ASSESSING THE EFFECTS

OF

DEPRIVATION

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Critical Points and Places to Start

- General Medical and Laboratory
- Developmental Neurology
- Genetics/Dysmorphology
- Pediatric Endocrinology/Growth Evaluation
- Developmental Neuropsychology
- Current (but changing) Social-Emotional
- Degree of Post-Institutionalization
- Family Structure and Supports

Research Into Deprivation

- **"Growth parameters help predict neurological competence in profoundly deprived institutionalized children in Romania" (Johnson, Federici, et al, Society for Pediatric Research Abstract, 1999)**
  - **Comprehensive medical/neuropsychiatric evals**
  - **n = 105 (total population), 45 testable**
  - **8 neurologically competent; 37 incompetent**
  - **Ht, Wt and HC "significantly different between the two groups" (competent: Z score range -6, and incompetent Z score < -9)**
  - **Conclusions: Growth parameters correlated highly with neurological competence vs. incompetence**

Profound, Global Growth Failure Afflicts Residents of Neuropsychiatric Institutes in Romania (Johnson, Aronson, Federici, et al; Society for Pediatric Research, Abstract 1999)

- **n = 59, age range 6-11 years, Institutionalized since birth**
- **Ht, Mean -3.56 +/- 2.0; Wt Mean – 2.47 +/- 1.29; HC Mean – 2.08 +/- 1.53**
- **Tricep/Mid-arm muscle circumference < 5th percentile**
- **Conclusions: Severely abnormal growth patterns suggests mixed etiology of protein energy, malnutrition and abnormal growth hormone secretion due to psychosocial deprivation**

Pre and Post-Pubertal Growth in Profoundly Deprived, Institutionalized Children (Johnson, Mason, Federici, SERA-Romania et al; Abstract submitted Pediatric Research, 2000)

- Summary of Data
  - Pre-pubertal males (mean age 8.64) showed profound growth failure (Ht –4.31; Wt –3.02; OFC –2.06).
  - Pre-pubertal girls (mean age 9.72) were most effected (Ht – 4.95; Wt –3.39; OFC –4.01).
- Conclusion: Significant relationship (p <.001) between length of institutional confinement and growth stunting. Children fell behind 1 month of growth in stature for every 1.6 month of orphanage confinement.

Growth and Pubertal Development in Internationally Adopted Children.

Mason and Narad,
Endocrinolgy and Diabetes, 2002, 9:26-31

- Major Points:
  - Consistency of "Institutional Short Stature" and short stature upon arrival
  - Multi-factorial etiology
  - Early catch-up growth with risks of early and rapidly progressing puberty
  - High-risk population for medical, psychological and developmental abnormalities

Local Brain Functional Activity Following Early Deprivation: A Study of Post-Institutionalized Romanian Orphans

(Chugani, et al; NeuroImage 14, 1290-1301, 2001)

- First study using PET and statistical parametric mapping (SPM), measuring the pattern of brain glucose metabolism.
- Romanian orphans vs. epileptics vs. controls.
- Romanian orphans showed "significantly decreased metabolism bilaterally in the orbital-frontal gyrus, the infralimbic prefrontal cortex, amygdala and hippocampi, lateral temporal cortex and the brain stem.
- Speculation: Dysfunction of multiple brain regions may be the result of early global deprivation and result in long-term cognitive and behavioral deficits.

Taratogenic and Other Risk Factors

- Alcohol-Related Neurodevelopmental Disorder
- Inadequate pre- and post-natal care
- Low birth weight / prematurity
- Chronic malnutrition and vitamin deficiency
- Heavy metal exposure (lead, mercury, magnesium)
- Herbicides and pesticides
- Chronic intestinal parasites and malabsorbtion syndrome
- Profound sensory deprivation
- Undiagnosed brain trauma
- Encephalopathic changes

Predictable Neurocognitive and Neurobehavioral Outcomes

- Lowered intellectual functioning
- Generalized, diffuse organicity
- Prefrontal cortex damage acquired in early infancy/ childhood (Damasio, et al; Developmental Neuropsychology, Vol. 18. No. 3, 2000)
- Linguistic and verbal memory deficits in children with less than 750 g birth weight (Taylor and Klein, Child Neuropsychology, Vol. 6, No. 1, pp.49-63, 2000)
- Visual-perceptual and spatial deficits (Kaemingk and Halverson, Child Neuropsychology, Vol. 6, No. 2, pp.115-128, 2000)

- "Cumulative Cognitive Deficits" (Gindis, The Post, No. 27, 2000).
  - Progressive cognitive language deficiency
  - Progressive cognitive/behavioral incompetence
  - Insufficient task motivation
  - Chronic academic failure
  - Neurobehavioral dyscontrol
- Early neglect and deprivation have profound effects on developing frontal lobe-executive functioning (Landry et al, Developmental Neuropsychology, 21 (1), 15-41, 2002) and Pollak, American Association for the Advancement of Science, 2002)

Correlation of Maltreatment and Neuropsychiatric Disorders

- Neuropsychiatric impairments in prefrontal cortex and superior temporal gyrus in children diagnosed with PTSD and "attachment disorder" (DeBellis, Society of Biological Psychiatry, 2002; Kramer, Behavioral and Brain Sciences, 15, 493-541, 1992).
- Neuropsychiatric research and clinical theory support Minimal Brain Dysfunction correlating with diagnoses of AD/HD, PTSD, Autistic-Spectrum Disorders, Mood Disorder, Psychotic Disorders.

- Abnormal cortisol levels producing "Acute Confusional States" in institutionalized children (Mason, Federici, Johnson, In Press).
- Institutionalized and traumatized children maintain cortisol elevations during "resting states".
- Questionable "lingering effects" of sustained elevations in serum cortisol (i.e. dementia?)
- Changes in prefrontal cortex production of Dopamine-I and Dopamine-II
- Irregularities in 5-H-1 and 5-H-2 serotonin produced in limbic- hypothalamic-pituitary-adrenal regions

Atypical Neuropsychiatric Profiles

- "Institutional Autism: An Acquired Syndrome" (Federici, 1998).
- Rutter (2000) references "Quasi-Autism"
  - Comorbid psychosocial growth failure, high risk pre- and post-natal factors, profound neglect, deprivation and abuse.
  - "Learned Helplessness" (Seligman, 1982) leading to "Conditioned Autistic-Autonomic Responses".
  - Actual "regression" to infantile autistic stage.
  - Time occupying and coping mechanisms
  - Clinical presentation similar to all PDD

Comorbidities with Institutional Autism

- Chronic/pervasive PTSD
- Often Minimal Brain Dysfunction/Static Encephalopathy
- Refractory depression, anxiety and brief psychotic episodes (i.e. disconnection from painful reality)
- Mood and behavioral regulatory disorders
- Multi-sensory neurodevelopmental impairments
- Multiple motor and sensory dyspraxias
- Generalized linguistic impairments
- AD/HD "symptoms"

Differential Diagnoses: Neurogenic vs. Psychogenic

- Classical autism has strong neurological correlates and broad range of impairments.
- Developmental history of autism (if known).
- Classical autism constitutes a "pervasive developmental disorder" vs. a learned response.
- Autism is a "continuum disorder" (Kanner's to Higher Functioning Autism).
- All autistic children make progress with institutional autistic children showing strongest rehabilitation potential.
- NOTE: Institutional Autistic children can "halt" behaviors

Mistakes and Misconceptions

- "All post-institutionalized children are delayed".
- "All post-institutionalized children are healthy".
- "All post-institutionalized children have AD/HD".
- Every child has "Reactive Attachment Disorder"
- "Give them time and they will "catch up".
- "The family needs to be patient".
- "They will be fine if you put them in school or daycare right away".
- "If they are not speaking their native language, they will learn English quicker".
- "Don't go see Dr. Federici—he finds too many problems".

Disturbances of Attachment: A Psychobiological Theory

- Bowlby/Ainsworth theory
  - Instinctive infant attachment behavior
  - Goal-corrected behaviors
  - Internal representations and working models
  - Secure base
  - Separation-loss
  - Neurobiological effects (norepinephrine, dopamine and seratonin)
  - Attachment and brain function: a parallel model

- Regulation of Neurobiological Change— the "Cascade Hypothesis" (Kramer, 1986; 1988)
  - Assessing integrity of amygdala-hippocampal complex
  - Availability for imprinting, habits and memory
  - Analytical functioning and perceptivity (executive functioning)
  - Facial recognition and body awareness (Prosopagnosia)
  - Behavioral, aminergic (noradrenaline) and neurosystems in attachment
  - Hierarchical mechanism in attachment (arousal, information processing, organization of input and inhibitory/disinhibitory responses)

Disturbances of Attachment in Young Children Adopted from Institutions

(Zeanah, Journal of Developmental and Behavioral Pediatrics, 2001)

- More evidence of institutional care impacting social-behavioral and regulatory functions as opposed to just "RAD".
- Autistic spectrum disorders commonly observed but not properly diagnosed.
- Indiscriminate sociability is not a reflection of disordered attachment (the "need" for social stimulation).
- Neuropsychologically-driven impairments drive poor logic, reasoning and social-internactional skills

- PTSD is a critical factor effecting attachment (Hoksbergen, et al, Romanian Adoption Project, the Netherlands, 2000-2002)
- "Internalization of trauma" leads to "externalizing behaviors".
- Post-institutional autism serves as a "defense mechanism and coping strategy" to new attachments
- Trauma produces ambivalence in attachments
- Chronic neuropsychiatric disorders interfere with social-reciprocal relationships
- Pervasive dysphoria and melancholia produce "detachment"
- Biological theories of depression/PTSD prevail

Challenging Conditions & Treatment Initial presentation to Physicians

- Diagnosed "Developmentally Delayed" as opposed to "Neurologically Impaired"
- Refractory AD/HD and behavioral dyscontrol
- Chronic complaints by families and teachers
- Multiple neurocognitive deficits, especially linguistic, memory and learning deficits
- Poor attachment vs. poor cognitions/perceptions
- "Fix it right now" mentality
- Atypical Autism with multiple comorbidities

Treatment Considerations: Where to Start

- Comprehensive Developmental Pediatric exam
- Full metabolic and serological studies
- Endocrinological/growth evaluations
- Pediatric neurology consultation
- Genetics/Dysmorphology
- Neuropsychological evaluation
- Speech/language, OT, PT evaluations
- Psychoeducational
- Assessment of "Family Dynamics"

Neurocognitive Rehabilitation

- More comprehensive than "special education"
- Focus on improving attention, concentration, information processing, linquistics, and visual-perception
- Increase planning, organization and "critical thinking"
- Working with assessed strengths vs. weaknesses
- Develop "Hierarchal Model" of recovery

Levels of "Cognitive Organization" (Luria and Vigotsky, 1968)

1. Attention, arousal and alertness (basis for information processing and behavior
2. Receiving, analyzing and storing information
3. Programming, verification, and regulation
   - Improvement of primary attention
   - Rehabilitation for information processing
   - Reorganization of executive functioning

Rehabilitation Techniques

- Special education interventions address “level of performance” vs. functional disability
- Pharmacological and structural interventions for attentional deficits
- Language and perceptual therapies to enhance information processing
- “Critical thinking” interventions to improve logic, reasoning, problem-solving & insight development
- Behavioral conditioning/counter-conditioning techniques

Most Effective Interventions

1. Applied Behavioral Analysis (ABA)
2. Behavioral Interventions for Young Children with Autism (Catherine Maurice)
3. A Work in Progress: Behavioral Interventions for Young Children with Autism
4. Neurocognitive rehabilitation for traumatic brain injury
5. Extensive language therapy for auditory processing, comprehension, reasoning and semantic-pragmatics

6. Exclusively LD and Remedia Publications
7. Earobics and FastForword
8. Computer-assisted interventions for brain dysfunction (www.learningfundamentals.com)
9. LinguiSystems (www.linguisystems.com)
10. Lindamood-Bell programs
    - Visualizing and Verbalizing
    - Language Comprehension for Critical Thinking
    - Lindamood Bell Phoneme Sequencing Program

Neurobehavioral Interventions

- Cognitive rehabilitation techniques
- Cognitive-behavioral interventions (cognitive restructuring and rehearsal)
- Stringent behavioral modification and environmental reorganization
- Pavlovian conditioning/counter-conditioning
- Flooding and implosion techniques
- Reality therapy
- Role playing, rehearsal and strategizing
- Neurobehavioral Family Therapy

Neuropsychopharmacology

- Different views, multiple opinions, “Symptom Focused” vs. “Etiological Treatment”
- Wide range of medications utilized
- “Medication Cocktails” are most dangerous
- Psychiatry must coordinate with Developmental Pediatrics, Neuropsychology and Family
- Caution in early medicating, over-medicating, and rapid changes in medication
- P-I/traumatized children respond very differently

Medication by Category and Disorder

- Are we treating the disorder or “symptoms”?
- Where is the proper diagnostic assessment?
- Who is competent to manage medication?
- Who are valid/reliable reporters?
- Every medicated child should be in a structured family therapy (less than 10% are in treatment)
- “Ritalin is not the answer”.
- I am still looking for a medication that fixes AD/HD, RAD, PTSD, ODD, PDD, and all the rest

Common Mistakes and Pitfalls

- All P-I/traumatized children look “AD/HD” and receive stimulants quickly and in volumes
- P-I children often have malnutrition, malabsorption, parasitic infections or somatic tendencies and react dramatically to “side effects”
- Over-medicating, under-medicating, or polypharmacy causes the most problems
- Developmental Pediatricians often refer to psychiatry for “evaluations” which can be cursory.

- Comprehensive neurodevelopmental/ neuropsychological evaluations before medicating
- Target most impairing symptoms but look for etiology/broad spectrum disorder
- Consider “impairing emotional-behavioral symptoms” as primary focus
- Children do very well on some “adult medications”
- Some “over the counter” medications work very well (i.e. melatonin, St. John’s Wort, Valerian)
- Best combination are multi-discipline therapies and medication

What Do We Really Want to Treat?

- Sleep Disorders
- Psychotic Disorders
- Rage Disorders
- Depression and Mood Disorders
- Anxiety spectrum Disorders
- PDD/Autistic spectrum Disorders
- PTSD (most impairing symptoms)

NOTE: There is no medication out yet for family dysfunction, RAD, or bad behavior. If there was, I would own the company and not be here today

Stimulants and Related Medications

1. Ritalin (regular and S.R.)
2. Dexedrine
3. Adderal and Adderal X.L.
4. Concerta
5. Strattera (under investigation)
6. Clonidine/Tenex
7. Wellbutrin

Stimulants: Pros and Cons

- Helpful with “simple AD/HD”
- Treats symptoms only
- Risk of rebound effects, irritability, agitation, appetite suppression, sleeplessness, and possible psychotic reactions
- Starting point for “medication cocktails”
- P-I children do poorly on stimulant medications alone
- AD/HD symptoms may “mask” true disorder

Proper Use of Stimulants and Anti-Hypertensives

- If you must, start with conservative stimulants vs. higher dose based on “mg per kg equation”
- Younger children tolerate Dexedrine and Adderal, particularly if there is “gross hyperactivity”
- Multiple dosing vs. single dosing
- Consider Concerta for pure AD/HD with behavior modification
- Adderal X.L. is dextro-rotary with potential for more side effects
- AVOID STIMULANTS WITH PTSD, PDD, DEPRESSION/ANXIETY OR PSYCHOSIS

- P-I/traumatized children "already feel bad"
- Rapidly address anxiety, agitation and sleep disturbance which may appear "AD/HD"
- Consider low-dose Clonidine or Tenex as initial treatment for impairing symptoms
- Low-dosing equals low maintenance (b.i.d. max)
- Try to avoid anti-hypertensives and stimulants
- If necessary, low-dose Clonidine/Tenex to address "rebound period"
- Can be used "prn"

Child & Adolescent Psychopharmacology News, Vol. 4, No. 3, June, 1999

"A Modicum of Anti-Depressants"

- SSRI's (Prozac, Paxil, Zoloft)
  - Zoloft has most action on Dopamine I and II
- Effexor, Celexa, Serazone (not that helpful)
- Anafranil for OCD (high anit-cholinergic effects)
- Atypical antidepressant Wellbutrin excellent for "triad" (AD/HD, depression and conduct disorder)
- Avoid tricyclics, especially with mood disorders, PDD or possible psychosis

NOTE: Thyroid hormone (L-thyroxine) offers hope for treatment-resistant Affective Disorder

AM J Psychiatry, 2002; 159 (11) 1896-1901

Efficacy of Anti-Depressants

- Zoloft best for PTSD/Intense Anxiety/Rage
- Paxil for OCD and panic
- Prozac for endogenous depression
- Wellbutrin excellent for "organic depressions" with prominent AD/HD, mood disorder and impulsivity
- Consider "broad spectrum psychotropics" such as low-dose Risperdal, Zyprexa or Seroquel
- New agent, Abilify, shows promise
- Anti-convulsants for diagnosed mood disorders (Tegretol for rapid cycling, Depakote, Trileptal)

Psychotropic Medications for Aggressive/ Disruptive Behaviors

- Questionable effectiveness with stimulants
- SSRI's somewhat helpful, particularly Zoloft
- Beta-blockers reduce "reactivity" (Propranolol)
- Wellbutrin shows most promise
- Low-dose Risperdal or Seroquel effective
- Anti-anxiety medications, esp. paroxetine/Buspar if comorbid anxiety exists (panic and phobias)
- Cognitive-behavioral therapy more effective

Child & Adolescent Psychopharmacology, Vol. 7, No. 5, October 2002

Pharmacotherapy of Pervasive Developmental Disorders, Mood and Psychotic Disorders

- Risperidone in autistic children reduces aggression, temper tantrums, impulsivity, hyperactivity and obsessions
  - Begin 0.25 mg b.i.d. dosing with titrations at intervals of 0.25 mg.
- Olanzapine (Zyprexa) "broad spectrum" in use
  - High affinity to D-1, D-2, D-4, 5H2, Alpha-1 and H-1 receptors
  - Low incident of EPS but risk of diabetes
- Abilify:lowest incidence of side effects & weight gain
  - Excellent for all mood and impulse disorders
  - Best available broad spectrum agent

Child & Adolescent Psychopharm., Vol. 5, No. 2, April 2000

Treatment of Children Experiencing Attenuated Psychotic Symptoms

- Schizophrenia, Schizo-Affective Disorder, Bipolar Disorders, Refractory AD/HD, and severe PDD
- Atypical anti-psychotics show greatest promise
  - Risperdal
  - Zyprexa (preferred with rage/mood components)
  - Seroquel (preferred)
  - Geodon (not highly effective in children)
  - Abilify (strong studies for all ages)
  - Two new medications hitting the market

Assessing Progress or Problems

- Frequent re-evaluations and "updates".
- Fine tune and coordinate multi-discipline interventions
  - Neuropsychology
  - Family Therapy
  - Occupational and Physical Therapy
  - Psychoeducational
  - PDD/Autism
- Conservative but comprehensive medication
- "Case Manager" is invaluable

INSTITUTIONAL SETTINGS: PHYSICAL AND PSYCHOLOGICAL CHARACTERISTICS

- Not where children belong
- Overcrowding and understaffed
- Clean on the surface? (multiple contaminants)
- Nutritional, environmental, social, educational and interpersonal deprivation and neglect
- Children "lost in time and space".
- Lack of sensory-integrative development
- Abuse and neglect/traumatic experiences
- "Exposure Factor": learning via imitation

SOCIAL-EMOTIONAL DEVELOPMENT IN THE INSTITUTIONAL ENVIRONMENT

- Infants: often languish in cribs most of the day
- Minimal time being held or fed.
- Group feedings or propped bottle technique
- Poor hygiene common leading to discomfort
- Lack of auditory, visual, tactile, kinesthetic stimuli (e.g. Sensory Deprivation)
- Inconsistent amount of crying or required "communication" between caretaker and child
- Medical conditions often left untreated

TODDLER STAGE

- Still cribbed much of the day
- Slightly more time ambulating and interacting
- Not many developmental toys or activities
- Kids left to play or interact on their own as opposed to having "adult supervision"
- Sometimes more physical contact but can be more related to restraint and control
- Early independence and autonomy often suppressed because it takes time and staff
- Children begin to become "random and confused" in their behaviors and attachments

OLDER TODDLER/EARLY CHILDHOOD

- Many still cribbed or restrained
- Cumulative effects of medical, nutritional and psychological deprivation
- Attachment disorders become more pronounced with formation of neurological or neuropsychiatric conditions
- Child desperate for activities but frustrated with deprivation: emergence of behavioral dyscontrol, institutional autistic behaviors and inability to function outside of the institution without strong supports

INTERNATIONAL ADOPTION VERSUS U.S. ADOPTIONS: Similarities & Differences

- Both groups abandoned, but not necessarily neglected in U.S. foster care systems
- Higher risk with international settings due to economic and environmental risks
- Both have potential for genetic and psychological damage
- Better care, nutrition and psychological development in the infant and toddler with U.S. foster care programs
- International settings have higher risk taratogenic factors and lack of medical care
- Both have attachment disorder issues

DO INSTITUTIONAL CHILDREN "CATCH UP" AFTER ADOPTION?

- Research suggesting catch up growth following global privation (Rutter, et al 1998)
- General growth, head circumference and health clearly improve but do neurocognitive functions?
- Correlation between time in institution and level/ severity of neurocognitive impairments
  - Medical condition treated vs. untreated
  - Exposure to high risk pre and post-natal factors
  - Taratogens
  - Effects of environmental and social deprivation on the developing brain

ASSESSMENT OF LONG-TERM NEUROCOGNITIVE AND EMOTIONAL RISKS

- Medical health and status correlates partially with neurocognitive and emotional development
- Neuropsychological impairments often surface years after catch up growth
- Better general medical and neurological health improve cognitive stability but do not necessarily predict long-term cognitive status
- Most neurocognitive impairments surface during school-age years and represent sequelae of early deprivation and/or damage

- Most children grow and improve medically and psychologically in a stable environment
- Neurologically damaged children maintain stunted growth patterns (head circumference, height, weight, speech and language, learning)
- Neurologically impaired children maintain neuropsychiatric patterns (atypical or "Institutional Autism", atypical or refractory ADHD patterns, multi-sensory neurodevelop-mental disorders, mood and behavioral dyscontrol, and attachment disorders based on neuropsychological deficits)
- Many families "wait" for cognitive and emotional "catch up".

WHEN AND WHERE TO ASSESS

- Up to 24 months, thorough medical, neuro-developmental and psychological assessment via Bayley and Battelle scales
- Aggressive assessment of speech and language and motor/sensory milestones
- Aggressive "push" for multi-sensory stimulation to enhance attachment and sensory-integration
- Limited daycare environments or extraneous caretakers
- Early developmental delays may foreshadow long-term delays
- Early interventions lead to better outcomes

WHY NOT WAIT 'TILL THEY START SCHOOL?

- A true neurocognitive delay or damage does not improve on its own.
- Early "red flags" involving motor, sensory and, primarily speech and language need the most assessment and early interventions
- Some children do well on their own, but the majority need assistance
- The "wait and see model" may only frustrate the child and family as learning and behavioral difficulties begin to manifest
- The "window of opportunity" starts at the time of adoption and gradually fades over time

HOW TO EDUCATE TREATMENT PROVIDERS: A GUIDE FOR FAMILIES

- Parents need to be advocates for their children
- Requiring baseline and comparison studies are essential to monitor progress (or difficulties)
- Presenting an objective "picture" of a child's strengths, weaknesses and needs
- Disclosing institutional information with caution and sensitivity
- Educating multi-discipline specialists regarding possible risk factors and delays that require active assessment and interventions
- Deprivation affects growth and development

- Medical health does not always guarantee psychological or neurocognitive health
- School interventions need to start early
- Arrangement for Individualized Educational Program or private services is very important
- Providing continual longitudinal comparisons regarding evaluations in order to assess progress, stagnation or regression
- Formulating proper neuropsychological and psychological diagnoses necessary for proper treatment planning
- Multi-discipline team evaluation (medical, neurological, neuropsychological, speech and language, occupational/ sensory-integrative and educational)

THERAPEUTIC HOME AND CLASSROOM

- Highly structured and intensive services during early formative stages of cognitive development (particularly 4 thru 7 years old)
- Small teacher-student ratio preferred
- Close monitoring over educational treatment goals and objectives
- Private services to augment school services
- Active parental involvement in special education process
- Parents acutely aware of strengths and disabilities
- Continual consultation and "second opinions"

SOCIAL-EMOTIONAL CHARACTERISTICS OF THE OLDER POST-INSTITUTIONALIZED CHILD

- Indiscriminant attachment behaviors
- Social-isolative behaviors
- Easily over-stimulated, lost and confused
- Total lack of "experience base"
- Inappropriate "reading" of social cues based on neuropsychological processing deficits
- Atypical ADHD, mood and behavioral profiles based on being deregulated in new family, social and school environment
- Pressure to "fit in" prematurely (i.e. Family's desire to have a "normal child")

- The older post-institutionalized child (adopted after 3-4 years old) needs continual training, rehearsal/role playing, reinforcements, conditioning, counter-conditioning, effective discipline in order to learn basic skills
- Absolute necessity to reduce family's need for stimulating the child and having immediate love and attachments
- Traditional psychotherapies are not typically effective as the older post-institutionalized child becomes "attached" to play therapy or outsiders very quickly
- A home-based, family oriented treatment model is recommended

NEUROPSYCHOLOGICAL PROFILES OF THE POST-INSTITUTIONALIZED CHILD

(Federici et.al. 1999, in Press)

- Sample based on 1500 post-institutionalized children from 7 countries
- Average age at adoption: 4.2 years
- Average time in institution: 24 thru 84 months
- All families were advised of "healthy child"
- 75% had diagnosis of speech and motor delays, perinatal encephalopathy or other CNS dysfunction (often unspecified)
- 50% referenced parental alcohol use
- Most records indicated "developmental delays" due to institutionalization/deprivation

GENERAL NEUROPSYCHOLOGICAL PATTERNS

- 450 (or 30% of sample) had the following:
  - Severe neuropsychiatric disorders
  - Mental retardation/global dysfunction
  - Pervasive Developmental Disorders/Autistic Spectrum Disorders (including Institutional Autism)
  - Fetal Alcohol Syndrome/Fetal Alcohol Effects
  - Multiple and severe learning disabilities/dyslexias
  - Severe/refractory ADHD
  - Multiple medical problems and medication needs
  - Complex emotional and attachment disorders

- 750 (approx. 50% of sample) displayed:
  - Mild-moderate learning disabilities
  - Speech and language disorders
  - Mid-range Attention Deficit Hyperactivity Disorders
  - Behavioral dyscontrol/emotional problems requiring treatment
  - Neuropsychologically-based attachment disorders (primarily due to neurocognitive dysfunction)
  - Required specialized academic and psychiatric care on a regular basis
  - Medication Management
  - Need for long term of rehabilitation

- 375 (approx 20-25% of sample) displayed:
  - Relatively "clean" neuropsychological and psychological profiles
  - Routine adjustments and expected acculturation issues
  - No major problems in language development or language transition
  - No real need for ongoing medical, psychiatric, neuropsychological or educational care aside from supportive services
  - Developed appropriate attachment in a reasonable period of time (within 12 months)
  - Minimal follow up required
  - Child "blended in" easily with peers

PROVISIONAL CONCLUSIONS AND FINDINGS

- Institutional settings have a modicum of high risk pre and post-natal factors
- Children residing in institutions are a very high risk population with potential long-term problems (neuropsychological and behavioral)
- Direct correlation between length of time in the institution and severity of neuropsychiatric impairments (ongoing delays and trauma)
- There is no such thing as a "healthy child" who has resided in an institutional setting for more than 24 months
- Many original medical records correctly indicated problems but lacked clarity

WHAT HAVE WE LEARNED: WORDS OF CAUTION AND OPTIMISM

- Institutions are not good places for children
- Children from post-institutionalized settings need multi-discipline evaluations and treatment immediately upon arrival and throughout their development
- Many children are very resilient and have strong brains and constitution to overcome institutionalization effects
- Many children started off genetically vulnerable and continue to "pick up" problems while institutionalized
- Aggressive treatment leads to optimal recovery and potential

ATTACHMENT DISORGANIZATION: THEORY AND TREATMENT

(Solomon and George, 1999)

- Bowlby and Spitz: Revisited
- Developmental Patterns of Hostile/Helpless States of Mind
- Unresolved parental fear in parent/infant affective communication
- Role-reversed behaviors of mothers of disorganized/insecure infants (frightening, hostile-intrusive)

DIMENSIONS OF DISRUPTED MATERNAL AFFECTIVE COMMUNICATION

1. Affective Errors
   - Contradictory Cues
   - Non-response or Inappropriate Response
2. Disorientation
   - Parent confused or frightened by child
   - Disorganized or Disoriented Parent
3. Negative-Intrusive Behavior
   - Verbal Negative-Intrusive Behaviors (mocking)
   - Physical Negative Intrusive Behaviors (aggressive)

4. Role Confusion
   - Parents expectations from the child
   - Sexualization (overly intimate)

5. Withdrawal of Parental Affection
   - Creation of physical distance
   - Creation of verbal distance

6. Leaving Unresolved Loss and Grief Issues
   - Creating childhood disorganization and frightening maternal behavior

ENHANCING DEVELOPMENTAL PATHWAYS: From Childhood Disorganization to Relationships

1. Shifting Disorganization to Controlling Behaviors
2. Moving child away from psychotic-autistic detachment to power-control issues in parental relationships
3. Defensive aggression better than withdrawal
4. Gradual retraining in aggression to assertiveness in relationships
5. Teaching parents tolerance/acceptance

Attachment Disorganization in Children with Neurological Disorders

1. Quantitative measurement of cognitive capacity (parent and child)
2. Maternal reaction to childhood diagnoses (ie acceptance, rejection or denial)
3. Ability to work at child's level of cognitive integrity and abilities
4. Acceptance of imperfection and need for continual attachment reorganization
5. Avoiding coercion with the limited child

Hidden Traumas:
Detachment, Disorganization and Rage

1. Breaking the silence: expression of violence and disorganization in the traumatized child
2. Non-invasive and guided fantasy approaches preferred
3. Understanding the importance of aggression, deviancy and sexualized behaviors
4. TRIAD: Post-Traumatic Stress Disorder, Major Depressive Disorder, Conduct Disorder
5. Silent Screams and Hidden Cries: art therapy interpretations (Wohl and Kaufman, 1985)

Dissociation in Traumatized Children:
The Ultimate Defensive Structure
(Frank Putnam, 1997)

1. Interaction between trauma, dissociation and memory
2. Pathological dissociation following severe abuse and neglect
3. Dissociation reflective of a child's ability and willingness to survive
4. "Behavioral States" interact with psycho-physiological functioning

5. "The Divided Mind"
   - Fantasy and imagination
   - Imaginary companions
   - Elaborated play identities
   - Elaborated daydreams
6. Chronic dissociation and altered states in daily life
   - Variable reality testing
   - Struggles in coping
   - Episodic fugue states
   - Persistent childhood multiple personality disorder/dissociative disorder

Therapeutic Alliance and Treatment Issues

1. Establishment of trust, safety and security
2. Persistence and patience
3. Control of behaviors
4. Dealing with loss, grief and mourning
5. Guilt and self-blame
6. Enhancing self-confidence
7. Eroding and diffusing dissociative states
8. Play therapy

PSYCHOPHARMACOLOGY FOR DISSOCIATIVE DISORDERS/PTSD

1. Baseline medical assessment
   - Rule out organic pathology
2. Target most impairing symptoms
   - Impulse Control
   - Affective Symptoms
   - Anxiety Symptoms and Panic Attacks
   - Sleep Disturbance
   - Somatoform Symptoms
   - Hallucinations

Damaged Children: Can They Be Saved? (Cline, 1999)

- Overview of disturbed children
  - Exposure to environmental deprivation
  - Exposure to neurotoxins in-utero or fragile genetics
  - Abuse, neglect and/or abandoned
  - Exposed to excessive violence, have neurological damage
  - Behavioral and attachment disorders
  - Post-Traumatic Stress Disorder
  - Inconsistent parenting and/or multiple moves and caretakers

Special Qualities of Damaged Children

- Withdrawal and isolation
- Attachment problems
- Severe control issues
- False sense of self/self-esteem
- Flight to or from others
- Superficiality
- Surviving frequent and intense trauma
- Misplacing blame and manipulating
- Skewed sense of family

A Broken Life: Traumatization
(Catherall, 1992)

- Primary trauma
  - Overwhelming emotion
  - Emotional numbing
  - Re-experiencing the trauma sensorially
  - Living with the primary trauma
- Secondary Trauma
  - Damaged connection with others
  - Damaged sense of self
  - Coping with secondary trauma
  - Damaged world view

Outcomes of Persistent Trauma

- Loss of illusions of security
- Loss of feelings of control
- Avoidance of a productive lifestyle
- Hyper-arousal
  - Sleep disorder
  - Increased startle response
  - "fight or flight" response
  - Fatigue and depression
- Survivor guilt

The Traumatized Family

- Enduring the survivor symptoms
- Transmission of symptoms (projection or displacement)
- Attempting to relate the experiences to one another
- Disowned feelings
- Total denial and minimization
- Movement towards recreation (and repetition) of the trauma

Negative and Confused Emotions: Will They Pass?

- Disgusted
- Trapped
- Crazy
- Bitter
- Overwhelmed
- Afraid and angry
- Victimized
- Sad and depressed
- Frustrated and exhausted
- Confused and guilty
- Rageful and resentful
- Remorseful and used
- Hopeless and hopeful
- Lonely and deceived
- Hurt and helpless
- Misguided
- Cautious
- Optimistic?

Parenting Damaged and Disturbed Children: How to Help

- Parents feel like failures
- Families must jointly overcome the primary trauma (actual act) and secondary trauma (emotional sequelae)
- Joint grieving of loss and dealing with rage
- “Outlining” a plan for family recovery in stages
  - Primary trauma-revisited
  - Secondary trauma-reintegration
  - Recreating family tasks, rituals and unity

Support and Encouragement

- Guarding against burnout and compassion fatigue
- Taking care of the patient and caretaker
- Take time to give and receive support
- Never try to control the uncontrollable
- Coping styles
  - Ignoring, forgetting, laughing, talking, numbing
  - Arousal seeking
  - Continually reliving the trauma

- Showing frustration is deadly
- Don’t take it personally
- Keeping family members healthy
- Strengthening your belief system
- Taking time to talk and time not to talk
- Everyone comes to grip with emotions at different rates
- Learning when to back off and allow “soul searching”
- Accepting social withdrawal as “coping”

Conventional and Behavioral Techniques

- Ignoring and minimizing PTSD rebellion
- Respecting physical boundaries
- Not taking anger personally, but containing rageful impulses
- Providing structure, safety and security
- Re-establish normalcy in the midst of PTSD
- Don’t lose sight of the “healthy child”
- Stress requires physical and psychological therapies
- Visual imageries and structural homework assignments

Cognitive Therapies
(Beck, 1997; Kendal and Braswell, 1993)

- Cognitive restructuring for irrational beliefs
- Rational behavior therapy to enhance problem solving (Maultsby)
- Brainstorming
- Role playing/role rehearsal
- Addressing cognitive errors and logical fallacies
  - Catastrophizing and pathologizing
  - Perfectionism and fault finding
  - Personalizing and entitlement

Cognitive-Behavioral Therapy for Impulsive Children

- Often coexists with ADHD type disorders
- Impulsivity and hyperactivity are critical factors
- Coexistence of oppositional-defiant patterns
- Learning disabilities very common, particularly language disabilities
- Treatment needs to be comprehensive assessment and multi-discipline interventions

Comprehensive Assessment Techniques

- Extensive parent interviewing
- Diagnostic rating scales (parent & teacher)
- Task performance measures (cognitive & psychoeducational)
- Assessment of interpersonal problem-solving skills
- Child self-report inventories
- Direct behavioral observations (home & school)
- Social-interactional evaluations in-vivo

Treatment Considerations for Impulsive Children

- A multi-discipline “problem-solving approach”
  - Creating “awareness” factors
  - Creating “functional cognitions”
  - Creating “self analysis and ratings”
  - Modeling and role rehearsal
  - Behavioral contingencies (“there is a price for everything and everything has a price”)
  - Response costs: reminders to stop and think
  - Homework assignments (parents and child)

The Role of Emotions: Affective Education

- Role plays and training
- Direct education, training tasks and building mutual interests
- Evaluating the child's individual temperament and level of cooperation and collaboration
- Accepting that not all children relate the same way
- Maintain a detached and rational training position

- Knowing when to use "rigid behavioral contingencies"
- Realization that behavioral change induces tension, upset and crises
- Attempting to maintain flexible thinking on the part of the therapist, child and family
- Trying to make therapy fun and recreational
- Individual and group work with parents
- Teaching parents to be practical/objective
- Teaching parents to be less reactive

Dealing with the "Explosive Child"
(Green, 1998)

- Assessment of the "Inflexible-Explosive Child"
- Common characteristics
  - Limited capacity for flexibility
  - Low frustration threshold
  - Concrete, rigid and "black and white"thinking
  - Moodiness and irritability
  - Hyperactivity and impulsivity
  - Frequent "meltdowns"
  - Neuropsychological deficits (executive skills)

- Different faces of the explosive child
  - Vacillates from tenderness to terrorism
  - Keeps people "off balance"
  - Selective and controlling communications
  - Use of threats to win conflicts
  - Intimidation is principal mode of communication
  - Plays one parent against the other
  - May have neuropsychiatric-biochemical problems (i.e. ADHD, Bipolar, schizophrenia)

High Spirited and Temperamental Children: How to Treat (Kurcinka, 1991)

- Temperament is a genetic trait
- Must rate child on the following scales:
  - Level of intensity
  - Level of persistence and energy
  - Level of sensitivity
  - Level of perceptiveness
  - Adaptability and regularity
  - First reactions
  - Mood

- Diffusing intense reactions
  - Assess early cues of volatility
  - Early interjection of soothing and calming activities
  - Use of imagination and sensory activities
  - Ample humor
  - Mandatory “working together” (adults only)
  - Choosing the battles you can win
  - Selective negotiations
  - Clear, precise and consistent rules

- Using firm voice and physical actions
- Avoiding over control and under control
- Being extremely persistent in being the parent
- Maintain eye contact and simple directives
- Closing the loop of conflict
- Creating an “escape” for the child’s rage
- Creating an “escape” for the parents rage
- Working together and reworking tantrums
- Learning to live with different temperaments

“Changing” Cognitions with the Impulsive Child

- Selective perceptions vs. reality situations
- Realistic vs. unrealistic expectations
- Using pleasing and displeasing behavioral exchanges (when to be “appropriate”)
- Communication skill deficits
- Constructive and destructive communication patterns
- Generating creative problem-solving or “brainstorming” as opposed to rigidity

Cognitive-Behavioral Therapy for Special Populations

- Excellent intervention for elective mutism or severely PTSD cases
- Alternate therapy for children with speech and language delays
- Assessment and treatment tool for highly fearful and sexually abused children
  - Systematic assessment and desensitization
  - Modeling and behavioral rehearsal
  - Recreating positive relationships and safety
  - Identifying and correcting irrational beliefs, particularly guilt and self-debasement

Working with Linguistically and Culturally Different Children (McNicol, 1998)

- Immigrant children and families
  - Second language acquisition process affects comprehension and therapeutic issues
  - Cultural factors must be respected
  - Assessment of language proficiency in native language
  - Caution in psychological testing procedures and interpretation of data
  - Professional assessment of deficits and strengths
  - Multi-cultural counseling imperative

Cognitive-Behavioral Play Therapy (Knell, 1995)

- A structured, relationship building and non-directive approach in dealing with trauma
- Behavioral training and limit setting part of the treatment program
- Children enjoy play but play needs to be structured and work oriented with goals
- Interjecting classical conditioning and operant conditioning with play (training and reinforcement schedules
- Using play as a means of "systematic desensitization" for trauma

Goals of Cognitive-Behavioral Play

- Shaping and positive reinforcement
- Shaping socially appropriate expression of feelings
- Reinforcement of other desired behaviors
- Continual behavioral training and rehearsal
- Teaching self-monitoring
  - Recording dysfunctional thoughts
  - Teaching coping strategies and "playing for change"
- Bibliotherapy (self-reporting and writing out desired goals and optimal solutions)

Play Therapy in Healing Trauma (Gil, 1996)

- Play as a form of therapeutic alliance
- Play as a form of recreating trust, safety and security
- Play to recreate and rework the trauma
- Play as an expressive therapy modality
- Family play interventions to recreate positive interactions
- Structured and guided play and fantasy to address specific traumatic events
- Art therapy as an assessment and treatment tool

Additional Cognitive-Behavioral Treatment Considerations

- Treatment of separation anxiety or post-traumatic stress/anxiety disorders
  - Use of relaxation training or hypnosis
  - Teaching and re-teaching fear-coping strategies
  - Teaching survivorship and assertiveness
  - Knowing when to "revisit" fear
  - Gradual re-exposure to trauma
  - Direct instruction for coping strategies
  - Joint sessions with parents to rework trauma and recreate safety and attachment

Reality Therapy Techniques (Glasser, 1974)

- Constant adherence to and functioning "within reality"
- Adherence to three major "tenants"

1. Understanding the difference between right and wrong
2. Taking responsibility for all actions with no blaming or avoidance
3. Respecting yourself and others at all times

Adherence to Basic Human Needs

- To learn to give love and accept love
- To feel worthwhile to ourselves and others
- To maintain a positive standard of behavior at all times without excuses
- Human beings are motivated to fulfill their needs and wants
- All human behavior is composed of doing, thinking, feeling and physiologic behavior
- All behavior is purposeful
- All behavior is based on perceptions

Holding Therapies: Controversies

- "Holding Time" by Martha Welch
  - Goals to eliminate conflict, tantrums, rivalry and oppositional behaviors
  - Directive and physical holds and restraint
- Is "Holding Time" Necessary?
  - Useful for parents and children?
  - Allows treatment for detachment, rejection via confrontation and resolution
  - Engages children to enhance attachment?

Additional Attachment Therapeutic Approaches

- High Risk: Children Without a Conscience (Magid and McKelvey, 1987)
  - Rage reduction therapies
  - Reworking the bonding/attachment cycle in the unattached and antisocial child
  - Working through intense rage via therapist/family holding and verbal expressions
  - Reliance on child's honest expressions and commitments to improved attachments
  - "Sequence of events" leads to recovery?
  - "Evergreen model" in Colorado

Adopting the Hurt Child (Keck & Kupecky, 1995)

- Holding therapy with focused reconstructive individual and family psychotherapy
- Interrupting the abuse and neglect cycle
- Reworking the child who has experienced impermanence
- Reconstruction of a realistic family for traumatized children
- Using holding and therapist/child attachment to heal old wounds
- Giving the damaged child a history & future

Treating Attachment-Trauma Problems in Children (Beverly James, 1994)

- More therapeutic as opposed to holding
- Dealing with traumatic attachments
- Assessing and treating disorganized affect
- Recreating healthy intimacy and trust
- Comparing and contrasting trauma and attachment
- Heavy emphasis on relationship and family reconstruction
- Insight-oriented and "recreation of the self"

Attachment Therapies

- Increased parental supervision and time
- Scolding vs. holding
- Holding and rocking techniques
- Holding for behavioral control and rage
- Transferring rage into words and productive acts (i.e. role playing)
- Rewards and point systems
- Practice re-parenting for the stages in which trauma occurred
- Accessing qualified professionals

Neuropsychological Profiles of International Adoptees

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Ultimate purpose of study:

- To understand the neuropsychological profiles of international adoptees with developmental, behavioral or emotional concerns
- To compare this population with previous populations of international adoptees with respect to preadoptive data, therapies utilized
- To identify potential correlates of later success with respect to educational, social and psychological functioning

Methods:

- Retrospective chart review
- International adoptees referred specifically for neuropsychological assessment
- Data gathered included:
  - Pre-adoptive history
  - Parent report of current history
  - Standardized assessment measures
  - DSM IV diagnoses

Demographics

		Current data (n=67)	Mason (2000) (n=339)
Country of origin	Russia Romania Others	49% 24% 27%	52% 30% 18%
Gestational age	Full term Premature Uncertain	22% 18% 60%	30% 21% 48%
Gender	% Females	64%	57%
Mean age @ adopt		3.18 yrs	3.67 yrs
Mean age @ assessment		7.14 yrs	8.0 yrs

Birth data available

(n=67 cases)

- Some birth history available: 48%
- Birth mother age: 43% (range: 14-37)
- Gravida: 42% (range: 1-8))
- Apgar scores: 18% (all but 1 > 7)
- Maternal alcohol use reported in record:
  - Yes: 16% (4 of these 11 referred as 'healthy')
  - No: 7%
  - Uncertain/unrecorded: 67%

Preadoptive diagnoses:

(n=67 cases)

- Language delay: 28%
- Perinatal encephalopathy: 16%
- Malnutrition: 15%
- Hypoxia: 6%
- Hypotonia: 5%
- Microcephaly. Psychomotor retardation, CNS dysfunction, intracranial hypertension: each 3%

Previous services utilized

(n=67 cases)

	Current study	Mason (2000)
Speech/language	51%	60%
Occupational Rx	45%	40%
Physical Rx	15%	21%
Sensory Integration	3%	24%
Attachment/holding	5%	13%
Stimulant Meds	13%	15%

Prior to Evaluation
(n=67 cases)

- Of children >7yrs of age:
  32% **repeated a grade** in school
- 32% reported seeing a **psychologist**
- 36% reported seeing a **psychiatrist**
  - 13% taking stimulants
  - 7% antipsychotics
  - 5% SSRIs
  - 5% adrenergics

Language Disorders Diagnosed
(n=67)

Mixed Rec/Exp Disorder	60%
Receptive Disorder	16%
Expressive Disorder	3%
Phonologic disorder	13%

* Only 17% without any language disorder

Attention Disorders Diagnosed
(n=67)

ADHD combined type	18%
ADHD inattentive type	3%
ADHD hyperactive type	6%
ADHD NOS	10%

* DSM III-R; DSM-IV diagnosistic categories

Specific Disabilities Diagnosed
(n=45 children at least 6 yrs of age)

Writing disorder	60%
Reading disorder	53%
Math disorder	31%
Borderline intellectual fnx	15%
Mild mental retardation	11%

Additional diagnoses
(n=67)

- Neurocognitive Disorder 29%
- Post-traumatic Stress Disorder 27%
- Autism Spectrum Disorder 22%
- Oppositional Defiant Disorder 22%
- Anxiety Disorder 18%
- Reactive Attachment Disorder 16%
- Major Depression 11%
- Dysthymic Disorder 9%
- FAS/FAE 6%

Preliminary Findings:

Of international adoptees referred for neuropsychological testing:

- Attention diagnoses 37%
- Language disorders 83%
- Learning disabilities prevalent
  - Especially writing (60%) & reading (53%)
  - Less math (31%)

Preliminary Findings

Of international adoptees referred for neuropsychological testing:

- Emotional disorders prevalent:
  PTSD (27%), Anxiety disorders (18%), Depression (11%), Dysthymic disorder (9%)
- Reactive Attachment Disorder (16%)
- FAS/FAE (6%)

Take home points:

- High risk of language disorders and learning disabilities
- Primary attentional disorders are NOT common
- Comprehensive assessment warranted
- Many unanswered questions….
  - ? Role of pre-adoptive diagnoses
  - ? Role of age or degree of impairment at adoption
  - ? Co-morbid clusters

Taking the Institution Out of the Child: A Systematic Process

- Can definitely take the child out of the institution: what is the best way?
- Stressful for the child and family to be adopted: new challenges and expectations
- Must understand how children grow up in institutional settings
- Respect for child's developmental experiences: positives and problems

Goals for Newly Adoptive Parents

- Understanding the effects of institutional life
- Understanding your child's strengths, weaknesses and areas needing rehabilitation
- Early interventions lead to more positive outcomes
- Accepting less than "perfection" and realizing there is no "quick fix"
- Accepting problems as they occur and working towards solutions
- Avoid dealing with major issues alone

Methods to Madness: Raising Special Children

- Know what you are dealing with, even if the information is difficult to accept
- Acceptance leads to new insight/motivation
- Outline a treatment plan and stick to it
- Get the best specialized help available
- "Pay now or pay later", its all the same
- Do not accept failure: find new methods

Strategies for Parents

- Quickly figure out what works and what doesn't (avoid obsessing over behaviors)
- Just remember "No good deed goes unpunished" (Federici, 1984-2001)
- Do more "action" as opposed to giving
- Try not to succumb to desperation or "giving up"…you signed up
- Take time for yourself and get new ideas

- Watch your own personal reactions
- Maintain a healthy emotional distance when working on major problem behaviors
- Try not to take it personally – it may be institutional behaviors and experiences resurfacing
- Be aware that parents often talk too much when the child is not even listening
- Accept the role of a "teacher and trainer" instead of being a parent and "friend"

Ways to Teach and Modify: A Guide for Parents

- Ignoring and forgetting to discipline does not help (i.e. kids like going to their room)
- Take an active stance and be directive but not confrontational
- Must know when to stimulate and reward, and when to avoid giving in (or giving up)
- Accept imperfection and teach compliance, attitude and prosocial behaviors

- Remember, you can teach a child to do anything, regardless of their disabilities
- Post-institutionalized children will continue to show their "true colors" over the course of time
- Must continually upgrade and intensify treatment interventions
- ALWAYS respect a child's cognitive strengths and limitations (children can only function at their inherent level)

How to Handle Disabilities and Differences

- Older post-institutionalized children who are adopted will create greater challenges
- Initial presentation can be quite misleading
- "Honeymoon period" can last from minutes to months
- Many children present with quasi or "Institutional Autistic" characteristics

- Frustrating and confusing behaviors stress new families and can lead to despair
- Important to understand self-stimulating behaviors, superficial or indiscriminant attachments, and avoidance
- Families must remember to be highly structured, focused and goal directed
- Consistency and firmness is the key to success
- Hard to do when you are trying to love your child and "fix all the years they have missed"

- Relationships and "attachments" take time to develop and strengthen
- No one attaches overnight
- Teach anything and everything to your child
- Don't assume they "get it" (trust me, they often don't)
- The "language of emotions" is a third language that an older child must master (after English transition)

Concluding Thoughts for Optimal Success

- Understand the "interplay" between cognitive and emotional functioning
- Respect child's abilities and disabilities
- Fix what you can and accept what you can't
- Continually adding specialized care
- Family members need to take care of each other but maintain a strong "hierarchy"
- Failures often lead to better understanding