

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**

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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**

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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**

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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**

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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 teratogenic factors and lack of medical care
- Both have attachment disorder issues

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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
 - Teratogens
 - Effects of environmental and social deprivation on the developing brain

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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

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- 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 neurodevelopmental disorders, mood and behavioral dyscontrol, and attachment disorders based on neuropsychological deficits)
- Many families "wait" for cognitive and emotional "catch up".

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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

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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

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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

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- 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)

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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"**

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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")**

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- **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**

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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**

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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

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- **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

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- **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

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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

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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**