

International Adoption of Post-Institutionalized Children:

Implications for School Counselors

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Abstract

During the last decade, nearly 190,000 children from outside the United States have been adopted by families in the United States, and many of these children have experienced orphanage care. These children are vulnerable to a complex constellation of deficits crossing behavioral, physical, educational and emotional domains. Parents and schools are often unprepared for the needs of these post-institutionalized adopted children. School counselors are in a unique position to help educators and parents develop appropriate interventions for these children. This article contains a brief review of the literature on post-institutionalized adopted children and implications for school counselors in interacting with these children, their parents, and their teachers.

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Families in North America and Western Europe are adopting children in increasingly large numbers (Pertman, 2000). The number of international adoptions increased from 8,987 in 1995 to 22,728 in 2005 (U.S. Department of State, 2006) totaling nearly 190,000 in the past decade, many of whom are adopted from orphanages. The recent surge in adoptions is due to a variety of factors which have increased the availability of children eligible for adoption, making it possible for increasing numbers of individuals to adopt (Keck & Kupecky, 2002). These factors include changes in adoption law in the United States, as well as changes in international political climates favoring adoptions.

For example, the public execution of Romanian dictator Ceausescu on Christmas day of 1989 opened floodgates for the abandonment of thousands of unwanted Romanian children. Ceausescu had demanded that women have large families, requiring a minimum of five children per family. With his execution, tens of thousands of impoverished families selected the weakest and youngest members of their families to place in the care of the state (Johnson, Edwards, & Puwak, 1993). Humanitarian groups that entered Romanian orphanages after the fall of the Communist regime discovered children living in desperate, almost unimaginable circumstances (Ames & Carter, 1992). The devastating impact of the nation's poverty was intensified in the institutional system, where children experienced chronic hunger, malnutrition, and maltreatment. Living in filth and human excrement, in stark rooms with colorless walls, were rooms full of infants who were eerily silent (McKelvey, 1994; Sweeney & Bascom, 1995). Child-to-

caregiver ratios ranged from 8:1 to 60:1 (Shirks, 1991; Williams, 1990). Overworked orphanage staff could do little more than prop bottles against the slats of lead-painted cribs. Deprivation of care, deprivation of touch, and deprivation of human warmth were the daily fare of these institutionalized children (Ames & Carter, 1992; David, 1990). When ABC's 20/20 program aired the first videos of institutionalized children, thousands of Americans found their hearts torn by pictures of the small, dark-eyed children who were hungry, naked, and starved for affection. These small children with searching faces and lifeless forms captivated the hearts of many individuals who rushed to adopt. However, few were prepared for what would follow.

Orphanage-reared children are vulnerable to a complex constellation of deficits. They often experience pervasive developmental problems in behavioral, physical, educational and emotional domains (Gunnar, 2001; Johnson & Groze, 1993). Parents, teachers, counselors, and health-care providers are often ill prepared to deal with the consequences of institutionalization, largely due to a lack of information about the developmental consequences of early deprivation. Many adoptive parents find themselves in a crossfire of treatments which are costly and all too often, ineffective. Parents are advised by bewildered professionals who, like themselves, fervently hope the children will "outgrow" their aberrant behavior in time. Time passes and many behaviors tend to persist and even intensify. In a study conducted by our lab (Cross, Purvis, & Ware, 2001), 86 families in a large metropolitan area reported on their experience of international adoption. Asked whether or not their adoption agency had adequately prepared them for the consequences of their child's institutionalization, only 7% reported that they were "definitely" prepared. The bulk of respondents replied that

they were “definitely not” prepared for the aftermath of institutionalization. Findings such as these underscore the need for pre- and post-adoption training for parents and professionals.

Deprivation Research

Many international children eligible for adoption bring with them compromised developmental trajectories, having experienced a wide variety of risk factors (Johnson, 2000). By definition, many children who are eligible for adoption, especially those with backgrounds of institutional care, have experienced maternal deprivation (Ainsworth, 1962), and environmental and nutritional deprivation (Gandelman, 1992), leading to an early childhood experience characterized by global deprivation (Gunnar, 2001; Rutter & The ERA Study Team, 1998).

Spitz was among those to first identify the effects of deprivation, which he aptly called “hospitalism” (Spitz, 1945). In his desire to educate fellows in the psychoanalytic and medical profession, he produced a crude, black and white video which he titled “Grief: A Peril in Infancy.” It depicted children who received institutional care. In this documentary, he videotaped the children’s initial protest of their parent’s absence, and later, following months of absence, their despondence (Provence & Lipton, 1962). Although his peers largely rejected his work, it became an impetus for the work of Harry Harlow (Harlow, 1958; Harlow, Harlow, & Suomi, 1971) and John Bowlby (Bowlby, 1951, 1969, 1982), among others. In his classic work on maternal deprivation in rhesus monkeys, Harlow found that infant monkeys separated from their mothers at birth were at high risk for a variety of psychological disturbances, despite the fact that these

infants' nutritional needs were well met. Isolated infant monkeys developed into young adults completely devoid of social competencies.

In his extensive work on attachment processes in humans, Bowlby (1951; 1969/1982) identified behavioral traits of children who experienced maternal separation or loss. Effects of maternal deprivation included delays in children's physical, emotional and intellectual development, as well as sleep disturbances, loss of appetite, inability to concentrate, and deficits in language development. Bowlby (1944) also studied the effects of neglect and abuse, finding deficits in moral reasoning, conscience, and appropriate behaviors in forty-four cases of "thieving children," who were characterized by depression, flat affect, hyperactivity, and affectionless detachment toward others. After investigating their childhood histories, Bowlby found these children to have been victims of dramatically disturbed upbringings; most had histories of violence in the home, rejection, abject neglect, or abuse.

International adoption has provided theorists and researchers a unique opportunity to reexamine the effects of deprivation. Although purposeful deprivation of care for human infants would be unthinkable, a natural experiment of monstrous proportions has presented itself in the form of institutionally-reared children. Our hope is that a review of research findings from this tragic natural experiment will provide new avenues of intervention and hope for families who have adopted children with histories of deprivation, abuse, neglect or trauma.

Effects of Deprivation

Post-institutionalized children display a variety of deficits and developmental delays. In a study of Romanian orphans adopted into Canada, Elinor Ames and her

colleagues (Ames, 1997; Fisher, Ames, Chisholm, & Savoie, 1997) found global developmental delays in 95% of the children at the time of adoption. A year following adoption, they reported that 45% of the children had persistent delays. In this study, length of orphanage stay was correlated with lower developmental levels for adaptive personal-social, and language development. These findings are consistent with studies conducted by medical teams who administer humanitarian aid to institutionalized children in which orphanage-reared children were documented to lose a month of cognitive development for every three months of orphanage care (Federici, 1998) and a month of physical and linear growth for every five months of orphanage care (Johnson et al., 1992).

In addition to *length* of institutional stay, the *timing* of institutional stay has been correlated with significant developmental deficits, with the most marked effect occurring for children institutionalized at birth. The absence of maternal touch, conversation, and playful interaction during the critical weeks after birth induce formidable challenges to later development (Ainsworth, 1965; Benoit, Zeanah, & Barton, 1989; Field, Schanberg, & Scafidi, 1986). These pervasive challenges commonly manifest in physical problems, relationship disturbances, sensory processing deficits and behavioral disorders.

Physical Problems

Physical problems such as anemia, malnutrition, and small stature are common in children who have experienced severe deprivation (Ames, 1997; Fisher, Ames, Chisholm, & Savoie, 1997); these problems may be quickly overcome when children are placed in a caring family environment (e.g., Rutter & The ERA Study Team, 1998). However, less recognized medical problems frequently affect these children including

severe food and environmental allergies, atypical seizures, and exposure to alcohol in utero, a complex range of symptoms recently named Alcohol Related Neurodevelopmental Disorder (ARND). Although the effects of allergens on behavior are not fully understood, it is widely reported that allergens are a factor that appear to affect behavior in some children (Mayron, 1979; Rapp, 1978). Children from impoverished backgrounds are especially susceptible to allergens (Purvis, Cross & Sunshine, 2007). Due to early malnutrition and sterile environments, post-institutionalized children may exhibit aberrant responses to foods, mold and pollen. Atypical seizure activity is common in children with histories of abuse, trauma and/or neglect and includes both absence and psychogenic seizures (Ito et al., 1998). Absence seizures are often unrecognized because their primary feature is a blank facial expression in which the child is “checked out” from three to twenty seconds. Some children experience dozens of absence seizure episodes in a twenty-four hour period (Segan, 2005). *Simple absence seizures* are primarily episodes of staring or blanking, while *complex absence seizures* include involuntary muscle movement such as eye blinks, rubbing of the fingers, contraction of muscles, and tasting movement of the mouth (Devinsky, 2004). However, in both cases, the child is amnesic of the episode and of what occurred during the episode. *Psychogenic seizures*, also called pseudoseizures, are episodes that resemble epilepsy but are psychological in origin and are typically induced by emotional triggers such as stress, fear, pain or other sensory stimulus like bright lights or loud sounds (Benbadis, 2005).

ARND is common among children born in Eastern Europe, is resistant to intervention and is associated with pervasive behavioral, learning and emotional

disorders. Prenatal alcohol abuse is reported in 19% (Johnson et al., 1992) to 41% (McGuinness, McGuinness, & Dyer, 2000) of internationally adopted children and comprises one of the most challenging medical conditions to post-institutionalized children and their families. Children who are exposed to alcohol during gestation are at risk for significant neurological impairments; features of the disorder include deficits in cause-and-effect thinking, learning disorders, attention problems, difficulties following directions, and behavioral problems such as outbursts of explosive rage. Clearly these behaviors comprise a significant challenge in the academic environment. (For a more comprehensive review of ARND see <http://fasdcenter.samhsa.gov/>.)

Relationship Disturbances

Relationship disturbances are also common following global deprivation. Chisholm, Carter, Ames, and Morison (1995) found that children who spent more than eight months in an orphanage were less secure in their attachment to parents than children who had been in an orphanage less than four months or those who were living with their biological parents. In a follow-up study (Chisholm, 1998), Romanian orphanage children who spent more than eight months in an institution showed more insecure attachment than the other two groups and had more atypical insecure patterns on a behavioral measure of attachment. At the time of the follow-up study, the children had been with their families for a minimum of 26 months as compared with 11 months in the original study, suggesting the persistent nature of their attachment disturbances. These studies clearly suggest a link between maternal deprivation and attachment. (For a comprehensive discussion of attachment research see Cassidy & Shaver, 1999.)

Sensory Processing Disorder (SPD)

Provence and Lipton (1962) were among the first to recognize the importance of sensory stimulation. Jean Ayers (1964; 1979), a contemporary of Provence and Lipton, explained the importance of sensory input as a developmental parameter for appropriately and effectively interpreting life experiences. Ayers (1964) called this process *sensory integration* and defined it as the process involving synthesis of sensory information such as touch, body position and body movement from which a behavioral response is organized. She noted that sensory integration served as the foundation for physical, social, cognitive, and emotional development. This theory, now referred to as *sensory processing*, continues to gain prominence today among physical therapists (Fisher, Murry, & Bundy, 1991; Wilbarger, 1995) and those who research childhood behavioral and regulatory disorders (Degangi, 1991; Greenspan & Wieder, 1993).

A number of researchers have tested Ayers hypothesis by examining sensory processing deficits, now called Sensory Processing Disorder or SPD, in post-institutionalized children (e.g., Cermak & Groza, 1998; Sweeny & Bascom, 1995). Recurrent themes, which emerge in each of these studies, include associations between SPD and decreases in cognitive, (Gunnar, 2001), motor (Sweeney & Bascom, 1995), and language skills (Ames, 1997). Sensory defensiveness involves the avoidance of, and the seeking of, sensory input, and has been documented by many researchers (e.g., Cermak & Groza, 1998; Haradon, Bascom, Dragomir, & Scripcaru, 1994; Sweeney & Bascom, 1995). Additionally, some aberrant behaviors of institutionally reared children may be attributed to sensory processing deficits, or sensory defensiveness. However, it is important to keep in mind that there are multiple

factors that contribute to problem behaviors in these children and that sensory processing deficits may be a contributing factor to these behaviors. When infants are raised in orphanages, they receive little handling and individual attention (Cermak, 1994). Children who lay in their cribs alone and unattended for the first years of life may refuse to be held, rocked or hugged. Often mistaken for behavioral or attachment disorder, the etiology may actually be tactile defensiveness. Simply put, the children lack organizing experience with the environment and reject tactile input because it is unfamiliar, unpredictable and distressing. The same is true for a child who received only bottles of milk and mush for his first two or three years of life who may later become orally *defensive* to the texture of solid foods. Refusal to eat may be seen as a medical or behavioral problem, although its etiology is, in actuality, lack of experience with the environment. Sensory deficits may globally impede the child's ability to participate in a novel environment because of increased anxiety and fear about the discomfort induced by unfamiliar sensory experiences.

Cermak and Daunhauer (1997) conducted research comparing post-institutionalized children adopted from Romania with biological children living in their family of origin and found that the adopted children demonstrated more problems in the domains of touch, seeking and/or avoiding movement, audition, and vision. These children also had more problems in the related areas of activity level, organization, social-emotional development, and feeding. Lin (2003) compared two groups of post-institutionalized children adopted from Eastern Europe and found that sensory processing problems were associated with the length of time the children spent in the orphanage. Lin (2003) also found that these sensory processing problems were a

significant predictor of behavioral problems. A synthesis of current research supports the finding that post-institutionalized children who exhibit SPD are at increased risk for a wide range of emotional and behavioral disorders (see for example, Waterhouse & Fein, 1984).

Behavioral Problems

Utilizing Achenbach's (1991) *Child Behavior Checklist* (e.g. Rosenthal & Groze, 1991; Marcovitch et. al., 1997) numerous researchers have documented an increase in behavior problems among post-institutionalized children, including elevated scores on the Externalizing Scale, and on the subscales of Delinquency and Aggression (Hoksbergen, Rijk, & Van Dijkum, 2004; Rosenthal & Groze, 1991). Other researchers have reported elevated Internalizing Problems (Withdrawn, Anxious/Depressed, and Somatic Problems); although when Internalizing Problems occur they are generally less severe than Externalizing Problems (Rosenthal & Groze, 1991). Children who score high on the Externalizing Scale are likely to have diagnoses of Oppositional Defiant Disorder and/or Conduct Disorder; children who score high on Internalizing Scales are likely to have diagnoses of Anxiety and/or Mood Disorders.

Clinical psychologists working with post-institutionalized children corroborate these research findings (Gray, 2002; Hughes, 1997). Gray (2002), in her book *Attaching in Adoption*, describes issues observed in her practice. Pervasive behavioral issues for children coming for therapy include: fear that their adoptive parents will abandon them (often seen as resistance to attachment relationships), fear of unseen dangers (manifested as hypervigilance, hyperactivity), fear of losing control (exhibited in control battles with adults), and fear of hunger (often seen in food hoarding). It is clear that

although the child has been removed from the dangers of the orphanage, early experiences continue to impact current behaviors.

Interventions and Implications

There is a burgeoning body of research describing the disorders and deficits induced by institutional deprivation; however, in stark contrast, there is a distinct paucity of information about how to restore the pervasive damage induced by institutional care. In a study by our lab (Cross et al., 2001) parents reported having attempted an average of seven interventions for their adopted child. In addition, a full third of the parents reported having such great expense from the physical, emotional and behavioral needs of their child, that they had exhausted all financial resources, including retirement and savings accounts.

It is important that professionals working with post-institutionalized children understand the nature of institutional care, and the significant impact it brings to not only the adopted child, but also the adoptive family. In addition, because deprivation induces global deficits, therapeutic modalities must also be global and integrative, in order to affect deep and lasting change for these children. In the following section, we will explore some of interventions that address the various effects of institutionalization as well as suggestions for school counselors who serve this population of children and their families.

Gather Information About Physical Health

As a counselor serving in the school setting, it is important to gather background information on the medical/physical history of the child. Following adoption, children generally see a family pediatrician who may treat them for conditions such as hepatitis,

tuberculosis, malnutrition, scabies and intestinal parasites (Albers, Johnson, Hostetter, Iverson, & Miller, 1997). These medical interventions are reported to have a high rate of success (Cross et al., 2001). Physical therapy, which is designed to strengthen a particular limb or muscle, may be necessary if the child has muscular problems. Speech and language therapy is also very helpful for post-institutionalized children who had little experience with conversational language prior to their adoptions. Referring families to appropriate specialists may provide valuable insight and support for the child's academic successes.

In addition, in cases of behavioral problems, medical evaluation for allergies, atypical seizures, and/or ARND may provide insight for helping the child succeed in their academic environment. If allergic sensitivities are present, they may be identified through collaboration in which parents and school personnel keep journals of behavioral episodes and work together to "connect the dots" to certain foods or rooms which may have induced the episode. Avoiding offending foods, and for example, adding a sanitizing air purifier to classrooms with mold, can significantly reduce problem behavior attributed to allergic reaction. Atypical seizure activity can be ameliorated through identifying fear triggers (again the behavioral journal is an effective tool) and working with the child to "use their words" to tell teachers or parents when they are beginning to feel anxious or afraid. In addition, teaching the child specific, proactive strategies for when they begin to feel afraid (e.g., talk to my teacher, breathe, count to ten). Teachers and parents alike are often amazed at the seemingly simple challenges that induce atypical seizure activity. An unexpected spelling test, an unfamiliar teacher-substitute, a

strange odor in the classroom, can all become powerful stimuli to a child reared in an orphanage setting (Purvis et al., 2007).

Be Aware of Potential Relationship Difficulties

Children adopted from orphanages often have difficulty relating to others – especially their parents and peers. Children who are either emotionally withdrawn, or who are indiscriminately friendly may have an attachment disorder (Zeanah, 2000; Zeanah & Boris, 2000). Attachment therapies are designed to ameliorate these and other consequences of maternal deprivation and include individual child therapy, child and parent therapy, attachment based playgroups, Play Therapy, and Theraplay® (Jernberg & Booth, 1998). Attachment-based negative behaviors are pervasive and difficult to change, and these therapies meet with various degrees of success. One relationship-based approach that has been used with groups in school classrooms is Group Theraplay®, (see *Play With Them: Theraplay® Groups in the Classroom*, Rubin & Tregay, 1989), which is designed to enhance relationship skills and teach prosocial behaviors. In addition, school therapists may want to be trained in the *Circle of Security* method that provides information about healing relational problems between children and their parents (Marvin, Cooper, Hoffman & Powell, 2002). (For more information see www.theraplay.org and <http://www.circleofsecurity.org/>)

Children also may benefit from social skills training through the use of “peer helpers.” Peer helpers can be same age children from the classroom who have strong social skills. These children can be used as “models” for at-risk children to observe and emulate. In addition, classroom “script practices” with puppets can enhance problem

solving and social skills through the playful practice of creating shared stories (e.g., Flavell, 1987; Schaefer, 1993).

Recognize Sensory Processing Disorder

SPD is very common among post-institutionalized children (Cermak & Groza, 1998; Sweeny & Bascom, 1995). A formal diagnosis by an occupational therapist (OT) can become an invaluable component of the child's Individual Educational Plan. In addition, OTs working in the school environment can make important suggestions for the enhancing learning environment for children affected by processing disorders. *The Out of Sync Child* (Kranowitz, 1998) is a powerful guide for teachers and parents. Three portions of the book will be of special interest to those working with these children. The *Sensory Profile Questionnaire* is a checklist that can be filled out by parents or teachers to assess processing difficulties and identify the exact nature of the disorder (e.g., tactile, auditory). Two chapters, *Your Child at Home*, and *Your Child at School* are filled with ideas about how to enrich the home and classroom environment to make them more sensory-rich and welcoming for children with SPD. Sensory integration activities can be brought into the schools by demonstrating recess activities to the children that will give them appropriate levels of sensory input (e.g., going across the monkey bars, swinging, climbing up the slide backwards). It is important to work initially with an OT in order to avoid giving too much sensory input, which may cause over-stimulation. Children with SPD often benefit greatly by being able to use sensory activities at their desks. Small fidgets (e.g. stress balls, Kooshballs, silly putty, etc.), gum, or suckers can be calming or alerting for these children and can be used with special permission from the teacher. In addition, teachers can plan times during the school week to teach

calming techniques (e.g., deep breathing, joint compressions) with the entire class at various times during the school day. Every child will benefit from these activities, and when carried out with the entire class, the child with SPD is not stigmatized or singled out.

Address Behavior Problems Proactively

Another category of interventions is behavioral modification. Some teachers of post-institutionalized children find merit in instituting behavioral rewards systems in the family, in which the child can earn coins, tokens, and/or rewards for practicing acceptable behaviors (Flavell, 1987). These programs can be effective for a short-term emphasis at the beginning of building a new skill. However, if reward programs are ongoing, the child's behaviors may become calculating and mechanical (i.e., the child won't perform the desired task without assurance of a reward).

Becoming aware of fear-driven behaviors is important for school counselors. Encouraging parents and teachers to observe pupil dilation, shallow breathing, and muscular "freezing" can often inform an adult that the child isn't being willfully disobedient, but is rather, having a fear-response, which would be addressed differently. Working with children on communication skills (e.g., "use your words and not your behaviors to tell me what you need") can become a powerful tool for guiding at-risk adopted children. Lastly, keeping in mind that children may have particular learning difficulties adding to their behavioral challenges when they become frustrated, it is imperative to encourage teachers, parents, and children to set realistic goals and to celebrate the children's accomplishments.

Become a “Mirror” for the Child

Children who suffer neglect frequently struggle with a deep sense of shame or “blackness” inside themselves. In working with this population of children, it is important to encourage parents, teachers and staff to become valuing “mirrors” for these children. Mirroring naturally occurs for children who, from their infancy, lay in the nurturing arms of their parents who gaze adoringly into the tiny faces. Interestingly, research documents two important facts about early development: first, the newborn, from birth, is attuned to faces over objects (Aslin, 1987), second, the field of vision for a newborn is exactly the distance from the crook of a parent’s arms to their face (Papousek & Papousek, 1987). This combination of proximity, touch, voice and facial expression, provides us with information about how to mirror a child’s preciousness to them, so that they can begin to internalize it. This can be achieved for older children by standing within 36 inches of them (proximity), putting a gentle hand on their shoulder or arm (touch), looking warmly into their eyes (mirroring value), speaking in a kind, gentle voice – and giving them authentic encouragement (e.g., You did a great job with that drawing! I love the colors you used for the sky.), appreciation (e.g., Thanks for helping me carry my papers. You are so good to me.) or praise (e.g., You are such a kind girl. You shared your snack so sweetly with your friend). It is important to remember that words should not be goal-driven or goal-oriented. Our purpose here is to mirror *value* and *worth*, not to encourage productivity or performance. Most comments should be about the innate preciousness of the child, and an expression of sheer joy in being with them (e.g., I love being with you! You are so precious to me!).

Create an Environment of Felt Safety

In working with children who have been adopted internationally, we can never forget that they may have been harmed significantly before they came to the safety of our care; they have become subject to primitive survival drives rather than higher-order cognitive drives (Perry, Pollard, Blakely, Baker & Vigilante, 1995). For example, adults are often dismayed by the food hoarding of children who may have spent their first eighteen months in an orphanage. Primitive memories such as chronic hunger are always present for some children and will be present throughout their lives (Schwartz & Perry, 1994). Driven by survival needs, these children cannot achieve higher functioning until primitive needs are met in a “language” they understand.

Felt safety is a term that describes creating an environment in which the child (not only the adult) knows he is safe (Purvis et al., 2007). For example, the child who has been starved during the first year of life may have problems with food stealing and food hoarding at school. By allowing that child to keep packaged, nutritious snacks such as raisins or nuts in a Ziploc bag in a desk or in a small fanny pack, caregivers and educators give that child an appropriate sense of control over his fear (i.e., “I won’t be hungry”) and make the environment feel safe and predictable (i.e., “I have permission to eat these snacks when I feel hungry”). In this way, the child begins to trust the safety of the caregivers and the environment, has appropriate control over fear of hunger, and can begin to function in higher levels of cognitive and relational processes.

Summary

It is important to realize that children adopted from backgrounds of profound deprivation are at high risk for global deficits across domains. Many if not most of their

deficits remain hidden, evading both discovery and treatment. Children with these risks frequently fall between the cracks for services, and in addition, many services designed for the typical school-age child may not be productive for these children. Post-institutionalized children desperately need continuity of care as well as parents, teachers, and therapists who are trained to embrace an integrative approach to their healing.

Research that identifies the availability and accessibility of appropriate services for post-institutionalized children would be useful. Additionally more research is needed to examine interventions for these children, particularly interventions which take into account the various areas in which the children may have deficits as discussed in this paper. These deficits may include physical problems, relational problems, and sensory processing problems. Some professionals tend to view behavior problems only through the lens of their profession. Further research in this area may provide post-institutionalized children with more beneficial care by widening the perspective of professionals to view the children's behavioral problems more holistically.

While learning new insights and compassion for the children who experienced early harm, it is important to remember that their parents are in need of compassion as well. Many adoptive parents are exhausted and frustrated. They may feel that they have failed as parents. A common lament from adoptive moms is an unspoken sense "I failed as a woman. I couldn't have a biological child. Now I can't even mother a child another woman gave birth to!" Adoptive parents may seem unusually negative, hopeless and stressed – they need compassionate understanding and practical support. This support may include helping them find respite care occasionally, so that they have small bits of

time to rest and regenerate, helping them find integrative therapies that empower them as parents, and helping them identify resources in the community for their children's needs. School counselors can support their emotional needs by giving them words of encouragement about specific achievements and interactions we observe, by inviting them to participate in some aspect of the classroom experience in which they are an "expert" (i.e., teaching crafts, calligraphy, drawing, writing, etc.) and by a pervasive attitude on our part which "mirrors" to them that we see them as competent, insightful, and wise parents – and that we recognize they are the real professionals who will bring healing to their adopted children. We can become strong allies for these families as we share their journey in the school setting. (*For more resources see [http://www.child.tcu.edu/ Secondary%20Pages/Training_Articles.htm](http://www.child.tcu.edu/Secondary%20Pages/Training_Articles.htm)*)

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