Raising the Post-Institutionalized Child Risks, Challenges and Innovative Treatment

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Introduction and Background

Adoptions have always been a very important part of American culture with a recent "evolution" to a higher volume of international adoptions as opposed to adopting from our United States social systems. Many people have chosen to adopt a child from a foreign country as they find the procedure quick and cost effective with very little waiting time and an abundance of younger children readily available. Furthermore, many people choosing international adoption have the belief that adopting an infant or even older child from another country will spare them the pain and hardship of waiting for a child to become available or, more commonly, having the opportunity to "pick and choose" from a large volume of children who the family believes will rapidly "fit in" to their current family structure, physical appearance, and greatly appreciate all what they can offer them in our somewhat extravagant and over stimulating American lifestyles. American families also believe they will be spared any possibility of involvement with the biological parents if they adopt from another country as there have been numerous high profile cases in the United States in which the biological parents come forward after an adoption in an effort to reclaim their child based on a defense of incorrect adoption, improper legal proceedings, or even a "change of heart".

Adopting the child who has been raised in an institutional setting abroad poses some very important "risk factors" which are not always properly understood, disclosed or explained to families. The statistics of families adopting abroad beginning almost three decades ago when Korean adoptions set the stage for international adoptions have grown at an astronomical rate. Central and South America have always been very prominent countries allowing international adoption but, following the fall of the dictator Ceaucesceu in Romania in 1989 and the multitude of dramatic television portraying the plight of the Romanian orphan housed in the most damaging of conditions brought thousands of Americans and Europeans to Romania on their own to adopt these very special children with unknown pre and post risk factors (Kifner, 1989; Battiata 1990, 1991) Romanian adoptions set the stage for other Eastern Bloc countries to open their doors to Americans and Europeans, with the former Soviet Union allowing for a great volume of international adoptions beginning in 1993. Many other Eastern European countries followed suit in international adoptions with the most recent surge of adoptions occurring in Southeast Asia, particularly China and now Vietnam as well as long-standing programs in Korea.

According to current US INS statistics, approximately 16,396 children were adopted from abroad by Americans in 1999. Although international adoption has been gradually increasing in the United States since the 1950s, it has dramatically increased over the course of the past decade. For example, from 1992 to 1999 alone, international adoptions in the United States increased from 6,536 to 16,396 children, representing a 250% increase in only 7 years. (U.S. Immigration and Naturalization Service, 2000). The principal reason for this huge increase in international adoption has been directly related to the shortage of adoptable children in the Unites States as most families desired young, healthy and Caucasian infants which typically resulted in years of waiting or the extensive time it took for the birth parents rights to be relinquished.

The incredible number of children arriving from overseas post-institutional settings has been directly linked to ongoing media attention and the creation of literally hundreds of adoption agencies specializing in international adoptions. United States has stayed in the forefront of international adoptions followed closely by Italy, Germany, France, United Kingdom and Israel. Many of the countries have tried very hard to promote inter-country adoptions or some type of alternate placement such as foster care programs, but due to the poor economic conditions, international adoptions have continued to be a more viable option. Families from all over the world have offered to provide a stable home and environment for these special and potentially high risk children who have been housed in institutional settings, some better than others, but the majority having deplorable conditions and extremely limited caretaking.

Institutionalization: What are the risk factors?

Many people ask "what do you think it was like for our internationally adopted child?" This is an extremely powerful question as it involves a discussion of the high-risk pre and post-natal factors, genetic risks, poor medical and nutritional care and, primarily, children who have lived without strong maternal bonding and attachment during critical formative years. Commonly, institutional settings have very poor caretaker-to-child ratios with some countries in Eastern Europe having 1 caretaker per 50 infants or even older children. Many people attempt to seek out the most optimal or sophisticated country to where children are provided better care and, for these reasons, South America and Southeast Asia are often looked upon as a better "risk" because of their fostering programs or abundance of paid caretakers. In the former Soviet Bloc countries, the decades of oppression and neglect as well as the extremely poor medical care and nutrition have been linked to delays in brain and physical growth and development as well as delays in social-emotional development and, primarily attachment (Johnson et al, 1992, 1996, 1997; Rutter, 1998).

After Internationally Adopting: What Do We Do?

Children being adopted from other countries come to the United States at varying ages and in varying medical conditions. There are many families who are very much aware of a child's specific physical or emotional disability and chose to adopt anyway. The majority of the children who have been adopted have very little accurate medical information which leaves huge gaps in understanding the child's early developmental experiences. With this paucity of information, families attempt to set forth and raise their child the way they were raised or in a similar manner should they have biological children.

With families who have adopted infants and toddlers (understanding that many countries will not allow a child to be adopted until they reach at least an age of 4-6 months with previous policies forcing the parents to wait until the child is 18 months of age), the natural parent-child cycle is to provide an abundance of nurturing, stimulation, developmental activities and active involvement by all immediate and extended caretakers. While this is certainly the most optimal form of intervention for the infant or early toddler, there may be medical and psychological factors which the family is unaware of or may not know the outcome for several years.

For example, the effects of malnutrition on mental development are well known and have often been linked to later learning and behavioral problems (Galler and Ross, 1998; Miller et al, 1995). Fetal Alcohol Syndrome and Effects are common risk factors which can produce physical, learning and neurobehavioral difficulties (Johnson, 1997; McGuinness 1998). Additionally, the effects of institutionalization on even the youngest of child can have profound effects on attachment, safety, security and coddling behaviors. Failure to Thrive Syndrome and early infant-toddler restlessness, sleep and feeding disorders, and even early onset emotional-behavioral problems have been reported by many researchers who have followed internationally adopted children (Ames, 1997; Zeanah, 1999, in press). Revisiting the profound effects of early maternal deprivation and care as pioneered by Bowlby, 1951, and Spitz, 1945, have clearly listed out that even brief periods of early infant-maternal separation can lead to a combination of cognitive, attachment and behavioral difficulties.

Most families provide tremendous nurturing and attention for their infant-toddler, but there are a select group who must return to work and place the child in some type of daycare or preschool program at a very early stage of "reattachment" to the new parents. For the child who may have medical and/or psychological-attachment-deprivation risk factors, a placement out of the home for extended periods of time can only promote further unattachment or indiscriminant attachment to other caretakers as opposed to the primary parental figures. Zeanah's work on infant-maternal attachment promotes the need for strong and consistent "reparenting" of the child who has already been deprived during critical developmental stages (Zeanah, 1993, 1996). The importance of aggressive reattachment and reparenting for a young child coming out of an institutional setting is of paramount importance as the child has had a loss of maternal attachment, stimulation and developmental experiences ranging from birth through 24 months with the damaging effects of early childhood deprivation expanding exponentially as the child becomes older and remains in institutional care.

Infants and toddlers most certainly require a stable and secure parental-family unit and hierarchy, and an abundance of pure maternal and paternal physical and emotional experiences. Research provided by Cermak and Daunhauer (1997) have consistently shown "sensory defensiveness" in the infant and toddler who has not been exposed to normal child rearing strategies. Therefore, many newly adoptive parents who have infants and toddlers may become shocked and overwhelmed when their affections are rejected as it should be emphasized that, even very young children who have been removed from institutional settings, can still be highly sensory and tactilely defensive and reject human contact because their preverbal and sensory-motor experiences do not allow for maternal comfort and nurturing to be so readily accepted. Newly adopted parents must be very sensitive to this issue and adequately prepared for this potential and somewhat provocative experience prior to their adopting an infant or toddler. While many families have extremely positive experiences after adopting the younger child, there are many families who try very hard to force the child into their arms for comfort and nurturing when the child's innate capabilities for this type of infant-maternal attachment are not yet formed.

Other methods which have been found to be extremely helpful for parents who have adopted infant-early toddlers from post-institutionalized settings is to provide a wide range of developmental play activities which involve parent-child involvement. For example, infant toys involving different textures, colors, noises and music in addition to frequent movement activities on the part of the child with the parents physical involvement will allow the child a "safety net" and feel connected to a person and reality as opposed to remaining alone and isolated in a crib by themselves which has been their earliest experiences. There are many infant-toddlers who may be defensive and inconsolable but parents need to continue to provide constant human contact, warmth, texture, stimuli to all of the senses and working through nutritional problems such as failure to thrive or oral-motor defensiveness. This takes tremendous patience and tolerance on the part of the parent which is why the child must have only the primary caretakers work consistently on these issues as opposed to ancillary figures such as nannies, daycare providers or even extended family members.

With gradual and consistent attempts at reattaching and soothing this type of post-institutionalized infant-toddler along with the ongoing introduction of developmental stimulation, sound and visual inputs, nutrition (which can sometimes be a source of aversion for the new child based on their early "imprint" of poor nutrition), the newly adopted child has a much stronger chance of rapidly overcoming this "defensive pattern" and learning how to become reattached in a healthy and mutually rewarding manner. It is often the parents frustration over the child's continual crying, lack of accepting soothing and nurturing, or even quasi-autistic tendencies such as rocking and self-stimulating which can promote parents becoming angry and detached themselves (Federici, 1998; Rutter, 1999).

Assessing and Treating the Older Post-Institutionalized Child: Challenges, Opportunities and the Need for Innovative Treatments

Many families opt to adopt older children from institutional settings from abroad. There are a large group of families who are more comfortable with having a child above the age of 3 or 4 years old as they feel they can more adequately "identify" physical, cognitive and personality traits and characteristics. Furthermore, families choosing to adopt older children are sometimes older parents who may not be interested in the "infancy period" but more interested in having an older child who may quickly assimilate into their family, particularly if they already have grown children. Adopting the older child may also make it easier on certain families who must work as the child can then be placed in a school-based program during the day while the parents maintain their jobs which, in turn minimizes daycare.

Adopting the older post-institutionalized child presents with an even greater risk than the infant-toddler. In remembering how children have lived in institutional settings, the older child has been exposed to even more years of vitamin and nutritional deficiency syndrome, poor medical care, a lack of developmental-educational experiences, in addition to being even further "detached" from maternal-caretaker relationships. The older child often develops a premature sense of independence and autonomy as they are left to their own devices to explore their institutional world; learn speech and language; toileting and eating habits; and relationships. Most of these developmental experiences are done without proper supervision, correction or effective discipline, and are often dealt with via harsh discipline, isolation to cribs

or beds, or, more simply, placing all of the older children in a room together without toys, games, or recreation under adult supervision which leads to chaos and confusion and a very skewed sense of a family hierarchy. The child begins to see an "institutional hierarchy" which is very typical to the Darwinian Theory of "Survival of the Fittest". These older children learn habits such as fighting, stealing food, hoarding behaviors, indiscriminant friendliness or fearfulness of adults who randomly intervene. Often the caretaker interventions are no more than isolating the child back to their cribs or beds where they remain depressed, despondent and somewhat confused and disoriented as the only stimulation they may have is their immediate surroundings which is often bleak and impoverished.

Hopelessness and helplessness sets in rapidly for the older child in an institutional setting and symptoms of "institutional autism" or quasi-autistic characteristics continue to surface as this is a child's means of providing self-stimulation (i.e. self-soothing via rocking and movement activities or time occupying behaviors) (Federici, 1998; Rutter, 1999). The rapid downward spiral of an older institutionalized child can be the precursor to more chronic states of unattachment, Post-Traumatic Stress, abandonment depression, fearfulness and anxiety related conditions, and behavioral disinhibition. Children become very angry and frustrated but, without a mode of expression or even an "audience", anger and despair becomes more internalized and "on hold" until the child has the next opportunity for expression.

Speech and language delays along with social-emotional delays are very common as the child continues in the institutional environment. As prospective adoptive parents review pictures, videos and medical records, this is only a "snapshot in time" as the child's cognitive and behavioral issues typically surface after being adopted. Therefore, prospective adoptive families would greatly benefit by having extensive pre-adoption counseling and awareness of how an older child has grown up in an institutional environment and that providing a "good and loving home" may not be enough as specialized and practical treatment strategies may bring about a more positive outcome since so many families attempt to love and nurture the older child when, in fact, a gradual treatment process involving "reintegration into the family" must occur first. The best interests of the older institutionalized child must outweigh the needs of the newly adoptive parents to give rapid love, affection and attachment which are complicated emotional-behavioral patterns which may be totally foreign experiences to many of these children. If an older child has received a degree of special treatment such as foster care or a especially assigned and paid for caretaker within the institutional setting, this may certainly facilitate a smoother transition to an American home but it is so very important that newly adoptive families understand that they are a very different experience to the older post-institutionalized child who may view them as objects of indiscriminant attachment or people who can be easily manipulated into giving all the things which they never had: food, clothing, toys, games, socialization and unconditional love in the absence of structure or consistency.

Traits and Characteristics of the High-Risk Post-Institutionalized Child

Many of the older children adopted will be initially cooperative, clingy, and indiscriminant. Other reported behaviors by Ames (1997) in post-placement interviews have listed out a variety of problematic behaviors which tend to surface over the course of time. These behaviors can include engaging or charming behaviors in a superficial way; difficulties with eye contact; and indiscriminant affection with strangers; destructive and hoarding tendencies; lying and deceitful behaviors; aggressiveness; inappropriately demanding and clinging, particularly when challenged with discipline; and cognitive delays, particularly speech and language deficits. Children with these patterns of neurocognitive difficulties often struggle greatly both at home and in school if not immediately assessed. Coming out of an institutional environment has already placed the child at risk for developmental delays and the child entering into a new family and educational system with demands and expectations may be grossly unprepared which begins the "acting out cycle" which can produce a tremendous stress and burden onto newly adoptive parents, particularly if they have not had experience in child rearing.

Even the most experienced family can be challenged by the older post-institutionalized child. The temptation to give love, affection and an abundance of stimulation is so tempting due to the parents honest desire to "make up" everything they child has lost in their years of institutionalization. Often, the more the parents give immediately upon arrival, the less they get in return in the long run. Families are often counseled to provide "love, nurturing and

stimulation" which may not necessarily be the best advice given the fact that that these are all experiences that the older post-institutionalized child has never experienced. Therefore, providing this level of basic indulgence or traditional parenting often promotes a mindset in the child that they will have anything and everything they want and will use "institutional behaviors" such as being demanding, yelling, aggressiveness, or self-stimulation as a means of obtaining a new set of stimuli which they are unable to adequately process or organize in a meaningful way. For the child who is cognitively delayed or impaired (i.e. mental retardation, autism or multi-sensory neurodevelopmental disorders), their ability to handle a flood of new experiences and relationships makes little sense due to processing deficits or an inability to comprehend what is actually required of them in terms of behaviors and emotional-social reciprocity.

It should also be strongly emphasized that there is almost always a degree of unattachment, post-traumatic stress and abandonment depression in the older post-institutionalized child beyond the age of 3-4 years. Many people will hold onto the belief system that they can "cure" the effects of institutionalization quickly when, in fact post-institutionalized children can show very intense patterns of childhood depression and anxiety through the manifestations of irritability, low frustration tolerance, lethargy and despondency, coldness and aloofness, indiscriminancy, or even rage and severe behavioral dyscontrol. There are many children who respond extremely well to their newly adoptive family environment which is most likely related to their having at least some developmental experiences of attachment, nurturing and maternal-caretaker involvement. This may be the exception as opposed to the rule but, nonetheless, Rutter (1998), has found that developmental catch up following adoption after severe global privation will, in fact, occur in the younger child as long as families remain involved and provide developmental-psychological interventions.

Innovative Treatments for the Post-Institutionalized Child: A Guide for Families and Mental Health Professionals

The most important intervention which families and professionals can provide to the older post-institutionalized child is an immediate and comprehensive medical and neurodevelopmental assessment. Understanding deficit patterns very early, particularly speech and language delays, cognitive-intellectual deficits, sensory-motor impairments and a rough estimate of the "stage of psychological development or trauma" will help plot out the most appropriate treatment interventions.

In expanding upon innovative treatment methodologies in dealing with the older post-institutionalized child, Federici (1998) strongly advises against the "wait and see model" as it is important to continually revisit the reality that the child has lived basically "detached" from proper maternal affection and caretaking. These are issues which need to be assessed and addressed early on with the main recommendation being for the older child is to arrange for a gradual "introduction" into a new family system, culture and language which is so foreign to all of these children a strategic and systematized plan of action should be undertaken to minimize later problems.

The following ideas and concepts may seem a bit extreme to many families who have adopted the older child, but is has been amazing as to the numbers who have come back into psychological treatment years after adopting an older child and stated "If we could have done it all over again, we would have done it much differently". Therefore, the concept of gradually "de-institutionalizing" a child at the onset of adoption makes the most sense as this will provide a true blueprint for families to follow which is organized, strategic while operating at the level of the child's development thereby bypassing the needs of the parents which may be noble and nurturing, but incongruous with the psycho-social and cognitive stage of the child.

For the child who has been institutionalized approximately three years or greater, the following treatment approaches may lead to the most optimal outcomes:

1. Prior to adopting their child, the family should prepare for potential difficulties ahead. Preadoption counseling should be undertaken with the parents being made aware of potential high risk medical and psychological factors and the strong probability of cognitive delays, particularly speech and language. Teaching the parents awareness of quasi or institutional autistic characteristics is very important as many children from institutional environments self-stimulate which causes parents great distress.

2. Parents should be prepared for the initial "meeting and greeting" with the child. An immediate act of indiscriminant attachment does not mean that the child automatically loves you or really understands the concept of attachment and affection. Parents fall in love with their adoptive child much quicker than the adopted child falls in love with their parents. Advising parents that attachment is a developmental process and not an immediately occurrence.

3. Parents should absolutely not try to fix everything right away as recovery can sometimes take years, if not life long with some children who have experienced profound damage. Parents need to remain calm and practical, with the initial focus being on taking care of transporting the child from the country of origin to their home and addressing any urgent medical needs which may occur during the in-country adoption process. Again, careful counseling with the parents regarding how the child may react in their presence upon first meeting and on the plane ride home is very important to prevent catastrophies. Consulting with a pediatrician and possibly considering some conservative medication to ease the child's anxiety and promote sleep can be beneficial in addition to being prepared for common medical conditions such as nausea, vomiting, diarrhea and infections. Getting the child home and into medical care is a priority.

4. Upon arrival home, it is very important for families to absolutely and unequivocally not over stimulate the child at any level. The child's room should be kept extremely basic (if not stripped) as providing an abundance of colors, sights, sounds and toys will surely promote chaos as these are experiences the child may have never had. It is important to remember that children who have resided in an institutional setting are very accustomed to having little, if any, stimulation. As time passes, families can gradually expose their child to new things, but gradual is the word and only by the principal caretakers as opposed to having a "family reunion" which will surely overwhelm the child.

5. Institutionalized children are used to a very rigid routine which should be kept up at some level upon arrival to their new home. Keeping a well structured routine involving eating, sleeping, activities and parental attention is necessary otherwise the child will become "random and confused" due to their inability to process everything their new home has to offer.

6. It is very important that families stay at home with their newly adopted child as possible and have only very few people around, preferably the immediate family. Having extended relatives and friends from everywhere will only produce more indiscriminant attachment as everyone wants to "make the child welcome and give them things". If at all possible, the primary caretaker should remain home with the child assessing any and all nuances of cognitive and emotional patterns along with a team of developmental experts before placing the child in any type of school-based program. Daycare should be avoided for an extended period of time (at least 12 months). Remember, daycare is just another institutional setting that the child will attach and adapt to as opposed to a family unit.

7. Over the course of the first 2-to-3 months, parents should try to find a way to communicate with their child in his or her native language, even if it is very basic. The child will learn English very quickly, but will feel more comfortable if the parents are able to communicate basic commands and directives in their native language. Even poor Russian or Romanian is better than speaking to the child in English which they absolutely do not understand, let alone if they are speech and language delayed. Using visual-graphic techniques, basic sign language and gesturing, or direct training methods (i.e. showing them how to do something with the parent being right there) is recommended.

8. Most children coming out of an institutional environment have an emotional-developmental age of 2-to-3 years old at best. Therefore, they require constant training via repetition, role playing/rehearsal on most everything they do such as bathing, toileting, eating, dressing and dealing with both human and animal relationships. Many children become very aggressive and demanding and take it out on others or family pets which is why it is so very important to keep stimulation to a minimum and direct supervision to a maximum.

9. Avoid taking newly adopted children to places which are totally overwhelming such as grocery and department stores, parks and recreational activities, Disneyland, or anyplace in

which there is sure to be "sensory overload". Most parents who have taken their children out in these type of public places prematurely usually regret it because the child runs aimlessly towards the stimuli and is difficult to stop.

10. Regardless of the age of the child, television and self-stimulating games such as Nintendo, videos or electronic games should be avoided as this will only promote social detachment and a new set of preoccupations.

11. A gradual introduction into socialization should occur over the course of months as opposed to the next day. Sending the child to daycare or school right away often results in disaster as the post-institutionalized child will play and socialize almost exactly the same way they did in their institution. This will usually take the form of indiscriminant attachments, aggressive play or remaining aloof and isolated.

12. Food is a very important concept to discuss as many families attempt to provide anything and everything which is contraindicated. Remember, children in the institution lived on a very regimented diet of the same things daily. If at all possible, keeping up a similar food regiment at first is recommended and then gradually introducing new food groups under strict supervision as children will often begin to hoard food or eat without any proper manners. Strict adult supervision and restriction of food intake will lead to better eating habits later on as food can often be another form of self-stimulation and self-soothing in the place of human relationships.

13. What is extremely difficult for families to do is to refrain from a child's tendency to exhibit indiscriminant friendliness. Again, many parents hug and hold their older child very tightly and the child may reciprocate, but this may be a total indiscriminant behavior on the part of the child without any substance or depth of emotional/attachment meaning. Parents need to maintain strict boundaries and hierarchy and gradually teach the child when, where and who to touch, hold or hug. Most all older post-institutionalized children will immediately reciprocate a parental affection with their own version of affection, but this may not be genuine as again, this was not a practiced behavior in the institution. The needs of the child must outweigh the needs of the parent to "fix everything" via love and affection which is often delivered immediately and with good intentions but out of synchrony with the child's developmental stage and depth of understanding.

14. Many children are cognitively or linguistically delayed. Parents must understand that the "wait and see model" may not be the best and that if a child is showing a pattern of impairments in their native language and behaviorally, that immediate special educational and behavioral interventions should be implemented. Examples would be providing increased structure, consistency, effective discipline and developmental therapies. The more structure, firmness and behavioral modification techniques applied early will help the child feel safe and secure even when they may rebel against the limits placed upon them. Rage and aggression should be dealt with directly by providing safe and nurturing holding techniques so no one becomes injured. Unconventional therapies should be avoided such as rage reduction or immediate "attachment therapy" for a diagnosis of Reactive Attachment Disorder which is a blurred and somewhat obscure diagnosis as all older children coming out of institutional settings have not had proper attachment experiences which is a given and should not fall into a psychiatric diagnosis immediately to where treatments or medications are prematurely provided.

15. Families must learn to rehearse and practice with their child methods in understanding personal space, boundary issues, eye contact, tone and pitch of their voice, self-control, and the ability to delay gratification and impulses. Most older post-institutionalized children have very little understanding in the recognition of facial expressions and body language which are an extremely important part in the development of proper attachment. These are skills to be taught as the child will not learn on their own or may learn from inappropriate role models.

Summary, Conclusions and Points to Ponder

To appreciate the full dimensions of an institutionalized orphan's medical, cognitive and emotional difficulties, we need to understand the road traveled by such a child and what has happened along the path of decline.

Imagine how this child came into being. Imagine the child in the mother's womb, assaulted by malnutrition, environmental poisons, nicotine, alcohol and perhaps life threatening medical conditions. Imagine the child born into a totally impoverished family, without enough food, shelter, clothing or medical care. Imagine that child abandoned, without the love and affection of a mother and father. Imagine the child placed in a stark and sterile hospital, with little human contact or stimulating activity, often kept tied to the crib. Obviously, such neglect can lead to psychological problems, but health problems are also a serious threat. As with any baby or young child left unattended for too long, these neglected orphans are exposed to so many high risk pre and post-natal factors that the brain and the psychology can become compromised.

After newly adoptive parents have brought their child home, the concept of recreating some aspects of their institutional setting and lifestyle may be the key to the initial stage of bonding and attachment as the child will then understand that you understand where they have come from. A gradual transition to a new and very complicated home life takes time, effort, consistency and a willingness on the part of the newly adoptive parents to implement innovative assessment and treatment strategies which may go against the grain of traditional parenting. If parents are able to objectively view how their child was raised and what their true needs are as opposed to the parents immediate need to create a family, long-term change and stability of the child will be more rapidly developed.

Never underestimate the power of the family structure and hierarchy which is vital for proper re-development of a child who may have been deprived and cognitively and/or emotionally damaged during formative years. Children of all types need supervision, support and education in a non-threatening and consistent manner with post-institutionalized children needing 50% more parenting than one had intended to give. Offering this level of intensity can be a cumbersome and overwhelming task, but it is the deep commitment that parents make to their child, whether biological or adopted, promotes the most optimal outcome.

Early assessment is the key, and problems need to be assessed the moment they arise. It has been very common in our society to view children as being able to "learn on their own and become independent" and, in no way, be overly controlled. The post-institutionalized child has already "learned on their own and was raised independent"—but not in the ways that we see as healthy. Therefore, teaching parents how to work at the level of the child is of paramount importance.

Success in parenting is driven by experience but, most importantly, proper understanding.

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