

Posttraumatic Stress Disorder: Thinking About the Adoptee's Trauma

The children adopted from abroad and from the child welfare system have experienced traumas that we really don't like to think about. It is so extremely painful to realize the reality of abandonment, neglect, sexual and physical abuse, residence in an orphanage, etc. that we often instead prefer to believe, "love will be enough" or he or she will "grow out of it." Yet, if we are to help our children heal, we—parents and professionals—must recognize that the circumstances, which bring children into institutional care and foster care rendered these youngsters helpless, left them fearful—terrified in many instances—and often threatened their lives.

This last statement goes along with the two main criteria for Posttraumatic Stress Disorder (PTSD) per the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) compiled by the American Psychiatric Association (APA):

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness or horror. (Note: in children, it may be expressed instead by disorganized or agitated behavior.)

These criteria attempt to portray or capture the experiences of the child who has been traumatized. This is not to say that other diagnoses applied to children are invalid. Certainly, many children have more than one mental health condition, or are also affected by [Sensory Integration Disorder](#) or [pre-natal drug and/or alcohol exposure](#). It is to say that all too frequently we offer a diagnosis that lacks a foundation in trauma. As treatment is based on the "label", the adoptive family languishes in services that don't address the actual problem.

So, we must be aware of PTSD. We must think about the child's trauma when seeking services or referring families to therapy. We must learn the characteristics of this condition. We must utilize interventions designed to alleviate the trauma in order for these children to recover from their past hurts.

Additional symptoms of PTSD, per the APA, in children and adolescents include the following. Some are exemplified/elaborated on to maximize understanding of this mental health disorder:

- Having frequent memories of the event, or in young children, play in which some or the entire trauma is repeated over and over.

Paula, adopted at nine-months of age, from an orphanage, is now age three. Daily, she sits with her dolls or her Fisher Price Little People. She spends much time arranging these toys in rows. Then, the "Ayi," (the word for her Chinese nanny), comes along and changes all the baby's diapers, or offers food. When the task is accomplished, Paula gets up and moves on to another activity. Later, she returns to her pretend orphanage and completes another task. Her Mom has made much effort to teach Paula how to play house. Paula resists having "parents" take care of her babies.

Julie and Robert, the adoptive parents of two typically developing adolescents, decided to adopt 5-year-old Lori as a result of strong religious convictions to give to someone less fortunate. Lori's arrival was met with several welcoming parties attended by supportive extended family

members as well as friends from their church and community. At one point in therapy Julie stated, “She received sixteen Barbie dolls, two Ken dolls and a Barbie Dream House. When Lori plays Barbie, Ken is always in the hot tub with several naked Barbies. In fact, all of Lori’s play is sexual. Lori, removed from her birth home because of sexual abuse, re-enacts her trauma. It is her effort to understand why this abuse happened to her.

As we learned in the previous post, [Implicit Memories, The Roots of Today’s Behavioral Challenges—Part One and Part Two](#), there are declarative or explicit memories—events we can recall. We have a conscious ability to retrieve the memory and state the facts and events. Lori has explicit memory of her sexual abuse. Paula, on the other hand, has nondeclarative or implicit memories. The implicit memory system operates 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. They cannot be recalled but they can be triggered (Briere & Scott, 2006.) Paula’s orphanage experience is triggered each day she wakes up in her adoptive family. She simply cannot comprehend how she got from a Chinese institution to an American family. It is not uncommon that children adopted internationally—at very young ages—re-enact themes consistent with orphanage life. In fact, many post-institutionalized children’s play is void of people! This is reflective of the overwhelming loneliness young children feel when confined to these facilities.

Frequently, parents report adopting from a “good” orphanage. Certainly, there are institutional settings that are clean and in which the caregivers are genuinely concerned about the children. However, the number of staff involved with a single infant, and the overall ratio of adults to infants and toddlers are key factors in the quality of care provided to these youngest children. When these factors are poor (as they most often are), PTSD is certainly a potential outcome. The article, [Trauma, PTSD, and Attachment in Infants and Young Children](#) offers more information about the impact of trauma on the youngest of children.

- Having upsetting and frightening dreams
- Having problems falling asleep or staying asleep

Adoptive parents are all too familiar with an array of sleep issues! Many children simply refuse to go to bed. Others toss and turn all night, wake up frequently, cry out in their sleep, wake up screaming, have difficulty waking up, are agitated upon waking and so on.

Anxiety rises as nighttime approaches. For many children, pre-adoptive trauma occurred during the dark hours of the day. Many children experienced abuse, were left alone, or felt profoundly alone from dusk to dawn. As such, when their bedtime nears, fear sets in. The brain can’t settle.

- Acting or feeling like the experience is happening again.

How often do you make a sudden hand movement and your adopted son or daughter ducks as if you are going to hit him or her? This is a source of annoyance for many adoptive parents. Yet, we have all heard of war veterans dropping to the ground at the sound of a car backfiring. PTSD is a diagnosis frequently associated with this population. Children—traumatized—act in a similar manner to post-war soldiers. The raising of a hand triggers the flashback of being beaten in a dysfunctional birth home.

- Showing more sudden and extreme emotional reactions

- Showing irritability or angry outbursts

Trauma—especially when experienced in childhood—impacts the [development and functioning of the brain](#). When confronted with danger, the brain moves to a state of alarm—think deer! The “flight” or “fight” response turns on and children—like frightened deer—respond with coping methods such as hypervigilance, dissociation, avoidance, numbing or angry outbursts. These are all forms of what is currently referred to as emotional dysregulation. These emotional responses were excellent coping skills when the youngster was living in his traumatic situation. Unfortunately, living in repetitive stressful conditions, alters the chemical composition of the brain and impairs cell growth. So, these patterns of reacting are ingrained in the brain. These children, once in a healthy family, continue to use these coping skills.

So, when a parent asks the adopted son or daughter, “Where is your backpack?” “Did you eat all the brownies?” “Did you take your sister’s iPod?” — the emotional reaction may be a sudden temper tantrum, a blank look or a total change of subject. Infuriated, the parent pursues the matter. The formerly traumatized child only goes deeper into his poorly formed emotional reactions. The posttraumatic stress disorder is in full motion in the adoptive home.

- Having problems concentrating
- Showing increased alertness to their environment

In conjunction with the above information, hypervigilant children are often misdiagnosed as hyperactive (i.e., AD/HD.) Again, think deer. Deer, because they are human prey, are very wary of every sound in their environment. They are ready to dart away in an instant. The son or daughter who had to be on guard for potential abuse or surviving neglect (the trauma of absence) is always distracted by the conversation and activity in the home, school—everywhere! He can’t sit still and focus because he is worried about what is going on around him. He irrationally thinks that he may need to protect or care for himself at any given moment.

Darlene, now a 14-year-old adoptee, survived years of sexual abuse at the hands of her birth father, birth grandfather and two birth uncles. She stated in therapy, “I knew who was coming to abuse me by the creek of the stairs. The four of them each sounded a bit different.” This is hypervigilance. To date, Darlene is still very aware of what is happening around her. Wouldn’t you be?

Robby, adopted at 5, now age 8, can’t stand it when his Mom is on the phone. He must interrupt or stand right next to her. He must hear what is being or said or thwart his mother’s efforts to have a conversation. In reality, Bobby, who moved seven times before entering his “forever” home is fearful of moving again. He equates the phone with the social worker coming to pack him up. He is hypervigilant about the phone and he dysregulates—has a fit—when he is prohibited from monitoring phone calls.

Overall, PTSD is a neuropsychological disorder. It impairs the actual manner in which the brain responds to its environment. This negatively affects the child’s psychological capacity to interact in appropriate social and emotional ways. More information about trauma’s impact on the mind and body is presented in our previous blogs, Neurofeedback: Training the Brain and The Brain on Trauma.

- Developing repeated or emotional symptoms when the child is reminded of the event.
- Acting younger than their age

We can all be reminded of positive or negative experiences. Reminders are referred to as triggers,

Nate, is now 3 ½ years old. He was adopted internationally when he was 14-months-old. Recently, he went on his first family vacation. Waiting at the airport and the plane ride to Disney World proved triggers for Nate. He became dissociative. His eyes took on a far away, glazed look. It was as if he couldn't hear his parent's words of comfort. He became whiny and clingy. He wanted to be carried. He regressed to a younger age due to the stress of the experience. The trip to Florida caused his implicit memory system to recall the journey home from Kazakhstan. He was flooded with feelings especially fear. Throughout the trip he repetitively asked, "Am I going home with you?" Weeks after the vacation, Nate finally recovered.

If your child is influenced, over and over, by triggers, locate an [adoption and trauma informed therapist](#). Triggers put the child back in her trauma. While re-playing the past, the child is losing the developmental value of current events. Cognitive, social, emotional and physical development are put on hold or only creep forward. Therefore, the posttraumatic son or daughter not only acts young, he remains "little" because his perseveration with the past prevents movement forward. A trigger management plan is put forth in our previous post, As Mother's Day Approaches: The Role of Triggers in Adoptive Families

- Worry about dying at an early age
- Having physical symptoms such as headaches and stomachaches
- Losing interest in activities

Untreated trauma continues to spread until it is stopped. As the child matures into adolescence, his trauma binds tighter and tighter. Depression and anxiety worsen. Consumed with emotions, intrusive memories, social delays that inhibit peer relationships, etc., the young person may withdraw from activities he once enjoyed. He becomes an observer rather than a participant.

- Repeating behavior that reminds them of the trauma

The negative behaviors of the traumatized adoptee seem bizarre to adoptive parents, brothers and sisters. Yet, to the adoptee, they make perfect sense. For example, Janie, often gets up at night and eats raw noodles or bread with ketchup. This aggravates her parents who want her in bed and eating in a healthier manner. To Janie, her food preferences are comforting. She was too little to cook the noodles when she lived with her birthmom and there usually wasn't lunchmeat to go with the bread. Bread, condiments and raw pasta make her feel close to her birthmom who she worries about to this day.

It is important to note that the psychological effects of trauma are likely to be most severe if the trauma is,

- Human caused
- Repeated
- Unpredictable
- Multifaceted
- Sadistic
- Undergone in childhood
- And perpetrated by a caregiver

Trauma, especially when untreated, can have a long-lasting impact on a person's well-being. View, [Ending the Cycle of Blaming Adoptive Parents: The Adverse Childhood Experiences \(ACE\) Study](#) to learn more about the negative aspects of trauma. You'll see, the adoptee's trauma is something to think about!

If you believe your son or daughter, or a child on your caseload is suffering from PTSD, discuss the matter with a mental health professional. If you don't get results, move on until you find the help you and your child need!