

International Adoption in the U. S:
Traumatic Stress and Normal Developmental Responses

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Abstract

The purpose of this paper is to present a review of literature on internationally adopted children in the U.S. that provides context, references for normal development, and describes traumatic stress with children. This gives counselors and other professionals who work with young children and families of international adoption a conceptual framework to understand experiences that may need to be mediated and normalized. The literature suggests that by developing sensitive and responsive social—emotional relationships with infants and young children, caregivers can foster resiliency. It is important to have an accurate reference for developmental effects with internationally adopted children so that we can aid these families as they deal with the complexity of adoption.

The international adoption of children by families in the United States is a practice for achieving parenthood while dealing with the limitations associated with domestic adoption and infertility treatment (Hollingsworth, 2003; Lancaster & Nelson, 2009). International adoption refers to the joining together of parents and children from different countries in legal adoptive families (Lancaster & Nelson, 2009; Levy-Shiff, Zoran & Shulman, 1997). This experience is often an exciting and positive experience but it is also a dramatic shift in family experiences, both for child and parent (Baldo & Baldo, 2003). These children have to deal with normal developmental tasks and those engendered by adoption plus the possible challenges that can result from being placed in a family with a different ethnic and cultural background (Levy-Shiff et al., 1997). It becomes difficult for many adoptive families to determine whether their current difficulties are related to adoption issues or common issues every family experiences (Becker, Carson, & Seto, 2002).

These adoption issues and normal development can be entangled with perceived traumatic stress, socio-emotional experiences, or can be due to non-linear developmental changes. For this reason I explore adoptive children's experiences to provide context, normal development to give a reference point, and traumatic stress with children to explain mediating experiences that may need to be normalized, addressed, and accurate reactions and developmental effects on children's development need to be understood.

The challenge for counselors is to see these children and families as strong, resilient, and brave survivors who are in unique and demanding multicultural experiences. It is important to avoid imposing a pathological view, but to instead see their lives as being full of transitions and role changes (Biafora & Esposito, 2007; Chamberlain, 1995; Henderson, 2007).

This journey of transitions requires these children to deal with their normal developmental tasks and those engendered by the international adoption process (Levy-Shiff et al., 1997).

The Adopted Children. The statistics from the U. S. Department of Homeland Security's Yearbook of Immigration Statistics (2009) showed that children of international adoption range in age from under one year to over nine years old; with 25% being under a year, 51% ranging from one to four years old; 14% ranging from five to nine years old. This presents a wide developmental age range for counseling professionals to be aware of when working with these children and their families.

Some of the factors that have been identified that can hamper children's adjustment are (a) older children being placed in families with different racial, cultural, and religious characteristics, (b) loss of access to the children's heritage or experiencing marginalization, (c) exposure to some measure of racism and hyper-visibility, and (d) difficulty forming a positive self-concept and integrated identity (Levy-Shiff et al., 1997; Reynolds & Medina, 2008).

In studies where adoptees showed serious, long-term behavioral and emotional problems, researchers identified several mitigating factors. These factors were birth country of origin, age at adoption, gender (with boys at greater risk), adverse pre-adoption experiences, and adoptive family functioning (Lee, 2003). However, longitudinal researchers report that overall, internationally adopted children are well adjusted and able to develop close attachments to adults (Reynolds & Medina, 2008).

In extreme cases, these children who had previously been institutionalized experienced traumatic stress disorders, had difficulty processing and integrating sensory information, manifested institutional autism, and engaged in behaviors such as hoarding food, rocking, and aggression (Lancaster & Nelson, 2009). Several researchers have reported a high risk of

attachment disorders, cognitive and developmental delays, and behavioral deficits among post-institutional (after adoption) children many years after adoption (Lancaster & Nelson; Reynolds & Medina, 2008). Severity of psychological impairment is typically contingent on the quality of care and duration of the child's stay in an orphanage with later placed children (greater than 24 months in orphanage) sustaining the most damage (Reynolds & Medina).

Normal Child Development and Attachment. The course of development is non-linear and many times variations in assessment results for development reflect different stages in the development rather than real deficiency; particularly when viewed longitudinally (Walker & Archibald, 2006). When the data was measured longitudinally for variability in the context of global speech, looking at between subjects and within subjects, it showed that a proportion of children at each age level, but not all children, spoke at least one run above five syllables per second; 45% of children at age four, 85% of children at age five, and 55% of children at age six. Two children, one boy and one girl, had mean articulation rates above 5 syllables per second (equivalent to that of adults). The fact that the boy spoke at this rate only at age 6 and the girl only at age 4, illustrates both individual differences and a non-linearity in the development of rate.

The meaning attached to specific behaviors can vary across developmental periods with high levels of behavioral variation and enormous changes in organization of behavior occurring during early childhood; normal behavior should be considered in terms of cultural norms, intensity, flexibility to environmental input, and organization (Banaschewski, 2010). Cultural norms are defined as the set of values, beliefs, perceptions, institutions, technologies, survival systems and codes of conduct held by members of a particular group of people (Carter et al., 2005).

Furthermore, normal development may depend on the quality of personal-social relationships, as these interactions seem to provide responsive stimulation crucial to normal development (I, 2008). By providing a primarily social—emotional relationship between caregivers and children it may allow for development of all major spheres of behavior (IX, 2008). In this study providing a social—emotional relationship showed a 45 point increase in the developmental quotients and had a multivariate effect size showing 45% of variance for typically developing children being explained by the social—emotional relationship.

The multiple domains children acquire such as neurobiological development, emotionality, behavioral control, executive control, and adaptive behaviors are multileveled and complex; the emotional connection with caregivers provides the support for infant and children's growth, development, and health (Andreassen & West, 2007). Collectively, studies consistently suggest that a major factor in children's development is the presence of a warm, sensitive, responsive social—emotional interaction with a relative few, consistent caregivers, especially between the ages of six and eighteen months of life. This social—emotional interaction has a high correlation ($r = .71$) with children's developmental gains (I, 2008), even showing that these relationships create opportunities for corrective mechanisms against insecure attachments during infancy (Lounds, Borkowski, Whitman, Maxwell, & Weed, 2005).

Development and changes in attachment behaviors have been described in four phases; phase I (reflexive attachment: 0 to 3 months) infants do not differentiate people when showing attachment behavior; phase II (procedural attachment: 3 to 6 months) infants show increasing orientation to familiar people; phase III (cognitive: 6 months on), infants actively seek proximity exclusively to familiar caregivers and use them as a secure basis from which to explore; phase IV (goal-corrected: from the third year on), the child based on interaction experiences and growing

cognitive abilities is able to see the attachment figure as an independent person with differing goals than their own (Delius, Bovenschen, & Spangler, 2008). This shows that some ranges of age are foundational during development, but provide room for corrective experiences. Such as the security of attachment at 24 and 36 months combined with parent sensitivity, being predictive of adaptive social attitudes and expectations and increased social problem-solving solutions in children (Raikes & Thompson, 2008); when including early parenting variables in the model, early parenting influences accounted for an additional 3% of the variance in children's socially competent solutions and produced a significant R^2 change.

Therefore development is dependent on many interpersonal variables (such as verbal encouragement, consistency, and a secure base relationship) that help stimulation and children's joint attention, cognitive skills, language development, attachment security, and source monitoring (tell difference between self and other), providing emphasis to the importance of these caregiver qualities in healthy normal development (Delius, Bovenschen, & Spangler, 2008; Dixon, Zelazo, & De Rosa, 2010; Lounds et al., 2005; Sui & Zhu, 2005).

Traumatic Stress. Traumatic stress, has been defined as being the perception that an event is negative, the suddenness of the event, and the lack of control over the event (Goodman & West-Olatunji, 2008). When looking at traumatic experiences, it is complex and often difficult to determine how to address the needs of trauma survivors (Follette, Palm, & Pearson, 2006). The effects of trauma are not limited to PTSD, and are often multidimensional, impacting numerous domains of life (Follette & Vijay, 2009). It is common for survivors of traumatic events to experience high levels of stress and suffering (Chopko & Schwartz, 2009).

Trauma can cause higher processing to shut down and people lose their sense of sequence, context, and story; the emotional and sensory system (limbic brain) is overwhelmed

and activates and organizes around fight, flight, or freezing responses (Johanson, 2006; Wilkerson, Johnson, & Johnson, 2008). Children's traumas often results in an entangled experience of acting out and experiencing distress (Johnson, 1997). This set of responses is especially present when the children cannot make sense of the sensory information. The effects of traumatic stress upon children's long-term development include interference in narrative coherence (ability to organize material into beginning, middle, and end), emotional regulation (including differentiating affective states, expressing those states, and understanding the origin and consequence of negative states), developmental transitions, and transitions in peer relationships (Johnson, 1997).

A most difficult challenge for caregivers of traumatized infants and young children is that they have an intensified need for security, tend to have regressive behavioral and physiological functioning, and increased levels of worry or anxiety (Gaensbauer & Siegel, 1995). These delayed reactions may take many forms including increased aggression, enuresis, sleep disturbances, nightmares, extreme fear of the dark and of enclosed spaces, and intense hypervigilance in anticipation of another traumatic event (Lipovsky, n.d.; Macy, Macy, Gross, & Brighton, 2003). There is a marked decrease in ability to concentrate, focus, memorize, or take pleasure in safe and calm play, while enacting multiple variations of high-risk play (Macy et al., 2003).

Trauma can affect the development of adaptive stress responses and stable and trusting attachment relationships in the first year of life. It can lead to trouble regulating anger and the making of connections with others in the second and third years (Gaensbauer & Siegel, 1995). Traumatic experiences often result in symptoms that appear at times unrelated to crisis (Johnson, 1997). Manifesting hours or days following, and a different set of symptoms may occur in the

weeks, months, or years after (Johnson). Interventions that address children's experiences need to involve some visual and action orientation, as this is how they access new information; it is their most comfortable mode for receiving communication and movement, consequently, is their most comfortable mode for expressive communication (Macy et al., 2003).

Theories suggest that caregiver sensitivity with infants and young children predict the development of emotion regulation, which may produce emotional resilience; the ability to recover and express positive emotions following extreme challenges (Conway & McDonough, 2006). Research has identified protective factors that facilitate the likelihood that children raised in harsh circumstances will be resilient with respect to long-term adjustment; such as positive adult relationships (such as with caregivers, teachers, relatives) (Dishion & Connell, 2006). Observational learning seems to work through the emotional memory system (limbic), operating independent of language. The limbic system has two central functions: 1.) encoding, storing, and retrieving of memories, and 2.) the moderating of the body's biochemical response to stress (Johnson, 1997). During extreme stress the result can be faulty memory encoding and retrieval and over- or under-responsiveness to stress. The emotional responses acquired this way become highly resistant to extinction; possibly explaining the ineffectiveness of language-based interventions on getting rid of such acquired fears (Suomi & Levine, 1998).

To summarize this review, research has shown significantly that individual differences and a non-linearity in the development was the trend. This provides those assessing young children's abilities with a new non-linear trend in expected growth and development (Walker & Archibald, 2006). Due to recent evidence experts are criticizing norm-referenced tools as inappropriate for use with children of diverse ethnic, racial, and socio-economic backgrounds and irrelevant to the intervention process (Allen, 2007). Children who are adopted away from

their institutional background appear to catch up remarkably in many respects. Interventions with children younger than 12 months were more effective than interventions starting at a later age. Similar effects have been found for children's physical growth, school achievement, and attachment security (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2008). To conclude, the security of attachment in infancy was not predictive of later individual differences in peer-related representations. Therefore, counseling of infants and children, regardless of the trauma, can be an effective process if counselors use experiential and non-verbal interventions.

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