

## **The post-institutionalised child**

**by Karleen Gribble**

### **Introduction**

Each year there are over 10 thousand intercountry adoptions worldwide. Many of these children have spent at least some of their life in an orphanage, experiencing institutional care, which has had a far-reaching impact on them. Most of these children will have some interaction with paediatric health or other childcare professionals in the months and years after their adoption. However, because theirs is a relatively rare situation it is understandable that knowledge of their special needs is outside the experience of most professionals. Nevertheless, given information, professionals can use their specialised skills to assist parents and play an important role in the lives of adoptive families.

This article aims to provide a background on the experience of children in institutional care and highlight issues for health or other childcare professionals to consider in caring for a post-institutionalised child. These issues include: developmental delays, over friendliness or "over attachment," sleep issues, peer interaction and language acquisition, food, hospitalisation, over friendliness or "over attachment", developmental delays, "hidden" symptoms, issues of diagnosis, and consideration of the needs of the parents.

### **The experience of children in institutions.**

#### **Institutional neglect**

The experience of a child in an institution is very different from that of a child in a family. Though institutions vary widely in the quality of care they provide, they generally have high child to caregiver ratios, which do not allow for individualized attention; they may also be lacking in heating, cooling, space, toys and nutrition. The physical and emotional deprivations of institutionalisation can result in a raft of problems including: a range of health issues, trouble with forming relationships (attachment difficulties), physical and developmental delays and language and sensory integration issues.

The most serious deprivation of institutionalisation is the lack of a consistent and sensitive caregiver with whom the child can trust and form a healthy attachment. Development of trust and a secure attachment normally occurs through interactions in which a primary caregiver meets a child's needs in an appropriate manner resulting in reduction of discomfort and in feelings of relief. This cycle of need-distress-gratification-relief-need is ordinarily repeated many thousands of times in the first years of a child's life but is absent or greatly reduced in the experience of institutionalised children. The absence of this attachment cycle in the early years of a child's life can be incredibly damaging and impact their ability to develop relationships and function in society.

## **Developmental processes**

High child to caregiver ratios also limit the physical experiences of children who may be restricted to a cot/room for extensive periods of time, may spend very little time in interaction with any adult and are unlikely to have treatment for any physical special need they have. As a result, many children will not meet gross or fine motor milestones during the time they are institutionalised. Nutritional deprivation or contamination of food or water with toxins such as lead or mercury can also impact development and health. Some children will experience sexual or physical abuse and infectious diseases and parasites are easily transmitted in the collective living conditions of an institution.

## **Health risks**

Many of the medical issues that need to be considered post adoption are obvious to medical practitioners who know to routinely test for infectious disease and parasites, reliability of immunization record and to organize developmental, hearing, sight and dental checks within an appropriate time frame. Guidelines for health care professionals are readily available on these topics and references are easily identified via a Medline search for example, however, there are matters that may be less obvious but are nonetheless important to consider.

Different children will be impacted differently by institutionalisation, not just because the quality of care they experience may vary but also because their internal resources for dealing with their environment and care or lack of care will be different. Some children, potentially those adopted at a younger age, will appear to emerge relatively unscathed but others may be profoundly affected. Few children will have all of the problems discussed here and many problems will likely be evident only for a short period of time. Children are remarkably resilient and sensitive caregiving results in incredible healing for a large proportion of children. However, it is vital that appropriate care be given in order for healing rather than exacerbation of problems to occur. Health and other child care professionals have an important function in assisting and supporting parents in their caregiving and play an extremely influential role in providing expert advice.

## **Developmental delays**

Children who have spent an extended period of time in institutional care are often developmentally delayed and retarded in growth due to physical and emotional deprivation. Children will often have three different "ages," a chronological age, a developmental age and an emotional age, which may vary widely from one another. Their developmental age will depend upon the care they have received prior to adoption. In many institutions, babies are left lying on their backs for extended periods of time and preschool aged children may be restricted to a cot for most of the day and therefore have poor gross motor skills. Even older children are likely to have had a limited opportunities for physical or fine motor activities and thus, will compare poorly to children in families. However, children often experience enormous catch up growth developmentally and physically after placement and can benefit from the assistance of physical therapy and early intervention services. It is also worth considering that although there is often rapid improvement post-placement, some children have permanent damage as a result of their early experiences. Children's emotional age will be related to the quality of relationships the child has had prior to placement. If the child has not had sensitive care from a primary caregiver their emotional growth will be severely retarded. Many suggest that the emotional age of

the child is linked to the length of time they have been in a family. Thus, a 5 year old adopted at 3 years will have an emotional age close to those of a 2 year old born into their family and may express this in their needs and behaviour.

### **What professionals can do:**

- *Arrange for developmental assessments shortly after placement, understanding that they can assist in tracking the child's progress but may not be a good indication of the long-term prospects for the child.*
- *Refer to early intervention services and do not assume that delays will be transient or be ameliorated without assistance.*
- *Consider the emotional age of the child in determining how tests might be administered, matching testing procedure with emotional maturity rather than chronological age (e.g. hearing or sight tests).*
- *Provide practical suggestions that may assist a child in overcoming delays.*

### **Over friendliness or "over attachment"**

Over friendliness to strangers (called indiscriminate affection in the literature) is a common behaviour in post-institutionalised children. In institutions, where there are few carers, children learn to be cute and engaging in order to maximize adult attention. This is a survival mechanism since children who receive no human touch are at increased risk of morbidity and death. Post-placement, children sometimes seek to be attractive to strangers, seeing every adult as a potential new caregiver. Perhaps because most caretakers in institutions are women and have failed them, many children show a definite preference for men (alternatively they may be scared of men). Children presenting indiscriminate affection need to learn that there are different types of relationships with adults and that family is something special. Parents have had success in teaching their children this by limiting the opportunity for contact with other adults and instructing those adults that they interact with of the boundaries they have set with their child. Younger children may be easily confined to their parent's arms. Older children may be told with whom they may cuddle (initially it is advisable that this is only mum and dad) or hold hands or talk and specific instruction on relationships provided. Emphasis can be placed on how parents care for their children and that children in families do not need to look after themselves.

Explaining to children the concept of "circle of care" is often helpful in aiding children to understand the inner sanctum of family and how extended family, friends and acquaintances are spread out like ripples on a pond; the distance from the centre indicating the closeness of the relationship. At the same time that children are seeking the attention of strangers (or sometimes apart from this behaviour), children may strive to distance themselves from their parents, particularly their mother and may appear to be very independent. Thus, children may avoid making eye contact, avoid physical contact, be stiff while being held or act in such a way as to attempt to make themselves undesirable to their parents. Fear of intimacy is behind this behaviour as post-institutionalised children have experienced multiple caregiver loss and learnt that they can rely only on themselves. This can be very difficult for parents, particularly the mother who is often the primary caregiver and the focus of the child's rejection (many children will be somewhat accepting of their father while vehemently rejecting their mother). It can also be easy for parents to come to consider that their child is naturally independent and to allow them to maintain emotional distance. This however, is not in the child's best interest as healthy independence can only grow from healthy dependence on a primary caregiver and the long-term consequences of

accepting distancing are serious. Families may need to be supported by family, friends and professionals if they are not to take the rejection of their child personally.

Parents often find that they are able to assist their child to trust and build attachment with them by being responsive to their needs and gently persisting with closeness, not accepting the rejection at face value. It is not a case of forcing closeness on a child but providing closeness in ways that the child finds acceptable and gently increasing their tolerance over time. If a child rejects comfort from a parent, the parent should remain with the child and continue to attempt to comfort them. Activities that build trust and maximize close physical contact can also assist; for example, carrying the child in a sling (note: since children are rarely carried in institutions, many do not initially know how to hold on when being carried), cosleeping, cobathing, swimming together, playing games that initiate eye contact, dancing together, massage and hand feeding. These activities can be a beginning for reinstating the attachment cycle that was disrupted by institutionalisation. Assisting the child to develop a secure attachment with a primary caregiver may be the most difficult part of parenting a child with past hurts. There is a continuum of attachment from securely attached to severely attachment disordered. As children with severe attachment disorder may exhibit extremely antisocial behaviour as they grow (including aggression, lying, cruelty and self destructive action) and find it difficult to function in society, early intervention on building attachment is vital.

Some children rather than rejecting parental care become what some view as "over attached," usually to the mother, and cannot tolerate being out of her sight. In fact, such children are insecurely attached and, fearing loss of another mother, determine to never leave her side. This can be wearing for mothers, however, resolution can only be achieved if the mother gives her child the closeness needed, allowing separation only when the child is ready to do so, moving from short periods of separation to longer and emphasizing the permanence of the relationship. Forcing separation will have the opposite affect of what is desired and will prolong insecurity of attachment.

Over friendliness, premature independence and "over attachment" can be challenging for parents not just because they may be difficult to deal with but also because Western culture values independence in children.

*What professionals can do:*

- *Support parents in their measures to deal with overfriendliness or "over attachment" and parenting in a way that promotes attachment.*
- *Encourage parents whose child is rejecting them not to take it personally and to persist in striving for closeness with their child. Refer families of children with severe attachment issues to professional assistance.*
- *Listen as parents describe their concerns, understanding that some children with a disordered attachment will present very well in public and save their troublesome behaviour for home.*

## **Sleep Issues**

Sleep problems are very common in newly adopted, post-institutionalised children and can be the most challenging aspect of parenting in the first year post-adoption. Both difficulty in getting to sleep and night waking may occur and last for months to years. It is not unusual for a newly adopted child to take several hours to go to sleep at night and to wake a dozen times per night or more in distress. However, sleep

difficulties are not the problem that needs to be solved, rather they are a symptom of an underlying issue. Possible reasons for sleep difficulties may be a result of trauma, an inability to feel safe, or that night has been an unsafe time for them in the past.

For most post-institutionalised children, adoption is a traumatic event. Their placement is often abrupt, with little or no preparation given to the child who experiences a change in caregivers and a drastic change in environment. Communicating to the child what is happening to them is often difficult because of language differences. Children may be able to consciously control their reaction to the stress of the new environment during their waking hours but in a more relaxed state during sleep their anxiety and or anger is exposed. Night is also a time when grief can more easily surface and the losses that a child has experienced are revealed.

Children may also have difficulty sleeping because they do not feel safe and to sleep well a feeling of safety is required. The upheaval in the child's life means that they know that any change is possible. They may fear what changes may happen while they are asleep and fight sleep, sleep with their eyes open or wake in fear during the night. Night can also be an unsafe time in an institution as are there generally few caregivers at night (one per 20 children is common). Thus, if children are being abused, it is likely to happen at night, resulting in feelings of unsafety at night.

Since sleep difficulties are a symptom of a deeper problem, sleep training techniques such as controlled crying/comforting are not suitable for children who have lived in an orphanage. Such techniques can cause further damage to an already hurt child as they learn that they cannot trust their parents to respond to their cries. However, in responding sensitively to children's cries at night, parents may assist the child in working through the trauma of placement, or other past traumas, and in feeling safe in their new environment. Being with the child as s/he goes to sleep is advisable. Some families find that co-sleeping, placing the child's bed next to or in the same room as the parents' bed alleviates symptoms. Co-sleeping in particular is mentioned by many parents as being pivotal not just in improving sleep for everyone (note: it can take a couple of weeks for parents to become accustomed to cosleeping) but also in promoting trust and attachment. Remaining close to the child during the day and maximising physical contact at every opportunity (for example; avoiding the use of prams and baby chairs but instead using arms, sling or lap) will also assist in building trust, attachment and improving sleep. It is important to realise however, that no intervention is likely to result in immediate alleviation of sleep difficulties but that time is required. Parents whose child has severe sleep difficulties will need to find strategies to assist them in coping with the situation. This may include catching up on sleep during the day or on weekends, sleeping whenever the child sleeps, suspending non-essential activities and garnering assistance from family or friends to maintain the household.

*What professionals can do:*

- *Support parents as they deal with sleep deprivation and parenting in a way that is outside the cultural norm.*
- *Assist in developing strategies for dealing with sleep problems/deprivation.*
- *Encourage parents by assuring them that they are doing something important by being there for their child at night and pointing out that every time their child exhibits distress is an opportunity to provide comfort and thus strengthen attachment.*

- *Provide advice on ways to help the child to feel safer (some elements of "protective behaviours" programs can assist with older children).*

## **Peer interaction and language acquisition**

It is conventional wisdom that children need to socialize with other children in a group environment in order to develop social competence. However, group childcare environments are not appropriate for the post-institutionalised child in the immediate post-adoption period. If children are placed in a group care environment they may become stressed because it reminds them of the institution they came from and they fear abandonment. Alternatively, they may seem to fit right in and wish to spend more time there, finding the closeness of family life stressful and wishing to avoid the intimacy there. Neither of these situations are in the child's best interests. Some families of post-institutionalised children find that the needs of their child may necessitate delaying schooling or homeschooling. If entry into daycare or school is necessary, the introduction should be made gradually. Each child needs to be considered individually as responses to alternative care varies widely and thus, it is not possible to give absolute timeframes or protocols that are applicable to all.

It is often suggested to migrant families that daycare or school may be helpful in language acquisition. However, as mentioned, group childcare environments are problematic for post-institutionalised children and since their adoptive families speak English, it is in interactions with parents and siblings that the new language is best acquired. It also needs to be recognized that issues associated with language acquisition for post-institutionalised children may be different from migrant children learning English as a second language. This is because migrant children are generally learning English within the context of speaking their first language at home and often after having obtained competence in their first language. However, post-institutionalised children most often do not have parents who speak their first language. In addition, children may not have developed age appropriate language competency prior to placement because the low child to caregiver ratio in institutions means that children associate primarily with same aged peers with similar language deficiencies. Thus, the building blocks of language may have been missed, presenting special issues for language acquisition.

*What professionals can do:*

- *Support parents in any requests they make with regards making entry to daycare or school easier for their child.*
- *Take care not to inadvertently usurp the parental role and be sure to assist the child to distinguish between themselves as temporary part-time caregivers and the parents as permanent family.*
- *Not accept inappropriate affection from the child and discuss any concerns you have with the parents.*
- *Observe language acquisition carefully and refer to speech therapy if necessary.*

## **Food**

There are several situations in which food can be an issue for the post-institutional child. Because many children have experienced food scarcity in institutional care they may hoard or overeat. This problem is usually mitigated with time and allowing the child to have free access to food (placing nutritious snacks where the child can reach them or packing a lunch box for the child to carry around). Restricting access

to food may make the problem worse. Children may also not have developed the capacity to recognise the feeling of satiety or hunger since they have been given food on a schedule and regardless of individual need. Parents may need to encourage their child to make a connection between body signals of hunger or fullness and their relationship to food.

Some children may not have experienced much variety in food and may need a gradual transition to other foods. In some cases, children may have been sustained solely on bottle feeds well past the age at which solid food would normally have been introduced and may refuse solid food. Problems with different textures may be a sensory integration issue, children may also have an overactive gag reflex or may be lacking muscle development to chew food.

It is also common for children to regress in eating habits at the time they are adopted. Regression is a frequently observed response to trauma and, as discussed previously, placement is traumatic. Children may also seek to regress in order to experience some of the nurturing that they missed out on earlier in life. Thus, children capable of feeding themselves may wish to be fed, children long weaned may request bottle feeding and some children pursue breastfeeding with their new mother. Regression should not be viewed as a problem but as an opportunity for nurturing. Adoptive families are encouraged to provide times where their child can be 'babied' and to bottle feed even if the child is well beyond the normal age of weaning.

*What professionals can do:*

- *Refer eating problems to specialist speech pathology if necessary.*
- *Support parents in "babying" their child.*
- *If concerned about dental caries, suggest preventative measures that do not involve weaning from the bottle.*

## **Hospitalisation**

Hospitals and the procedures that happen there can be frightening for any child but for post-institutionalised children there are additional reasons why they might be anxious. The hospital environment, for many children, is reminiscent of the institution in which they once lived and this can create great fear, as they may believe they will be abandoned at the hospital. In the short term they may react to this stress by shutting down, disassociating, talking incessantly, becoming hyperactive, or uncooperative (note: these symptoms may be seen in any stressful situation and some post-institutionalised children suffer from post-traumatic stress disorder). Some parents have found that even a day visit to a hospital can disrupt the child for several weeks. Thus, time in a hospital should be minimised and for example it may be helpful to arrange for the child's history to be discussed with health care professionals via telephone and for waiting before an appointment to be minimised (parents may suggest that they wait outside the hospital building and be called by mobile phone when their child is to be seen).

In addition, post-institutionalised children who are hospitalised may need to have their parents with them at all times, regardless of their age. The potential seriousness of the long-term consequences of not doing this cannot be understated. If the child feels that they have been abandoned in the hospital because their parents have not been allowed to remain with them the attachment relationship that has been developed since adoption may be severely damaged. If the primary caregiver of a

child is ill or requires hospitalisation this can be extremely scary for children who may regress or otherwise express their anxiety.

*What professionals can do:*

- *Assist in modifying hospital procedures in order to minimise time spent in the hospital environment and to allow parents to remain with their hospitalised child at all times, including at night.*
- *Be understanding if the child is difficult or uncooperative because of fear/anxiety.*
- *Explore delaying procedures that require hospitalisation to allow the child time to adjust to life in their new family and for strengthening of relationships prior to another stressful event.*
- *Make accommodations to minimise the impact of parental hospitalisation on the child.*

### **"Hidden" symptoms**

Some unusual behaviours may present in post-institutionalised children that may not at first appear to be connected to a child's history but are indeed related.

Children who have been institutionalised may have difficulty in recognizing the signals their body is sending them. Such abnormal physical responses have already been discussed in relation to feeding but can also present in relation to pain responses and waste elimination. Thus, children may have an abnormally high tolerance to pain and may not recognize the need to go to the toilet (for example, physical discomfort may be expressed as emotional discomfort or as anger). The lack of recognition of body signals in relation to food and waste elimination is a direct result of the regimented life of an institution where eating, sleeping and toileting are on a schedule, regardless of body signals. A separation of body signals and action results in the quenching of normal response in some children. High pain thresholds can result, as caregivers are consistently unable to respond to a child's pain or discomfort. Parents of newly adopted children who exhibit an inability to recognize body signals may need to assist their child to make a connection between what their body is experiencing and why they are experiencing it.

Lack of a responsive primary caregiver can also result in a child not developing normal object constancy (since the primary caregiver is the first 'object') and they may have difficulty in recognising/recalling the existence of something they cannot see or in distinguishing their own boundaries. An example that illustrates how this is revealed is a school aged child who stands in front of a parent with eyes covered saying, "you can't see me". This "real space" conceptual incapacity fuels its emotional counterpart and a child seen to commit a naughty deed may deny responsibility expressing the same emotional lack of objectivity (sometimes referred to as "crazy lying"). Underdeveloped object constancy is another reason why children may find separations from parents difficult. Responsive caregiving and playing baby games that involve breaking and regaining contact (eg peek-a-boo) and reliability in returning after separations can assist children in developing this vital developmental milestone.

In addition, since primary caregivers act as regulators of infant physiology and emotion, children who have lacked this external regulator do not develop normal self-regulation and have difficulty dealing with stress. Thus, post-institutionalised children may appear loud or hyperactive, be disorganised in their behaviour and have

difficulty managing and recognising emotions. Parents sometimes describe how their child oscillates from being in control to being out of balance. In situations where the child is out of balance they find that bringing the child physically closer to them, limiting choice (essentially acting as an external regulator) and reducing stress is of assistance.

Another impact of non-responsive care in institutions is that post-adoption some children expect that their parents will be similarly unresponsive and so do not cry when they are hurt or in need. For instance, children have been known to be sick during the night but will not call out to awaken their parents but will lie in their vomit and waste until morning. A baby who does not cry when upset, hurt or in need because they do not think their parent will respond is not a "good" baby but a badly hurt child who is internally distressed but unable to express it. Such children need to be taught that parents care for their children and want them to ask for help. Parents can assist their child by watching them carefully for any signs of discomfort, intervening to provide what is needed as early as they can. Children may also appear very happy after only a few days post-placement, laughing, joking and being engaging. However, this response has a similar root as "over friendliness" in children believing that they need to be attractive to adults in order to survive and families and professionals should not be fooled that the child has "settled in."

Self-soothing is common in post-institutionalised children, using such methods as finger sucking, rocking, head banging or masturbation. It is unwise for parents to seek to forcibly remove self-comforting behaviours from their children. However, self-soothing is a sign that a child is in need of comfort and such behaviours should be gently discouraged with the parent attempting to be a source of comfort to the child. It is important that the child not be made to feel that they are doing something shameful in self-soothing.

Some post-institutionalised children self-mutilate by scratching or biting/hitting themselves or pulling off fingernails. In some cases they are hurting themselves because they have the poor physical boundaries and abnormal physical responses described earlier and causing pain is a way of feeling something. In other cases, neglect has left children feeling unlovable and deeply shameful and their self-harm is in response (this sense of shame is also seen in out of proportion responses to correction, lack of confidence, performance anxiety or perfectionism). In still further cases, self-mutilation occurs in response to stress and as a distraction from emotional pain. In order for self-mutilation to be extinguished, the root cause of the behaviour needs to be addressed. Sensory integration therapy, reducing stress and assisting the child to develop a secure attachment are helpful in reducing self-mutilation.

Post-institutionalised children are often bossy and controlling in relationships having been used to needing to look after themselves. Post adoption they seek to control their world because being in control equals safety. This is an artefact of anxiety and one that needs to be resolved so that the child can learn to trust their parents to care for them. Parents may need to constantly remind children that it is their job to look after them and that they do not need to look after themselves. Providing preparation for changes/transitions can also assist the child to feel safer. Allowing the child to control everything will be counterproductive in the long term.

It is tempting to think that a child from deprived conditions should be given as much stimulation as possible in order to help them to catch up. However, this is not a good idea as children are under an incredible amount of stress post-placement as they

learn to survive in a new world. This stress has been measured in high cortisol levels and is evident in some of their behaviours. For instance, it is common for children to be hypervigilant meaning that they never relax but watch everything very carefully, seeking patterns and understanding of what is required of them. This often results in children picking up new things very quickly. However, minimisation of stress should be something that parents aim for and since post-institutionalised children have been used to a very small, predictable world it is advisable for parents to also restrict the flow of new things so there is not too much for the child to have to process.

The stress that children are under and the limited world in which they have lived, leads to other problems. Many children have difficulty with any transition (e.g. from wake to sleep, from home to out etc) and may take a long time to be comfortable in a new environment or with new people. Routine is often very important to children, as predictability helps them to feel safer. When meeting a new person, it may take months of interaction before the real personality of the child is revealed (many children are very good at masking their real selves/putting on a brave face). In addition, many experiences normal to children in families are foreign to them and extreme reactions to situations such as seeing a dog or walking on grass are to be expected. Older children may not know how to play with toys and need to be taught how to play.

Many children exhibit great grief at the loss of previous caregivers. Exhibition of grief is a sign that the child had been attached to their caregiver and this is a good thing as the child can transfer this attachment to their new parents. A child who does not grieve a previous caregiver may not have been attached to anyone and may have difficulty building attachment without prior experience of an attachment figure. Thus, allowing the child to grieve is important and if possible, it is helpful to maintain contact with previous caregivers.

*What professionals can do:*

- *Support families as they deal with these "hidden" symptoms and validate their concerns (especially important because family and friends may discount the reality of these issues).*
- *Encourage parents in providing sensitive caregiving and a structured, limited environment.*
- *Understand that it can take a long time for a child to be comfortable in a new situation or with new people, including professionals, and*
- *Support families as they deal with the distressing manifestations of their child's hurt.*

## **Issues of diagnosis**

Issues associated with trauma, abuse or neglect can make diagnosis and treatment of other problems difficult. Thus, a holistic, multidisciplinary approach is required. Although the effects of institutionalisation on children can be devastating and long lasting, not all of the problems that a child presents with may be a result of institutionalisation.

It is also easy to forget where post-institutionalised children have come from when they present well groomed and looked after with their caring adoptive family. Thus, it is easy to make assumptions about what to look for based on the child's current environment and not their previous one and miss opportunities for early diagnosis and treatment.

*What professionals can do:*

- *Take the child's history into account when diagnosing and devising treatment plans.*
- *Not assume that all the problems that the child presents with are a result of institutionalisation.*
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## **Consideration for the parents**

When a family adopts a child from an institution they are taking a step into the unknown. Often little is known about the child they are adopting and there is no way for them to predict how the child will adjust to being in their family and what problems will arise. The initial adjustment of a child post-adoption can last for a very long time, at least a year, sometimes longer. The best-prepared family may find themselves surprised by what they encounter, thus, the parents of a post-institutionalised child also have special needs. A parent or a 4 year old who has been with them since birth is not in the same position as a parent of a 4 year old who has only been in the family 6 months. Society considers that the birth of a child into a family, though a joyful event, is also difficult and support is often forthcoming at this time, however, adoption of a child, particularly an older child is often not similarly supported. Lack of support and understanding from those around them can add to the isolation that new parents feel. Parents can find it especially difficult to explain to others the special needs of their children, for example if their child has age appropriate cognitive development but is emotionally delayed. In many cases, the initial period of caring for their child will be physically exhausting but also emotionally exhausting as they invest their energies in seeking to help their child. Further, the development of relationship between parent and child is a two way process in which both the child and parent must participate. Depending upon their history this will be easier for some parents than others. Parenting can bring to the surface previously unrecognised personal difficulties that should be dealt with, as it is through self-awareness that problems in this area can be overcome. Although this article presents a quite extensive list of potential issues that families might face, it is far from exhaustive and families may have other concerns not mentioned here.

*What professionals can do:*

- *"Prescribe" rest and avoidance of outside activities if parents are overdoing it and seeking to get back to normal too quickly.*
- *Support parents by providing a listening ear and not dismissing concerns expressed about their children.*
- *Recognise that you may not be able to materially change the situation for the family but your support, caring and encouragement can make a big difference to the parents' ability to cope.*
- *Understand that some parents may not have a basis for comparison of normal child development and will need assistance in identifying where their child is in need of help.*
- *If appropriate, explore with parents how their history and how they were parented may impact difficulties they have in providing sensitive caregiving to their child.*
- *Be aware that families may be dealing with a multitude of issues and if they do not follow a course of treatment immediately this does not mean that they are not serious about helping their child but that they may have more urgent priorities.*

- *Ask parents "what can I do to help?"*
- *Provide parents with positive reinforcement for the hard work they are doing with their children.*
- *Retain the lines of communication open with parents, understanding that you are all seeking to care for the child, but in different ways and each must be able to hear and respect the others viewpoint.*

## **Adopted and foster children who have not been institutionalised**

A significant proportion of children adopted via intercountry adoption have not experienced institutionalisation but resided in foster care prior to adoption. This is generally a much better situation for children and means that many of the issues described here are less likely to occur. However, even children who have been in excellent foster care since shortly after birth have still experienced multiple loss of caregivers and a dramatic change in environment at adoption. Thus, they may still grieve post-adoption and for example have sleep difficulties that have a root in feeling unsafe. Generally the more moves a child has experienced the greater the impact and, as with every new placement, the cycle of attachment needs to be reinstated. The approaches for building attachment with post-institutionalised children also apply here. Foster children with histories of abuse, neglect and/or multiple placements will present with many of the same issues as post-institutionalised adopted children and similar care strategies may be helpful.

## **Conclusions**

This article presents a summary of the issues with which post-institutionalised adopted children may present and ways in which health and other child care professionals may assist them and their families. It is very important that it be kept in mind that not all children present with these issues and that for many children the problems they have are relatively short lived. Post-institutionalised children are not abnormal and to pathologise them because of their history does them and their families a great disservice. Rather, the responses described here are normal reactions to an abnormal environment. Children are not meant to live in institutional care but in families and for many children growth in a family after adoption provides them the opportunity to heal from past hurts. Although the immediate post-placement period can be challenging for families seeing their child grow and heal is something that parents and those who have assisted them find particularly rewarding.

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\* Recommended reading *Karleen Gribble is the mother of two children, one born to her and the other adopted as an older child from institutional care in China. Her adopted child came home with a physical disability and developmental delays that have necessitated consultation with and treatment by a wide range of health and other child care professionals. This article has arisen out of her experience as she found that providing information to professionals about the affects of institutionalisation helped facilitate communication, optimised individualization of care and provided her with the assistance she needed to help her daughter. Karleen is also a scientist (BRurSc, PhD) and is Adjunct Research Fellow in the School of Nursing, Family and Community Health at the University of Western Sydney, NSW, Australia where her research focuses on adoptive breastfeeding and the non-nutritional impact of breastfeeding.*