

I'd rather be in Austin right now...



Newark Airport 10.29.2011

LIFE IN AN INSTITUTION

Home...

Where is my heart?

*Special acknowledgment
to
Dr. Ronald Federichi and
Dr. Todd Ochs
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Zhitomir, Ukraine, 2000



Moscow, Russia, 2005



Petergof, Russia, 2008



INSTITUTIONAL SETTINGS: PHYSICAL AND PSYCHOLOGICAL CHARACTERISTICS

- **Deprivation and neglect**
 - **Nutritional,**
 - **environmental,**
 - **social,**
 - **educational and**
 - **interpersonal**
- **Abuse and other traumatic experiences**

INSTITUTIONAL SETTINGS: PHYSICAL AND PSYCHOLOGICAL CHARACTERISTICS

- **Not where children belong**
- **Overcrowding and understaffed**
- **Clean on the surface? (multiple contaminants)**
- **Children “lost in time and space”.**
- **Lack of sensory-integrative development**
- **“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**

SOCIAL-EMOTIONAL DEVELOPMENT IN THE INSTITUTIONAL ENVIRONMENT TODDLERS

- **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**

SOCIAL-EMOTIONAL DEVELOPMENT IN THE INSTITUTIONAL ENVIRONMENT 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 VERSUS U.S. ADOPTIONS: *Similarities & Differences*

International Adoptions	Domestic Foster Care Adoptions
Neglect	Not necessarily
Higher risk secondary to environmental and economic factors	Theoretically lower risk
	Potential for better care, nutrition and psychological development in infant and toddler
Higher potential for teratogenic effects	

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

International Adoptions

Domestic Foster Care
Adoptions

Abandonment

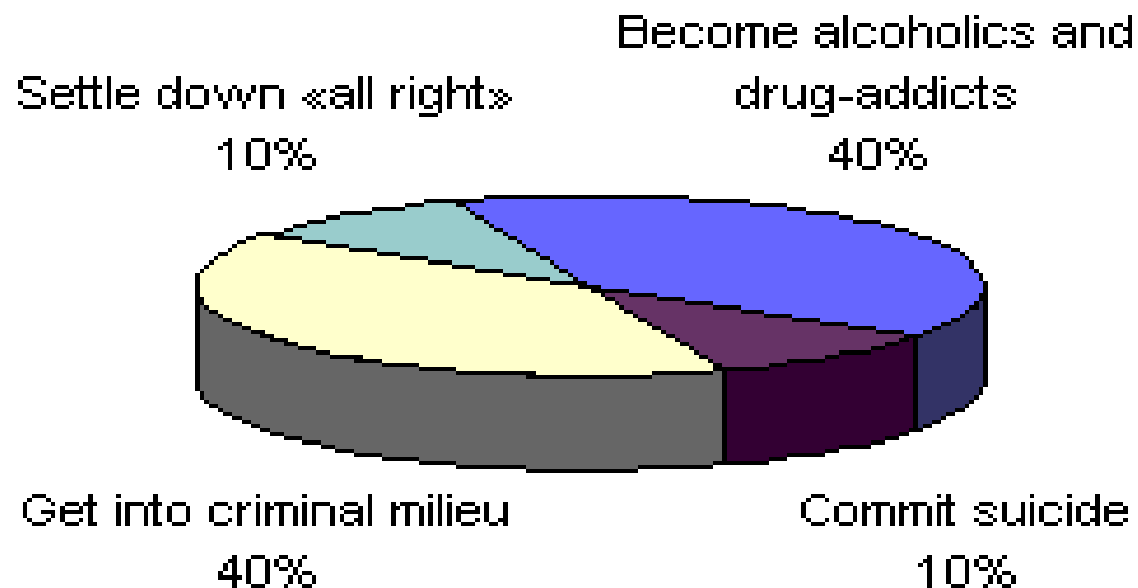
Potential for hereditary problems and psychological
damage

Attachment issues

Same outcomes

OUTCOMES OF RUSSIAN ORPHANAGES

State-run orphanages leavers:



*80% of girls can become prostitutes

OUTCOMES OF US FOSTER CARE

- **60% of male foster care alumni were convicted of crime, compared to 10% of non-foster youth (1)**
- **3/4 of female foster care alumni were on public assistance by 24 years of age (1)**
- **1/3 of female foster care alumni gave birth within 3 years of leaving foster care (2)**
- **57% of foster care alumni were diagnosed with major mental illness (2)**

(1) Mark E. Courtney, et al, Midwest Evaluation of the Adult Functioning of Former Foster Youth, Chapin Hall at the University of Chicago, 2010

(2) Amanda Singer, Assessing Outcomes of Youth Transitioning From Foster Care, State of Utah, Department of Human Services, 2006..

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**

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**

ASSESSMENT OF LONG-TERM NEUROCOGNITIVE AND EMOTIONAL RISKS

- **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”.**

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**

HOW TO EDUCATE TREATMENT PROVIDERS: A GUIDE FOR FAMILIES

- **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”)**

SOCIAL-EMOTIONAL CHARACTERISTICS OF THE OLDER POST-INSTITUTIONALIZED 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)***

- **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**

GENERAL NEUROPSYCHOLOGICAL PATTERNS

- **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**

GENERAL NEUROPSYCHOLOGICAL PATTERNS

- **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**

Children are not made for

LIFE WITHOUT A FAMILY

(institutions or not)