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Boris Gindis
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Introduction
Adoption Is Not an Event; It Is a Process

International adoption is a fact of our life. According to the Bureau of Consular Affairs (2020), US Department of State statistics, 278,745 children were adopted from abroad by US citizens from 1999 through 2019. As reported by Johnson (2017), 66,208 children were adopted from abroad by US parents from 1989 to 1999. Therefore, from 1989 through 2019, 344,953 orphans from overseas became parts of American families. As reported by Jones and Placek (2017), international adoption in the United States was peaking between 2004 and 2006 and was gradually declining, particularly after 2011. However, according to a number of recent publications (Mounts & Bradley, 2019; Schrager, 2020), the decline in the number of adopted children from 2006 to 2020 is limited to only young babies. The number of international adoptees between the ages of 5 and 12 has fallen only slightly since 2006, while the number of children under age 1 has fallen 90 percent. Although historically a vast majority (almost 80 percent) of internationally adopted children were infants and toddlers between the ages of 3 months and 3 years, the percentage of older (ages 5–17) adoptees has been growing since 1999, and in the years 2014 through 2019, the majority of international adoptees were children older than 3 at the time of adoption (US Department of State, Bureau of Consular Affairs report dated March 2020). Another definite trend revealed in the last decade is the change in the racial and ethnic composition of adopted children: the proportion of adopted children who were white fell from nearly two-thirds to less than half and the proportion of adopted children who are being raised by parents of a different race from themselves has increased by nearly 40 percent (Zill, 2020; US Department of State (2019), Bureau of Consular Affairs report).

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Within the last decade, international adoption has changed its qualitative and quantitative characteristics. As presented in Pinderhughes, Matthews, Deoudes, and Pertman, (2013, p. 12):

> Intercountry adoption has changed comprehensively and is still in the midst of its transformation from a robust but largely unmonitored process through which tens of thousands of infants and toddlers moved into new homes annually, into a smaller but better-regulated system serving primarily children who are older and/or have special needs.

Indeed, we see two distinct trends in the field of international adoption (US Department of State, Annual report on intercountry adoption, 2018) that will likely prevail in the foreseen future:

1. Fewer countries will be on the "donating" side and, due to changing policies in these countries, special needs and older children may constitute the largest percentage of children available for international adoption.
2. Due to improved pre-adoption care (e.g., better conditions in orphanages worldwide) and greater availability of post-adoption services in the United States, adopted children will have better prospects for development than in the past.

"Older" (age 5 and up) internationally adopted (IA) children as a special category of patients in our clinics and students in our schools are the subject of this book, while methods of mental health rehabilitation and academic remediation of international adoptees are its content. I strongly believe that adoption is not an event, but a process that includes restoration of physical health, emotional stability, mental capacity, and learning capability of former orphanage inmates. My 30 years of clinical work with late-adopted (after the age of 5) international adoptees have convinced me that rehabilitation and remediation of this group of children is a highly specialized process. We often hear the saying "it takes a village to raise a child," and nothing could be more relevant to bringing up an international adoptee. Synergetic efforts of the parents, school, professionals, and state-run agencies are the precondition of success. No less important are the methods of rehabilitation and remediation. These are the clinical procedures, teaching mediums, and parents' techniques that are needed to scaffold the victims of prolonged neglect to the level of being self-sufficient and productive members of our society. The description of such methodologies, verified through research and clinical practice, is the substance of this book.

The United States provides the context of clinical practice, mental health rehabilitation, and educational remediation for this book, although a significant part of research data comes from Canada and Western

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Europe. The remedial models suggested in the book could be applied in and outside the United States with appropriate modification and adaptation to local circumstances.

Following the major didactic principles, I will start with the definition: who are internationally adopted post-institutionalized children? I suggest the following five distinct attributes that clearly describe IA children and separate them from other groups of our patients and students:

1. IA children are legal orphans, as defined by US Immigration Law: "A child may be considered an orphan because of the death or disappearance of, abandonment or desertion by, or separation or loss from, both parents. The child of an unwed mother or surviving parent may be considered an orphan if that parent is unable to care for the child properly and has, in writing, irrevocably released the child for emigration and adoption" (US Citizenship and Immigration Services Glossary, 2020).
2. IA children were born outside of the countries accepting them, in different racial groups with various languages and diverse social/cultural environments.
3. IA children used to reside in nonfamily settings, such as orphanages, hospitals, or foster care.
4. These children have been legally adopted by citizens of economically advanced countries and brought to these countries to live permanently with their new families. Adoption is the legal process that establishes a parent–child relationship between individuals who are not related biologically (The Free Dictionary by Farlex, 2020).
5. These children are ages 3 months through 17 years at the time of adoption.

The focus in this book is on the so-called "older," or "late-adopted," or "school-age" children. The term "older child" is, of course, a relative one, particularly in the context of adoption. Some adoption literature uses this term to refer to children older than 2 years of age at the time of adoption, while others use it to refer to those from ages 5 to 6 and up to adolescent ages (Robinson, 1998). In this book, the term "older" (and its synonyms "late-adopted" or "school-age at adoption") is used to describe children adopted after their fifth birthday, who on arrival are considered preschoolers, early grade students, or middle school students, or even high school students (ages 14–17). The major point is that these children spent at least 5 years or their early childhood in overseas institutional care and on arrival are to be included in our educational system.

For the sake of parsimony, I use the words "international adoptees" or "internationally adopted (IA) children." Despite their unique physical

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traits, age, various backgrounds, and distinct language and cultural differences, nearly all international adoptees display certain prominent common features.

First, every one of the "older" international adoptees had to live through painful, trauma-producing experiences in their pre-adoptive life. In addition to a prolonged and severe trauma, international adoptees often have genetic- and epigenetic-based ailments, passed to them by their stressed out and disturbed biological parents. These children often suffer physical and mental imbalances due to environmental toxins and deprivation before adoption. As aptly formulated in the Evan Donaldson Institute report (2010, p. 5):

> Most adopted children, because they suffered early deprivation or maltreatment, come to their new families with elevated risks for developmental, physical, psychological, emotional, or behavioral challenges. Among the factors linked with these higher risks are the following: prenatal malnutrition and low birth weight, prenatal exposure to toxic substances, older age at adoption, early deprivation, abuse or neglect, multiple placements, and emotional conflicts related to loss and identity issues.

Second, the language of the accepting country becomes the adoptees' new native language while their first languages are subjected to rapid attrition. The majority of IA children start learning their new language – whether English, Spanish, Italian, and so on – several years later than their peers, and their process of acquisition of the new language is different from the "typical" ways of mastering the native language in their peers. They go through a process of discarding their native language and learning the new language as a survival skill.

Third, contrary to popular belief, rather than solving all the problems, the child's arrival in the new motherland introduces new challenges. Family life, with its relationships, is uncharted territory for children brought up in orphanages. In the new circumstances, none of their proven behavioral models apply. The loss of culture for an "older" adoptee is just as imminent. Finally, the Western educational system often presents a painful challenge for years to come. Post-adoption traumatization may include a mismatched family, negative school experiences, and rejection by peers.

The majority of older international adoptees are children who experienced complex childhood trauma. Traditionally, the phenomenon of adverse childhood experience is studied in the same cultural and linguistic environment. However, in IA children, a radical change in the social situation of development has taken place: from institutional care to family life, from extreme deprivation and neglect to attentive and protective

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middle-class style of parenting, from native language and culture to sweeping changes in the cultural/linguistic setting. To the best of my knowledge, only limited research exists regarding the situation when a traumatized person completely changes his/her social/cultural environment as the social situation of development.

The issues presented by the IA children call for creation of a comprehensive system of remediation and rehabilitation specifically for them. Their treatment needs to address physiological, psychological, and social aspects of recovery, be developmentally appropriate for various ages, and aim at maximum recovery possible. A clear understanding that we deal with children whose development has been mediated by complex, prolong, and severe trauma is the basis for their successful healing.

Three professional terms, constantly used in this book, need explanation: rehabilitation, remediation, and compensation.

Rehabilitation is a restoration of a person to a better condition of physical and mental health through training and therapy. The main types of rehabilitation therapy are occupational, physical, speech and language, and mental health, which all aim at the improvement of functioning, reduction of symptoms, and enhancement of the well-being of the patient.

Remediation is a specific process, which uses psychological and educational methods to correct cognitive and academic deficit to the point where it no longer constitutes an obstacle to age-appropriate functioning. Remedial methods and services are therapeutic, corrective, and restorative means, intended for correction or improvement of one's skills in a specific field. To remediate means to correct something deficient, to make up for a lack of something, to get to the root of the problem, and to overcome the issues that prevent successful functioning. In practical terms, remediation involves reteaching of a patient using special remedial methodologies, different from mainstream teaching/learning methods.

Compensation is a process of teaching and learning "work-arounds" for performing a specific task or function. Compensation includes modification and adaptation of the curriculum, usage of the alternative ways to accomplish a goal of the study, application of assistive technologies, accommodations in test taking, and other means of support.

Remediation and compensation should not be considered alternative approaches where either one or the other is selected. The IA children should have both approaches available to them concurrently to enable them to regain as much as possible. The goal with them is to achieve the highest level of their functioning, and finding the right balance between remediation and compensatory approaches is essential.

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In a way, international adoption is a "natural experiment" in the study of complex childhood trauma. Scientific research of "older" IA children's development under stress, whether prenatal, postnatal, during the adoption transition, or in post-adoption life, can provide us with discoveries that could be extrapolated to all children who experience severe adversity in their life. We cannot ignore the wealth of data and research opportunities presented by studying internationally adopted children and adoptive families.

In the peak of international adoption in the United States (first decade of the new millennium), Dr. Janet Welsh (2007) and her associates had undertaken a comprehensive literature review to find out about rehabilitation and remedial/therapeutic interventions for IA children and their families. The findings were rather disappointing: very limited treatments and remedial methodologies were in existence specifically for IA children while known methods may not be applied to this very special category of patients/students without significant adaptation. Now, more than a decade later, I have evidence, presented in this book, that there are methodologies – newly invented or substantially modified existing ones – that could be effective for rehabilitation and remediation of international adoptees. This book is fully devoted to the description and critical analysis of what we, as a "village," can do to make victims of systemic neglect and trauma become valuable members of our society.

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CHAPTER 1

Internationally Adopted Children
Development Mediated by Early Childhood Trauma

What Is a Complex Childhood Trauma?

For the last three decades, a massive, systematic, multidisciplinary, and focused investigation of adverse early childhood experiences has been developing in the United States and many other countries. Researchers and practitioners in the field of mental health came to an understanding that continuous repetitive traumatic experiences during early childhood produce a wide range of distortions in human development. The concept of complex childhood trauma is not uniformed and homogeneous, which is reflected even in the circulating terminology, such as "adverse childhood experience," "prolonged traumatic stress," "repetitive traumatization," "recurring distress," "complex childhood trauma," "relational childhood trauma," "early childhood trauma," "developmental trauma disorder," and so on. What is important to note is that behind all these terms there is an understanding of the affected child's exposure to multiple traumatic events and the wide-ranging, long-term impact of this exposure.

In my view, the most advanced and eloquent conceptualization of this issue is presented in the works of van der Kolk (2003, 2005, 2015) and his associate group of psychologists and psychiatrists. These scientists proposed that multiple and long-term traumatic conditions and events, often against the background of neurological weaknesses and impairments, result in distorted neurodevelopment, designated as developmental trauma disorder (DTD). The concept of DTD was presented to the research and clinical communities as a complex somatic and neuropsychological phenomenon, which is chronic, relational (caused by humans), and significant enough to affect the development of a child (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). In many cases, DTD is formed before the child has the verbal and reasoning ability to process and store the traumatic experience in memory, resulting in the central nervous system (CNS) accumulating the traumatic incidents as somatic distress and undifferentiated pain/afflicts (van der Kolk, 2015).

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In my previously published book (Gindis, 2019), I presented the paradigm that international adoptees bestow the extreme case of development mediated by DTD. In the same book, I suggested the following definition of DTD, which I have assembled from different sources (Gindis, 2019, p. 37):

> Early childhood trauma is a condition caused by repetitive and pervasive, subjectively highly stressful events, mostly within the interpersonal context of the child's life that have an adverse, wide-ranging, and long-term physiological and psychological impact on the development and maturation of high psychological functions, thus compromising neurodevelopmental integration of sensory, emotional and cognitive systems into cohesive whole of a mature socially-adjusted individual.

The subjective nature of the consequences of adverse childhood experiences should be emphasized: what causes the traumatic impact on one child may not produce the same effect on the other. The reaction to the potentially trauma-producing events or conditions is predetermined by the child's genetic equipment, the system of social support available to the child, previous trauma history, and many other factors. When stress is extreme, repetitive, and profound while the social buffering is absent or insufficient, like in the case of abandoned children, it may result in epigenetic modifications and in the formation of behavior patterns that are maladaptive in many contexts and may contribute to the later psychosocial problems with emotional regulation, impulse control, logical thinking, and social behavior (Putnam, 2006).

The stress response, while essential in times of threat, is designed to return to a baseline state when the threat is no longer present: this is a typical pattern of normal human functioning. But we do not see this in many international adoptees: adversity in early life shapes the experience-dependent maturation of stress-regulating pathways underlying emotional functions. Practitioners working with the IA population observed that children who experienced traumatic events in the past continue to experience heightened neurochemical reactions in the present without the existence of a threat (Gunnar & Donzella, 2002; De Bellis, Hooper, Spratt, & Woolley, 2009; Pollak et al., 2010). The release of adrenaline facilitates reinforcement of threat memory, and there is some evidence that failure to regulate the sympathetic nervous system response may lead to a stronger encoding of traumatic memory (Heim & Nemeroff, 2002; Heim & Binder, 2012). The neurological research shows to what extent trauma affects a child on a biological and hormonal level as well as psychologically and behaviorally; it is truly a complex mixture of biological,

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psychological, and social phenomena (Rothschild, 2000; Ogden, Kekuni, & Pain, 2006). If not addressed, DTD can distort the developmental trajectory for the remainder of the individual's life span, as it is linked to a wide range of problems, including addiction, chronic physical conditions, depression, anxiety, self-harming behaviors, and other psychiatric disorders.

And now, having all that was presented above in mind, let us imagine a child who has been abandoned by birth parents or has lived in an extremely dysfunctional, abusive family as an infant and toddler; was placed in an orphanage to live through the neglect and deprivation of institutional milieu; and then was adopted by strangers into a different sociocultural environment. This child would be at exceptional risk for DTD. This assumption is very true, as revealed by research, clinical practice, and families' experience: the vast majority of IA children does have DTD to some extent – ranging in degree from overwhelming and incurable to mild and recoverable; but no survivor of this abnormal background escapes it without consequences.

There are many factors in a life story of an IA child that cause, sustain, and consistently contribute to the formation of DTD. Among the most significant are the following:

- *Inherited transgenerational trauma* (transmitted from destitute, battered, often homeless, unemployed, and drug- and alcohol-addicted mothers)
- *Organically based encephalopathies* of different etiologies related to prenatal conditions, birth circumstances, and adverse postnatal physical environments. (In some IA children, these impairments are so significant that their entire further development is affected by them, as in the case of Fetal Alcohol Syndrome Disorder)
- *Adverse social circumstances* (dysfunctional and abusive biological family, total abandonment, institutionalization, international adoption, and post-adoption stress)

Contrary to common beliefs, the change from an objectively adverse pre-adoption social situation of development to an objectively favorable post-adoption life does not cut the chain of traumatic impacts in IA children. Adjustment to a new physical, cultural, social, and linguistic environment is a traumatic encounter by itself: the previous experience forms the background, but the new trauma of not fitting in, not connecting with, and not being accepted by the new social milieu creates additional and more subjectively important traumatic events. The long-lasting consequences of earlier traumatization continue to affect the development but

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are now mediated by the mounting challenges of social adjustment and competition. There are certain factors that mediate the impacts of these conditions, such as the age of the child, the intensity and duration of adverse experience, and resilience forces (a counterbalance to traumatic impacts).

Symptomatic Presentation of DTD in Older IA Children

Symptoms of DTD in older international adoptees could be depicted as mostly physiological and mostly psychological, although in reality both groups of symptoms are closely intertwined. Physiological symptoms of DTD include sensory integration difficulties, musculoskeletal pain, abnormally decreased or increased pain threshold, sleep disturbance, hyperarousal and hypo-arousal, problems with digestion, oversensitivity to touch or sound, and other physiological indications (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; van der Kolk, 2015). It is a consistent finding that even after years in an adoptive family, IA children may continue to demonstrate an abnormal response to stress on a basic biological level – such as increased cortisol in saliva (Gunnar & Quevedo, 2007), and increased heart rate and blood pressure (van der Kolk, 2003; Fisher, 2014) – and in observable behavior. Physiological symptoms of DTD are most comprehensively presented in a number of monographs, authored by Rothschild (2000), Ogden et al. (2006), Fisher (2014), and van der Kolk (2015), to cite just a few relevant publications. Therefore, I will concentrate on the psychological symptoms of DTD in IA children.

Psychological Symptomatology of DTD

The psychological consequences of DTD reveal themselves in many forms and shapes. Van der Kolk (2003, 2005, 2015) defines psychological symptoms of DTD as an inability to concentrate and pay attention; chronic anger, fear, and anxiety; self-loathing and self-destructive behavior; limitations in self-regulation of feelings and behavior; aggression against others; dissociation; and inability to negotiate satisfactory interpersonal relationships. What is presented below are observable patterns of DTD-caused overt behaviors in IA children, victims of a prolonged complex childhood trauma.

Dysregulated High Psychological Functions

The most prominent feature of psychological symptoms of DTD in older IA children is the impaired regulation of high psychological functions:

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