



Case Studies from the Child Development Center

Internationally adopted child displays persistent behavior problems

By Mark Simms, MD, medical director, Child Development Center, Children's Hospital of Wisconsin; professor, Pediatrics, Medical College of Wisconsin.

FY was a 4-year-old girl who was adopted from China approximately 10 months earlier. Her adoptive parents came to the International Adoption Clinic at Children's Hospital of Wisconsin because of concerns about her behavior. Since joining their family, FY had sought attention frequently. She often displayed impulsive and overly excitable behaviors. Her father described her energy level as "frenetic." Her preschool teachers also noted these behaviors.

FY was very solicitous of other's attention and seemed to be rather indiscriminate in approaching strangers. Although she appeared to use her adoptive parents as a "secure base" when distressed, she did not like to snuggle with her parents, and they described her as rather independent and self-sufficient. They also said she was "very bossy" and behaved as if she were the parent or "in charge." When FY's parents tried to punish her, sometimes she would cry for hours. At other times, she did not seem upset when disciplined. Afterwards, she did not show any remorse or change her behavior.

At times, FY appeared to be sexually provocative in her mannerisms, but her parents had not observed her to engage in any overt sexual behaviors. In addition to FY, the family consisted of two biological children, ages 12 and 10, and a 3-year-old adopted daughter from China. FY's parents reported that she would stare and glare at her siblings when she was not included in their activities, and she was particularly jealous of her younger sister.

At the time of the adoption, FY's parents received very little information about her. They were told she had been abandoned at about age 1 month and went to live with a foster family until she was about 9 months old. She experienced several other placement changes until age 2 ½, when she went to live with the foster family who raised her until the adoption. The foster mother told the adoptive parents that FY was "very clever," but also "extroverted, restless and obstinate." Subsequently, FY told her adoptive parents that this foster mother beat her with a spoon to the point that she bled from her buttocks.

Following her arrival in the United States, FY learned English very quickly. Initially she was observed hiding things, but that stopped within a few weeks. She did not seem to overeat or have trouble sleeping. She was fully toilet trained and able to dress by herself.

During our evaluation, FY sat quietly and played appropriately with toys while her parents were interviewed. She cooperated well during the physical examination and did not appear restless or anxious. When it was time to leave, FY took great pride in her ability to tie her own shoes.

Pediatric reactive attachment disorder

FY's behavior patterns were consistent with a form of reactive attachment disorder. It frequently is seen in children who have experienced multiple caretaker disruptions during early childhood. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, children with this disorder have "markedly disturbed and developmentally inappropriate social relatedness in most contexts."

The two main types of RAD include an inhibited/emotionally withdrawn form in which children fail to initiate or respond appropriately to social interactions. They appear excessively inhibited, hyper-vigilant and display highly ambivalent behaviors toward others. The second type of RAD, the disinhibited/indiscriminate form, is characterized by a lack of selectivity in seeking comfort, security and nurturing from adult primary caretakers, and a tendency to be overly friendly with relatively unfamiliar adults. Caregivers often describe these children as only superficially attached to them.

Other signs of RAD include:

- A lack of interest in seeking comfort when hurt, frightened or ill.
- Seeking comfort in an odd or ambivalent manner.
- A pervasive lack of compliance with caregiver requests and demands.
- Fearful over-compliance to caregiver instructions.
- Excessive clinging and dependence on caregivers.
- The inability to use the supportive presence of the caregiver when needed.

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Internationally adopted child displays persistent behavior problems - cont.

RAD is not unique to internationally adopted children. These behaviors also are seen in children who are placed in domestic foster care because of severe neglect and/or abuse.

In addition to disturbances in social interaction, RAD includes dysfunction in a number of physiological regulatory systems. For example, psychosocial dwarfism, a reversible form of growth hormone deficiency, was described in the 1960s and attributed to the inhibition of growth hormone secretion caused by an extremely chaotic social environment. These children grow rapidly when they are placed in a hospital or foster home setting. Other unusual symptoms seen in children with RAD suggest additional hypothalamic and pre-conscious regulatory dysfunction such as:

- Overeating to the point of gorging and vomiting.
- Excessive drinking.
- Disrupted sleep patterns, including night wandering.
- Unpredictable and extreme rage behaviors.
- Hiding and hoarding of food and other objects.
- Compulsive lying and stealing.
- Abnormal sensitivity to pain, including hyper- and hypo-responsiveness.

Recent functional neuroimaging studies on former Romanian orphans demonstrated decreased activity in infralimbic and temporal cortical regions. Of interest is the evidence of RAD symptoms in children who were adopted at very early ages, in some cases by 6 months old. The symptoms suggest that regulatory "set points" may be established early in infancy and create problems that are not under voluntary control.

The prevalence rate of severe RAD is not known. In milder cases, improvement in problem behaviors often occurs over the first six to nine months after adoption. Unfortunately, severe symptoms of RAD may lead to disruption/dissolution of the adoption or breakdown of the adoptive family, such as divorce. While many types of attachment therapies have been proposed and are practiced, there is little scientific evidence of efficacy for any of them. Some therapies have been associated with severe adverse consequences to the children and their families, including death of the child.

While most children require some time to adjust to their new family following adoption, physicians and other health and mental health providers should be alert to signs and symptoms of RAD. In the absence of proven evidence-based treatments, families should be directed to reasonable supportive services to address the child's needs. These may include special education programs, psychotherapeutic interventions, recreational and social programs, and family/couples counseling.

References

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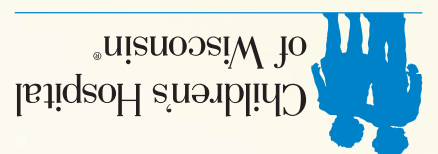
It also is available online at www.chw.org/childdevelopment, Related Links.

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