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BEHAVIORAL AND MENTAL DISORDERS

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From THE HANDBOOK OF INTERNATIONAL ADOPTION MEDICINE by Laurie C. Miller.

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BEHAVIORAL AND MENTAL DISORDERS

INTRODUCTION

In 1960, child psychiatrist Marshall D. Schechter reported a hundredfold increase of adopted patients in his practice compared with what would be expected in the general population. This claim (based on a small group of children seen by one psychiatrist), though reportedly based on a misinterpretation of the published adoption literature, received widespread publicity, reinforcing the notion that adoptees frequently have mental and psychiatric disturbances.

Adoptees are over represented among mental health care recipients: about 8% - 10% of children receiving in-patient or out-patient psychiatric services are adopted. However, the reasons for this are complex.

Adoptive families may be more likely to seek help for problems because of their relative maturity, socioeconomic status, and familiarity with social service availability. Indeed, adoptees are underrepresented in juvenile court populations, possibly because adoptive parents seek psychiatric care if their child demonstrates delinquent or undesirable behaviors. Similarly, adoptees may be underrepresented among adult mental health populations, perhaps because psychological issues are addressed during the teenage years.

Nonetheless, professionals and parents may wonder if adopted children, especially those adopted internationally, are at increased risk for behavioral and mental disorders. Genetic factors, separation from birth parents, environmental exposures (both pre- and postnatal), some facets of adoption itself, and the adoptive home environment all potentially increase the likelihood of these disorders.

This chapter is divided into four sections. The first reviews the links between genetics and mental health disorders (schizophrenia, affective disorder, and antisocial personality disorder). In the second, the relationship between adoption and behavior problems, as well as the difficulties interpreting research in this area, are discussed. The third section explores the risks of mental health disorders in international adoption and the relationship between behaviors observed in the orphanage and after adoption. Finally, the fourth section examines the long-term mental health outcome of adoptees.

1. GENETICS, ADOPTION AND MENTAL HEALTH DISORDERS

The genetic components of various mental disorders have been investigated in hundreds of twin, family aggregation, and adoption studies. Possible or likely genetic factors have been identified for a number of psychiatric conditions, including schizophrenia, affective disorders, antisocial behavior, conduct disorder, autism, dyslexia, attention-deficit hyperactivity disorder, conduct disorder. Tourette Syndrome and obsessive-compulsive disorder have been linked to such factors.

In this section, the links between mental disorders and adoption are reviewed. *It is prudent to interpret these data with caution*, as many factors contribute to the development of such problems.

Adoption studies may be biased by variations in age at adoption, pre-adoptive placement, age at evaluation, and experiences in the adoptive home. For example, adoptive families may themselves have increased incidence of mental disorders and stress. Accurate and complete information about birth families may also be lacking, especially about birth fathers.

Schizophrenia and Adoption

Numerous adoption studies support current hypotheses of a genetic basis for schizophrenia. Adopted-away children of schizophrenic mothers have three- to fourfold risk of developing schizophrenia compared with adopted-away children of mothers without this diagnosis. The risks of disease expression are increased if the adoptive home is unstable. Mental illness is more common among biologic relatives of schizophrenic adoptees. The inheritability of schizophrenia may be as high as approximately 70%.

Affective Disorders and Adoption

Genetic susceptibility contributes to the expression of depression and bipolar disorders. Adoption studies support this conclusion. However, investigators agree that environmental factors are crucial in modulating disease expression. Heritability of major depression is estimated in the range of 31-42%, although certain subtypes may be higher. Inherited variations in regional brain volume and shape increase susceptibility to depression, although this is not certain. Other factors, such as prenatal alcohol exposure (possibly mediated via postnatal exposure to maternal depression) or early adverse life events (possibly mediated via altered hypothalamic-pituitary axis responsiveness), also contribute to disease expression. Genetic evidence links affective disorders to autism spectrum disorders, conduct disorder, and hyperactivity.

Antisocial Behaviors and Adoption

Several studies show that children adopted at birth from "antisocial biologic backgrounds" exhibit increased antisocial behaviors. One study evaluated 246 adoptees separated at birth from their biologic parents. One or both birth parents of nearly half the children had a psychiatric condition. Children were evaluated after age 10 years.

Having an antisocial or alcoholic birth parent predicted antisocial behavior in the adoptee at adolescence. Environmental factors, including a psychiatrically ill adoptive family member, divorced adoptive parents, or exposure to multiple foster mothers, also significantly correlated with antisocial behavior among the adoptees. In addition, mental retardation in the biologic family of the female adoptees predicted increased antisocial behavior.

2. ADOPTION AND BEHAVIOR

Do adopted children exhibit more behavioral problems than their non-adopted peers? Adoption itself is a risk factor for mental health disorders. Adoption undoubtedly influences the family's responses to the child. Unresolved issues related to infertility, adoption, or beliefs about the child's heritage may alter parental availability, affection, or involvement. The adoptive family may have psychological 'issues', and the adopted child may experience disruptions, stresses, and trauma in that environment.

Few studies account for variation in the child's age at adoption, the care received prior to adoption, the composition of the adoptive family, and how the adoption was handled in the family (kept secret, celebrated, etc.). The acceptance of the adoption and the adopted child by grandparents and other relatives also affects the family dynamics.

The experience of institutionalization also contributes to the likelihood of behavioral problems. Mismatch of temperament is more likely to occur in adoption, and this may contribute to mental health disorders.

Furthermore, mental conditions may be over-diagnosed among adoptees. Well-meaning but misinformed mental health professionals may make things worse for the adoptive family in crisis by their failure to recognize and support existing bonds at times of family stress.

Finally, many studies compare the mental health of adopted children with that of their birth parents. However, the sources and accuracy of information regarding diagnoses in birth parents may be questionable. At the time medical history is obtained (often at relinquishment), birth parents may be young, and mental disorders may not have fully emerged or been properly diagnosed or recorded. Little or no information is usually available about birth fathers. Most studies evaluate a narrow age range of children: some behaviors may improve, while others may not have yet emerged.

A survey of adopted teens found that most had positive self-concepts, warm relationships with their parents, and psychological health, comparable to non-adopted teens. Although one-third received counseling or psychotherapy, most of those reported good mental health. Positive adoption outcomes likely are underreported.

Behavior Problems and Internationally Adopted Children

Additional components may influence the behavior of international adoptees compared with that of domestically adopted children. Many international adoptees are transracially adopted. They appear physically different from their parents and perhaps from their siblings. They may belong to a racial minority in their communities. Within the family and community, these children are "visibly" adopted. The effect of this visible adoption has not yet been fully evaluated. Results may differ in various receiving countries.

For example the Scandinavian countries receive many internationally adopted children from Asia and Latin America. These countries are relatively homogeneous; adopted children may be mistaken for immigrants and assumptions made about socioeconomic class, education and background. Even in more heterogeneous societies, such as the Netherlands, internationally adopted children may stand out compared to their Dutch-born peers. About 30% of 7 year old internationally adopted children in the Netherlands scored in the clinical range on the Child Behavior Check List, compared to 10% of controls. When biologically related and unrelated international adoptees were compared, genetic contributions were identified as important to attention problems and externalizing behaviors.

In a larger study, behavior issues were investigated among 2,148 international adoptees in the Netherlands. The children were adopted from Korea (32%), Colombia (14.6), India (9.5%), Indonesia (7.9%), Bangladesh (6.7%), Lebanon (4.9%), Austria (5%), and other countries (19.4%) (a different distribution of birth countries than that for children adopted by American parents). The majority of adopted children had scores similar to non-adopted Dutch children on the Achenback Child Behavior Checklist. However, nearly four times more 12 to 15 year old adopted boys had delinquent behaviors ("Steals outside the home," "steals at home," "hangs around children who get into trouble," "vandalism," "lying and cheating," "truancy") and other misconduct, and more than three times more scored in the deviant range on the Hyperactive scale.

About three times more adopted 12 to 15 year old girls scored high on the Schizoid scale ("hears things that are not here," "stares blankly," "strange ideas," "day –dreams or get lost in her thoughts," "strange behavior," and others). Notably, the adopted children scored better than non-adopted children in sports and non-sports activities. More adopted than non-adopted children were attending special schools (13.2% versus 4.4%). Adopted children from lower socioeconomic adoptive homes showed better academic performance, fewer school problems, and higher total competence scores than children from higher socioeconomic homes.

Researchers suggest that, in general, the older the child at placement the greater the risk of "delinquent and uncommunicative syndromes" in boys and "cruel, depressed, and schizoid" syndromes in girls, although the relationship of problems to age at adoption was complex and unclear. No country-specific differences were noted, although boys from Colombia, Lebanon and some European countries had higher problem scores.

Prospective parents are cautioned against the application of these results to all internationally adopted children because of the variations in age at adoption and experiences prior to adoption. Nonetheless, the studies suggest that adopted children are more likely to have behavioral issues in adolescence than their non-adopted peers.

3. RISK OF MENTAL DISORDERS IN INTERNATIONAL ADOPTION

Pre-Adoptive Medical Records

Family medical history, especially mental health history, is rarely if ever available for internationally adopted children. If available, interpretation of psychiatric diagnoses from culturally different medical systems is difficult. For example, a birth mother reported to have "depression" may have the expected emotional responses to her difficult circumstances which require that she relinquish her child, rather than major depressive or bipolar disorder. A recent small survey suggests that most relinquishing birth mothers in Russia are clinically depressed.

"Antisocial personality" may refer to a parent who has engaged in minor or major criminal activity, or simply to a young woman who has become pregnant out of wedlock. Parents may be incarcerated for reasons that might or might not be valid in the United States. "Oligophrenia" is seen occasionally on pre-adoptive records from Eastern Europe. This has been variously translated as mental retardation, depression, and schizophrenia. These examples highlight the difficulties in understanding various categories of psychiatric illnesses from another culture.

Lack of information about family mental health disorders should not be construed to mean that no problems exist. Little information is available about birth fathers. However, birth mothers with mental retardation, mental illness, antisocial behaviors, and /or substance abuse likely favor birth fathers with similar qualities. Thus, some children inherit a double dose of unfavorable genes.

Finally, fabricated or exaggerated psychiatric diagnoses are occasionally included on pre-adoptive medical records for "legal reasons" (e.g. to expedite the adoption of the child). It is usually impossible to differentiate among these various situations, but a request to the adoption agency or intermediary for further information is often warranted.

4. MENTAL AND BEHAVIORAL DISORDERS AT ADOPTION

Children residing in institutional care often exhibit abnormal behaviors. These behaviors are usually adaptations to an abnormal, under responsive environment. Such behaviors often persist in the early post-adoptive period. These behaviors must be differentiated from intrinsic behavior problems that may persist after adjustment to the adoption. In this section, the manifestations of depression, autistic-like behaviors, and aggression in the orphanage and after adoption are discussed.

Depression

In the orphanage. Depression is probably the most underdiagnosed condition among institutionalized children. The earliest clinical descriptions of childhood depression derive from observations of institutionalized children. "Anaclitic depression" describes the behavior of infants left without maternal care: characteristics include "withdrawal, weight loss, insomnia, weeping, and developmental retardation." Less dramatic symptoms of depression may be readily observed among children in most orphanages, and clearly relate to the lack of a consistent primary caregiver.

After adoption. Some children display symptoms of depression after adoption. Withdrawal, anorexia, lack of eye contact, limited motor activity, and limited language production are normal reactions to the drastic change in environment experienced by the children. Parents must be prepared for this reaction and accept that their children may grieve for lost caregivers and the loss of the familiar environment. Sleep disturbances and feeding difficulties are common.

While such behaviors are generally transient, some symptoms of depression may persist. In some children, symptoms may emerge some time after the adoption, even if the initial adjustment was smooth. Memories of lost friends, caregivers, and places may be triggered by comments, books, movies, school projects, or other events in the child's life. Months and years after adoption the child's interpretation of this experience may lead to depression, shame, and sense of worthlessness ("if I had been good, my birthmother would have kept me").

Exposure to newborns and young infants, arrival of a new sibling (by birth or adoption), and passage through typical developmental stages (graduations or other achievements, dating, intimacy, marriage, parenthood) may all amplify a sense of loss associated with adoption. Pediatricians and adoptive parents must be sensitive and aware of possible triggers of depression at various lifestages.

"Autistic" Behavior

In the orphanage. The autism spectrum disorders are a heterogeneous group of conditions that share the characteristics of lack of eye contact, aloofness, failure to orient to name, failure to use gestures to point or show, lack of interactive play, lack of interest in peers, and language delays. Many of these characteristics are

common in institutionalized children. Malnutrition, prenatal exposure, and prematurity contribute further complications. Social factors may also play a role. For example, gestures and interactive play may not have been required or encouraged in the orphanage environment. Children may have been forbidden to point or ask for things, forbidden to explore, and never engaged or taught peek-a-boo or pretend play. Some children may have sensory dysfunction that interferes with enjoyment of physical experiences.

Parents traveling to collect their child sometimes observe autistic-like behaviors. Care must be taken to distinguish these from the normal adaptive behaviors of a child removed from a familiar environment and placed in the care of well-meaning but frightening strangers. Withdrawal, lack of interactive communication, and lack of eye contact are typical responses of a child in the first hours or days after placement. Lack of response to the child's name sometimes results from (unintentional) mispronunciation by the parents, unfamiliarity with the new name, or an undiagnosed hearing problem.

Many parents describe their child as "shut down", or "completely passive and withdrawn" during the first hours and days after placement. Observation over time is perhaps the best means to differentiate these adjustment behaviors from the more serious conditions "acquired institutional autism" and "true autism".

After adoption. Some children continue to display autistic-like behaviors for a considerable period of time after adoption. These children have significant impairment of social and communication skills, but in contrast to typical autism, this "quasi-autism" (or acquired institutional autism) tends to improve to some extent by age 6 years. Furthermore, although some children have severe mental impairment at arrival, many have dramatic improvement in IQ in the first several years after adoption. In contrast to typical autism, these children usually have (or achieve) a normal head circumference, and unlike the male preponderance in typical autism, boys and girls are affected equally.

Aggression

In the orphanage. Some children may display aggressive, violent behaviors when first encountered in the orphanage. In poorly supervised environments, normal childhood aggression may not be controlled. Some children may hit, bite, scratch, and push as a matter of course in order to have access to food, water, toys, and caregivers. In some situations, extreme corporal punishment may be used.

After adoption. Aggression appears after adoption for several reasons. In some children, violent behavior has been a way of life, and no other ways to interact or solve problems have ever been explored. In other children, fear provokes aggressive acts. The child may not understand the realities of adoption (leaving behind friends, caregivers, all that is familiar) for a complete change in environment, culture, and language. Others may fear that they have now been removed beyond the reach of birth family, and that misbehavior is necessary so that they can return "home." For some children from abusive backgrounds, placement in an adoptive family creates anxiety that the abuse will recur, whereas in the orphanage, some sense of safety was garnered from the presence of the other children. Inability to communicate, fright, fantasy and poor preparation for adoption may all contribute to aggressive behaviors. Severe aggression may signal reactive attachment disorder discussed elsewhere in this training.

KEY POINTS FOR INTERNATIONALLY ADOPTED CHILDREN

- Genetic susceptibility contributes to mental disorders in adopted children.
- Unstable adoptive environment increases the likelihood of expression of mental disorders.
- Adoptees generally have more behavioral and mental health disorders during childhood and adolescence than non-adopted peers.
- Symptoms of mental health disorders are common at adoption and immediately thereafter as children adjust; many of these symptoms are transient.

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