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Speech and Language in Children Adopted Internationally at Older Ages

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Relatively little is known about the speech and language development of children adopted from other countries at older ages. The majority of children are adopted as infants and toddlers under the age of 2. Studies of internationally adopted children's cognition and language development have primarily focused on this group (Glennen, 2007; Glennen & Masters, 2002; Roberts et al., 2005; Rutter and the English and Romanian Adoptees Study Team, 1998). However, children adopted at older ages undergo a different language learning experience than younger children. On the positive side they begin the language transition with more developed abilities in their first language. These existing language skills provide a scaffold which accelerates the language learning process (Snedeker, Geren, & Shafto, 2007). However, these children have two risk factors working against them. The first is that longer stays in institutionalized settings such as orphanages negatively impact child development and are linked to worse developmental outcomes (Johnson & Dole, 1999; Morison, Ames, & Chisholm, 1995; O'Connor et al., 2000). Children adopted at older ages typically experience longer stays in orphanages. However, some older children reside with family members for several months or years before orphanage placement (Miller, 2005a). Their outcomes may be better or worse, depending on the family circumstances that led to the orphanage placement. Other children reside in foster care before adoption and tend to have better outcomes (Miller, Chan, Comfor, & Tirella, 2005).

The second risk factor working against older internationally adopted children is that they typically begin school before their English language abilities have fully developed. On the surface, internationally adopted children seem to be faced with the same academic learning issues as bilingual children. However, bilingual children with appropriate family and community support typically maintain their first language (L1) while in the process of learning English (L2). Academic concepts that aren't understood in English can be reviewed in L1. In contrast, internationally adopted children rapidly lose L1. Expressive use of L1 erodes within 2 to 4 months of adoption, comprehension is lost within 4 to 6 months (Gindis, 2003). Until English develops, internationally adopted children have no language for teaching or explaining academic concepts. This leaves them academically vulnerable during the language transition years. During the transition period most of these children will require extra academic support such as English as a Second Language, Title I assistance, and extra tutoring. However, some older internationally adopted children require even more support including speech and language services.

The dilemma is determining which children require extra speech and language services when there is no proficient language to assess. During the transition period, neither L1 nor L2 are valid indicators of language ability. While there are no perfect solutions to this dilemma, preliminary evidence from current research provides some insights. In addition relevant case history infor-

mation from the birth country can help guide the decision process. The purpose of this article is to provide initial information to assist speech language pathologists in making decisions about assessment and intervention for children adopted from other countries at older ages.

Case History Information

Relevant case history information can provide background evidence for the presence or absence of language or speech delays in L1. This information is readily available from some countries, and less available from others. For example, in Russia parents are provided with brief translated summaries of medical records and are usually given time to discuss the child's health and development with the head of the orphanage (Miller, 2005b). In other countries such as China, written records are available, but children are typically brought to meet parents at a civil adoption center or hotel. The caretakers who bring the children usually can't answer health or developmental questions (Miller, 2005b). Speech language pathologists should ask parents for any information about early development, speech and language or other relevant medical areas. Sometimes parents will not have written records but will have anecdotal information that indicates a speech or language delay in L1. For example, a translator might comment that the child is hard to understand, or a caretaker might indicate that the child doesn't listen as well as other children in the orphanage. These anecdotal pieces of evidence should also be considered when determining if a child has a delay or disorder in L1.

While medical and assessment reports from the birth country can be helpful, they just as frequently are incorrect or uninterpretable (Mason

& Narad, 2005; Miller, 2005b). Sending countries usually attempt to provide honest information about the child. However, developmental 'assessments' in many orphanages consist of subjective judgments from orphanage staff, or antiquated methods of testing such as snapping fingers to test hearing. In addition, medical practices in other cultures are different from western medicine and often difficult to interpret. For example, in Russia children are routinely given neurological diagnoses such as perinatal encephalopathy, hypotrophy, and insufficiency of cerebral circulation (Miller, 2005b). These are valid diagnoses according to Russian medical practice, however upon follow-up in the United States, these diagnoses are rarely confirmed (Johnson & Dole, 1999). Physicians who specialize in international adoption medicine are experienced at reviewing medical and developmental information from other countries. They can provide insight regarding which information is valid and which should be ignored.

The final case history piece is determining if the child received speech and language services in the birth country. Russia, and other countries that were part of the former Soviet Union, have speech language pathologists (logopedists) who work in orphanages. A child receiving speech therapy in these countries likely had true delays in expressive language, articulation, or both. Children adopted at older ages are at risk for communication disorders if the case history indicates that L1 abilities were delayed, or indicates they received speech and language therapy. These children should be monitored closely soon after arriving home. If English language abilities do not emerge at a rapid pace, the children should be considered for speech and language intervention.

Assessments in L1

Internationally adopted children lose their birth language (L1) quickly. As previously stated, expressive use is lost within 2 to 4 months of arriving home, comprehension is lost within 4 to 6 months (Gindis, 2003). Ideally, L1 abilities should be assessed within 2 to 3 months of arriving home by a speech language pathologist who speaks the language. If that option is not available, the assessment should be conducted using a trained interpreter who speaks the language. Guidelines that establish best-practices for assessing bilingual children can be followed soon after the child arrives home (Genessee, Paradis, & Crago, 2004; Goldstein, 2000). After the 4 month window of opportunity disappears, then children cannot be validly assessed in L1. The only exception is when parents are able to maintain L1 in the adoptive home by speaking the language, or having a caretaker or tutor who speaks the language. In addition, children adopted in sibling groups often maintain the language for longer periods, especially if the oldest siblings were literate in L1 at the time of adoption.

Assessments in L2

After L1 disappears, English is the only language available to assess speech and language disorders. However, while the child is in the process of learning English, standard norms cannot be used. Ideally local norms based on internationally adopted peers learning English should be used. At this time such local norms don't exist, however preliminary evidence from a longitudinal study provides an initial glimpse at the typical rate of language acquisition experienced by these children.

In an attempt to develop local norms for older children, I have been tracking language development in

children adopted between the ages of 2.0 and 5.11. The children were initially evaluated within 3 to 4 months of arriving home, re-evaluated 2 more times within the first year, then annually thereafter. At this point, 13 children have been home 1 year, and 10 children have been home 2 years. Their rate of language learning has been nothing less than incredible. One year after adoption average standard scores on the Clinical Evaluation of Language Fundamentals-Preschool (CELF-P; Wiig, Secord, & Semel, 1992) receptive language composite were 93.23 (sd = 9.28) with a range from 81 to 106. Similarly, standard scores on the Peabody Picture Vocabulary Test III (PPVT-III; Dunn & Dunn, 1997) averaged 93.07 after one year home (sd=7.27, r=78 to 108). CELF-P expressive language standard scores were slightly lower, averaging 89.00 (sd=15.03) but were more variable with a range of 69 to 118. Articulation was also developing well. Scores on the Goldman-Fristoe Test of Articulation (Goldman & Fristoe, 2000) averaged 96.76 (sd=9.62). Although these data are preliminary and more children need to be studied, after one year home children adopted between 2 and 5.11 years of age should fall within normal limits on tests of English language comprehension (Standard Score > 80). Children who are not showing signs of rapid gains in comprehension likely have true language learning issues that need more than typical English as a Second Language (ESOL) services.

After 2 years home, the children's language abilities had improved even further. This information is based on a limited sample of 10 children but provides an initial glimpse at the rapid rate of language learning experienced by these children. Two years after adoption, the children averaged standard scores of 100.7 on the CELF-P receptive language composite (r=89-124). Expressive

language composite standard scores on the CELF-P averaged 100.9 (r=81-124).

Clearly after one year home children adopted at older ages were still in the language transition process. However, measures of language comprehension can be used to determine which children are lagging behind their peers and require more support from speech language pathologists. In addition, preliminary limited evidence suggests that after 2 years home, children adopted between 2 and 5.11 years of age complete the transition from the birth language to English. Two years after adoption they can be assessed using English language standard norms to determine the presence of speech and language disorders.

Conclusion

Determining speech and language disorders in children adopted at older ages is an inexact science at this time. During the language transition process these children lack proficiency in any language, making the process of valid speech and language assessment difficult. However, case history information from the birth country combined with careful use of English speech and language assessment measures can be used to determine which children are progressing slowly through the language transition process and are in need of further support, including speech and language services.

Author Information

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