REFORM Talk Mental Health Package

Let's Get Real Adoptive Parenting and PTSD (Pages 2-3)

The unpreparedness that we discuss is not about why you adopt or your feelings about adoption, but in the ***adoptive parenting***. That is what will truly matter to your child. The first step of getting real is being aware that PTSD is common in internationally adopted kids and foster-to-adopt kids. Even more important is to understand that behaviors may not just be a transition or adjustment. Most post adoption media and blogging that touches people –these stories of supposed enlightenment--focus really only on the first few months. What you see in those first few months does not necessarily translate into behaviors you will see later. The behaviors may be different, worsen or become compounded. New school years are often a transition time that set off PTSD behaviors. Trying to assess any learning disorders at the same time as that transition can be quite difficult.

It is important to mention (though this post won't focus on it) if corruption/trafficking has been part of your adoption process, then PTSD can take on a whole new meaning.

Recommendations about PTSD

The discussion portion of this 2003 study in Romanian children really is a great way to look at what should be done:

"To confirm this hypothesis it would be necessary to see that **all foreign adopted children are tested at the moment of placement in the adoptive family**. Then adoptive parents should receive **appropriate services after children are placed in their homes**. After some time, **probably 3 to 5 years, the adoptees should be tested again.** In addition, more information about the circumstances in Romanian orphanages would be necessary, because we have to reconstruct the past of the adoptees. Only general information of the living conditions of the adoptees was available. Nevertheless, it seemed plausible that the high incidence of problem behavior consistent with PTSD was related to these circumstances of social and physical neglect and abuse…**Specialized assistance** seems required immediately after placement of the adoptive child in the family and later on. **However, this assistance is not provided to the parents.** It is undesirable that seriously damaged toddlers and young children be placed with adoptive families with virtually no guidance and support."

The highlighted parts of the above discussion are not included in any kind of postadoptive screening. Screening suggested by the American Academy of Pediatrics is mostly about developmental and infectious diseases issues and obvious physical needs. No one has taken data like this and lobbied for PTSD screenings. Why? We can guess that it has to do with removing the "shine" from the adoption process and that is both **sad and dangerous for the child** that needs specialized attention but whose behaviors may be chalked up to transition or whatever fantasy that adoptive parents have made up in their minds when the child does not meet their expectations. I would

argue that **all** adoptive parents need to truly be **therapeutically trained**-training way more in depth than states and Hague regulations require.

There are several possible ways to go about addressing PTSD. One way is to be evaluated by a psychologist familiar with adoption issues. Another method is to use therapy involving neurotransmitters. An article about use of this can be found here.

PTSD can also be one of several disorders your child may have and also may require medications through a psychiatrist.

Sorting this out will take a long time and will likely take multiple types of therapists. Out of pocket costs will be unpredictable.

Some good links to get started on understanding PTSD:

American Academy of Child and Adolescent Psychiatry

One of the links on our home page: National Child Traumatic Stress Network

Comprehensive list of worldwide resources can be found here.

You need to RECOGNIZE the issue, then ADDRESS the issue, then RE-EVAULATE the issue and RE-ADDRESS as needed.

CAFETY and Advice for Families Placing Children in RTC (Page 4)

We have added a new link to our list on the home page. CAFETY stands for Community Alliance For The Ethical Treatment of Youth . They address issues in Residential Treatment Centers (RTCs). They currently have chapters in New York, Texas and California.

CAFETY "is a member-driven, peer-support, and advocacy organization that promotes and protects the human rights of youth who are at risk or have been confined in residential programs"

"**Our 'Care, NOT Coercion' Campaign**

We believe the state has an important role in ensuring that youth and those with disabilities receive non-coercive care and are protected from treatment that undermines their human dignity. CAFETY's Care, NOT Coercion Campaign works to increase awareness of such problem programs and states that allow such practices as a result of inadequate regulatory policy or ineffective monitored. Some facilities escape regulation entirely and are often known as behavior modification programs, character building schools, wilderness programs, gay re-education camps, boot camps, or therapeutic boarding schools."

Tips for Parents Deciding on Placement

The website provides a brief and expanded question and checklist for families considering placement. The pdfs can be found here and here .

Points of Advocacy

CAFETY conducted a survey of participants in RTCs in July 2010. They presented their Points of Advocacy report in July 2011. The 32-page pdf can be viewed here. This is a must-read for anyone considering placing their child into an RTC.

Problems Identified in Previous Survey and Congressional Hearings

Statistics from a 2006 survey and subsequent Congressional Hearings can be found here.

Wilderness Camps: Tips, Support HEAL (Pages 5-6)

One alternative that adoptive parents use for temporary behavioral care is a wilderness camp. Unfortunately many of these camps have been associated with abuse. The organization HEAL has tips, support, abuse support and information that is a must-read before enrolling your child into a wilderness camp.

According to their homepage, HEAL "is an egalitarian network of activists self-empowered to plan events, create change, and make the world a better place for all life. Our goals include the liberation of humans, nonhuman animals, and the earth! We work in cooperation with like-minded organizations that put compassion in action!" They have chapters in Colorado, Iowa, Illinois, Knetucky, New York, Washington and Wisconsin.

Warning signs about abuse and questions to ask before enrolling can be found here and is pasted below:

"A Treatment Center/Wilderness Program/Boot Camp/etc. Is Likely Abusive If:

1. Verbal and/or written communication between the client and family members is prohibited, restricted or monitored.
2. The program requires the parents or client to sign a form releasing the program of liability in case of injury during treatment.
3. The program requests/demands legal custody of juvenile clients.
4. The program houses clients in foster homes or host homes instead of allowing them to reside with their parents.
5. The client or parents are forbidden from discussing the daily happenings at the facility. Often this policy is called “confidentiality.”
6. The client is denied access to a telephone.
7. Client phone calls are monitored.
8. The program uses confrontational therapy.
9. The staff includes former clients of the program.
10. Clients are restrained or otherwise physically prevented from leaving the facility.
11. The program claims that self-injury or cutting/carving on ones body is normal behavior for a client in treatment.
12. Parents are not allowed to stay with their child during the entire intake/entry process.
13. The program inflicts physical punishments on clients such as exercising, running, food restrictions, and cleaning.
14. Reading materials are prohibited or restricted.
15. The facility does not have a clearly visible sign outside the building stating the name of the program.
16. Clients must submit “chain of commands” or any other such requests for basic needs such as clothes, shoes, personal items and medical care.

17. The program is run or staffed by persons who lack adequate experience or credentials.
18. The program requires parents or siblings of clients to volunteer services and/or raise money for the facility.
19. A medical doctor (MD) is not present at any time during normal operating hours.
20. Clients of the program conduct, participate in or supervise the intake/entry process.
21. Staff members offer to help the parents obtain a court order forcing the client into the program.
22. Clients are observed on any level of the program, while bathing, dressing or using the toilet.
23. The purpose of the program is to treat drug abuse, but the program does not conduct a drug screen prior to entry.
24. The program requires clients to be strip-searched.
25. The program does not allow clients to follow their religion of choice.
26. Staff members must approve friends, siblings, family visits, or employment.
27. Juvenile clients are not afforded an education in accordance with state requirements.
28. Medication is recommended, prescribed, approved or dispensed by anyone other than a medical doctor (MD).
29. Staff members make statements such as “your child will die without treatment” to the parents of prospective clients.
30. Clients escort/supervise other clients.
31. The program lists a post office box instead of a physical street address.
32. Clients have to “earn” the right to speak during group sessions.
33. Clients are denied outside activities on any level/phase.
34. Staff must approve the withdrawal of clients from treatment.
35. The program expects total and unquestioned support of parents.
36. Clients on any phase/level are forbidden to speak to other clients.
37. Program questions parents in-depth but cuts off parents' questions and/or refuses to answer or redirects when asked specifics about program policies and procedures.
38. See the Federal Trade Commission warnings and suggestions at: http://www.ftc.gov/bcp/edu/pubs/consumer/products/pro27.shtm "
39. HEAL also links to a 2004 DOS announcement about the dangers of foreign behavioral centers in this pdf.
40. They also have a list of organizations that they are investigating for abuse here. They take complaints from former participants.

Suicide Prevention Resources and Support for Survivors (Pages 7-9)

Statistics

Suicide statistics at The National Institute of Mental Health show that "[i]n 2007, suicide was the third leading cause of death for young people ages 15 to 24.1 Of every 100,000 young people in each age group, the following number died by suicide:

• Children ages 10 to 14 — 0.9 per 100,000

• Adolescents ages 15 to 19 — 6.9 per 100,000

• Young adults ages 20 to 24 — 12.7 per 100,000

As in the general population, young people were much more likely to use firearms, suffocation, and poisoning than other methods of suicide, overall. However, while adolescents and young adults were more likely to use firearms than suffocation, children were dramatically more likely to use suffocation.

There were also gender differences in suicide among young people, as follows:

• Nearly five times as many males as females ages 15 to 19 died by suicide.

• Just under six times as many males as females ages 20 to 24 died by suicide."

Mental Health Disorders and Suicide

Healthy Place adds that "[i]n any one year, 2-6% of children will try to kill themselves. About 1% of children who try to kill themselves actually die of suicide on the first attempt. On the other hand, of those who have tried to kill themselves repeatedly, 4% succeed. About 15-50% of children who are attempting suicide have tried it before. That means that for every 300 suicide attempts, there is one completed suicide."

This resource indicates higher likelihoods of attempting suicide if the child has a major depressive disorder, mood disorder, substance abuse and even anxiety disorder.

"The vast majority (almost 90%) of children and adolescents who attempt suicide have psychiatric disorders. Over 75% have had some psychiatric contact in the last year."

Warning Signs

You can find warning signs at American Society of Suicidology

"Here's an Easy-to-Remember Mnemonic:

IS PATH WARM?

I Ideation
S Substance Abuse

P Purposelessness
A Anxiety
T Trapped
H Hopelessness

W Withdrawal
A Anger
R Recklessness
M Mood Changes"

"A person in acute risk for suicidal behavior most often will show:

Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,

Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,

Talking or writing about death, dying or suicide, when these actions are out of the ordinary. "

General Tips for Prevention if You Detect Warning Sign(s)

From the *Healthy Place* website, here are six tips:

1. Take it seriously
2. Take away the taboo from talking about suicide
3. Get some help
4. Supervision
5. Avoid manipulation
6. Preventing suicide by restricting access to guns, pills, etc.

Crisis Numbers and Support

The American Society of Suicidology website shares the following crisis resources:

"**IF YOU ARE IN CRISIS AND NEED IMMEDIATE HELP, please call 1-800-273-TALK (8255)**

A directory of crisis centers can be found here .

There is a support section for suicide loss survivors at: Suicide Loss Survivors Support

Also, The National Hopeline Network 1-800-SUICIDE provides access to trained telephone counselors, 24 hours a day, 7 days a week. Or for a crisis center in your area, go here.