Changing Trends in International Adoption: Implications for Speech-Language Pathologists

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Abstract

The changing trends in international adoption show higher numbers of older children as well as children with special needs being adopted globally. This article reviews the latest literature regarding the language abilities of postinstitutionalized children who were adopted at older ages. The article also offers recommendations on best assessment practices for these children.

International adoption (IA) is a global phenomenon. Each year, tens of thousands of children are adopted by citizens from countries around the world including, the United States, Italy, Spain, France, and Canada (Selman, 2012a). However, the trends in IA have changed over the past decade (Selman, 2012b). As of late 2012, the countries which sent the highest number of children for adoption were China, Russia, Ethiopia, Columbia, and Ukraine. However, over the years, the total number of annual adoptions from these countries has declined steadily (Selman, 2012a). A number of reasons are responsible for this shift, including tighter governmental regulations, ban on adoption from select countries (Russia) to select countries (USA), as well as longer waiting periods and increasingly stringent requirements in select countries (China).

The second change is a shift in international adoption demographics. There is a consistent trend among sending countries to place for adoption greater numbers of older, preschool, and school-aged children and fewer numbers of infants and toddlers (Selman, 2012a; 2010). For instance, of 9,319 internationally adopted children adopted into families by the United States in 2011, 44% were over 3 years of age and 28% were between 5–17 years of age (U.S. Department of State, Intercountry Adoption Bureau of Consular Affairs, 2012).

In addition, in the past several years, there has been a significant increase in special needs adoptions from Eastern European countries such as Latvia, Lithuania, and Poland (Selman, 2010) as well as from China, which as of 2008 has shifted almost exclusively to intercountry special needs placements (Selman, 2012a).

Subsequent to the school-aged child's arrival to the receiving country, a major concern that arises is the issue of appropriate school placement (Gindis, 2005) and whether speech language services should be provided to the child in question. Unfortunately, due to their unique linguistic status (rapid birth-language attrition long before the acquisition of second

language is complete), many speech-language pathologists continue to experience difficulties with determining the best service options for these children (Scott & Roberts, 2011).

The aim of this article is to review the latest literature regarding the language abilities of postinstitutionalized children who were adopted at older ages. In this article, I will discuss language development of older children post-adoption, explain the difference between conversational and cognitive language competencies, offer pre-adoption recommendations, address select pre-assessment preparations, and provide recommendations on best assessment practices for these children.

Language Development of Older Children Postadoption

Research on speech-language abilities of older children who were adopted internationally is still very limited. While assessment guidelines were created so that speech language pathologists could use them with newly adopted children up to age 24 months, and some assessment recommendations have been suggested for children over the age of two, no specific assessment criteria are currently available for newly arriving older children who are being internationally adopted (Glennen, 2007; Glennen, 2009).

Several studies have found that age of adoption was strongly correlated with language outcomes (Glennen & Masters, 2002; Krakow & Roberts, 2003; Roberts et al., 2005). In other words, older children who were internationally adopted were potentially at greater risk of having poorer language outcomes than were children who were adopted at younger ages.

With respect to early language acquisition, older internationally adopted children can acquire the second language (L2) via two different learning models: the *additive model* (adding L2 to the first language [L1]) and the *subtractive model* (L1 is replaced and eventually eliminated by L2) (Gindis, 2005). However, because internationally adopted children are typically adopted by parents who do not speak their birth language, most internationally adopted children learn L2 via the subtractive model of language acquisition. As a result, L1 attrition occurs very rapidly postadoption (Gindis, 2004; Glennen, 2009).

Birth Language Attrition

Gindis (2005) has found that children adopted between 4 and 7 years of age lose expressive birth language abilities in L2 within a 2 to 3 month period and receptive abilities within a 3 to 6 month period post-adoption. He also found that birth language attrition was more rapid in younger children (3.5 to 4 years of age) whose expressive language was just emerging or was delayed or impaired at the time of adoption (Gindis, 2008).

Studies also find that the "initial" stage L2 acquisition is rapid during the first year (Geren, Snedeker, & Ax, 2005; Gindis, 2005; Pollock, 2005). This could be because internationally adopted children are experiencing an abrupt transition from environments of low language stimulation (institutions and orphanages) to environments with high language stimulation (new home or school) where well-educated parents or professionals will spend time stimulating these children's language abilities. Some authors also assert that internationally adopted children who were adopted into monolingual families "need functional English for survival"—thus the incentive to acquire L2 is very powerful (Gindis, 2005; p. 299).

In less than 1 year, many internationally adopted children display impressive language gains (Glennen, 2009). Data from parental surveys and research studies as well as published clinical studies, show that "fully functional communicative fluency is usually achieved by international adoptees of school age within the first 6 to 12 months of their life in their new country" (Gindis, 2005, p. 301).

Nevertheless, according to Scott, Roberts, and Glennen (2011), there is "a gaping hole in our current understanding of the language development of internationally adopted children who are adopted at older ages" (p. 1166). Furthermore, caution is urged when it comes to

interpretation of these children's language accomplishments postadoption (Glennen, 2009; Hough & Kaczmarek, 2011; Scott & Roberts, 2011).

Communicative versus Cognitive Language

Upon arrival, most internationally adopted children quickly attain *communicative language fluency* (CLF), or the ability to express basic wants and needs as well as interact with others socially on a daily basis in familiar contexts (Gindis, 2005). This differs from *cognitive language mastery* (CLM) or what Silliman and Scott call the *mastery of "academic language register"*, which refers to the child's ability to meet the rigorous academic demands of the classroom in order to successfully keep up with the curriculum (Gindis, 2004; Gindis, 2005; Scott & Roberts, 2011; Silliman & Scott, 2009).

The above terminology should not be confused with Cummins' (1984) basic interpersonal communication skills (BICS) / cognitive academic language proficiency (CALP) model, developed for bilingual language learners., Although the two models are similar, there are marked differences. For instance, according to Cummins (1984), when it comes to BICS, it takes bilingual school-age children approximately 2 years to reach native language proficiency. In contrast, as mentioned above, it takes internationally adopted school-age children only a fraction of that time to develop the same abilities. In a similar manner, research cites a period of approximately 5–7 years for bilingual children to develop CALP (Collier, 1995; Cummins, 1984). However, at present researchers are uncertain about how many years it takes for internationally adopted older school-aged children to display similar mastery because no such reliable data are currently in existence (Scott & Roberts, 2011).

Moreover, the BICS/CALP model was originally developed to apply to immigrant children from low socioeconomic backgrounds who experienced a disconnect between home and school language use (Gindis, 2005; Scott & Roberts, 2011). In contrast, this is considered a nonissue for internationally adopted children who are typically adopted by affluent, well-educated parents (Scott & Roberts, 2011; Tan & Yang, 2005). Questions may arise about older internationally adopted children foundational language abilities and early literacy skills pre-adoption. Researchers have found that the lack of consistent caregiving and prolonged time spent in an institution correlates with greater language delay and deficits as well as poorer long-term outcomes across cognitive, socioemotional, and physical domains (Judge, 2003; Tarullo & Gunnar, 2005).

Some studies found good language outcomes for younger (under 2 years of age) children post institutionalization during school years (Scott, Roberts, & Krakow, 2008). In other studies, researches have shown that many older internationally adopted children struggle to meet academic language requirements and display poorer language outcomes than peers adopted at younger ages or non adopted peers (Beverly, McGuinness, & Blanton, 2008; Desmarais, Roeber, Smith, & Pollock, 2012; Hough & Kaczmarek, 2011; Scott et al., 2011).

So, how can speech-language pathologists determine which older internationally adopted children will require services post-arrival and which will not?

Pre-Adoption Recommendations

To start, pre-adoption recommendations can be made to parents to try to obtain as much background information as possible regarding the child's prenatal and medical histories, early development, and pre-adoption experiences in the birth country, including history of neglect and sexual, physical, and emotional trauma (Gordina, 2009; Glennen, 2007; Hwa-Froelich, 2012). Parents should also be advised as to what questions to ask the orphanage personnel and/or adoption caseworker regarding the child's birth language and/or academic abilities in order to determine if language delays or deficits are present. Samples of pre-adoption questions are available in Glennen (2009, pp. 53–54).

In certain countries, for older children (3+ years of age), speech and language delays in the birth language may be documented in adoption records and translated for the parents (Miller, 2005). However, often parents will be given only a general statement of delay with no explanation on what basis the delay was diagnosed or whether any speech-language services were provided. In some countries (e.g., Russian Federation,) additional records are available and can be requested from the orphanage (Gordina, 2009). Orphanages located in the former Russian republics, for example, are required to maintain educational, developmental, and behavioral summaries, speech-language evaluation reports, and, when applicable, speech-language treatment summaries (Gordina, 2009). For school-aged children copies of transcripts, communication books (known as dnevnik), and school notebooks/workbooks should also be available (Gordina, 2009).

Importance of Anecdotal Information

If the parents are unable to obtain additional records, it is recommended that they seek anecdotal information from the orphanage personnel or caseworker regarding the presence of birth language delay/disorder. This information should also be considered when qualifying the child for services (Glennen, 2007). It is also recommended that parents try to videotape the child during speaking tasks such as telling a story, recalling an episode from daily life, or engaging in conversation with a familiar person. These samples can later be analyzed in order to determine if speech-language deficits are present (Glennen, 2009).

Postadoption Assessment Preparation

Upon arrival to the receiving country, a comprehensive speech-language assessment is recommended if a speech-language pathologist who speaks the child's birth language is available. However, due to rapid birth language attrition, an evaluation in the birth language will not be valid after approximately 4 months in the receiving country (Glennen, 2007). That period is even shorter for children with speech-language abilities that are delayed and disordered (Gindis, 2008). Afterwards, the child should be evaluated in L2 in order to determine how rapidly he or she is acquiring the language (Glennen, 2007). To optimize assessment procedures, and to make informed decisions regarding postassessment recommendations, careful consideration of risk factors is needed (Glennen, 2007; Hough & Kaczmarek, 2011; Jenista, 2000).

Records Review

Careful review of pre-adoption records and available postarrival assessments by adoption professionals (e.g., pediatrician, psychologist) should be performed. The latter is very important as it will indicate which pre-adoption diagnoses are valid and whether any additional medical diagnoses affecting speech, language, and cognition were added postarrival (Gindis, 2004; Miller, 2005). It is also important because there may be times when internationally adopted children arrive to a receiving country with undetected disorders and deficits such as infections, visual and hearing impairments and alcohol-related deficits (Jenista & Chapman, 1987; Johnson, 2000; Miller et al., 2007). Lack of detection is further increased in children adopted from economically developing countries or from hard-to- access insular, regional orphanages, where they may fail to receive consistent and appropriate medical care, thus, deficits may be missed or unrecognized (Ladage, 2009).

A Note on Alcohol-Related Deficits

Alcohol-related deficits are also a particular concern for children adopted from Russia and other Eastern European countries (Davies & Bledsoe, 2005; Johnson, 2000; Ladage, 2009). Any anecdotal information that the parents may have gained regarding maternal alcohol

use during pregnancy will be very important. Knowledge and attitudes among Russian physicians regarding Fetal Alcohol Spectrum Disorder (FASD) has only recently began to shift toward better detection practices. Thus, information regarding maternal alcohol consumption and/or the presence of alcohol-related phenotype may not be documented in the pre-adoption records (Balachova et al., 2010; Varavikova & Balachova, 2010).

Select studies of children in Russian orphanages reveal a high percentage of children presenting with FASD phenotype (Miller et al., 2006). However, diagnoses of full and partial FASD as well as Alcohol-Related Neurodevelopmental Deficits are also of significant concern (Landgren, Svensson, Stromland, & Gronlund, 2010), considering that they may also significantly affect language abilities in the areas of listening comprehension, verbal expression, verbal reasoning, social skills, and executive functioning (Coggins, 2011; Hyter 2012).

Although a number of studies report greater delays and poorer outcomes for children adopted from Eastern Europe, it is important to note that "significant developmental concerns can be seen in children from any country" (Ladage, 2009, p. 9; see also Abrines et al., 2012; Beverly et al., 2008; Eigsti, Weitzman, Schuh, de Marchena, & Casey, 2011; Hawk & McCall, 2011; Hough & Kaczmarek, 2011).

Presence of BirthLanguage Delay

If the child's records contain a notation regarding a birth language delay, this should be considered a serious concern (Gindis, 1999). Birth language delays transfer and affect the new language (McLaughlin, Gesi Blanchard, & Osanai, 1995). These delays will typically continue to persist unless appropriate and relevant interventions are provided. According to Glennen (2009), "Any child with a known history of speech and language delays in the sending country should be considered to have true delays or disorders and should receive speech and language services after adoption" (p. 52). Children who will be arriving to receiving countries with medical diagnoses that could affect their speech language abilities should be assessed and considered for therapy services as well (Ladage, 2009).

Assessment Recommendations

Most authors agree that these children's language abilities should be retested and monitored at regular intervals during the first several years post-arrival. Glennen (2007) recommends three evaluations during the first year post arrival, with annual reevaluations thereafter, whereas Hough and Kaczmarek (2011) recommend a similar reevaluation schedule (3 to 4 times a year) for a period of 2 years, post arrival. However, because a number of studies have identified that some internationally adopted children continue to present with language-based deficits many years (5+) postadoption, it is recommended that an individualized approach be used with respect to frequency and type of reassessments, because deficits can manifest during any given period post arrival (Beverly et al., 2008; Desmarais, et al., 2012; Eigsti et al., 2011; Hough & Kaczmarek, 2011).

Initial Assessments

Typically during the initial assessments, children should be demonstrating rapid language gains in the areas of receptive language, vocabulary, and articulation (Glennen, 2007, 2009). During the first several reassessments, standardized scores cannot be reported, so clinical judgment should be used to determine whether adequate gains are demonstrated. For children adopted between 3 to 4 years of age, standardized tests can be used to validly assess the above areas, but not expressive language after 1 year home (Glennen, 2009). When assessing expressive language 1 year post-arrival, Glennen (2009) recommends using "peer-based local norms" [to] "provide insights into who is doing well and who has a true language-

learning disorder" (p. 60). It is recommended that assessors use language samples and dynamic assessment measures provide a more accurate picture of the child's abilities (Gindis, 2005; Hough & Kaczmarek, 2011).

Follow-Up Monitoring of Possible Problem Areas

As these children's basic comprehension and expression abilities improve, it is very important to ensure that they continue making gains in all of the other areas of language that contribute to academic success. Specific areas of weakness identified by studies include impaired verbal memory and sentence comprehension, reduced sentence length and complexity, reduced discourse and narrative abilities, as well as impaired reading and writing abilities (Beverly et al., 2008; Croft et al., 2007; Dalen, 2001; Dalen, 1995; Desmarais, et al., 2012; Hough & Kaczmarek, 2011; Loman, Wiik, Frenn, Pollak, & Gunnar, 2009). Problem solving and verbal reasoning as well as social pragmatic skills and executive functioning were found to be additional areas of weaknesses (Gindis, 2005; Glennen & Bright, 2005; Jacobs, Miller, & Tirella, 2010; Tarullo, Bruce & Gunnar, 2007; Welsh & Viana 2012).

Focus on Behavior

Behavior difficulties, especially for children adopted from Eastern European countries, were documented in a number of studies as well (Abrines et al., 2012; Barcons-Castel, Fornieles-Deu, & Costas-Moragas, 2011; Glennen & Bright, 2005). Close attention should also be paid to postinstitutionalized children diagnosed with psychiatric disorders, considering there is a strong correlation between psychiatric disorders and language impairment, particularly social pragmatic language abilities (Cohen et al., 1996; Hyter, 2003).

Future Research Directions

Given the limited number of relevant studies, there is an urgent need for research in the area of language acquisition of postinstitutionalized children adopted at older ages. Based on clinical practice, longitudinal research is also urgently needed in the area of social pragmatic language development of post-institutionalized children adopted at younger ages (under 24 months).

Conclusions

Understanding the combined impact of risk factors (e.g., institutionalization, early maltreatment, pre and postnatal trauma) on the development of language abilities is a critical piece in determining appropriate service delivery for older internationally adopted children. It is recommended that clinical decisions be made on individual case-by-case basis and that parental and teacher input be considered in the decision making process. Children, who reportedly struggle academically after adequate exposure to L2 do not merit a "wait and see attitude" and should begin to receive appropriate intervention services as soon as possible (Hough & Kaczmarek, 2011; Scott & Roberts, 2007). Services should focus not only on improving these children's communicative language competency but also on those higher level language abilities (Gindis, 2005), including verbal reasoning skills, gestalt processing ability, social pragmatic abilities, and executive function skills that contribute to academic success.

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