The Series: Why Love Isn't Enough: The Potential Risks Involved in Adopting From Home or Far Away

Introduction

By Arleta James, PCC

This is the Introduction to a series of posts on related challenging topics. The purpose of this series is to make clear that today's waiting children—international and domestic—infants and older children—are a traumatized population. The effects of trauma do not fade with love alone! Such myths as—"Love will be enough", "Kids will be fine once in a good family", "A young child won't have problems"—are just that: myths!

This series is also a result of clinical experience with traumatized adoptees and their families. Daily, I hear parents state, "We weren't told about all the problems we would have!" "Our agency should have done more to prepare us!" "Our agency lied to us!" "We adopted so young! We had no idea a young child would have any problems!" All of these tragedies can be offset!

Today we know that children who have experienced institutionalization, neglect, abuse, abandonment, the pre-natal insult of drug and/or alcohol exposure, and so on, can—and often do—arrive in the adoptive family with a myriad of issues. Knowledge of these traumas is the key to your post-placement ability to cope and adapt.

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We also know that you—prospective adoptive families—come to the adoption process along many avenues. Yet, in common, is an optimism and excitement for the child who is to arrive in the family! There is a desire to offer an abundance of love to a boy or girl in need. There is an enthusiasm about the opportunity to shape a child's entire future. Likely, without such exuberance there would be fewer adoptions! In this series, we are asking you to temper these feelings with factual information. Consider the topics being put forth, and then educate yourselves accordingly! You must augment your agency's adoption education program. Pre-adoption classes are only a beginning! Depth of understanding the journey you are about to embark on can only come from additional reading, attending ongoing trainings and networking with veteran adoptive parents!

You may want to print this post or others in the series. Put them in a binder. Study them, returning to them over time. As you educate yourself, ask, "What does this information mean for me as the parent?" "What will this mean for the children I already parent?" "What does this mean for the child I am adopting?"Keep them handy! They will make valuable references post-adoption. Please know that the purpose of this series is education. It is not meant to discourage any family from adopting. But, it is meant to help families think hard prior to adopting. My other article, (see "articles" on this website) *"While Families Wait: Ongoing Adoption Education for Prospective Adoptive Families"* offers concrete steps parents can take to line up post-adoption support and services before the new son or daughter arrives. Early intervention is the key to solving problems once identified and acknowledged!

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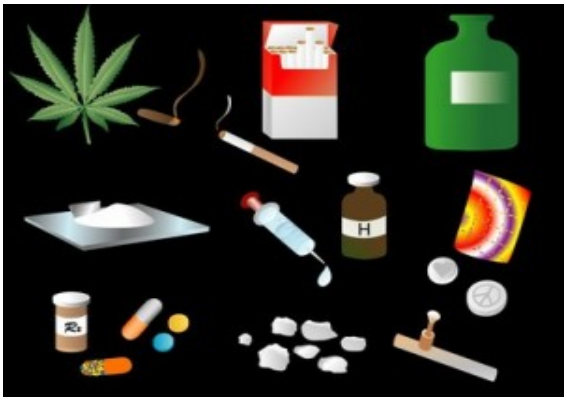
Why Love Isn't Enough! Part One – Pre-Natal Drug and/or Alcohol Exposure



Prenatal drug and alcohol exposure is a concern in the US as well as in many sending countries. Among the substances most commonly used inappropriately during pregnancy are tobacco, alcohol, marijuana, opiates (cocaine, heroin and methadone are opiates for example) and methamphetamines.

Studies estimate that at least 13%-45% of the children from the former Soviet bloc nations (and Romania) have full-fledged Fetal Alcohol Syndrome (FAS) and another 60% were exposed prenatally to alcohol These statistics would indicate that a very large proportion of children from these countries may eventually be diagnosed with issues which fall along the continuum of Fetal Alcohol Spectrum Disorders (FASD) (Chasnoff, Schwartz, Pratt & Neuberger, 2006.)

In the United States, FASD is the leading known preventable cause of mental retardation and birth defects, and a leading known cause of learning disabilities! (NOFAS, online.)How many would-be adoptive parents are aware of these statistics, have educated themselves about FASD and are prepared to deal with it?

There appears to be a growing trend of heroin use by women from Asian countries and from Central and South America. Heroin use has made a resurgence in Eastern Europe and the former Soviet Countries. (Center for Adoption Medicine, online.) In addition, cocaine and marijuana use in the South American countries continues at high levels, including among women of child-bearing age (Chasnoff, Schwartz, Pratt & Neuberger, 2006.)

Certainly the US is not immune to tobacco, cocaine, heroin, or marijuana usage during pregnancy! The rates of specific drug usage in various countries are included in the blog article "Prenatal Drug Exposures." Click on the headings in the article to locate the country statistics.

How many adopting parents know about these trends and have educated themselves about the effects of pre-natal exposure to opiates, methamphetamines, and marijuana in case their children present with resulting problems?

Complicating this topic is that it may be difficult for the adoptive family to know whether or not, and if so, which specific types of substances were utilized by the birthmother of their child during her pregnancy. This is because obtaining such information is often via self-report rather than by toxicology screening upon the birth of the child. Birthparents feel shame about such use and have not been well enough counseled about the importance to their child's future health, growth and well being to rise above that shame and pass along this information to adoptive parents.

It is important for prospective parents to realize that no one substance can be associated with any one particular problem. This is because substance-abusing parents are more likely to utilize a combination of drugs and alcohol during a pregnancy. Therefore, it is difficult to sort out the effect of any individual substance.

Below are some of the known problems associated with alcohol, cocaine, marijuana and tobacco during pregnancy,

Tobacco

Tobacco is one of the most harmful substances a woman can use during pregnancy (Chasnoff, Schwartz, Pratt & Neuberger, 2006.) It produces a very high rate of babies of low birth weight (LBW), premature birth and health problems in the newborn and child. In addition, a woman who admits to using tobacco during pregnancy is more likely than a non-smoker to have used alcohol or illegal drugs as well. Premature birth is described below. To study the impact of LBW, please go to Low Birth Weight Development Center.

According to the Mayo Clinic, the risks of premature birth vary depending on how early a baby is born. Although survival is possible for babies born as early as 23 to 26 weeks, the risks are greatest for the youngest babies.

Complications of premature birth may include:

- Difficulty breathing
- Episodes of stopped breathing (apnea)
- Bleeding in the brain (intracranial hemorrhage)
- Fluid accumulation in the brain (hydrocephalus)
- Cerebral palsy and other neurological problems
- Vision problems
- Intestinal problems
- Developmental delays
- Learning disabilities
- Hearing problems

For some premature babies, difficulties associated with prematurity may not appear until later in childhood or even adulthood. Not performing well in school is often a prime concern. Some studies suggest that premature babies may face an increased risk of type II diabetes and cardiovascular disease in adulthood. But not all preemies have medical or developmental problems. By 28 to 30 weeks gestation, the risk of serious complications is much lower. And for babies born between 32 and 36 weeks, most medical problems related to premature birth are short term.

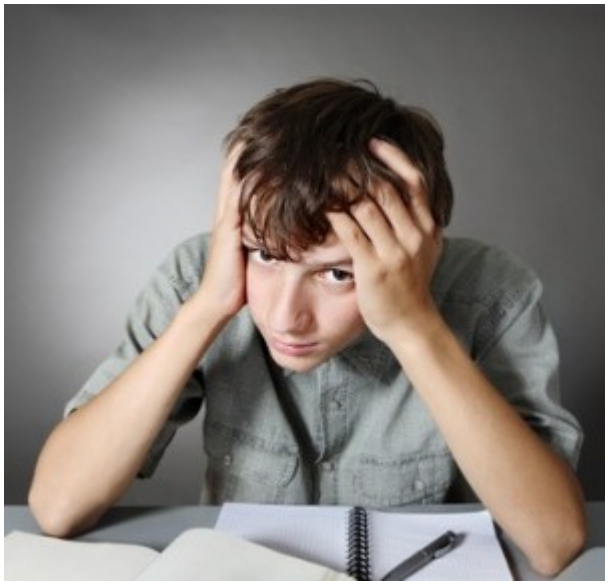
Alcohol

An overview of the potential difficulties that result from pre-natal alcohol exposure is located at the Centers for Disease Control and Prevention fact sheet, Fetal Alcohol Spectrum Disorder. As this fact sheet makes clear, children exposed to alcohol prenatally may have,

- abnormal facial features
- small head size
- shorter than average height

- low body weight
- poor coordination
- hyperactive behavior
- difficulty paying attention
- poor memory
- difficulty in school, especially with math and reading
- learning disabilities
- speech and language delays
- difficulties understanding patterns (NOFAS, online)
- intellectual disability or low IQ
- poor reasoning and judgement skills; difficulty predicting "common sense" outcomes (NOFAS, online)
- sleep and sucking problems as a baby
- vision or hearing problems
- problems with the heart, kidneys or bones
- abnormalities of the limbs, hands or feet (NOFAS, online)

Children do not "outgrow" FASD and its serious consequences. They become adolescents and adults who may have difficulties with learning, attention, memory and problem solving (NOFAS, online.) FASD, then, becomes a lifelong problem for those affected and their families.



Prospective adoptive parents are encouraged to learn the terms utilized to describe the array of potential life-long problems that fall under the FASD umbrella: What is FASD? What is Fetal Alcohol Syndrome (FAS)? What is Alcohol-related Neurodevelopmental Disorder (ARND)? What is Alcohol-related Birth Defects (ARBD)?

Adoptive parents-to-be will find more than 15 books, websites, blogs and videos that cover FASD in detail in my article, Fetal Alcohol Spectrum Disorder: An Explosion of Information.

Opiates

Using any of the addictive opiates such as cocaine, heroin, methadone, codeine etc. during pregnancy can cause poor growth in the womb and premature labor. Infants exposed to these drugs can develop poor muscle tone and have difficulties interacting with their environment. Parents may see shaking, arching of the back, clenching of the fists, curling of the toes, trouble feeding, sleep disturbances and frequent startle reactions. For a new parent, these issues may feel rejecting or create guilt, in that the parent may be unable to console and enjoy their long-awaited child.

Prenatal cocaine/crack cocaine (the freebase form of cocaine that can be smoked) have been the subject of much debate sine the 1980's. The current perspective is as follows:

> *Crack baby is a term for a child born to a mother who used crack cocaine during her pregnancy. There remains some dispute as to whether cocaine use during pregnancy poses a threat to the fetus. One complicating factor is the smoking of cigarettes, because almost all crack users also smoke cigarettes. The official opinion of the National Institute on Drug Abuse of the United States warns about health risks while cautioning against stereotyping:*
>
> *Many may recall that at one time babies born to mothers who used crack cocaine while pregnant were written off by many as a lost generation. They were predicted to suffer from severe, irreversible damage, including reduced intelligence and social skills. It was later found that this was a gross exaggeration. However, the fact that most of these children appear normal should not be overinterpreted as indicating that there is no cause for concern. Using sophisticated technologies, scientists are now finding that exposure to cocaine during fetal development may lead to subtle, yet significant, later deficits in some children, including deficits in some aspects of cognitive performance, information-processing, and attention to tasks—abilities that are important for success in school.*

Marijuana

Marijuana does not have a direct effect on the pregnancy, yet there is an impact on fetal brain development. Children whose mothers have used marijuana during pregnancy have a higher rate of learning and behavioral problems, especially related to planning and follow through with a task.

In conclusion, keep in mind that adoption agencies, orphanages, child welfare agencies, etc. can only tell prospective adoptive parents what they know to be true about a prospective child's background. Certainly, these agencies need to make full disclosure of all information that they have! Yet, many substance-abusing parents do not report their full history of drug and/or alcohol consumption. And the impact of prenatal drug and alcohol exposure (as with many other traumas) may only become clear as the child matures.

Love will not be enough to erase the long-term residual effects of a pregnant mother's use of tobacco, alcohol, opiates, marijuana, and other drugs. Nor will ignoring the possibility or "hoping for the best." A child won't "grow out of it" either. It will take information, therapy, special education, etc. to help the child recover to the best degree possible. Fortunately, today's adoptive family has a wealth of opportunity to investigate the needs presented by the international and domestic population of waiting children. Use the Internet and

your local library. Attend trainings in your community, as well as such as those sponsored by the North American Council on Adoptable Children. Connect with veteran adoptive families. Locate essential post-adoption services long before your new son or daughter arrives—perhaps even before you have been matched with a particular child. Early intervention is a key for each member of families built by adoption!

Why Love Isn't Enough: Part Two – Neglect

Neglect affects both the domestic and the inter-country adoptee. As I wrote in the earlier post Neglect: There is No Such Thing as "a Little"', we really need to understand that the impact of this trauma has serious consequences that don't always vanish when the child is moved to a loving, healthy home!

Neglect comes from a lack of experience. In fact, neglect means that the child lives in a chronic state of hunger, filth, and loneliness. The neglected child is not provided the food, clothing and shelter needed. Furthermore, neglect may involve simply ignoring the child; failing to respond to his pleas; leaving him to his own devices; failing to stimulate his senses by talking to him, carrying him about, encouraging his exploration of his world. Neglect may also include lack of medical care and/or mental health services as well as providing poor supervision, no supervision, or leaving the child in the care of someone who is not capable. For example, a ratio of 1 orphanage staff to 5 or more infants or toddlers is not sufficient and creates a neglectful situation. This would be like having quintuplets—only your mother, mother-in-law, sisters, aunts, friends, etc. aren't available to help out!

As an international example,

Brittney arrived in America after thirteen months in a Chinese orphanage. She uttered no sounds. She was unable to crawl or walk. She did not reciprocate facial expressions or smiles. She rarely cried as a means of informing her adoptive parents of her needs. She was used to a life of lying in a crib; waiting for a bottle, waiting for potty time, waiting to fall asleep, etc. She was accustomed to a change in caregivers with each eight hours that passed. She was not used to having two loving caregivers who would respond to her cues. She was certainly not familiar with adults who desired to play with her and nurture her.

Study the photos below provided courtesy of adoptive families whose children are from China, Russia and Kazakhstan. What do these children see from their cribs? Who is talking to them? Who is holding them? Do they have adequate toys to facilitate development? Do they have adequate opportunity and space to move—to develop muscle tone, and to achieve milestones (i.e., rolling over, walking, babbling, talking, reaching, grasping, etc.)? What do they hear? How often are they allowed out of their cribs? Do adults facilitate any type of learning or play? How do the children look? What do you think their perceptions are of adults? What type of intervention will you need post-adoption to help a child who has been institutionalized?

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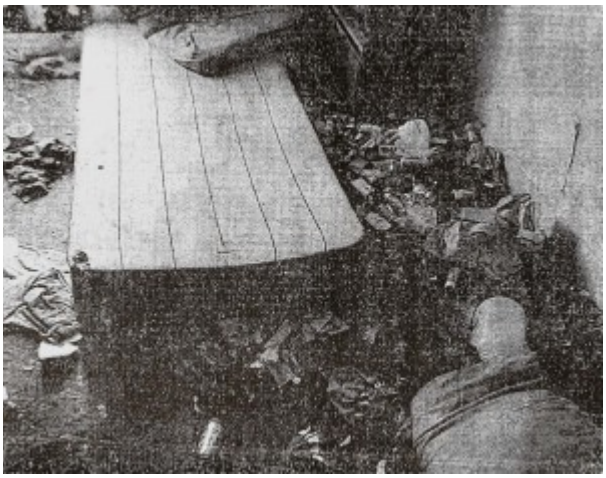
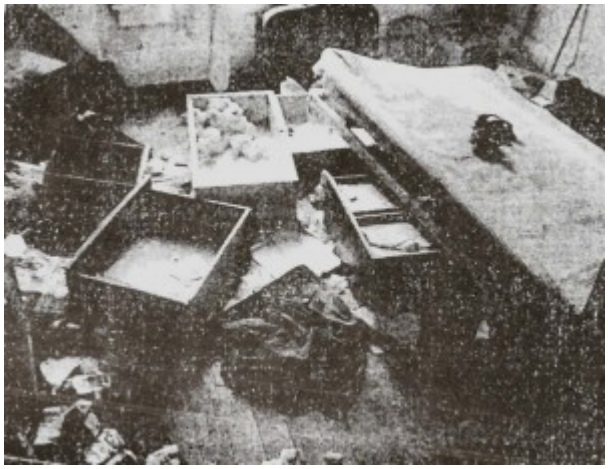
As a domestic example,

> *The police removed 4-year-old Robert and his birth brother from their birthparents due to reports of physical abuse. Upon entering the home, police saw cockroaches scatter. There were piles of dirty clothing, which served as the beds for Robert and his siblings. The cupboards were empty. There was no running water. A bucket, located behind the house, was being used as a toilet.*

Robert was removed from a living situation similar to the one below. Again, the photos are courtesy of an adoptive family. What do kids like Robert learn in such a home?





Neglect causes children to lack trust in caregivers. It damages their sense of self. Neglect may also involve malnutrition and failure to thrive. It can lead to developmental delays in all domains of development—cognitive, social, emotional and physical. These children need immediate stimulation—nurture—upon being adopted or placed into foster care. ***We need to go back with deliberateness and provide the neglected child with the experiences missed—no matter what the child's age at time of placement with a healthy adoptive family.*** We cannot expect that he or she will "grow out of it." See my article, "Nurture: The Ring that Holds the Keys for ways to stimulate the child who experienced pre-adoptive deprivation – Part One and Part Two.

Prospective adoptive parents are encouraged to read *Parenting the Hurt Child, Attaching in Adoption: Practical Tools for Today's Parents* or Welcoming a Brother or Sister Through Adoption to comprehend the long-term effects of neglect on their son or daughter-to-be.

Further, neglect and pre-natal substance exposure are believed to be the main culprits in the development of Sensory Processing Disorder (SI.) SI is caused by the brain's inability to accurately process information coming in through the senses—eyes, ears, skin and nose. Humans need accurate sensory data to function. The child with SI is overwhelmed easily, aversive to touch, hears sounds too loudly, lacks depth and field

perception, etc. Trips to the store, parties, the school playground, and so on are difficult for the SI child to navigate. The child's fun and family outings are interrupted by this disorder. Check out the Sensory Processing Disorder Resource Center or *Sensational Kids: Hope and Help for Children with Sensory Processing Disorder* before you new son or daughter arrives.

In conclusion, the neglected child will arrive much "younger" than his or her chronological age. This has implications for every facet of adoptive family life—birth order, sibling relationships, expectations, education, social skills, daily living tasks, behavior, and so on! The adoptive family must be prepared to access an array of services to bring this child into accord with his actual age. The neglected child will also arrive with significant control issues—even if adopted at a young age. In his mind, he survived on his own. He may not know how to relate to or appreciate a loving Mom, Dad, brother or sister. Acquiring new parenting tools will be essential to managing the day-to-day control battles. Love will not be enough to earn the trust of the child deprived beyond what any child should ever experience!

Why Love Isn't Enough: Part Three – Sexual Abuse

Certainly, sexual abuse is a difficult topic to discuss. However, social workers believe that at least 75% of children who enter foster care have experienced sexual abuse somewhere (Child Welfare Information Gateway, 1990). This means that families adopting from the child welfare system must anticipate adopting a child with a history of sexual abuse. Clinical experience with children adopted from institutional settings in foreign countries makes clear that children in these settings are not immune to sexual abuse either.

Perpetrators are not always adults. Many juveniles commit sexual acts on other children. Once a child is sexualized, the child tends to replicate the behavior in a home or institutional setting. It is important to point out that *most children who have been sexually abused do not go on to be life-long sexual*

perpetrators. Children most often learn to stop this behavior when provided with information from and re-direction by their adoptive parents, perhaps with the assistance of professionals.

Sexual abuse includes inappropriate kissing; fondling of a child; the child fondling or masturbating an adult; exposing the child to pornography; having the child participate in oral sex, intercourse, pornography, etc. Approximately 10% of sexual abuse victims are between the ages of 0 and 3. Between ages 4 and 7 years, the percentage almost triples to 28.4%. Ages 8 to 11 account for a quarter (25.5%,) of cases, with children 12 years and older accounting for the remaining 35.9% of cases (Putnam, 2003; U.S. Department of Health and Human Services, 1998).

Following are several examples of sexual abused children who came to be adopted,

> *A single foster mother adopted Sally and Maureen, birth sisters. Already in the home were two younger foster children. One evening, the foster mother entered the younger children's bedroom and found Sally fondling one of the other children's genitals. Subsequently, both Sally and Maureen revealed that their birthfather had orchestrated a sexual relationship between them. He would direct them in acts of kissing and fondling each other's vaginas and breasts. Maureen reported that he smiled and laughed while he watched the girls act out sexually with one another.*
>
> *Rose reported that her birthfather and his brothers frequently "got together to watch television." During these times, Rose was made to take off all her clothes and walk about so these men could touch her as they chose to. Rose also reported that her birthmother was present. A perpetrator by omission, the birthmother never opted to stop this sexual abuse.*
>
> *Five-year-old Jeffrey arrived from Bolivia. Present in his new family were two parents and their two children by birth, ages 10 and 12. Motivated to adopt by a desire to provide a child a loving home, the family was surprised by Jeffrey's perpetual stealing, hoarding food and destruction of household items. However, the family was devastated when Jeffrey sneaked into their female birth child's bedroom during the middle of the night and attempted to "get on top of her." In therapy, Jeffrey talked about the chronic sexual activity between children in the orphanage. The institutionalized children, lacking adult nurture, utilized sexual gratification as a means to offset their fears and loneliness.*

Sexual abuse is often a trauma that comes to light post-adoption, rather than pre-adoption, as two of these examples demonstrate. Frequently, the adoptive family is the first to learn about the child's sexual trauma. If your agency asked you which special needs you "would" and "would not" want to parent, checking the "no sexual abuse" box is of no avail if the agency is unaware of a child's prior sexualization.

Children tell when they feel safe and more certain that their days of moving are really over. Other children shock and traumatize the entire new family by acting out their own sexual abuse on a sibling. ***Prospective adoptive parents cannot be encouraged enough to take precautions when moving a new son or daughter into their home!*** Many examples of such preventative measures were provided in my previous article, Sexual Safety in Adoptive Families.

Long-term issues of sexual abuse victims include ,

- self-perception as different from others,
- less trust of those in their environment,
- less socialcompetence and more social withdrawal. These children have fewer friends during childhood, less satisfaction in relationships and report less closeness with their parents,
- poor self-esteem,
- four times the rate of teen pregnancy than found in non-abused girls.
- greater rate of physical problems such as headaches, stomach pain, asthma, bladder infections and chronic pelvic pain,
- lower overall academic performance,
- depression. Sexually abuse children are more than four times as likely to receive a diagnosis of Major Depression as nonabused children. Adults with a history of sexual abuse may have as much as a four-time greater lifetime risk for Major Depression than do individuals with no such history,
- development of sexual aversions or sexual preoccupation expressed in the form of pornography consumption, excessive masturbation and an overactive sexual fantasy life,
- substance abuse. The sexually abused child is eighteen to twenty-one times more likely to become a substance abuser in adolescence,
- an increased number of sexual partners and consequently much higher rates of sexually transmitted diseases, including HIV,
- more frequent suicidal behavior and/or greater suicidal ideation in adulthood (Briere & Elliott, 1994; Kendall-Tackett, Williams & Finkelhor, 1993; Putnam, 2003; Putnam, 2006; Trickett, McBride-Chang & Putnam, 1994 and Trickett & Putnam, 2003).

It is clear from the above facts that these children may require—long-term—academic and mental health services. Yet, consider the following information provided by Casey Family Services in their white paper, "Strengthening Families and Communities: An Approach to Post-Adoption Services."

> *"All families seeking mental health services for their children confront a patchwork of underfunded services and supports, guided by an often-bewildering mix of theories, philosophies, and treatment interventions. The vast majority of families—adoptive or otherwise—inevitably relies on publicly funded services or services available through private health insurance programs. Thus, they routinely face limitations in the availability, intensity, and duration of mental health services. The challenge of finding competent mental health services is even more complex when adoption-related issues are a component of the mental health services (Casey Center for Effective Child Welfare Practice, 2000)."*
>
> *"Although adopted children and adolescents comprise only a small minority of the population in the United States, Canada and other countries, they have been reported to account for a significant number of young patients treated in mental health settings. Adopted children are three to six times more likely than non-adopted peers to be referred for mental health services (Ingersoll, 1997)."*

Key Point—*Many families will adopt children with mental health disorders*. In some cases, these needs will be identified prior to the adoption. In other cases, the mental health needs will be identified as the family becomes familiar with the child, as the child matures or as the child gains the comfort to reveal their trauma.

Key Point—*There is a mismatch between the population of adoptive families needing services and mental health providers who understand the needs of each member of the adoptive family.* Locating competent adoption- and trauma-literate trained mental health providers may prove challenging. Pre-adoption is the time to explore the resources in your community! Identify adoption therapists, adoption medical clinics, adoption support groups and so on. Review your health insurance and determine what services are covered. If you are adopting from the child welfare system, understand your rights regarding adoption subsidy. Many parents want to forgo subsidy for altruistic reasons. Re-think this! Subsidy is your child's entitlement, and post-adoption it often proves essential.

Be ready post-adoption to deal with your child's trauma early and head-on! Each member of your family will benefit!

For more information on the impact of sexual abuse on your prospective son or daughter please see, Welcoming a Brother or Sister Through Adoption, Parenting Adopted Adolescents, or Parenting the Adopted Child. You may also visit my other articles, Nurture and the Sexually Abused or Aggressive Adoptee, Teen Sexuality within a History of Sexual Abuse, or, again, Promoting Sexual Safety in Adoptive Families.

Why Love Isn't Enough: Part Four – Physical Abuse/Domestic Violence

Physical abuse and domestic violence are also traumas affecting both domestic and intercountry adoptees. Here are some examples,

George came into foster care at age 4½ and was placed with a family who subsequently adopted him. In therapy, at age 8, he clearly described an incident in which his birthfather became angry with him and hit him over the head with a wine bottle. He recalled the bottle shattering upon impact.

Diane and Donald were removed from their birth family at ages 6 and 1 due to a physical altercation between their birthmother and her paramour. This incident involved the paramour stabbing the mother. As a result, she was hospitalized. Diane stated, "I tried to get between them but he pushed me away."

Dustin and Kristen entered their pre-adoptive family at ages 5 and 4. Shortly upon their arrival into this family, Dustin became angry with a neighbor child and immediately located a plastic bag. He then attempted to place the bag over the child's head. Fortunately, an adult intervened. When asked why he had done it, Dustin was quite clear that his birthfather often "beat me with a belt" and "tied bags over my head" when he was angry. It was certainly a long time before Dustin was able to play without adult supervision.

Mark, a 4-year-old, arrived into his adoptive family after a four-year stay in a Ukrainian orphanage. Early in his placement he presented an array of behavioral difficulties. Attempts to consequence Mark were often met with his running to cower in a corner or a closet. Frequently, he would cover his face and shout, "No, please don't hurt me!" Bewildered by this behavior, the family entered mental health services. Over time, Mark described that some members of the orphanage staff would hit the children with sticks for behavioral infractions. He assumed the adoptive family would do the same.

As our examples make clear, children who were physically abused or who witnessed domestic violence in their birth or foster home or a foreign institution may move into the adoptive home and hit, shove, push, kick and so on—much to the shock of adoptive parents, brothers and sisters! This is not usually a behavior familiar to typically-developing kids, Moms and Dads! Traumatized adoptees will repeat the patterns of behavior they learned in a dysfunctional birth home or orphanage until they learn a new way to act. Aggression can be a behavior resistant to change in a short period of time.

Infants and toddlers who have experienced neglect may become aggressive as they mature. This latter group wasn't shown love in infancy. So, their moral development will lag behind. They may not be able to show affection, empathy and remorse until parents have the right tools and therapy to help teach these skills. Children who resided with substance-abusing birth parents are at greater risk for abuse (Child Welfare Information Gateway, 2009.) ***This information is presented because many children will arrive in the family with a complex trauma. That is, you won't just be adopting a child who "only" had prenatal cocaine exposure, or "only "pre-placement neglect. Likely, your new son or daughter will have experienced various traumas. Thus, your healing efforts will be compounded and long-term.***

The child who has experienced violence presents with distorted assumptions, like those that follow, about the appropriate use of violence and aggression. A component of healing the violent child is a cognitive therapy designed to correct these faulty perceptions.

- She may think that aggression is a means to solve problems. In homes replete with domestic violence and physical abuse, it is the strongest member of the family who gets what he wants (Perry, 1997).
- He may wonder, "What is happening to my birthmom now?" Many children are preoccupied with the status of their birthmother, who lived as a victim of domestic violence. They question her safety. They question whether or not she is alive or dead. They feel guilty that they are not present to protect her. Frequently, children will comment, "I am older now and I could help take better care of her."
- She may think, "I was not behaving and this is why I was abused." or "I made my birthmom mad and this is why she hit me." As with sexual abuse, children who have experienced physical abuse believe that they were the cause of the abuse.

A child who has been a victim of unpredictable sexual or physical abuse learns that if this abuse is going to happen, it is far preferable to control when it happens. As a result, children who have been physically assaulted will frequently engage in provocative, aggressive behavior in an attempt to elicit a predictable response from their environment (Perry, 1997). This means that the child is soliciting anger—from you! He believes it is easier to provoke a "beating" than to wait for one to occur. This is why anger management is an essential requirement for parents in adoption-built families.

Prospective adoptive parents are encouraged to evaluate how they manage anger ***before*** boarding the plane or having a visit with the prospective son or daughter. Post-adoption you will need many tools and outlets to maintain a peaceful presence within the midst of the chaos an aggressive son or daughter can bring to the family.

Key Point: In each of our topics in this series—neglect, sexual abuse, prenatal drug/alcohol exposure, etc.—we are including the types of negative behaviors that can result from each trauma. Overall, when you combine all the behavioral issues from each of the eight posts, you will see that you need to expect such behaviors as lying, stealing, pee and poop issues, poor hygiene, destruction of household items, profanity, food issues (i.e., hoarding, gorging, overeating, eating slowly, eating candy and sweets chronically, etc.), being overly affectionate with strangers, talking loudly, persistent chatter, chronic nonsense questions, mumbling, having no boundaries and on and on. These behaviors will provoke anger in each family member—especially since these behaviors will take time—a long time—to change or eliminate!

Key Point: Adoptive parents need to expect behavioral difficulties. These unwelcome behaviors will occur with a frequency and intensity well beyond that of a "normal" child. Adoptive parents need to understand that changing these negative behaviors may be a difficult process. Behavioral change will occur gradually over a long period of time. There will be no birth without labor pains. There are likely few adoptions that will occur without behavioral pains!
Returning to the main topic of this post—aggression—requires a safety plan just as we pointed out with sexual abuse. The issues to put into the plan answer questions like these:

- During a temper tantrum or a violent outburst, where should the other children go?—To their rooms? To a neighbor's home?
- How will the other children know when it is safe to reconnect with their parents?

Key Point: These issues are raised as adoptive parents-to-be need to consider the impact of negative behaviors on the children already in the home. Families whose composition includes birth and/or previously adopted children who are developing typically are in essence opening their homes to children who have experienced some of the worst atrocities that exist in our world. Adoption may mean that the adoptee's new brothers and sisters will be directly exposed to children who have had very disparate life experiences as well as to children who exhibit difficult behaviors. Therefore, parents must acquire information (not just about a particular child, but about behavior difficulties of any adopted child) in advance of placement in order to develop their capacity to handle the adopted child's needs, and parents must ensure that their resident children have the information and tools needed to cope with the changes adoption could bring to the family.

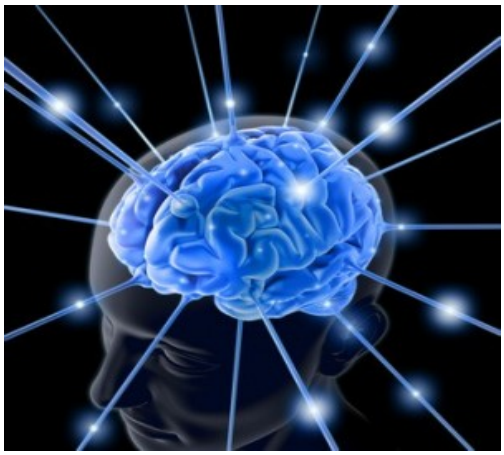
If you are a family whose composition already includes birth and/or previously adopted children, you are encouraged to read Welcoming a Brother or Sister Through Adoption. This book offers suggestions as to how to prepare your typical kids for the arrival of a new sibling, as well as post-adoption solutions to cries of

"He gets away with more than I do", and the grief that will flow because the family is "not the same as it was."

Prospective adoptive parents are also encouraged to review my articles, Parenting and Healing the Aggressive Adopted Child, Nurture and the Sexually Abused or Aggressive Adoptee, and Sibling Rivalry in Adoptive Families – Part One, Part Two and Part Three.

Why Love Isn't Enough: Part Five – The Impact of Trauma on Brain Development

Certainly, most adoptive parents—prospective or veteran—have no expectation that understanding some "brain basics" could lead to a more successful adoption outcome in putting their newly configured family together! Yet, the brain is affected—long-term—by the experiences it encounters pre-natally and in the early years of one's life.



Actually, the brain grows more in the first year of life than at any other point in time, and brain growth is 90% complete by the time a child is three-years-old! Brain development is contingent upon environment. A nurturing, sensorily stimulating environment best incubates and forms the brain. When this process is interrupted by neglect, physical abuse, sexual abuse, pre-natal drug and alcohol exposure, maternal stress, etc., the brain may be unable to form the pathways and connections that lead to emotional regulation, development of social skills or a secure attachment. Areas of the brain responsible for memory, learning, empathy and remorse can also be impaired by these early traumas. Early experiences have disproportionate importance in relation to the manner in which the brain develops, and subsequently to the way in which the developing brain functions.

The stress of living in a chaotic and/or neglectful environment (i.e., an orphanage, a dysfunctional birth home, etc.) creates a brain—a human being—more vulnerable to stress (i.e., real or perceived.) (Child Welfare Information Gateway, 2001.) The child, traumatized prior to adoption, arrives in the new family with an overactive stress response system. So, he or she will enter the states of "flight"(dissociation) or "fight" (hyperarousal) easily and long after placement even in a healthy family system.

In a child who has experienced trauma, "flight" often manifests itself as the child being in a "fog." Following directions, understanding academic instruction, participating in conversation, and so on will all be hard when a child isn't fully "present", and thus can't fully see, hear or comprehend what is going on around him or her.

We all experience dissociations. For example, while driving, we may cognitively disconnect from the steering wheel. We are deep in a thought process that isn't even conscious. When we snap out of this state, we wonder how the car managed to stay on course! Traumatized children enter such a state on and off throughout the day, or they may maintain this state for days at a time. It should be obvious—from the driving example—that it would be difficult to function in a normal environment when plagued with frequent dissociation.

"Fight" in a child who has experienced trauma can take the form of intimidating body posture, shouting, profanity, stomping, slamming, raising fists, or full-blown aggression. A routine encounter—a social studies test, a disagreement with a peer, a request to complete a chore—can escalate the child into a state of fear very quickly; a temper tantrum occurs, an argument ensues, an object gets thrown. Parents, siblings or peers are left wondering what has happened!

In essence, children with histories of trauma are like deer. Deer flee in an instant when frightened. Deer are hypervigilent—always wary of their environment. Traumatized children operate in a similar fashion. Physiologically, they quickly enter a state of "fight" or "flight," even when others see no visible threat or demand.

In a state of ***calm***, we use the higher, more complex parts of our brains to process and act on information. We make rational decisions because we can weigh the pros and cons of our choices. In a state of ***fear***, we use the lower, more primitive parts of our brain. As the perceived threat level goes up, the less thoughtful and the more reactive responses become. Actions in this state may therefore be governed by emotional and reactive thinking styles. There is little ability to think about the consequences of actions taken.

The brain develops in a user-dependent way (Perry, 2006.) The repetition of experiences strengthens the brain's pathways. So, chronic stress sensitizes neural pathways and over-develops the regions of the brain involved in anxiety and fear. Children who experience the stress of physical or sexual abuse will focus their

brains' resources on survival and responding to threats in their environment. Unfortunately, such children's brains continue to overreact even after their placement in a safe and healthy family.

While chronic abuse can result in the over activation of the stress response system, neglect can result in other problems. Again, a child is considered neglected when physical and psychological needs go unmet. Lacking in stimulation, neural pathways don't develop as they should. The impact of neglect was explained in depth in Part Two of this series.

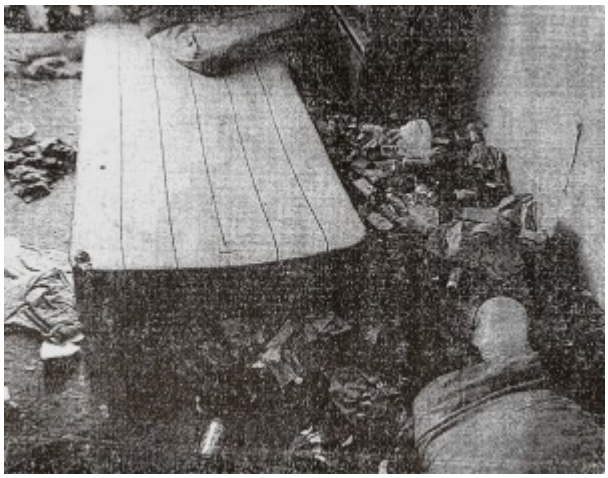
Understanding and learning to recognize the appearance of this phenomenon of emotional dysregulation—flight or fight—can save adoptive families years of unproductive therapeutic intervention, as well as untold number of conflicts within the home. For example, the "hypervigilent" child is often deemed "hyperactive" or "oppositional." The child receives a mental health diagnosis of Attention-Deficit/Hyperactivity Disorder or Oppositional Defiant Disorder. The adopted son or daughter is prescribed a stimulant medication (i.e., Ritalin®, Concerta, etc.), and the family is directed to a course of behavioral modification. However, a diagnosis such as Posttraumatic Stress Disorder—a trauma based disorder—is often more accurate. Cognitive therapies, neurodevelopmental reorganization, neurofeedback, sensory processing treatment, infant massage, The Listening Program and medications for mood regulation will likely offer more productive results for such a child! The educated family seeks and obtains the appropriate diagnosis and early intervention!

Parents welcoming previously traumatized child will also want to learn a bit about the implicit memory system. There are declarative (or explicit) memories—events we can recall—a fun trip to an amusement park, high school graduation, moving into a first home, etc. We have a conscious ability to retrieve explicit memories and state the facts and events.

Nondeclarative (or *implicit*) memory operates very differently. Implicit memory systems store emotions, sensory experiences (sounds, smells, etc.) and expectations and assumptions about relationships based on prior experiences. Implicit memories form early in life, prior to the individual having language. Implicit memories cannot be recalled by the brain in picture form, but they can be triggered. Once triggered, an emotional reaction occurs (Briere & Scott, 2006). For example, let's return to this photo first seen in part two of this series.

This child's implicit memory system is storing the event of being tied to a potty in a foreign orphanage. The infant only knows that this type of restraint is ***very*** uncomfortable, and that it is carried out by adults. Once adopted, traveling by car—strapped into a car seat—can trigger the feelings associated with having been tied to the potty. The adoptive family which has not thought about implicit associations for the child would be confused at the temper tantrum that may ensue each time the family attempts to make a trip to the local grocery store, favorite restaurant or park!

In this photo of the birth home of a domestically adopted child, also first seen in part two of this series, the smell of alcohol permeated this home. The debris alongside this "bed" consists of empty beer cans. Intoxicated birth parents proved the source of much physical abuse (and neglect) for the toddler and infant removed from this house.



The adoptive dad who has a beer upon arrival home from the office, or parents who enjoy a glass of wine with dinner, may inadvertently trigger the implicit memory of this abuse in their new child. The child, then, goes from playing calmly to becoming fearful. His brain goes on alert for what it perceives could be coming

next—pain from abuse! His brain—primed for surviving a harsh environment—won't automatically distinguish between his new, healthy adoptive family, and his past violent birth parents.

Fortunately, we now have therapeutic interventions that can restructure implicit memories. We can utilize a technique referred to as *cognitive feeding*—described and exemplified in Implicit Memories: The Roots of Today's Behavioral Challenges—to help bring calm to the adoptive family. Once again, the family that seeks information will have the tools and coping skills to more successfully transition the newly arrived son or daughter into their family!

The information and examples above should make clear that every pre- and post- adoptive parent needs to understand some "brain basics." We refer prospective parents to *Nurturing Adoptions: Creating Resilience after Neglect and Trauma* and *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are*. Readers can also peruse other articles on this website (see "articles" under the navigation tools),

- The Brain on Trauma
- Consequences vs. Reactions: Parent "Deerly"
- Neurofeedback: Training the Brain
- Posttraumatic Stress Disorder: Thinking About the Adoptee's Trauma.
- Implicit Memories: The Roots of Today's Behavioral Challenges – Part One and Part Two

Why Love Isn't Enough: Part Six – Abandonment and Multiple Moves

Abandonment

No form of adoption evades the psychological presence of the birthparents. As soon as the adoptee—even if adopted as a young infant—comprehends that he was not born to his adoptive parents, he becomes aware that another mother and father "gave him away." Ken Watson, adoption professional, points out, *"Adoption is not just a legal act that transfers parental rights but an event that profoundly changes all of the participants for the rest of their lives. The bottom line is that adoption, no matter how early or how successful, means that the child always experiences a painful loss of the birth family. When families fall apart, the children do not leave their trauma behind. Such a loss can be a serious blow to an adopted person's self-esteem."*

The child does not always recognize the safety risks that were involved in his day-to-day living situation with abusive or neglectful parents or the birthmother's decision that the child would have more opportunities with an adoptive family. The child's perception is that he was somehow defective or that she made her birthmother angry and thus the abandonment occurred. Examples follow,

Carl, now age 8, *adopted from a Kazakhstan orphanage at the age of three, is certain that his birthmother left him, as a newborn infant, at the hospital due to his being born with Cerebral Palsy. He genuinely believes that if his legs were like those of "other kids" she would have "kept me." Carl's condition was diagnosed when he was 2 by a team of American doctors who were visiting his orphanage. His birthmother had no idea that he had Cerebral Palsy when she abandoned him.*

Susan's birthmother became angry with her due to Susan's mishandling of a glass doll, a fourth birthday gift from the birth grandmother. As a result of Susan's inability to handle the doll correctly, it shattered. The birthmother subsequently dragged Susan up a flight of stairs and dropped her over the railing. This resulted in Susan sustaining several broken ribs. Susan and her older siblings were quickly removed from their birthmother's care. The children never returned to their birth home despite a significant family reunification effort. In therapy, at age 13, Susan stated, "If I hadn't made her mad, we would still be with her."

Kenneth, age eleven, resided in a Russian orphanage for six months after his birth. He is very angry that his birthmother did not "keep me." Additionally, he questions why there was "no one in the whole country who wanted me," and he inquires, "Why didn't the orphanage ladies take me home?"
Kenneth's story makes clear that international adoptees have an additional layer of abandonment issues. They feel unwanted by an entire country.
In most instances, a child loves birthparents no matter what the circumstances. This is often difficult for adults to understand.

Kathryn, the adoptive parent of a 15-year-old son, was quite saddened when her son stated that he continued to have strong feelings for his birthmother. His sentiments were articulated in therapy four years

after being adopted by Kathryn and her husband. He expressed that his birthmother would change if she knew how her actions had affected him. He believed that if only he could talk to her she would be "sorry." Thus, she would make the changes necessary for him to live with her. Kathryn struggled with this information for quite some time. She felt that all of her efforts as a "good mom" had been in vain. She stated, "I have been the mom helping him with his homework, taking him to his baseball games and virtually just doing everything to give him a good life. After years in our family, he still wants her. He wants the mom who beat him and sold him sexually in order to support the family. What have all my efforts really meant?"

Kathryn's sentiments are best clarified by Vera Fahlberg in her book, *A Child's Journey Through Placement,*

"Resolution of the grief process for children separated from birthparents means acceptance of having two sets of parents. Many times it is adults who adopt with the expectation, "I want a child to love me," who have the greatest difficulty accepting that the child has two mothers or two fathers. The attitudes of parents who are threatened by the importance of other caregivers in their child's life may pose the biggest obstacle for him. Although most parents readily accept the fact that they can love more than one child, many have difficulty accepting that children can love more than one mother or father. The child may love each in different ways, but it does not have to be one over the other."

Continuing with Fahlberg,

"Each mother must be acknowledged for the role she has in the child's life. This helps the child psychologically separate from the birthfamily and join the adoptive family."
According to Fahlberg, psychological separation includes

- the child understanding his/her adoption story, and
- coming to the realization that there is no ability to return to live with a previous care giver—birthmother, favorite orphanage care giver, foster parents who did not opt to adopt the child, etc.

"Children cannot make optimum use of their placements until they have resolved their grief and formed new attachments. Unresolved separations may interfere with the development of new attachments. New attachments are not meant to replace old ones. They are meant to stand side by side with existing relationships. The success of a new relationship isn't dependent on the memory of an earlier one fading; rather the new one is likely to prosper when the two relationships are kept clear and distinct (Bowlby,1980.)

Interference with the development of new attachments may occur when the child's focus is on the past rather than the present (Fahlberg, 1991.)

In essence, the child must be helped to come to terms with the abandonment and any other early traumatic experiences. Once the past is placed in perspective, the child is free to move on and accept the adoptive parents as his Mom and Dad. Certainly, for many adoptees, this will be easier said than done. Psychological separation tasks and reaction also vary depending on the developmental age of the child.

Prospective adoptive parents must gain comfort with this concept of the child loving "them" and "another." It is the adoptive family that will be helping the child process the grief about the abandonment.

Multiple Moves

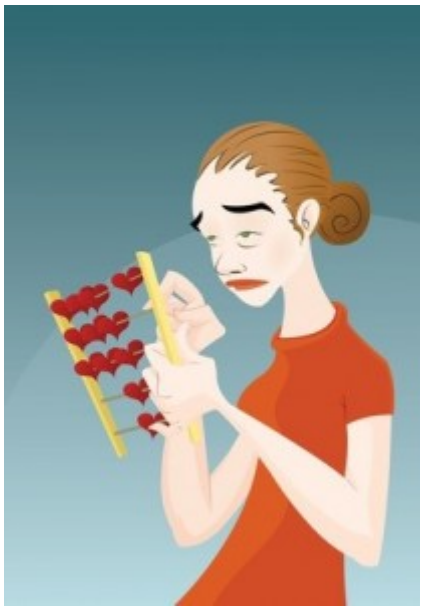
Overall, the majority of children available for adoption—international or domestic—have experienced more losses than only that caused by their abandonment.

The new son or daughter flying from abroad to America with his or her new parents is experiencing at least a third move—birth family to orphanage to adoptive family. The international adoptee experiences loss of birthfamily, orphanage caregivers, siblings, culture and so on. Luis, for example, feels he lost a "brother" in his transition to his adoptive family.

Luis resided in an orphanage in Mexico for almost six years. He developed a close tie to another boy who was in the orphanage. He refers to this boy as his brother to this day. Luis has ongoing guilt regarding the fact that he now has a rich life full of food, toys and family members while this brother remains in residence in grim conditions. Luis has a profound sense of sadness over the loss of this brother.

The longer a child remains in foster care, the more placements he or she is likely to have. Thirty-seven percent of foster children in 1998 were reported to have had three or more placements (Barbell & Freundlich, 2001). This means that the child has lost at least three sets of parents, siblings, friends, school mates, pets, communities, toys, clothing and holiday rituals. Each new family has a unique set of values, beliefs, and ways of celebrating.

Stop for a moment and really think about the losses the waiting children have experienced! These losses are overwhelming whether an international or domestic adoption!



Donna summarizes the thoughts of many children who have experienced multiple moves,

Donna, currently 18, was adopted at age 10, after three failed reunification efforts and four foster care placement. She states, "It was hard for me to move from foster home to foster home and settle down to a family that cares. Trying to trust them and love them back is really hard, because it got messed up somewhere in between all the homes I've been in. My adoptive family has bent over backwards to show their love for me, but it is still hard for me. I know in my head that they won't do the things to me that my birth family did, but there is still that side of me that says, be careful, someone might leave you or you might get hurt."

The child feels that he has lost everything that is most important—time and time again. As a result of these multiple, repetitive losses, people and things begin to lack meaning.

Toys can be removed for behavioral infractions and the child is not fazed.

Things are often lost or broken. There will be more at the next house.

Living is based on today, because tomorrow could mean another move, on to new people and new experiences.

There is no point getting settled and making plans. There is no point getting attached.

Additionally, children who move are at great risk. Repeated moves jeopardize their opportunity to develop secure attachments and trusting relationships with adults. A body of evidence links multiple placements with behavioral and mental health problems, educational difficulties, and juvenile delinquency (Barber, Delfabbro & Cooper, 2001; Children and Family Research Center, 2004; Cooper, Peterson & Meier, 1987; Dore &

Eisner, 1993; Hartnett, Falconnier, Leathers & Testa, 1999; Palmer, 1996; Pardeck, 1984; Proch & Taber, 1985, 1987; Smith, Stormshak, Chamberlain & Whaley, 2001; Stone & Stone, 1983.) Thus, any family adopting a child who has moved may need to access a variety of services to help this child recover.

In conclusion, the loss of birthfamily and the subsequent losses experienced by today's "waiting" children contribute to the arrival of a grief-stricken child from foster care or a foreign orphanage. As adults, we have many misperceptions about children and grief. We may think that

- children don't grieve (Trozzi and Massimini, 1999). There is a desire to deny that children experience loss.
- children will simply overcome unpleasant life events; the adoptee will just move beyond or forget about being raped, abandoned, beaten, abused, losing siblings and friends, being left in an orphanage and so on. This is very unlikely!
- children need to be helped to "get over" their grief and move on. Actually, children will experience parts of their pain for the rest of their lives. Loss—and thus grief—is developmental.
- children are too young to understand what happened. Remember the implicit memory system from Part Five of this series? If not, go back and review.
- children need to be shielded from grief. "It would hurt her too much to talk about it." Actually, what hurts are the traumatic pre-adoptive experiences! Allowing children to struggle silently with their trauma is unacceptable!

Children who are not provided opportunities to grieve are at risk for

- decreased social, emotional and cognitive developmental growth
- attachment difficulties
- regression to earlier stages of development for an extended period of time
- inability to concentrate—impaired academic progress
- physical difficulties—fatigue, stomachaches, appetite changes, headaches, tightness in chest, shortness of breath, low energy, difficulty sleeping, etc.
- depression

- anxiety
- engaging in risk-taking behaviors
- withdrawal from friends or extra curricula activities.

Why Love Isn't Enough: Part Seven – Attachment

"Is there anyone for whom the past doesn't shape the present?" (Siegel, 1999)

Touch is critical to human development (Perry & Szalavitz, 2006). Loving touch sets in motion a healthy attachment. Attachment, in turn, is the context in which all development—cognitive, social, emotional, physical and neurological—becomes possible. In essence, our attachment to a nurturing caregiver sets in motion all facets of our human development.

Attachment, in family life, is also the blueprint for all subsequent close relationships. Attachment is a relationship (Gray, 2002.)

If you have parented (or cared for) an infant, stop for a moment and think about the hours you spent holding, stroking, touching, rocking, caressing, kissing and hugging the baby. As your child grew, touching and holding continued—hugs and kisses before getting on the school bus or while bandaging a boo-boo, snuggling while watching television or reading books, pats on the back for accomplishments, stroking hair as a gesture of affection, and lots of kisses and caresses just out of love!

As a result of consistent and predictable parental nurture—the cycle of needs, and support, this child develops a *secure attachment.* The child trusts his parents to meet his needs, "My parents are always there for me." He feels good about himself, "I am worthwhile." He seeks out his parents when he needs help or comfort, "I can rely on my parents." He has absorbed the skills to navigate life. He can develop solutions, handle stress, regulate emotions, follow directions, complete tasks, and the list goes on.

He demonstrates empathy and remorse, “I have hurt Mom’s feelings. I need to make this right.” He strives to have fun. He explores his environment. He seeks parental praise for a job well-done, “I want to please my parents.” He enjoys intimacy. He seeks out companionship, “I want to be around others.” He can do all of these things within relationships with parents, peers, teachers, coaches, neighbors, etc. His blue-print is “I am safe within relationships.” He applies his secure model of attachment to all human interactions.

In adulthood, this secure attachment will allow him to continue to have close interpersonal relationships. He will feel love and give love. He will understand his past—emotional baggage will not interfere with his capacity to interact in his marriage, with his children, in his career and so on.

As we have been learning in this series, many adoptees arrive in the family having been deprived of *enormous* amounts of emotional and physical nurturing in the months or years prior to the child’s adoption. Or, their sense of touch, love and affection may have become skewed because abuse has taught them that affection is sexual or that being beaten is the way touch is administered from a parent to a child. Their style of attachment and their ability to navigate relationships reflect their traumatic experiences and is ***insecure***. Of course, parents want their new son or daughter to be affectionate and to know that their parents are reliable. Yet, parents need to understand that there might not be “love (attachment) at first sight!” Attachment is a process that takes mother nature 18-36 months to complete! In that time period, the healthy parent works at forming that attachment—feedings at 3:00 A.M. are work—albeit pleasurable work! The child with a history of the traumas described in this series may not simply move into the home and form an attachment. Trauma has skewed the blueprint! In some instances, the relational template was fractured hours or days after the abandonment, or even pre-natally by drug and/or alcohol exposure. We aren’t just talking about the older arrivals! Even infants can enter a family with attachment interruptions! Therefore, forming an attachment to your adopted son or daughter may also take work—a lot of it!

Pre-adoption is a wonderful time for parents to begin facilitating an attachment to their eagerly awaited son or daughter. Work on the following tasks before your little one or adolescent moves in.

Learn All You Can about Attachment

You are already off to a good start reading this post! Now, keep reading. Today's "Readings and Resources" (at right) are packed with attachment-related books, websites and articles. If you don't like to read—then listen! There is an audio library at Journey to Me. CD's of the North American Council on Adoptable Children conference workshops can be purchased via Adoption CDs – www.adoptioncds.com and presentations of the ATTACh—The Association for the Treatment and Training in the Attachment of Children—conference are available using printable order forms on the ATTACh website. Information presented by the experts in the fields of adoption and attachment is only a click away!

While educating yourself, pay specific attention to

- the signs and symptoms of attachment disturbance in children under age 5 and over age 5
- the types of interventions that promote attachment immediately following placement. For example,

The article, 10 Tips for the First Year of Placement and any of the many wonderful Adoption Learning Partners trainings and recorded webinars – www.adoptionlearningpartners.org offer an array of ideas to facilitate attachment post-placement.

Think carefully about the recommendations. Determine how you can carry them out post-placement.

Educate Your Extended Family and Support System as You Educate Yourself

Many attachment-oriented recommendations advise limiting the child's contact to his or her parents upon arrival as can be discerned from the titles of the links above. This is difficult for eager aunts, grandparents, friends, neighbors and the children already in the family to understand. Yet focusing the child on his new parents can be a critical component of beginning the attachment process. As you learn about attachment, send those vital books, CDs and links on to your relatives and close friends. If possible, take them to your pre-placement adoption education classes. Attend an attachment-related workshop or conference as a family! Help your extended family and friends understand that their support is essential, but may take the

form of making a casserole, providing a gift certificate for a cleaning service or offering to do your grocery shopping during the early days and months following the arrival of your new son or daughter!

Plan to Devote as Much Time as Possible to the Child

Again, attachment takes time—no matter the age of the child! This statement can't be said often enough! Carefully look at your work responsibilities. What type of leave is available to you? How many commitments do you have beyond work? Can these be reduced post-placement for at least a year if need be? Will you have to use childcare, or can you provide a stay-at-home parent for at least a year? In a dual parent family, can the two parents take separate family and medical leave time to extend the amount of time that the child is at home with at least one parent? If a stay-at-home parent is absolutely not feasible during the first year, do you have one trusted friend or relative who can provide childcare, instead of using a day care facility? Keep in mind, your child will require appointments—visits to the adoption medical clinic/adoption-informed pediatrician, physical, occupational or speech therapy, mental health counseling, school enrollment/special education services, and so on—more time! Of course, if you already parent children, time is essential to maintaining their attachments to you!

How will you make the time to ensure the attachment of your new arrival?

Prepare Yourself Mentally for Potential Attachment Difficulties

There is so much negative information about children with interrupted attachment or full-blown Reactive Attachment Disorder. So, post-placement, it can be frightening to think that the child's behavior may be attachment-related. Valuable time can be lost seeking services after the child has arrived. Pre-adoption is the time to let yourself explore how you may feel if the child doesn't reciprocate your love and attention in the manner you desire. Overall, the child's mental health must be viewed in the same manner as would be a serious medical condition. You wouldn't wait to obtain treatment for juvenile diabetes, once identified! You absolutely cannot wait to treat a disturbed attachment!

Locate an Attachment-Informed Professional

Before placement, visit ATTACh and locate the attachment-informed professional nearest you. Please note, this may be a drive or a flight away! Know this beforehand. Few professionals specialize in enhancing the

attachment of international and domestic adoptees. Yet, a trip to a specialist will be worth it! The local therapist who lacks education about trauma, adoption and attachment—or all three—is not the best resource. Again, valuable time will be wasted, not to mention the financial loss of an ineffective service.

Absolutely Don't Listen to "Myths" if You Suspect an Attachment-Disturbance

Trust yourself as a parent—even if you are a first-time parent. You will know your child best! If you suspect something isn't quite right, don't be lulled by well-meaning statements like, "He will grow out of it" and "All kids do that." Go directly to the professional you located through ATTACh or give me a call at the Attachment and Bonding Center of Ohio. Don't take the advice of your post-placement adoption social worker at face value either. Most adoption social workers are not trained to evaluate attachment or lack thereof.

Know there is Hope

A diagnosis of attachment difficulties or Reactive Attachment Disorder does not mean that the situation is hopeless. In fact, just the opposite is most often true! With appropriate services, these children can grow and thrive! I see this every day! This is not to say that the path to healing is easy. Yet, this is to say that this path can be traveled with success!

Why Love Isn't Enough: Part Eight – Genetics

The topic of genetics brings us to the "nature vs. nurture" debate. Certainly, there seems to be agreement that traits—a notable feature or quality in a person—are often passed from generation to generation (Learn.Genetics™, online.) There are physical traits that are inherited—hair color, eye color, height, etc. There are heritable traits that predispose us to an increased risk of getting diseases like sickle cell anemia, cystic fibrosis, heart disease, cancer and certain types of mental illness. Studies of twins who have been separated at birth and raised apart show that many have similar behavioral traits in the areas of food preferences, fashion, political beliefs, religious participation and so on (Minnesota Center for Twin and Family Research, online.)

Yet, the environmental influences in our lives are just as important in shaping our traits, and sometimes these environmental factors can even change a trait (Learn.Genetics™, online)! So, the nature vs. nurture debate is far less dichotomous today! This is fabulous news for adoptive parents!

Coming to light in the study of genetics is that human development is a biological, cognitive and socioemotional process. The three spheres are inextricably intertwined (Santrock, 2008.) Our genes exist in an environment, and the environment shapes their activity (Santrock.)

- *Biological processes* produce changes in an individual's physical nature. Genes inherited from biological parents, the development of the brain, height and weight, the hormonal changes in puberty, etc. reflect the role of biological processes in development.
- *Cognitive processes* are changes in the individual's thought, intelligence and language.
- *Socioemotional processes* involve changes in the individual's relationships with other people, changes in emotions and changes in personality (Santrock.)

Intelligence

Let's look at intelligence, an area that is often of concern for prospective adoptive families. The concept of hereditability attempts to tease apart the effects of heredity and environment in a population. Hereditability studies conducted by the American Psychological Association determined that the hereditability of intelligence is about .75 (1.00 is the strongest correlation), which suggests a strong correlation between intelligence and heredity. Yet, studies looking at adopted children, who are moved into better environments than the child had in the past showed an increase in IQ by an average of 12 points (Santrock.) In essence, much existing research regarding heredity and environment has failed to take into account the radically different environment provided the child post-adoption. Environmental influences we provide children (and adults) do make a difference!

Key Point: Research changes what we think we know! Intelligence is a wonderful example of an area of study that has advanced as time marches forward. In your lifelong journey with your child, new information will become available as will new treatment approaches! Adoptive families who stay abreast of current trends can utilize an array of services over the long-term. Each service provides a healing piece for your adopted son or daughter, and your entire family!

For more interesting reading about the impact of environment on IQ, see "Sterotype Threat: How Your Child's Beliefs about People can Hinder His Performance in School…and Life ", and "The Abecedarian Project"

On the other hand, according to Ira Chasnoff in his book, *The Nature of Nurture* school aged drug- and alcohol-exposed children, whether living in their biologic home or an adoptive home, demonstrated significantly higher levels of

- *anxiety/depression* (The child feels the need to be perfect, feels unloved, feels others out to get him, feels worthless or inferior, is nervous/high strung/tense; seems sad-unhappy, worries, is nervous/anxious.)
- *social problems* (The child acts too young for age, is clingy, doesn't get along with others, gets teased a lot, not liked by other kids.)
- *thought problems* (The child is unable to get his mind off certain thoughts, repeats certain actions over and over, stares, has strange ideas, exhibits strange behavior.)
- *attention problems: (*The child can't concentrate for long, can't sit still, restless; confused; daydreams; impulsive; poor schoolwork; stares.)
- *delinquent behavior* (The child shows no guilt after misbehaving, lies/cheats; prefers older kids; steals; hangs around with kids who get in trouble.)
- *aggressive behavior* (The child argues a lot; demands attention; destroys things of his own or others, is disobedient at home and/or school, is stubborn, has sudden changes in mood, talks too much, is unusually loud, displays temper tantrums/hot temper.)

Part three of this series described similar and unique behaviors that plague the child with a history of sexual abuse. Parts two and five made clear behavioral difficulties resultant from neglect and the impact of trauma on neurological development. Overall, the child with behavioral problems may have "normal" intelligence, yet because of his or her negative behavioral problems, he may be unable to learn! His socioemotional and biological experiences continue to affect his cognitive capacities long after his being placed in a healthy environment.

Thus, in this area of intellect, parents need to understand the interplay of all three spheres of development on their child's ability to learn and grow academically. Many factors contribute to the child's school performance. Pre-adoption is a good time to examine your expectations in this area. Can you accept a child who is "bright" or "smart", but who may not live up to his potential until the negative behaviors are alleviated? Keep in mind, behavioral change takes time! You only have to think about making and keeping a New Year's resolution to understand this!

Key Point: Trauma and traits co-mingle to bring into the family a child for whom the concept of "psychological fit" is important. Psychological fit relates to the interplay between parental experiences, expectations, desires and wishes, and the child's capabilities and performance (Trout, 1986). Experiences, expectations, desires and wishes will have to be tailored to "fit" with the unique characteristics of the adoptee. This will be a process for each member of the adoptive family—parents, the children already in the family and the child about to move into the family. Read more about this process in my article, "Psychological 'Fit': A Place Where Parents, Brothers, Sisters and the Adoptee Must Come Together."

Mental Health Diagnoses

Mental health is another area influenced by both genetics and environment. For example, adopted children seem to have higher rates of Attention-Deficit/Hyperactivity Disorder (ADHD.) While all of the causes for this mental health disorder are unknown, 30% to 50% of children diagnosed with ADHD have a relative with ADHD (Santrock.)

The new science of addictions describes drug addiction as a chronic disease characterized by changes in the brain, which result in a compulsive desire to use a drug. A combination of many factors—including genetics, environment and behavior—influence a person's addiction risk. Returning to the content of parts three and four of this series, the correlation between abuse and addiction was noted. Those families adopting children with a history of physical and/or sexual abuse, or who learn about such terrible experiences post-placement, or wherein there is a birth family history of substance abuse want to understand these links. Services immediately post-placement can contribute to mitigating the effects of the early environment, and thus reduce the potential for your beloved son or daughter to utilize illicit substances. Therapeutic interventions can resolve the trauma, and help parents reduce the environmental risk factors that contribute to substance abuse.

If we peruse websites such as those of the Mayo Clinic, the American Academy of Child and Adolescent Psychiatry, and the National Institute of Mental Health, we find the same physical and environmental factors influencing such mental health conditions as Bi-Polar Disorder, Obsessive-Compulsive Disorder, Depression, Anxiety and so on.

Key Point: *Many families will adopt children with mental health disorders*. In some cases, these needs will be identified prior to the adoption. In other cases, the mental health needs will be identified as the family becomes familiar with the child or as the child matures. Mental Health America, the nation's leading

nonprofit organization dedicated to helping people live mentally healthier lives, has concluded that Americans are more likely to view mental illnesses as personal or emotional weaknesses rather than real health problems. Certainly, how an illness is viewed affects how the condition will be treated.

Further, it is important to recognize that there is a trend to decrease support to the adoptive family once a placement has been made and the adoption has been finalized. It is not unusual for the placing agency to view their task as complete at this point: the child has a home and the family has a child. The agency moves on to facilitate matches for other children and families. So the task of identifying, locating and implementing services often falls to the family.

Think about the following:

What are your views on individuals with mental health issues? Do you see a mental health disorder as a "health problem" or an "emotional or personal weakness?"

Do you know anyone with a mental health issue (i.e., depression, anxiety, alcoholism, etc.)? If so, what have you learned from this experience that would be applicable to parenting a child with special needs?

Are you aware that children receive medication for various mental health issues (i.e., depression, anxiety, impulsivity, attentional difficulties, etc.)? Do you have a perspective on this?

Are you willing to seek professional mental health services?

What type of mental health coverage do you have through your health insurance policy?

Have you ever utilized therapy or support groups? Do you know if adoptive parent support groups exist in your area?

Do adoption—trauma—attachment—focused services exist in your community? What is the cost of these services?

Do you have any experience with special education?

Do you have the capacity to be assertive? Do you mind being persistent? Acquiring services is best described as being the "squeaky wheel getting the grease." That is, parents often have to advocate for services.

Who comprises your personal support system? Are they learning about adoption along with you?

How well do you acquire new information?

How much effort have you made to seek out information specific to adoption and trauma at this point in time?

If married, is your spouse participating in this learning process,or, is this endeavor one-sided?

As this series has made clear, trauma leaves in its path a residue that love alone cannot erase. Preparation and early intervention are the two main keys to post-adoption outcome.

"It is very apparent that families who make an informed decision and are prepared beforehand do better once the child arrives and feel more positive about the adoption." (Iverson and Johnson, 2005).

In conclusion, know that I'll be here blogging or I'll be at ABC of Ohio providing therapy. I'll also be available on facebook! I'llcontinue to put forth quality information to help you meet any challenges you may face!

Good luck on your journey!