoptees,^{23–25} but in contrast to studies on sleep in younger adoptees.^{13,16} The discrepancy might be due to the age compositions in the studies. It is possible that other factors are more important in the first years in the adoptive family, when the adoptees are adjusting to their new situation and the parents are establishing new routines. Furthermore, Rajaprakash et al¹⁶ emphasized that the adoptees in their study were exposed to similar degrees of preadoption adversity. It is possible that the effect of age at adoption in the present study could be related to the experiences before adoption, as age at adoption is related to the length of time spent in unfavorable conditions. Indeed, a previous study on adults from the general population identified a graded relationship between adverse childhood experiences and self-reported sleep problems,²² and such experiences are also related to sleep disturbances among adolescents.²¹

Strengths of the present study include the broad assessment of sleep problems and sleep duration and the inclusion of a measure of depression. Furthermore, the adoptees who participated in the survey were identified by use of the Central Adoption Registry, ensuring correct identification. As adoption status was not a topic in the survey, the adoptees were invited on the same grounds as their nonadopted

peers. The possibility to compare the adolescents who had been adopted with peers from the same population extends on previous studies and is a major strength of the present study.

The use of self-reported data is an important limitation. Sleep duration was measured by self-report, and although self-reported sleep parameters, including SOL and WASO, typically differ from those obtained from objective assessments,^{44,45} recent studies have showed that such self-report sleep assessments can be recommended for the characterization of sleep parameters in both clinical and population-based research.⁴⁶ Furthermore, the accuracy of self-reported sleep is in general good for adolescents.⁴⁷ The inclusion of both time in bed and SOL and WASO is a significant study strength, as most population-based studies rarely provide these detailed measures. Although time in bed was reported separately for weekdays and weekends, SOL and WASO were reported jointly, indicating a typical night. It is possible that these vary, with for instance shorter SOL associated with later bedtimes on weekends. Reporting these separately would give a more accurate picture of the actual sleep patterns on weekdays and weekends.

A limitation concerning the adoption sample is the small number of internationally adopted adolescents who participated in the youth@hordaland-survey, limiting the statistical power to detect differences between the adoptees and their nonadopted peers. Furthermore, the response rate of the adoptees is not known. The linkage to the Central Adoption Registry was performed after the study was conducted, and we do not know how many adoptees were invited to participate. Comparing the number of participants to the total number of children born from 1993 to 1995 and adopted to Hordaland suggests that the participation rate might be lower among adoptees compared with nonadopted adolescents. However, we do not know how many of these adoptees still resided in Hordaland at the time of the survey.

The composition of the adoptive sample regarding age at adoption and country of origin deviated somewhat from the statistics of children born from 1993 to 1995 and adopted to Hordaland County. This could influence the representativeness of the sample as most participants were adopted from Korea and at an early age, both of which are associated with less problems among adoptees.⁴⁸ This suggests that adoptees with a more favorable background were more likely to participate in the survey, and therefore, the problems faced by internationally adopted adolescents in general could be underestimated in the present study. This is especially likely as the adoptees who had been adopted after they were one year old showed significantly more sleep problems compared with those adopted earlier in life.

A limitation regarding the entire sample of the youth@hordaland-survey is the school-based nature of the survey. Although all adolescents born from 1993 to 1995 and residing in Hordaland at the time of the survey received information about the survey and log on details, it is likely that adolescents who were present at school during the data collection are overrepresented in the study. As sleep problems have been related to absence from school,⁴ adolescents with sleep problems could be more likely to be absent from school on the day of the survey, and sleep problems might therefore be underreported in the present study. Still, this limitation is likely to affect the internationally adopted participants and nonadopted participants in the same manner and not influence the differences identified between the two groups.

Conclusion

The present study suggest that internationally adopted adolescents sleep substantially shorter, are awake longer during the night, and have higher rates of insomnia compared with their nonadopted peers. Of note, the sleep duration of the adoptees on school days is much shorter than the recommendation for this age group and is

likely to have important consequences, given the already established associations between sleep and school functioning. In the present study, symptoms of depression could explain parts of the increased odds of insomnia among the international adoptees, suggesting that both sleep problems and depressive symptoms should be considered when choosing interventions for this group. The finding that higher age at adoption is related to more sleep problems is especially noteworthy, as the age of adoption among international adoptees has increased during the past decade following international regulations. It is therefore possible that international adoptees entering into adolescence today are at higher risk for sleep problems compared with the adolescents in the present study, but further research is necessary to investigate such assumptions.

Acknowledgments

The authors are grateful to all participants who made this study possible and would also like to thank the Bergen Child Study group.

This work was supported by the grant Mental Health from the Norwegian Research Council, under grant number 228911.

References

- Shochat T, Cohen-Zion M, Tzischinsky O. Functional consequences of inadequate sleep in adolescents: a systematic review. *Sleep medicine reviews*. 2014;18(1):75–87.
- Dewald JF, Meijer AM, Oort FJ, Kerkhof GA, Bogels SM. The influence of sleep quality, sleep duration and sleepiness on school performance in children and adolescents: A meta-analytic review. *Sleep medicine reviews*. 2010;14(3):179–189.
- Beebe DW, Field J, Miller MM, Miller LE, LeBlond E. Impact of multi-night experimentally induced short sleep on adolescent performance in a simulated classroom. *Sleep*. 2017;40(2).
- Hysing M, Haugland S, Stormark KM, Bøe T, Sivertsen B. Sleep and school attendance in adolescence: Results from a large population-based study. *Scandinavian Journal of Public Health*. 2014;43(1):2–9.
- Fallone G, Owens JA, Deane J. Sleepiness in children and adolescents: clinical implications. *Sleep medicine reviews*. 2002;6(4):287–306.
- Park H, Chiang JJ, Irwin MR, Bower JE, McCreath H, Fuligni AJ. Developmental trends in sleep during adolescents' transition to young adulthood. *Sleep medicine*. 2019;60:202–210.
- Hysing M, Pallesen S, Stormark KM, Lundervold AJ, Sivertsen B. Sleep patterns and insomnia among adolescents: a population-based study. *Journal of Sleep Research*. 2013;22(5):549–556.
- Taylor DJ, Jenni OG, Acebo C, Carskadon MA. Sleep tendency during extended wakefulness: insights into adolescent sleep regulation and behavior. *J Sleep Res*. 2005;14(3):239–244.
- Gradisar M, Gardner G, Dohnt H. Recent worldwide sleep patterns and problems during adolescence: a review and meta-analysis of age, region, and sleep. *Sleep medicine*. 2011;12(2):110–118.
- Johnson EO, Roth T, Schultz L, Breslau N. Epidemiology of DSM-IV Insomnia in Adolescence: Lifetime Prevalence, Chronicity, and an Emergent Gender Difference. *Pediatrics*. 2006;117(2):e247.
- American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. Fifth ed. Arlington, VA: American Psychiatric Publishing; 2013.
- Radcliff Z, Baylor A, Rybarczyk B. Adopted youth and sleep difficulties. *Pediatric Health, Medicine and Therapeutics*. 2016;7:165–175.
- Tirella LG, Miller LC. Self-regulation in newly arrived international adoptees. *Physical & occupational therapy in pediatrics*. 2011;31(3):301–314.
- Rettig MA, McCarthy-Rettig K. A survey of the health, sleep, and development of children adopted from China. *Health & social work*. 2006;31(3):201–207.
- Tan TX, Dedrick RF, Marfo K. Factor structure and clinical implications of child behavior checklist/1.5–5 ratings in a sample of girls adopted from China. *J Psychiatr Psychol*. 2007;32(7):807–818.
- Rajaparakash M, Kerr E, Friedlander B, Weiss S. Sleep disorders in a sample of adopted children: a pilot study. *Children (Basel, Switzerland)*. 2017;4(9).
- van der Vegt EJ, van der Ende J, Ferdinand RF, Verhulst FC, Tiemeier H. Early childhood adversities and trajectories of psychiatric problems in adoptees: Evidence for long lasting effects. *Journal of abnormal child psychology*. 2009;37(2):239–249.
- Johnson DE. Long-term medical issues in international adoptees. *Pediatr Ann*. 2000;29(4):234–241.
- Verhulst FC, Althaus M, Versluis-den Bieman HJ. Damaging backgrounds: Later adjustment of international adoptees. *Journal of the American Academy of Child and Adolescent Psychiatry*. 1992;31(3):518–524.
- Wang Y, Raffeld MR, Slopen N, Hale L, Dunn EC. Childhood adversity and insomnia in adolescence. *Sleep medicine*. 2016;21:12–18.

21. Bader K, Schafer V, Schenkel M, Nissen L, Schwander J. Adverse childhood experiences associated with sleep in primary insomnia. *J Sleep Res.* 2007;16(3):285–296.
22. Chapman DP, Wheaton AG, Anda RF, Croft JB, Edwards VJ, Liu Y, et al. Adverse childhood experiences and sleep disturbances in adults. *Sleep medicine.* 2011;12(8):773–779.
23. Beckett C, Breidenkamp D, Castle J, Groothues C, O'Connor TG, Rutter M. Behavior patterns associated with institutional deprivation: A study of children adopted from Romania. *Journal of developmental and behavioral pediatrics : JDBP.* 2002;23(5):297–303.
24. Beckett C, Maughan B, Rutter M, Castle J, Colvert E, Groothues C, et al. Do the effects of early severe deprivation on cognition persist into early adolescence? Findings from the English and Romanian Adoptees Study. *Child Dev.* 2006;77(3):696–711.
25. Merz EC, McCall RB. Behavior problems in children adopted from psychosocially depriving institutions. *Journal of abnormal child psychology.* 2010;38(4):459–470.
26. Askeland KG, Hysing M, Aarø LE, Tell GS, Sivertsen B. Mental health problems and resilience in international adoptees: Results from a population-based study of Norwegian adolescents aged 16–19 years. *Journal of adolescence.* 2015;44:48–56.
27. Askeland KG, Hysing M, La Greca AM, Aarø LE, Tell GS, Sivertsen B. Mental health in internationally adopted adolescents: a meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry.* 2017;56(3):203–213.e1.
28. Roskam I, Stievenart M. Is there a common pathway to maladjustment for internationally adopted and non-adopted adolescents? *J Appl Dev Psychol.* 2014;35(3):215–222.
29. Sivertsen B, Harvey AG, Lundervold AJ, Hysing M. Sleep problems and depression in adolescence: results from a large population-based study of Norwegian adolescents aged 16–18 years. *European child & adolescent psychiatry.* 2014;23(8):681–689.
30. Zhang J, Paksarian D, Lamers F, Hickie IB, He J, Merikangas KR. Sleep Patterns and Mental Health Correlates in US Adolescents. *J Pediatr.* 2017;182:137–143.
31. Liu X, Buysse DJ, Gentzler AL, Kiss E, Mayer L, Kapornai K, et al. Insomnia and hypersomnia associated with depressive phenomenology and comorbidity in childhood depression. *Sleep.* 2007;30(1):83–90.
32. Urrila AS, Karlsson L, Kiviruusu O, Pelkonen M, Strandholm T, Marttunen M. Sleep complaints among adolescent outpatients with major depressive disorder. *Sleep medicine.* 2012;13(7):816–823.
33. *Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents [press release].* US: John Wiley & Sons; 1995.
34. Sharp C, Goodyer I, Croudace T. The Short Mood and Feelings Questionnaire (SMFQ): A unidimensional item response theory and categorical data factor analysis of self-report ratings from a community sample of 7-through 11-year-old children. *Journal of abnormal child psychology.* 2006;34(3):365–377.
35. Turner N, Joinson C, Peters TJ, Wiles N, Lewis G. Validity of the Short Mood and Feelings Questionnaire in late adolescence. *Psychol Assess.* 2014;26(3):752–762.
36. Lundervold AJ, Breivik K, Posserud MB, Stormark KM, Hysing M. Symptoms of depression as reported by Norwegian adolescents on the Short Mood and Feelings Questionnaire. *Frontiers in psychology.* 2013;4:613.
37. Cohen J. *Statistical Power Analysis for the Behavioral Sciences.* Second edition. Hillsdale, New Jersey: Lawrence Erlbaum Associates; 1988.
38. *StataCorp. Stata Statistical Software: Release 15.* College Station, TX: StataCorp LLC; 2017.
39. Gregory AM, O'Connor TG. Sleep problems in childhood: a longitudinal study of developmental change and association with behavioral problems. *Journal of the American Academy of Child & Adolescent Psychiatry.* 2002;41(8):964–971.
40. Fricke-Oerkermann L, Plück J, Schredl M, Heinz K, Mitschke A, Wiater A, et al. Prevalence and course of sleep problems in childhood. *Sleep.* 2007;30(10):1371–1377.
41. Danielsson NS, Harvey AG, Macdonald S, Jansson-Frojmark M, Linton SJ. Sleep disturbance and depressive symptoms in adolescence: the role of catastrophic worry. *Journal of youth and adolescence.* 2013;42(8):1223–1233.
42. Fernandez-Mendoza J, Li Y, Vgontzas AN, Fang J, Gaines J, Calhoun SL, et al. Insomnia is associated with cortical hyperarousal as early as adolescence. *Sleep.* 2016;39(5):1029–1036.
43. Nielsen T, Carr M, Picard-Deland C, Marquis LP, Saint-Onge K, Blanchette-Carriere C, et al. Early childhood adversity associations with nightmare severity and sleep spindles. *Sleep medicine.* 2019;56:57–65.
44. Lauderdale DS, Knutson KL, Yan LL, Liu K, Rathouz PJ. Self-reported and measured sleep duration: how similar are they? *Epidemiology (Cambridge, Mass).* 2008;19(6):838–845.
45. Kong AP, Wing YK, Choi KC, Li AM, Ko GT, Ma RC, et al. Associations of sleep duration with obesity and serum lipid profile in children and adolescents. *Sleep medicine.* 2011;12(7):659–665.
46. Zinkhan M, Berger K, Hense S, Nagel M, Obst A, Koch B, et al. Agreement of different methods for assessing sleep characteristics: a comparison of two actigraphs, wrist and hip placement, and self-report with polysomnography. *Sleep medicine.* 2014;15(9):1107–1114.
47. Dillon HR, Lichstein KL, Dautovich ND, Taylor DJ, Riedel BW, Bush AJ. Variability in self-reported normal sleep across the adult age span. *The journals of gerontology Series B, Psychological sciences and social sciences.* 2015;70(1):46–56.
48. Tizard B. Intercountry adoption: A review of the evidence. *Journal of child psychology and psychiatry, and allied disciplines.* 1991;32(5):743–756.