ADOPTION EDUCATION

THE EFFECTS OF INSTITUTIONALIZATION

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

THE EFFECTS OF INSTITUTIONALIZATION

INTRODUCTION

Most internationally adopted children are placed with their families after residing for months or years in orphanages or other institutions. Many of the problems seen in these children after arrival in the United States have been attributed, rightly or wrongly, to institutional care during critical early phases of development.

The adverse effects of institutionalization on young children have been recognized for many years. However, many factors contribute to outcome, including prenatal exposures, genetics, the reasons that the child was placed in the institution, and the individual experience of the child within the institution prior to adoption.

WHO ARE THE CHILDREN?

Very few residents of orphanages and baby homes throughout the world are truly orphans, that is, children whose parents are deceased. Most children living in institutional care have been abandoned by their families. Abandonment occurs for many reasons, including parental illness (mental or physical), inability of the parent(s) to care for the child because of family discord, drug and/or alcohol use, mental retardation, imprisonment, or lack of emotional, financial or other resources.

Some children are placed in orphanages after parental rights have been terminated, often because of abuse or neglect. As in the U.S., poverty, single parenthood, parental psychiatric disease (especially maternal depression), and/or drug or alcohol abuse increase the likelihood of abandonment. Political and economic constraints (such as the “one child policy” and preference for boys in China) may also lead to abandonment.

CARE OF ABANDONED CHILDREN

Although living in orphanages and other institutions may adversely affect children, it may be far preferable to the alternatives. In some countries, infanticide, especially of females, is practiced. Unwanted children may lead stark and dangerous lives alone on the streets, may be ‘sold’ into servitude as laborers, servants, or even as child sex workers, or may be neglected, exploited, or abused by family members. Thus, when reviewing the ill effects of institutional life, it is important to remember the bleak alternatives that abandoned children may face if such facilities did not exist.

Abandoned children have existed throughout human history. Throughout much of history, society paid little heed to abandoned children, offering no support and no organized response to their needs. In Western culture, orphanages were first established in the mid-19th century as a humanitarian response to the horrific conditions faced by abandoned children.

THE RISKS OF INSTITUTIONALIZATION

Institutional care presents many risks to growing children.

Lack of Medical Care

Lack of medical care is a grave concern for many institutionalized children. Children's medical problems may be unrecognized by inattentive, overburdened caregivers, or, if recognized, there simply may be no money to pay for needed medications, surgeries, or other treatments. Orphanages throughout the world are filled with children with treatable or correctable medical conditions, even under local standards of care. These children may be consigned by their families to a lifetime of institutional care because of lack of resources to address their problems. For example, cleft lip/palates or club feet are not repaired, and hearing or other adaptive aids are not available.

Exposure to Infections

Children living in group settings are also at higher risk for exposure to infectious diseases, greater severity of illness, and acquiring resistant organisms. Respiratory (pneumonia, tuberculosis) and intestinal (bacteria, parasites) infections are particularly commonplace. In settings with faulty immunization practices, vaccine-preventable diseases (diphtheria, measles, hepatitis B) may occur. Care in many orphanages may be 'over-medicalized,' resulting in increased needle and medication exposures compared with children living with their families. For example, in many parts of the former Soviet Union, institutionalized children are routinely given series of injections of vitamins or other agents – more than 200 injections in some children prior to age 3. In Romania, needle exposures may also be frequent – HIV-negative children received approximately 140 needle exposures by age 4 years. In some settings, institutionalized children may be exposed to blood products such as intravenous gamma-globulin (used to boost the immune system of ailing children).

Inappropriate Medical Care

Although not documented, it is certainly possible that children living in institutional care may be at risk of inappropriate medical care as well. Sedatives or other medications may be given to improve sleep or modify behavior that cannot be managed in the group setting. Conceivably, children may be used in "experimental" research protocols without proper oversight.

Growth

Growth delays are common among institutionalized children for many reasons. Wasting and stunting have been reported among 35-64% of orphanage residents in Malawi, Kenya and India and among post-institutionalized children from Russia, China, Romania and other countries. Children may suffer from deficiencies of calories, fat, protein, and micronutrients (vitamins, iron, and iodine). At arrival, height, weight, and head circumference are less than the fifth percentile in nearly 50%, 35% and 40% of post-institutionalized children. The actual number of children with growth delays is considerably greater: many children at the fifth, tenth, or even higher percentiles show rapid recovery after adoption, which suggests that earlier measurements did not reflect their true biologic potential.

Poor growth may have a psychological component. Depression, probably the most under-diagnosed condition among institutionalized children, may cause poor appetite. Furthermore, lack of stimulation results in an inefficient use of ingested nutrients. Many children residing in orphanage care have true psychosocial dwarfism which is disproportionate delays in linear growth. Intriguingly, linear growth delays are quite consistent among several distinct populations of international adoptees. Data derived from children adopted from China, Russia, and Romania produce nearly identical curves demonstrating that for every approximately 3 months of institutional care, children lose approximately 1 month of height age.

Physical Neglect

Children in orphanages may also suffer from physical neglect. In some settings, basic hygiene is not maintained. Lack of nurturing physical contact is common and is particularly harmful during infancy. Bottle propping is commonplace in orphanages, as an understandable response to the need to feed many hungry infants with too few staff. Children miss out on the loving food-related human interactions that are critical for early emotional development. Lack of physical attention increases self-stimulatory behaviors as infants and young children seek to restore the sensory input necessary for normal brain development.

Other physical risks of institutional life may include toxic exposures (such as lead) and the lack of exercise and opportunity to play. Many institutionalized children have never been outdoors: adoptive parents often report the wonderment their child displays on seeing the sun, moon, clouds, and sky for the first time.

Developmental Delays

Delays in cognitive development are also common among institutionalized children. Because cognitive function in young children is critically dependent on experience, it is not surprising that most children display significant developmental delays. Even children in clean, well-kept orphanages with lots of toys and games suffer from a scarcity of experiences of the outside world. Most have never been off the grounds of the orphanages (except perhaps for frightening trips to the hospital where they may be abandoned without familiar caregivers for weeks or months). Children lack the experience of going to parks, stores and different homes and of the life of their village or town. Indeed, many exist as virtual prisoners of the orphanage.

Perhaps the most critical risk faced by institutionalized children is emotional neglect. Caregivers of young infants may all wear masks, depriving children of the experience of seeing human faces. Depression is common in orphanages. In virtually all institutional settings, children lack a one-to-one or 'primary' caretaker. A common schedule for caregivers is a 24-hour shift every 3 or 4 days. Thus, each day the child is faced with a different caregiver's style of feeding, baths, bedtime and emotional responses. As a result, the child experiences inconsistent responses to his or her needs. The problem is exacerbated by the common practice in most orphanages of moving children from group to group, depending on age and developmental skills. Thus, when the child learns to sit, he is taken from caregivers he has known and loved for many months. When the child walks, he is moved again.

In well-staffed orphanages in the United Kingdom in the 1960s and 1970s, by 2 years of age, children had been cared for by 24 different adults, by 4 years by 40 different adults; and by 8 years of age by more than 80 different adults. Of course, emotional neglect of a different type occurs in understaffed orphanages. Although it is hoped that this type of institution no longer exists, the 170 residents of the Romanian Babeni Orphanage for 'unsalvageables' were cared for by one pediatrician and six attendants during the day, and three attendants at night. Not surprisingly, 75% of children did not know their names or ages, 55% had failure to thrive and 15% had obvious evidence of physical and sexual abuse.

Behavior Problems

Behavior problems are common among institutionalized children. For example, of 300 children age 12-21 years living in orphanages in Bangalore, India, one-third had obvious behavior problems, and 10% of these required immediate psychiatric help. Problems were worse among those institutionalized before age 4 years. Similarly, Turkish boys living in orphanages had more mental symptoms than comparison children residing with their families. In Iraqi Kurdistan, behavior problems worsened over time among orphans living in institutional care, but decreased among orphans assigned to foster care. The institutionalized children also had a higher frequency of post-traumatic stress disorder. Some of these behaviors can be considered "normal" responses to an abnormal environment.

Sensory processing problems are seen in some institutionalized children. Compared with family-raised peers, 73 children adopted from Romania showed greater problems in 5/6 sensory processing domains: touch, movement-avoids, movement-seeks, vision, and audition, and 4/5 behavioral domains: activity level, feeding, organization, and social-emotional. Eating problems, stereotypes, attachment disorders and indiscriminate friendliness are all more likely among post-institutionalized children.

Abuse and Neglect

Sadly, even in institutions charged with protecting the welfare of children, physical and sexual abuse and dire neglect occur. In 1996, Human Rights Watch reported on the condition of children in some Chinese orphanages. Of 55 children admitted to a particular orphanage in January and February 1992, 24 died within 9-10 months. The report implies that most of the children died of starvation. A report from Christian Solidarity International describes a group of abandoned Russian children in government care, incorrectly confined to psychiatric facilities and subject to medications to treat psychological disorders and other treatments. Neglect and other horrific abuses have been delineated in some Russian orphanages in disturbing reports by Human Rights Watch.

THE EXPERIENCE OF INSTITUTIONALIZATION

Surprisingly little is documented about the actual hour-by-hour experience of children living in institutional care. In one study, crying patterns among institutionalized Korean infants were compared with those of infants living with their families. The institutionalized children cried twice as much as the home infants, had half the contact period with caregivers, and were alone much longer. In a time-use study comparison with family-reared children attending day care, orphanage children spent significantly less time with adults, engaged in significantly fewer activities, and spent less time in adult-led activities. The children in the orphanage spent approximately 70% of waking time alone and only 30% with a caregiver; the children in day care showed the opposite pattern.

ORPHANAGE CULTURE

Orphanages are part of the society in which they exist, and consequently reflect the beliefs and attitudes of that society. Abandoned children or handicapped individuals may be grouped with “unwanted and outcasts ... lepers ... convicts ... political prisoners and the mentally ill” as people who must be isolated from society. Staff in such institutions may lack clinical skills, training, educational and financial resources.

The psychological milieu of the orphanage is another factor that contributes to the outcome of the child. Orphanage staff views of the children reflect the attitudes of the culture and society, ranging from “all children are valuable”’ and “children are innocent” to “not even their parents want them, so why should we care” or “there must be some defect in these children or else they wouldn’t be here.”

A worker in a Romanian orphanage described the mindset where he worked as follows: “A woman who abandons here child (is) a bad person regardless of her reason for this action … The way the parents are looked upon as persons is reflected in the way the child is treated … in institutions … the only thing one knows about the parents is that they abandoned the child … this reflects badly on the child.” To support his observations, he states that the treatment of children changes when the child is assigned for adoption: “The child will be taken special care of, given the best food, dressed better, hugged and given more attention.” His interpretation is that the child then ‘starts to reflect the personality of the adoptive parents who are always thought of as rich and … civilized people.”

Thus, the experience of early deprivation in institutions may contribute to delayed growth, cognition, and social/emotional development. Children may demonstrate behavioral problems such as hyperactivity, indiscriminate demands for affection and attention, superficiality of relationships, and absence of normal anxiety of failure or rebuke. Psychiatric authorities state that “group rearing of abandoned children is inherently destructive and incompatible with normal psychological development.

IS THERE SUCH A THING AS A "GOOD ORPHANAGE"?

Despite all the difficulties of caring for abandoned children in group settings, many orphanages make heroic efforts to provide good care under extremely difficult circumstances. Many orphanage workers dearly love and have deep compassion for the children in their care. At their best, orphanages provide physical safety and material needs, and promote health, developmental function, academic achievement, and psychological well-being.

Various systems of care have evolved in different regions of the world, reflecting local cultural beliefs, financial constraints, and developmental awareness. For example, in Cambodia, most children share a single caregiver with two or three other children. The caregiver frequently holds or carries the children, and usually sleeps with them in a hammock. In many Russian orphanages, a multidisciplinary approach is taken. Orphanage staff often includes educators, speech therapists, physical therapists, and music therapists in addition to caregivers, medical staff, and support staff. Children spend part of each day with the specialized therapists alone or in groups, and have the opportunity for individualized attention and to form an attachment to someone who will be consistent despite changes in group assignment.

Many of the interventions that improve child welfare are low cost, and can be implemented even under difficult circumstances. This was demonstrated in Eritrea, where restructuring of the Solumuna Orphanage resulted in remarkable reductions in neuropsychiatric symptoms among the children. The orphanage was restructured to mix the ages of the children, the staff lived with the children, children had personal possessions, spaces, and time, and orphanage policies were designed to promote the children's autonomy. In contrast, another orphanage in the region had the same staff to child ratio, was segregated by age, policies were designed to promote security and predictability, and the staff functioned in a supervisory role. These children had more frequent behavioral symptoms, especially mood disorders.

In Ethiopia, orphanage children performed as well as family children in various behavioral and psychological testing, especially those who entered the orphanage early. Superior social interactions with peers have been seen among orphans from Ethiopia and Romania. Indeed, in many countries, orphanages may appear attractive to desperately poor families. Availability of food, clothing, shelter, education, and health care may persuade some impoverished families to place their children in institutional care.

For example, children in Malawian orphanages for more than one year were less likely to be malnourished than village children. In India, of 3822 children from 70 institutions, nearly all had signs of calorie, vitamin, and mineral deficiencies and of growth delays when compared to age-matched rural and urban poor, but the institutionalized children had better growth and better self-help, motor, socialization, and imagery skills. In an enriched setting in a Tehran orphanage, children "surpassed even American home-reared children from predominantly professional families in achievement on developmental scales.

Thus, under the best of circumstances, long-term permanent orphanage care may provide nurturing, stable, and consistent care and be a realistic alternative for children in some circumstances where adoption and foster care are not options.

HETEROGENEITY OF THE ORPHANAGE EXPERIENCE

Institutional life is extremely heterogeneous; thus, post-institutionalized internationally adopted children have come from widely variable backgrounds. Some factors that affect the quality of care in the institution are obvious, such as the staff/child ratio, staff training and awareness of basic child development needs, and the financial and other resources available. The philosophy of the institution is also vitally important.

The most critical factor, however, is the individual experience of the child. This overrides all other considerations. This experience is affected by the duration of institutionalization, the child's life experience prior to institutionalization (including genetic factors, prenatal exposures, family history, birth history), and the child's experience in the orphanage. The child in the crib that all adults must pass during the daily routine will likely have a different experience from that of the child whose crib is in the back corner of the room and whose needs are attended to last of the group.

The social, engaging child likely will have these qualities reinforced, although a quieter, more timid child may be more readily ignored. The child who becomes a "favorite" may receive special privileges, foods, outings, and attention, compared to the child who is perceived as "difficult" or a "trouble maker." Thus, the effects of institutionalization – even in children of the same age, in the same room, in the same orphanage – are profoundly different.

OUTCOME OF CHILDREN RAISED IN ORPHANAGES

Very few data exist on the long-term outcome of children raised in orphanages. Although some investigators believe that institutionalization in early childhood increases the likelihood of psychiatric impairments and joblessness as adults, this is not universally accepted, nor is the institutionalization always to blame. Deficits in language development, intellect, personality, and social skills among orphanage alumni are not necessarily caused by orphanage care. Furthermore, although adverse childhood experiences result in increased frequency of acute and chronic psychosocial disorders in adult life, only a minority of exposed children are affected, and it is clear that variation in the severity, pervasiveness, individual differences in susceptibility and interactions with later life stressors are all important. Not surprisingly, institutional experience may affect later parenting style.

The outcome of children adopted from institutional care in other countries is at present unknown but is an area of active investigation. Although many children do well, some international adoptees have long-term cognitive, learning or psychosocial problems.

THE RIGHTS OF INSTITUTIONALIZED CHILDREN

The rights of institutionalized children are recognized by the UN Convention on the Rights of the Child. This international document includes the following provisions:

> "All children have the right to education, the right to home, the right to family the right to the highest standard of health and medical care available, and the right of protection from abuse and neglect". Children without families are guaranteed "appropriate alternative family care or institutional placement," and disabled children are guaranteed the right to special care, education, and training "to help achieve the greatest degree of self-reliance and social integration possible." Finally, all institutionalized children are guaranteed the right to periodic review of placement.

As of 2004, this Convention has been ratified by all countries of the world except the United States and Somalia. Nonetheless, this important document reflects recognition by the international community of the inherent rights of children, and those specifically left without parental care. It is hoped that these rights will be recognized and protected for the hundreds of thousands of abandoned children throughout the world.