Navigating Challenges Within the Available Systems of Care in an International Adoptee: A Case Presentation

Zuleimye Valle Blás, MD MPH

The author has no disclosures.

Background

Adopted children and children placed in foster care are at increased risk of developing a range of mental health, behavioral, and psychosocial adjustment problems.[1]
After adoptive placement, an international adoptee has to cope with integrating the loss of their culture and birth family into their lives. They may face problems regarding their divergent identity as most international adoptees are raised by parents who do not share their racial and cultural background.[2]

Research shows that the population of adoptive/foster parents are typically resourceful individuals highly motivated to participate in interventions.[1] However, if these interventions within systems of care lack the cultural appropriateness needed for clinical application, then the interventions become ineffective.

Systems of care are family driven, community based, and culturally and linguistically competent for their families and youth with, or at risk of, mental health challenges in order to help them function better at home, in school, in the community, and throughout life.[3]

However, there are many challenges to systems of care implementation including funding availability, workforce shortages, deficiencies in cross-systems collaboration, and variability in insurance coverage.[4]

Case Introduction

This case explores the international adoption of an older child's struggles with accelerated acculturation and the challenges of poor linguistic and cultural appropriateness in the available systems of care.

Case Presentation

A 14-year-old Hispanic female with diagnoses of ADHD, RAD, and PTSD.

Biological factors:
Predisposing: unknown history of prenatal care including +/- in-utero toxic exposures or birth complications, unknown sexual abuse history.
Precipitating: multiple medication changes.
Perpetuating: chronic mental health illness requiring multiple CSU admissions.
Protective: good health, good response to medication, lack of substance use history, and average intelligence.

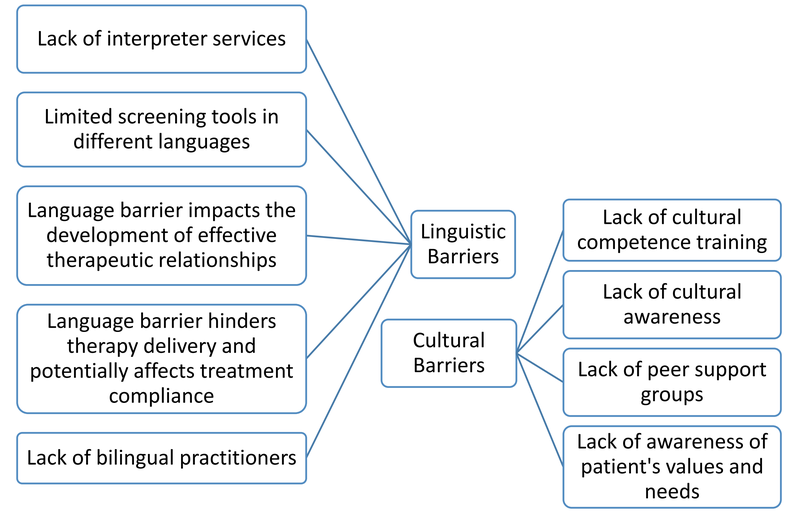
Social factors:
Predisposing: language barrier, immigration, late adoption with separation from biological siblings.
Precipitating: interpersonal trauma, immigration, marital separation of adoptive parents, and recent relationship break-up.
Perpetuating: language barrier, adoptive parents separation, lack of culturally competent services, and chronic discord with adoptive father.
Protective: positive relationships with friends and family, religiousness, good interpersonal support, pro-social activities like soccer and softball, strong church support, and working in school. In addition, alongside agencies involved in care such as wraparound services, counseling, psychiatry, school with IEP, PCP, and CSU.

Psychological factors:
Predisposing: history of insecure attachments, fear of abandonment, low self-esteem, ACEs score 6 or higher which includes: history of neglect, physical abuse, domestic violence, poverty, institutionalized from ages 3-11.
Precipitating: difficulty with transitions and re-experiencing of abandonment feelings after separation of adoptive parents.
Perpetuating: lack of adaptive coping mechanisms resulting in engagement of risky behaviors such as elopement; borderline personality traits; fears of abandonment with sensed lack of belonging; limited insight.
Protective: good response to secure attachments.

Acute stressors include recent break-up with boyfriend, which has exacerbated her emotional dysregulation, fear of abandonment, low self-esteem and self-worth, and thoughts of self-harm. However, she has good social support and medication response, thus she will benefit from culturally competent and integrative services.

Discussion

Although the patient and their adoptive family were highly motivated to participate in treatment, they struggled to find linguistically and culturally competent interventions within our available systems of care.



According to a study, patients in a culturally-focused psychiatric consultation intervention program agreed that it is more important that their provider speak their language than that they have the same cultural background.[5]

Although we should strive for both culturally and linguistically competent systems of care, language is a great place to start.

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Acknowledgements

The author would like to thank Dr. Andrea Fritschle, Dr. Luis Hernandez Cobian , Dr. Mary Ashley Mercer, and Dr. Justine Larson for their contributions.