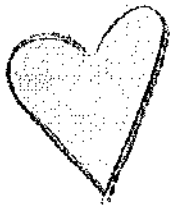
RESOURCES AND ADDITIONAL READINGS



RESOURCES

race & culture

Love Isn't Enough (formerly antiracistparent.com)
Thought provoking blogs, podcasts and courses.

http://loveisntenough.com/

A Look at Colorblindness

http://tech.mit.edu/V122/N3/col122-3ph.3c.html

Thinking and Teaching About Transracial Adoption

http://www.abanet.org/publiced/focus/f96adop2.html

Colorblindness: The New Racism? (be sure and check out their other articles, too)

http://www.tolerance.org/magazine/number-36-fall-2009/colorblindness-new-racism

Harlow's Monkey (thought provoking blog)

http://harlowmonkey.typepad.com/harlows_monkey/adoptive_parents_being_an.html

Pact, An Adoption Alliance (excellent resource focused on transracial adoption)

http://www.pactadopt.org

7 Common Transracial Parenting Mistakes

http://nysccc.org/family-supports/transracial-transcultural/voices-of-parents/7-common-transracial-parenting-mistakes/

Adopted (look at film clips, their movie and book, too)

http://www.adoptedthemovie.com

`http://www.childwelfare.gov/adoption/adopt_parenting/`

`http://www.cdc.gov/immigrantrefugeehealth/adoption/`

Resources for Parents of Children with Reactive Attachment Disorder

Websites

- www.radkid.org
  - RadKid.Org seeks to serve as a resource and source of mutual support for parents or others who are parenting children with reactive attachment disorder.
- www.attach.org
  - Association for Treatment and Training in the Attachment of Children
- http://www.attachmenttherapy.com/index.htm
  - With all the knowledge, skills and resources at our disposal, we are committed to excellence in the implementation of effective and sound clinical practices for the promotion of healthy adult attachments.
- http://adsg.syix.com
  - Attachment Disorder Support Group
- http://attachmentparenting.org
  - Attachment Parenting International
- http://attachmenttherapy.com
  - Evergreen Consultants in Human Behavior
- http://forums.delphiforums.com/radkid/
  - A support forum for parents and guardians of children with attachment disorders and difficulties with emotion.
- www.radzebra.org
  - Attachment & Trauma Network
- www.thelittleprince.org
  - Information for those struggling with attachment disorders
- http://members.tripod.com/`judyarnall
  - Resource center for information about attachment parenting
- www.danceofattachment.org
  - To help children and adults who struggle to develop healthy attachments with others because of missed essential building blocks due to loss, neglect, abuse, trauma and developmental challenges.

BOOKS

Golden, H.V. & Bartels – Rabb, L.M/ (1993). Real Parents Parenting the Adopted Child. Cross Road. New York, New York.

Gulden, H.V. & Vick C. (2005) Dance of Attachment: An adoptive Parent's Guide to Fostering Healthy Development.

Hughes, D. (1997). Facilitating Developmental Attachment and Building Bonds of Attachment. Jason Aronson, Inc.

Kagan, R. (2004). Rebuilding Attachments with traumatized Children. The Haworth Maltreatment and trauma Press.

Keck, G. & Kupecky, R. (2002) Adopting the Hurt Child. Pinon Press.

Siegel, D.J. & Hartzell, M. (2003). Parenting From the Inside Out. The Penguin Group, New York, New York.

Thomas, N. (1997). *When Love is Not Enough: A Guide to Parenting Children with RAD – Reactive Attachment Disorder*. Glenwood Springs, CO: Families by Design

ARTICLES

Chaffin, Hanson, Saunders, Nichols, et al. (2006). Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems. *Child Maltreat,* 11, 76.

Cooke, P.K. & Forrest, D. (1993). Attachment Disorder: An emerging concern for school counselors. *School Guidance & Counseling,* 27(3).

Millward, R. Kennedy, E., Towlson, K., Minnis, H. (2006). Reactive attachment disorder in looked after children. *Emotional and Behavioral Difficulties,* 11(4), 273-279.

Schwartz, E. & Davis, A.S. (2006). Reactive Attachment Disorder: Implications for School Readiness and School Functioning. *Psychology in the School,* 43 (4), 471-479.

National Adoption Information Clearinghouse

330 C Street SW
Washington, DC 20447
(703)-352-3488 Fax: (703)-385-2206 (888)-251-0075

Written by Debra G. Smith, ACSW Director of the National Adoption Information Clearinghouse 1994

Transracial and Transcultural Adoption

Transracial or transcultural adoption means placing a child who is of one race or ethnic group with adoptive parents of another race or ethnic group. In the United States these terms usually refer to the placement of children of color or children from another country with Caucasian adoptive parents.

People choose to adopt transracially or transculturally for a variety of reasons. Fewer young Caucasian children are available for adoption in the United States than in years past, and some adoption agencies that place Caucasian children do not accept singles or applicants older than 40. Some prospective adoptive parents feel connected to a particular race or culture because of their ancestry or through personal experiences such as travel or military service. Others simply like the idea of reaching out to children in need, no matter where they come from.

Adoption experts have different opinions about this kind of adoption. Some say that children available for adoption should always be placed with a family with at least one parent of the same race or culture as the child. This is so the child can develop a strong racial or cultural identity. These people say that adoption agencies with a strong commitment to working with families of color and that are flexible in their procedures are very successful in recruiting "same race" families. Other experts say that race should not be considered at all when selecting a family for a child. To them, a loving family that can meet the needs of a particular child is all that matters. Still others suggest that after an agency works very hard to recruit a same-race family for a certain period of time but does not find one, the child should be placed with a loving family of any race or culture who can meet the child's needs.

Despite the experts' differing opinions, there are many transracial and transcultural families, and many more will be formed. If you are or wish to be a parent in one of these families, this factsheet will help you by answering two questions: (1) What should you do to prepare for adopting a child of a race or culture different from yours? and (2) After adoption, what can you do to help your child become a stable, happy, healthy individual, with a strong sense of cultural and racial identity?

How You Can Prepare for a Transracial or Transcultural Adoption

Preparation for adoption is important for anyone thinking about adopting a child. It is even more important for parents considering transracial or transcultural adoption because it will introduce you to all aspects of adoptive parenthood, help you learn about adoption issues, and help you identify the type of child you wish to parent. Any adoption agency that conducts and supervises transracial or transcultural adoptions should provide this important service. If you are undertaking an independent adoption, you should seek counseling and training in these areas. You should also read as many articles and books as you can on the subject. (See the resource list at the end of this factsheet.)

The following sections describe some issues to consider as you prepare for a transracial or transcultural adoption.

Examine Your Beliefs and Attitudes About Race and Ethnicity

While you may think you know yourself and your family members very well, it is important to examine your beliefs and attitudes about race and ethnicity before adopting a child of another race or culture. Try to think if you have made any assumptions about people because of their race or ethnic group. There are two reasons for this exercise: (1) to check yourself -- to be sure this type of adoption will be right for you; and (2) to prepare to be considered "different."

When you adopt a child of another race or culture, it is not only the child who is different. Your family becomes a "different" family. Some people are comfortable with difference. To them, difference is interesting, wonderful, and special. Other people are not so comfortable with difference, and are scared by it. Thus, some friends, family members, acquaintances, and even strangers will rush to your side to support you, while others may make negative comments and stare. During the pre-adoption phase, you should think about how you will respond to the second group in a way that will help your child feel good about himself or herself. (We'll give you some ideas a little later.)

When your child is young, an extra hug and a heart-to-heart talk might be all it takes to help him or her through a difficult situation. While the hugs and the heart-to-heart talks never stop, as your child gets older, you and your child will need more specific coping skills to deal with the racial bias you might face together as a family. Are you ready to fully understand these issues and help your family deal with whatever happens?

Think About Your Lifestyle

Before considering a transracial or transcultural adoption, take a look at your current lifestyle. Do you already live in an integrated neighborhood, so that your child will be able to attend an integrated school? If not, would you consider moving to a new neighborhood? Do you already have friends of different races and ethnic groups? Do you visit one another's homes regularly? Do you attend multicultural festivals? Do you enjoy different kinds of ethnic foods? How much of a leap would it be to start doing some of these things?

It is important for children of color growing up with Caucasian parents to be around adults and children of many ethnic groups, and particularly, to see adult role models who are of the same race or ethnic group. These people can be their friends, teach them about their ethnic heritage, and as they mature, tell

them what to expect when they are an adult in your community. Can you make these types of relationships available for your child?

Consider Adopting Siblings

It is always good for siblings to be adopted together. It is no different in the case of transracial or transcultural adoption. Siblings who are adopted together have the security of seeing another person in the family who looks like them. They are able to bring a part of their early history and birth family with them to their adoptive family, which may help them adjust better. And with internationally adopted children, being together might mean they will be able to keep up their native language.

Let's say, then, that you have examined your beliefs and attitudes about race and ethnicity. You have thought about your lifestyle and considered adopting siblings. You are sure you want to adopt a child from another race or culture. What comes next?

How You Can Help Your Child To Become a Stable, Happy, Healthy Individual With a Strong Sense of Racial or Cultural Identity

The seven parenting techniques listed below were compiled from books and articles on adoption and by interviewing experts in transracial and transcultural adoption. Some of these "techniques" are common sense and apply to all adopted children. However, with transracially or transculturally adopted children, these techniques are especially important.

Parents in a transracial or transcultural family should do the following:

- Become intensely invested in parenting;
- Tolerate no racially or ethnically biased remarks;
- Surround yourselves with supportive family and friends;
- Celebrate all cultures;
- Talk about race and culture;
- Expose your child to a variety of experiences so that he or she develops physical and intellectual skills that build self-esteem; and
- Take your child to places where most of the people present are from his or her race or ethnic group.

The next sections provide more information on these techniques.

Become Intensely Invested in Parenting

Dr. Larry Schreiber, former president of the North American Council on Adoptable Children (NACAC), an umbrella organization for a large number of adoptive parent support groups in the United States and Canada, wrote a column about his transracial adoption experience in the Winter 1991 issue of Adoptalk, [1] the NACAC newsletter. He characterizes transracial parenting as a "roller coaster of exaggerated parenting." As a Caucasian adoptive father of African-American, Latino, Korean, Cambodian, East Indian, and Caucasian children, he describes transracial parenting as the most joyous experience of his life. He admits that he doesn't really know what it is like to endure the racially-biased

name-calling that his children have experienced, but he was always there for them when they needed to be comforted and to help them get through those difficult times.

Dr. Schreiber says that transracial parenting has both complicated and enriched his life. He had to work hard to help his children develop their cultural pride and self-esteem in a world that sometimes does not understand or is unkind to people from different cultures. However, he believes his children did overcome these difficulties and were able to develop positive cultural identities, mostly because of the help his family received from adoptive parent support groups and from other adults of the same cultural groups as his children.

Ms. RoAnne Elliott is another experienced adoptive parent in an interracial family who has written about the importance of investing in parenting. An African-American woman, Ms. Elliott encourages parents in transracial families to empower themselves and believe strongly that their family belongs together. She writes, "You need the firm knowledge in your heart and in your mind that you are the best parent for your children. This empowerment is key, since you can't parent well if you don't feel confident, competent, and entitled to do so."[2] She says that being in an interracial family is the opportunity of a lifetime, allowing you to embark on "a journey of personal transformation, growing in your ability to nurture your children along the way. This involves an alert awareness of difference and an optimistic expectation that cultural differences among us will lead to rewarding personal connections and friendships."[3]

The message, then, is that transracial parenting is not laid-back, catch-as-catch-can parenting. According to these two experienced adoptive parents, the demands are great, but so are the rewards.

Tolerate No Racially or Ethnically Biased Remarks

As adoptive parents in an interracial or intercultural family, you should refuse to tolerate any kind of racially or ethnically biased remark made in your presence. This includes remarks about your child's race or ethnic group, other races and ethnic groups, or any other characteristic such as gender, religion, age and physical or other disability. Make it clear that it is not okay to make fun of people who are different, and it is not okay to assume that all people of one group behave the same way.[4] Teach your children how to handle these remarks, by saying, for instance, "I find your remark offensive. Please don't say that type of thing again," or "Surely you don't mean to be critical, you just don't have experience with . . ." or "You couldn't be deliberately saying such an inappropriate comment in front of a child. You must mean something else."

Try to combat the remarks while giving the person a chance to back off or change what has been said. This way you will teach your child to stand up to bias without starting a fight -- which could put your child at risk. In addition, by being gracious and giving others a chance to overcome their bias/ignorance, you can help to change their beliefs and attitudes over time. Positive exchanges about race will always be more helpful than negative ones.

Surround Yourselves With Supportive Family and Friends

While you were thinking about adopting transracially or transculturally, did you find some people in your circle of family and friends who were especially supportive of your plans to become a multicultural family? If so, surround yourself with these people! In addition, seek out other adoptive

families, other transracial or multicultural families, and other members of your child's racial or ethnic group. You will be surprised by how helpful many people will want to be, whether it is to show you how to cook an ethnic dish or teach you some words in their language. According to Ms. RoAnne Elliott, "You need a supportive community comprised of many races -- those who will be role models and provide inspiration, those who will stimulate your thinking, those who fill your desire for cultural diversity, and those who will challenge you in constructive and respectful ways.[5]

Celebrate All Cultures

As a multicultural family, you should value all cultures. Teach your child that every ethnic group has something worthwhile to contribute, and that diversity is this country's and your family's strength. For example, you might give your Korean daughter a Korean doll, but you might also start a collection for her of dolls of many different racial and ethnic groups. If your child is from South America, go to the Latino festival in your town, but also visit the new Native-American art exhibit, eat at the Greek fair, and dance at the Polish dance hall. Incorporate the art, music, drama, literature, clothing, and food of your child's ethnic group and others into your family's daily life.[6] Invite friends from other cultures to celebrate your holidays and special occasions, and attend their events as well.

The area of religion brings up special concerns. You may wish to take your child to a place of worship in your community where most of the members are from the same ethnic group as your child; for example, you could bring your East Indian child to a Hindu temple or your Russian child to a Russian Orthodox church. What an opportunity to meet people of his ethnic group, find adult role models, and learn the customs of his heritage! However, before you do this, be sure you could be supportive if your child decides to practice that religion. If you have your heart set on raising your child in your own family's religion - one that is different from the religion practiced in the place of worship you will visit -- tell your child that the visit is for a cultural, not religious, purpose or perhaps decide not to visit at all. Practically speaking, you can impose your religious practice on your child for only a few years. As an adult, your child will ultimately decide whether to practice any religion at all, and whether it will be one that people of his or her heritage often practice, your family's religion, or yet another one that he or she chooses.

While it is important to teach your child that differences among people are enriching, it is also important to point out similarities. One expert suggests that in an adoptive family the ratio should be two similarities for each difference.[7] For instance, to a young child you might say, "Your skin is darker than Daddy's, but you like to play music, just like he does, and you both love strawberry ice cream." As much as you want to celebrate your child's distinctive features, he or she also needs to feel a sense of belonging in the family.

Talk About Race and Culture

How has race or culture defined you? What is life like for a Latino person in America? What is life like for a Caucasian person? An African-American person? An Asian person? How are persons of different ethnic groups treated by police officers, restaurant employees, social organizations, or government agencies? What do you think about interracial dating and marriage? As a multicultural family, you need to address these and other racial matters.

Talk about racial issues, even if your child does not bring up the subject. Use natural opportunities, such as a television program or newspaper article that talks about race in some way. Let your child know that you feel comfortable discussing race-the positive aspects as well as the difficult ones. On the positive side, a child of a certain race may be given preferential treatment or special attention. On the other hand, even a young child needs to know that while your family celebrates difference, other families do not know many people who are different. These families are sometimes afraid of what they do not know or understand, and may react at times in unkind ways. It can be difficult to deal with such issues, especially when your child is young and does not yet know that some adults have these negative feelings, but you have to do it. You will help your child become a strong, healthy adult by preparing him or her to stand up in the face of ignorance, bias, or adversity.

Stand behind your children if they are the victim of a racial incident or have problems in your community because of the unkind actions of others. This does not mean you should fight their battles for them, but rather support them and give them the tools to deal with the blows that the world may hand them. Confront racism openly. Discuss it with your friends and family and the supportive multicultural community with which you associate. Rely on adults of color to share their insights with both you and your child. Above all, if your child's feelings are hurt, let him talk about the experience with you, and acknowledge that you understand.

Ms. Lois Melina,[8] a Caucasian adoptive parent of Korean children and a noted adoption writer, lists five questions for you to ask your child to help him or her deal with problem situations:

- What happened?
- How did that make you feel?
- What did you say or do when that happened?
- If something like that happens again, do you think you will deal with it the same way?
- Would you like me to do something?

It is important to leave the choice of your involvement up to your child. This way, you show that you are available to help, but also that you have confidence in your child's ability to decide when your help is needed.

Expose Your Child to a Variety of Experiences so That He or She Develops Physical and Intellectual Skills That Build Self-Esteem

This parenting technique is important for all children, but it is especially important for children of color. Children of color need every tool possible to build their self-esteem. While society has made strides in overcoming certain biases and forms of discrimination, there remain many subtle and not-so-subtle color or race-related messages that are discouraging and harmful to young egos. Be alert to negative messages that are associated with any race or culture. Point them out as foolish and untrue. Emphasize that each person is unique and that we all bring our own individual strengths and weaknesses into the world. Frequently compliment your child on his or her strengths. Draw attention to the child's ability to solve math problems, play ball, dance, play a musical instrument, ride a bike, take photographs, perform gymnastics, or any other activity that increases confidence. Self-esteem is built on many small successes and lots of acknowledgement. A strong ego will be better able to deal with both the good and the bad elements of society.

As your child gets older, keep in touch with his or her needs: this might mean buying him or her a few of the in clothes or enrolling him or her on the popular teams. Stay in tune with your child's natural skills and talents, and do whatever you can to help him or her develop them at each age.

Take Your Child to Places Where Most of the People Present are from His or Her Race or Ethnic Group

If you bring your African-American child to an African-American church, or your Peruvian child to a Latino festival, your child will experience being in a group in which the number of people present of his ethnic group is larger than the number of Caucasians present. Adoptive family support group events are other places where this might happen. Children usually enjoy these events very much. If you adopted a young child from another country, you might consider taking a trip to that country when the child is older and can understand what the trip is all about. Many adoptive families who take such a trip find it to be a wonderful learning experience.[9]

Another benefit of such an experience is that it might be one of the few times when you feel what it is like to be in the minority. This will increase your awareness and ability to understand your child's experience as a minority individual.

Other Sources of Information

Transracial adoption is a "hot" topic in the media and in adoption circles. There is quite a lot of activity in this area of adoption practice. We offer the following brief sections for your information.

Where Can I Find Out More About Transracial or Transcultural Adoption?

Child Welfare Information Gateway often receives questions about which adoption agencies place children transculturally or transracially. The answer is twofold. Their names often signal the kinds of adoptions they conduct (for example, if they have the word "international" in their name). These agencies are marked with an asterisk in Information Gateway's National Foster Care & Adoption Directory. However, many agencies are not as open about their policy on transracial adoption because of some of the controversial issues surrounding this type of adoption. Ask your local adoption agencies about their policies in this area, especially if you are strongly considering this type of adoption.

Legislation

In 1994, transracial adoption was the subject of a bill before Congress submitted by Senator Howard Metzenbaum of Ohio. After intense debate, the Multiethnic Placement Act (MEPA) passed both houses of Congress. One positive outcome of the debate is that people who historically have been on opposite sides of the question are beginning to reach some common ground. One point that everyone agrees on is that adults of all cultures need to work together to help adopted children of all cultures reach their highest potential.

Statistics

Although available statistics are rough estimates, several sources show that the percentage of transracial or transcultural adoptions in the United States is significant. For example, one source estimates that 1,000 to 2,000 African-American children are adopted by Caucasian families each year.[10] Data from the Immigration and Naturalization Service show that U.S. families adopted 7,088 children from other countries in 1990. This means that there were roughly 8,500 transracial or transcultural adoptions in 1990. In that same year, there were almost 119,000 adoptions of all kinds.[11] Since approximately half of the adoptions in any year are stepparent or relative adoptions, in 1990 there were about 59,500 nonrelative adoptions. The percentage of transracial/transcultural adoptions (8,500 of 59,500) then, comes out to more than 14 percent.

Conclusion

Adopting a child of another race or culture can be a richly rewarding choice for many families, although there are also many unique challenges and concerns. Hopefully the information provided in this factsheet will provide food for thought and become part of the ongoing discussion in your home. The resources listed at the end of this factsheet should also be helpful.

Bibliography

Abramovitz, Melissa. "Living in a Racially-Mixed Family: A Question of Attitude." *OURS*, Jul-Aug 1991, v24 n4, p. 27.

Ahn, Helen Noh. *Identity Development in Korean Adolescent Adoptees: Eriksonian Ego Identity and Racially Ethnic Identity*. Berkeley, CA: University of California School of Social Welfare, 1989.

Barnes, Donna. "Building a Family: One Color at a Time." *AdoptNet*, Nov-Dec 1992, v3 n6, pp. 7-8.

Bartholet, Elizabeth. *Family Bonds: Adoption and the Politics of Parenting*. Boston: Houghton Mifflin Company, 1993.

Bates, J. Douglas. *Gift Children: A Story of Race, Family, and Adoption in a Divided America*. New York: Ticknor & Fields, 1993.

Brooks, Dorothy Elizabeth. "Black/White Transracial Adoption: An Update." *OURS*, Jul-Aug 1991, v24 n4, pp. 19-21.

Caldwell-Hopper, Kathi. "Adopting Across Lines of Color." *OURS*, Jul-Aug 1991, v24 n4, pp. 23-25.

Darden, Edwin. "Biracial and Proud!" *F.A.C.E. Facts*, Jan-Feb 1991, v14 n3, pp. 10-11.

Elliott, RoAnne. "Can White People Nurture Black Kids Effectively?" *Pact Press*, Autumn 1992, v1 n3, p. 8.

F.A.C.E. "How to Keep Racism from Defeating Your Child." *F.A.C.E. Facts*, Apr-May 1991, v14 n4, p. 22.

Flango, Victor Eugene and Flango, Carol R. "Adoption Statistics by State." *Child Welfare*, May-Jun 1993, v72 n3, pp. 311-319.

Frey, Susan. "Interracial Families." *AdoptNet*, Jul-Aug 1991, v3 n4, pp. 40-41, 46.

Gilles, Tom and Kroll, Joe. *Barriers to Same Race Placement*. St. Paul, MN: North American Council on Adoptable Children, 1991.

McFarlane, Jan. "Self-Esteem in Children of Color: Developmental, Adoption, and Racial Issues. *OURS*, Jan-Feb 1992, v25 n1, pp. 24-29.

_____. "Building Self-Esteem in Children and Teenagers of Color." *OURS*, May-Jun 1992, v25 n3, pp. 28-33.

McRoy, Ruth G. and Zurcher, Louis A., Jr. *Transracial and Inracial Adoptees*. Springfield, IL: Charles C. Thomas, 1983.

Melina, Lois. "Cultural Identity Goes Beyond Ethnic Foods, Dolls." *Adopted Child*, Dec 1988, v7 n12, pp. 1-4.

_____. "Transracial Adoptees Can Develop Racial Identity, Coping Strategies." *Adopted Child*, Jan 1994, v13 n1, pp. 1-4.

Neal, Leora and Stumph, Al. "Transracial Parenting: If It Happens, How White Parents and the Black Community Can Work Together." *Adoptalk*, Winter 1993, p. 6.

Nelson-Erichsen, Jean and Erichsen, Heino R. *Butterflies in the Wind: Spanish/Indian Children with White Parents*. The Woodlands, TX: Los Niños International Adoption Center, 1992.

O'Rourke, Lisa, Hubbell, Ruth, Goolsby, Sherrell and Smith, Debra. "Intercountry Adoption." Washington, DC: Child Welfare Information Gateway Fact Sheet, 1988, revised 1994.

Pederson, Jeff. "Traveling to Your Child's Country of Origin." *OURS*, Mar-Apr 1992, v25 n2, pp. 40-42.

Pohl, Constance and Harris, Kathy. *Transracial Adoption: Children and Parents Speak*. New York: Franklin Watts, 1992.

Raible, John. "Continuing the Dialogue on Transracial Adoption." *Adoptalk*, Summer 1990, p. 5.

Register, Cheri, M.D. "Are Those Kids Yours?" *American Families with Children Adopted from Other Countries*. New York: Free Press, 1991.

_____. "Are White People Colorless?" *OURS*, Jan-Feb 1994, v27 n1, pp. 32-34.

Richmond, Ann Freeman. "The Transracial Debate: A White Perspective." *Adoptalk*, Winter 1992, pp. 16-17.

Schreiber, Larry, M.D. "From the President." *Adoptalk*, Winter 1991, p. 2.

Simon, Rita and Altstein, Howard. *Adoption, Race, and Identity: From Infancy Through Adolescence*. New York: Praeger, 1992.

Thorp, Judy. "Our Trip to Chicago's Little India." *OURS*, May-Jun 1992, v25 n3, pp. 36-38.

Van Gulden, Holly. "Attachment and Bonding in Adoptive Families," Workshop at Families Adopting Children Everywhere (F.A.C.E.) Conference, Towson, Maryland, May 1992.

Resources

Magazines/Newsletters

Adoptalk
North American Council on Adoptable Children
970 Raymond Ave, Ste. 106
St. Paul, MN 55114-1149
(612)-644-3036

Adopted Child
P.O. Box 9362
Moscow, ID 83843
(208)-882-1794
F.A.C.E. Facts
Families Adopting Children Everywhere
P.O. Box 28058 Northwood Station
Baltimore, MD 21239
(410)-488-2656

Interrace Magazine
Biracial Child Magazine
P.O. Box 12048
Atlanta, GA 30355
(404)-364-9690

Adoptive Families
3333 Highway 100 North
Minneapolis, MN 55422
(612)-535-4829

Pact Press
3315 Sacramento St., Ste. 239
San Francisco, CA 94188
(415)-221-6957

National Origanizations

Adoptive Families
3333 Highway 100 North
Minneapolis, MN 55422
(612)-535-4829
How many books, toys, etc., of different cultures for sale.

National Council for Adoption (NCFA)
1930 17th St., N.W.
Washington, DC 20009
(202)-328-1200

North American Council on Adoptable Children (NACAC)
970 Raymond Ave., Ste. 106
St. Paul, MN 55114-1149
(612)-644-3036

Note: Each of the above organizations holds conferences in which workshops on relevant topics are audiotaped. For a list of all workshop/tape titles, contact Von Ende Communications, 3211 St. Margaret Dr., Golden Valley, MN 55422 (612)-529-4493.

Latin American Adoptive Families
40 Upland Road
Duxbury, MA 02332
(617)-934-6756

People of Every Stripe
P.O. Box 12505
Portland, OR 97212
(503)-282-0612

Local Parent Support Groups

There are too many of these to mention here. We have listed a few of the larger well-know ones. Contact NAIC, AFA, or NACAC for listings of all groups in your state.

Biracial Family Network
Box 489
Chicago, IL 60653

F.A.C.E. Facts
Families Adopting Children Everywhere
P.O. Box 28058 Northwood Station
Baltimore, MD 21239
(410)-488-2656

Interracial Family Association of Seattle
2802 33rd Ave. South
Seattle, WA 98144
(206)-764-2746

Interracial Family Circle
P.O. Box 53290
Washington, DC 20009
(410)-325-9739

Latin America Parents Association (LAPA)
South-Central New Jersey Chapter
P.O. Box 2013
Brick, NJ 08723
(908)-249-5600
Northern New Jersey (201)-385-6278;
New York (718)-236-8689;
Connecticut (203)-721-0197;
Washington, DC, Metro Area (301)-431-3407.

Pact, an Adoption Alliance
3315 Sacramento St., Ste. 239
San Francisco, CA 94118
(415)-221-6957

Audiovisual Materials

"Adoption: The Korean Teen Experience" (VHS; 36 minutes; 1984)
Contains excerpts from a discussion among teenagers of Korean origin in which they share their experiences of being adopted by American families. Available from Children's Home Society of Minnesota, 2230 Como Ave., St. Paul, MN 55108 (612)-646-6393. Purchase price $70.00; rental $30.00 (plus $4.00 shipping and handling; Minnesota residents add 6.5% sales tax).

"American Eyes" (VHS; 30 minutes; 1991)
Tells the story of a Korean-born 16-year old boy named John who was adopted by a Caucasian American family at the age of 10 months as he encounters racial prejudice at school and suffers blows to his self-esteem and cultural identity. The tape touches on a number of other topics, including America's pluralistic society, minority rights, and contributions of multiethnic and multiracial groups. Excellent for support groups of families with teenage children adopted from other countries. Available from The Media Guild, 11722 Sorrento Valley Rd., Ste. E, San Diego, CA 92121-9823, (619)-755-9191 or (800)-886-9191, fax (619)-755-4931. $295.00

"A Candid Talk About Loss in Adoption" (VHS; 38 minutes; 1990)
Discusses losses incurred by adopted persons and the stages of child development related to those losses and shows how adoptive parents can help children understand and deal with issues of loss. Issues of cultural and ethnic identity in transracial adoption are also covered. Features Mary Martin Mason and Deborah Johnson, both adopted persons and adoption professionals. Available from

AdopTapes, 4012 Lynn Ave., Edina, MN 55416 (612)-922-1136. $29.95 (plus $3.50 shipping and handling).

"A New Life in America" (VHS; 10 minutes; 1991)
Explains how and why Korean adoption works in the United States and what Korean-born children feel and experience as adoptees. Provides an orientation to adoption as a lifelong experience that is helpful for prospective adoptive parents, their extended families, young adoptees, and their classmates. Available from the Children's Home Society of Minnesota, 2230 Como Ave., St. Paul, MN 55108 (612)-646-6393. $15.00 (plus $4.00 shipping and handling; Minnesota residents add 6.5% sales tax).

"Raising a Child of a Different Race or Ethnic Background" (audiocassette; 90 minutes; 1990)
Covers the issues families face when they decide to adopt transracially or transculturally. Emphasizes the need for families to help their children develop skills to deal with being minorities and a positive attitude toward their race or culture. Available from Adopted Child, P.O. Box 9362, Moscow, ID 83843 (208)-882-1794. $11.00

"Transracial Adoption: Now That They are Grown" (audiocassette)
An audiotape of an actual workshop session on transracial adoption as seen through the eyes and experiences of several adult adoptees. Facilitated by Barbara Tremitiere, it presents pertinent questions that help the listener assess the challenges and implications of transracial adoptions. Available from Tremitiere Ward and Associates, c/o Barbara Tremitiere, 122 W. Springettsbury Ave., York, PA 17403. $10.00 (plus $1.50 shipping and handling).

"Winning at Adoption" (VHS, 120 minutes; 3 audiocassettes, 60, 45, and 90 minutes; 1991)
This videotape offers concrete steps prospective adoptive parents can take towards building their families by adoption. Presenters include leading adoption practitioners from all sides of the adoption triad. Areas covered include how to select and agency or attorney, specific strategies for finding a child, making adoption work for both the adoptive and birth families, and adoption as a lifelong process. The audiocassettes cover Adoption Readiness,Transcultural/Transracial Adoptions, Adopting a Child With Special Needs, and About the Birthfamily. Also includes a 60 page workbook. Package is available from The Family Network, P.O. Boc 2995, Studio City, CA 92614-0998 (800)-456-4056. $88.00 (Plus $5.00 shipping and handling).

Training Programs

Adoptions Together
3837 Farragut Avenue
Kensington, MD 20895
(301) 933-7333
Contact: Debbie Riley, Director, Family Resource Center
Program Title: "Transracial Adoption"

Association of Black Social Workers
Child Adoption, Counseling and Referral Service
1969 Madison Ave., #6 DFL
New York, NY 10035-1549
(212) 831-5181
Contact: Leora Neal, Executive Director
Program Title: "If Transracial Parenting Happens, How White Parents and the African-American Community Can Work Together"

Black Adoption Services/Three Rivers Adoption Council
307 Fourth Ave., Ste. 710
Pittsburgh, PA 15222
(412) 471-8722
Contact: Program Director
Program Title: "Promoting Racial Self-Esteem in Black Children Who Are Transracially Adopted"

Children's Home Society of Washington
Adoption Resource Center
3300 NE 65th Street
Seattle, WA 98115
(206) 524-6020 or (800) 456-3339
Contact: Training Director
Program Titles: "Interracial Adoption;" "Cross-Cultural Adoption"

Family Resources
1521 Foxhollow Road
Greensboro, NC 27410
(919) 852-5357
Contacts: Bernard and Joan McNamara, Executive and Associate Directors
Program Title: Transracial Adoption

Perspectives Press
P.O. Box 90318
Indianapolis, IN 46290-0318
(317) 872-3055
Contact: Patricia Irwin Johnston, Publisher and Educator
Program Titles: "Embracing Difference"; "Opening Ourselves to New Issues"

Southern Connecticut State University
Department of Counseling and School Psychology
501 Crescent Street

New Haven, CT 06515
(203) 397-4564
Contact: Dr. Nancy Janus, Professor
Program Title: "Adoption Issues Institute"

Linda Yellin and Associates
27600 Farmington Road, Suite 107
Farmington Hills, MI 48334
(810) 489-9570
Contact: Linda Yellin, Director
Program Title: "Education, Information, and Support for Families Who Adopt Children of a Different Religion or Ethnic Group"

Footnotes

1 Schreiber, p. 2.
2 Elliott, p. 8.
3 Elliott, p. 8.
4 Melina, 1988, p. 2.
5 Elliott, p. 8.
6 Thorp, p. 36.
7 Van Gulden, F.A.C.E Conference Workshop, 1992.
8 Melina, 1988, pp. 3-4.
9 Pederson, p. 42.
10 Brooks, p. 10.
11 Flango and Flango, p. 317.

This material has been taken from the National Adoption Information Clearinghouse Web site as reviewed and approved for addition to this site on December 28, 2003.

The National Adoption Information Clearinghouse http://naic.acf.hhs.gov, can be reached toll free at 1-888-251-0075,or by e-mail at: naic@calib.com

ADOPTING AN INSTITUTIONALIZED CHILD:

WHAT ARE THE RISKS??

By Dana Johnson, MD, PhD

After reviewing the medical records of nearly 1,000 institutionalized children, I can conclusively state that the most difficult area in adoption medicine is predicting the needs of children adopted from orphanages. Unfortunately, there is no shortage of dogmatic opinion, both positive and negative, on the outcome of these children. Recently I have been quoted as saying that 85% of institutionalized children are normal. If so, why are so many families seeking help for their adopted children through organizations like PNPIC? Confused by what you have heard? I am.

The major problem is that we are only beginning to understand how these kids are doing. Studies utilizing appropriately selected and tested institutionalized children have been too few to say with any certainty what percentage are normal (even if we could define what we mean by "normal"). It is also quite clear that the situation changes with time. Some children resolve problems, whereas others begin to exhibit them as the years pass. All contemporary studies of institutionalized adoptees from abroad deal with a rather narrow span of time–within two to five years of placement. Without valid data, we are left with our own opinions–which, of course, are shaped by our personal experience with adoption, by conversations with families we have come into contact with in our practice, and by our own world view.

What do we really know, and what can we say about institutionalized children as a group? More importantly, what can we say about the child you have adopted or are considering adopting? Certainly, no one is in a position to provide statistics on what percentage are abnormal or normal. Even if we did have those data, they would address the status of institutionalized children at an early age. Twenty years from now, worries that your child had language delays at four years of age will be replaced by concerns of whether your child has acquired the tools to be successful as an adult; *e.g.,* a positive self-image, a high school diploma and independent living skills. No one is in the position to even speculate on these long-term issues.

Following are questions and answers which address issues that I feel should be considered when adopting an institutionalized child. Since I am offering advice in the absence of irrefutable facts, you are entitled to know my personal view on this subject. Nothing would please me more than to have all institutionalized children find permanent homes. However, nothing would make me feel worse than having a family adopt a child they were unprepared to parent.

What are the chances that my child will be normal on arrival? Let me be blunt. The chance of an institutionalized child being completely normal on arrival in your home is essentially zero! Here's why:

- Kids aren't in orphanages because they come from loving, intact families with a good standard of living and ready access to good health care and nutrition. Abandonment by a destitute, single parent with poor prenatal care and inadequate diet is the most common reason why a child is available for adoption. The second most common reason is termination of parental rights because of neglect and/or physical/sexual abuse (often alcohol related). Over 50% of institutionalized children in Eastern Europe are low birth weight infants, many were born prematurely, and some have been exposed to alcohol in utero. Finally, children with major medical problems or physical handicaps may be placed in orphanages by their parents due to limited access to corrective treatment and rehabilitation services. These kids are a **high-risk group** by any standard.

- An orphanage is a terrible place to raise an infant or young child. Lack of stimulation and consistent caregivers, suboptimal nutrition and physical/sexual abuse all conspire to delay and sometimes preclude normal development. All institutionalized children fall behind in large and fine motor development, speech acquisition and attainment of necessary social skills. Many never find a specific individual with whom to complete a cycle of attachment. Physical growth is impaired. Children lose one month of linear growth for every three months in the orphanage. Weight gain and head growth are also depressed. Finally, congregate living conditions foster the spread of multiple infectious agents. Intestinal parasites, tuberculosis, hepatitis B, measles, chickenpox, middle ear infections, etc., are all found more commonly in institutional care settings

Will I be able to determine the nature and severity of my child's immediate health needs prior to arrival? I have seen very few children for whom sufficient information on prenatal factors, birth weight, and postnatal growth and development was available to say that the child was normal. A more common situation is identifying children who clearly are very abnormal. These are children who have the typical facial and growth characteristics of fetal alcohol syndrome, children with clear neurologic abnormalities and children with autistic-like behavior. It is impossible to predict the exact needs of most children, which is why you should have your child evaluated by knowledgeable professionals after arrival. Most institutionalized children, especially those older than two years of age, need rehabilitation services to correct deficits imposed by orphanage life.

Even if a child initially appears normal, remember that many problems are not apparent at the time of arrival in your home. For example, children with significant attachment issues often do not exhibit these behaviors until they feel secure in their new environment. The challenges of school, particularly the transition between kindergarten and first grade, may unmask subtle intellectual impairments and learning disabilities.

If my child isn't normal on arrival, when will he/she catch up? This is a question that no one can answer with certainty. We do know that your child will progress far better in your home than he/she would have in the orphanage, and that most children make tremendous gains in growth and development during the first years with their adoptive families. Unless a child is truly neurologically impaired, gross and fine motor skills as well as strength respond well to improved nutrition and a stimulating environment. However, many children, especially those who spent considerable time within institutional care settings, continue to show delays in language and social skills, behavioral problems, and abnormalities in attachment behavior even after several years in their adoptive home. In most situations, areas of delay respond to appropriate treatment, but resolution of the problem may take time and expert guidance. In some situations, therapy will improve but cannot correct the fundamental problem; e.g., fetal alcohol exposure. In these situations, the challenges will be life-long.

Since my child will likely have medical and/or developmental needs, will I be able to locate appropriate therapeutic resources within my community? Your child's most important resource is you and your family. Your commitment to your child's well-being is the single most important factor in success. However, despite what you may have heard, love alone may not be enough. Expert help is frequently needed to rehabilitate a child who has suffered prolonged neglect and abuse within an orphanage.

One of the most frustrating situations a parent can face is having a child with a problem, but no access to help. Hope for the best but prepare for the worst. Before you accept a referral, seek out the resources in your community that may be necessary. These include speech and language pathologists; occupational therapists with training in sensory integration therapy; neuropsychologists who have experience evaluating institutionalized children; and therapists with experience in post-institutional behavior problems and attachment disorders. Some of these services may be available for free within your school system, but many will involve significant expense. Be sure to check with your health plan to see what services are covered, at what level, and for how long. Careful investigation of these areas may help you decided if adopting an institutionalized child is an option for your family.

What are the chances that our child will have severe problems?

The likelihood that you will adopt an institutionalized child with problems so severe that they disrupt the fabric of your family is small. Educate yourself with information available through organizations such as PNPIC, then honestly evaluate your own capabilities as a parent. You may decide that the risk, though low, is too great for your situation.

If you decide to proceed, you can lower your chances of adopting such a child by obtaining appropriate information from your agency and having it reviewed by a knowledgeable physician prior to accepting a referral. An important part of this process is

being prepared to say no if you recognize that the needs of a certain child exceed your capabilities. Be aware, though, that you will never have all the information you need to eliminate this risk. Don't drive yourself wild in an endless search for that one final piece of information that will guarantee a correct decision. The best decision you can hope to make is one that is well-reasoned, based on the information that is available, accompanied by the "leap of faith" that is a mandatory part of all conscious decisions to parent. If you cannot knowledgeably assume this risk, international adoption–particularly of an institutionalized child–may not be for you.

Will we be satisfied that we made the choice to adopt a child from an orphanage? The answer to this question is the reason I remain optimistic about adopting institutionalized children. A study involving a questionnaire returned by a large number of families who adopted from Romania revealed that 90% had a positive view of their adoption. However, being satisfied with their decision to adopt did not mean that their children were problem free (whose children are?). Less than 10% of families were ambivalent about their decision, and only a small percentage were considering disruption of the adoption.

IN SUMMARY:

- Don't expect your child to emerge from an orphanage unscathed.
- Prepare in advance to rehabilitate your child.
- Institutionalized children are a high-risk group. Make sure that you are prepared to take on the parenting challenges.
- Optimism is appropriate. Most families feel positively about their adoption.

Planning for the Health Needs of Your Institutionalized Child

By Dana E. Johnson, M.D., Ph.D., and Margaret K. Hostetter, M.D.

The mountain of paperwork, hours of meetings, stressful interviews and empty checking account fade from view as you tear open the envelope containing information on your assigned child. Onto the table spill pictures, perhaps a video and a written description of your child that most likely contains some medical information. How do you evaluate the health status of a child from afar, particularly if they have spent their formative years in an institutional care setting?

Before you start dealing with specific details in the referral documents, consider the following:

You are entitled to information on the health of any child you are considering adopting.

Your agency has an obligation to provide medical information about a child they are placing with you. Frequently available are: family medical history; circumstances surrounding pregnancy, labor and delivery; weight, length and head circumference at birth and at the time of referral; developmental milestones attained; immunization status; and health history since birth. Any information that is available should be provided to you in English. However, information may not be available in some situations; e.g., an abandoned child, an uncooperative orphanage director, an orphanage located in a very remote location, etc. Talk to your agency about what information is likely to be provided and if additional information can be obtained if necessary.

Just because information is available doesn't mean it's correct.

Medical information may be confusing, obscure or frankly bogus. In some countries, specific diagnoses may be applied to children simply to make them available for international adoption or to garner more support for the orphanage where they are housed. On the other hand, diagnoses made in the country of origin should never be discounted or ignored. Consult your agency or a medical professional familiar with current trends in international adoption for help interpreting these records.

You are entitled to a reasonable amount of time to evaluate information on a specific child.

Adequate time for consideration is one of the cornerstones of good decision making. The decision you are about to make will affect you for the rest of your life. Gather as much information as you can from adoption and medical professionals, and from friends and family. Then put the cute pictures away (or don't look at them at all) and, as dispassionately as possible, consider all the issues involved in accepting the referral. The world, however, is not a perfect place and there may be situations where a rapid decision is necessary; for example, when a country is about to suspend international placements. If this is a possibility, your agency should alert you in advance to the medical issues which you are likely to face. If a rapid decision is necessary, you would then have had time to inform yourself about the health problems that are common in your child's country of origin.

You are entitled to knowledgeable, unbiased medical advice.

Your agency should have a list of community and national resources that can assist you in evaluating the medical status of your child. A list of physicians and clinics can be found at the end of this document.

You know more than you think you do.

You know a lot about the country from which you are adopting. There is a direct relationship between a nation's economic status and its health care delivery system. Therefore, children from a country where economic standards are high will receive good health care, immunizations will be up to date, medical information will be accurate, and the possibility of getting follow-up information will be quite good. The opposite is true in destitute countries—children are at increased risk for a variety of infectious diseases, immunizations will be incomplete or non-existent and information may be inaccurate, with little likelihood that additional information will follow.

Even if you have never had a child, you know that their job is to grow and develop. If a child is not growing and/or developing in a normal fashion, there may be a problem. The two major exceptions to this general rule—premature infants and children who grow up in orphanages or hospitals—are discussed in Understanding the Medical Information in Your Referral Packet.

Finally, It's okay to say no.

With a biologic child you have the opportunity to make choices. You influence your child's genetic makeup through your selection of the other parent, you have the opportunity to optimize medical and personal care during the pregnancy, and you control your child's environment during the formative years of life. You don't have those options with an adopted child, but there are other choices you can and should make. You are searching for a child that you are capable of parenting. Your family's size, job commitments, income, insurance coverage and general health are all issues that must be considered carefully when adopting a child who may have special needs. Remember, your whole family as well as your adopted child participate in the benefits and burdens of any adoption decision.

Understanding Medical Information

Understanding the Medical Information in Your Referral Packet

Medical diagnoses. In our study of over 300 potential adotees from Eastern Europe, specific medical diagnoses were listed in over 90% of referral documents. However, many of these diagnoses were obsure (vegito-visceral syndrome); utilized arcane terminology (oligophrenia); or had terrifying prognoses such as perinatal encephalopathy, muscle tone abnormalities (e.g., spastic quadraparesis, pyramidal syndrome, myotonic syndrome), hypertension-hydrocephal syndrome and intrapartum spinal trauma. What do these diagnoses really mean and are they correct?

The use of medical terminology differs among countries. The best example is perinatal encephalopathy, a diagnosis listed in close to 100% of children referred from Russia. To most physicians in the United States, perinatal encephalopathy is an ominous condition which denotes a child at high risk of cerebral palsy and mental retardation. In Russia, the diagnosis may be made if the attending physician feels there is evidence from the history or physical exam that the child was "stressed" at some point in the pregnancy, delivery or post-partum period. In other words, the child--in their minds--is at risk for neurologic damage. A course of therapy is then prescripbed and most children "recover" by a year of age. Complicating the use of this term is that the diagnosis may also be applied in situations where the orphanage director doese not want to appear to be placing too many "normal" children abroad or of the institution wants to be eligible for additional funding.

The indiscriminate and non-medical use of these and other terms has led many adoption professionals to advise their clients to ignore the m edical diagnoses listed in their child's medical history. However, you should never completely igore any diagnosis unless the records contain evidence that suggests the diagnosis is incorrect.

Your first step is to seek counsel from your physician. A child with a diagnosis of "perinatal encephalopathy" who rolls over at four months, sits at seven, and walks at twelve does not have the motor impairments consistent with their diagnosis. However, acquisition of developmental milestones within an institutional care environment is usually delayed. In situations where the accuracy of a diagnosis is questioned, seek assistance from a physician who has experience interpreting adoption medical information.

The videotape. You will perhaps never be able to adequately describe the feelings you experience when you first see your child; however, in addition to life-long memory, videotapes can provide unique and invaluable medical information about your child. When reviewing the video, remember the following:

A video captures only a tiny fraction of your child's life. The bright lights, additional attention and conflicting commands from caregivers often confuse a child--portraying them either immoble, non-communicative zombies, or as performing puppets with little sense of self-direction or awareness. Time of day and relationship to mealtimes make a tremendous difference in how a child responds--parents, think about what it's like before doing dinner time in your home.

A video is rarely well enough made or of sufficient technical quality to confirm a specific medical diagnosis; it is another piece of information. While all pieces of information are valuable, remember to interpret it in the context of all other information available on your child.

The embassy physical. U.S. immigration law mandates a medical examination by an embassy-approved physician prior to issuing an entry VISA to the United States. This examination is designed to detect infectious diseases that have an impact on public health, not to detect other medical problems in your child. Worldwide, tremendous variability exists in the quality of this examination. Don't count on the embassy physical doing anything more than confirming that your child is alive.

Growth and developmental milestones. Growth and development proceed on the basis of biological, not chronological, age. Subtract the number of months your child was premature from his/her chronological age to determine the corrected gestational age. The corrected gestational age, not chronological age, should be used for plotting growth and evaluating development. For example, a child born at 28 weeks gestation is three months premature (a full-term baby is born at 40 weeks gestation). Six months after birth, this child should be plotted at the three-month point on growth curves and should have reached three months on a developmental checklist. As a general rule, you can stop correcting for prematurity by a child's second birthday.

Growth and development can be altered by the environment in which a child develops. The most common type of growth failure seen in orphanages is psychosocial growth retardation, a stress-induced failure of linear growth (kids are short). Children with psychosocial growth retardation fall behind one month of growth for every three to four months of orphanage life. If a child was in the orphanage from birth to four years of age, we would expect the height to be appropriate for a 36- to 39-month-old child (about 9 to 12 months behind). The weight may also be affected, but not as much as height. Growth failure due to malnutrition is much less common and affects weight more than height.

The most important measurement may be head circumference, which increases in size in response to brain growth. A head that is too small or too large may signal significant neurological problems.

Development can be altered by too much or too little attention. The Korean child who is continually carried by a foster mother may not have gross motor skills (sitting, crawling, etc.) that are age appropriate for children born in the United States. These delays rapidly correct when a child is given a chance to explore the environment on his/her own. Too little attention, the usual situation in institutionalized care settings, leads to significant delays in all areas of develpoment--delays that may not resolve quickly. Evaluating an institutionalized child is difficult because delays may be caused by the deficiencies of orphanage life, or they may be due to true neurologic abnormalities or innate intellectual impairment.

History of alcohol use during pregnancy. Alcohol ingestion during pregnancy is the leading cause of preventable mental retardation in the world today. In Eastern Europe, maternal alcoholism was mentioned in 17% of women studied and fetal alcohol syndrome in 2.4 of referral documents. It may be possible to diagnose fetal alcohol syndrome using growth and development information and pictures/videotapes, but the diagnosis can be missed early in life even by experts. It is almost impossible to diagnose milder degrees of alcohol impairment, sometimes referred to as fetal alcohol effect, prior to arrival in this country. If you are conisdering adopting an alcohol-exposed child, you must read *The Broken Cord* by Michael Dorris, a beautifully written and extremely informative book about parenting an adopted child with fetal alcohol syndrome.

Blood tests in the country of origin. Pre-placement blood testing is variable. A defined battery of tests is not currently required for VISA approval for the majority of orphans. In some cases, testing may be ordered by the Embassy for the Embassy's physician when a specific communicable disease is common in the community or suspected in your child. Some agencies or countries have a set testing protocol for children prior to referral. Therefore, blood tests may

have been performed on your child. If not, five questions should be asked prior to requesting blood tests for specific diseases:

- **Can the test be done?**
  Medical facilities in some countries are so limited, it is impossible to test for certain disorders. Some countries fail to acknowledge that diseases such as AIDS are a problem and may therefore refuse to do the test.

- **Will the test be performed correctly?**
  Countries with limited medical infrastructures may not have the capability to perform the test accurately. There will be a result, but if the reagents are outdated, the equipment obsolete or the technician poorly trained, it may be meaningless.

- **Will the results be reported accurately?**
  Outright dishonesty, while rare, does occur.

- **Will blood drawing place the child at risk of catching the disease for which you are testing?**
  Disposable needles and syringes are often difficult to obtain and sterilization procdures may be lax. Aside from mother-to-infant transmission of hepatitis, syphillis and HIV during pregnancy, labor and delivery, transmission through needles contaminated with infected blood is the most common way for these diseases to infect children.

- **Was the test done at a time when the results would be meaningful?**
  For example, hepatitis B has an incubation period of up to 12 weeks. A child with a negative test for hepatitis B virus (hepatitis B surface antigen) at two months of age may actually be positive at a later point in time. With HIV, the most commonly used test does not identify the virus, but only tests for the protective antibody. A child infected with HIV may not reliably produce the antibody until 18 months of age.

- **Should the child be tested prior to approval?**
  After considering the issues of safety and validity, consider one more factor: Will the result really change your mind about proceeding with the adoption? If not, don't ask that the test be performed.

COMMON INFECTIOUS DISEASES

Hepatitis B profile, to include HBsAg, anti-HBs, and anti-HBc:

Because hepatitis B (HVB), a viral disease that affects primarily the liver, is endemic in most countries placing children in the United States, it is very important to screen for it. The virus is transmitted person to person by percutaneous (needle stick or biting), mucous membrane, or sexual exposure to infected bodily fluids, particularly blood and serous fluid from exudative (weeping) skin lesions. Saliva and semen carry smaller quantities of the virus.

When adults and older children are exposed to hepatitis B, most fight the infection effectively and clear the virus from their systems. The immature immune systems of infants and very young children, however, may not identify this organism as an invader. These children do not clear the virus from their system and become chronic carriers of the virus-at risk for exposing others and for developing ongoing liver damage and liver cancer. Ninety percent of children infected in the first six months of life will have chronic, life-long disease.

The risk of hepatitis B in international adoptees reflects the overall prevalence in the country of origin: 8 to 10 percent in Asia, sub-Saharan Africa, and parts of South America; 2 to 7 percent in Eastern Europe and Northern China; and less than 2 percent in Western Europe and the United States. The close confines of institutional care settings increase the risk of transmission.

An initial screening when your child first arrives in the United States and a second screening after the maximum incubation period of 12 weeks are recommended. The hepatitis B profile rather than the simple testing for hepatitis B surface antigen should be used.

When the risk of transmission of hepatitis B to other family members was examined, infection rates ranged from 5 to 37 percent, with increased risk when the adoptee was less than 3 years of age. While all household contacts are at risk of being infected, caregivers are at the highest risk of acquiring hepatitis B. The hepatitis B vaccine series is mandatory for household members when a family adopts a child who is hepatitis B surface antigen positive.

Delta hepatitis virus has been recognized in a number of adoptee's who test positive for hepatitis B surface antigen. Therefore, a screening for antibodies to delta virus should be included in the evaluation of any child with chronic hepatitis B infection. All children with either acute or chronic hepatitis B infections should be referred to a pediatric liver or infectious disease specialist.

Parasites in International Adoptees

Intestinal and cutaneous (skin) parasites are commonly encountered in international adoptees. In general, intestinal parasites are more common in older children and in countries where water treatment and sewage disposal standards are poor. Cutaneous parasites are ever present. While a number of different organisms can be identified, a few deserve special attention. Giardia lamblia is a waterborne parasite encountered very frequently in institutionalized children of all ages. Not only can Giardia cause distressing symptoms in your child, it is easily transmitted to other family members. Scabies and lice are extremely common cutaneous pathogens that can be difficult to diagnose and treat because of secondary skin infections. Prompt treatment is very important to avoid infection of other family members.

Tuberculosis in International Adoptees

What should I do if my child is diagnosed with tuberculosis?

Tuberculosis is an infection caused by the bacterium Mycobacterium tuberculosis, which differs in many ways from the bacteria that cause other childhood infections such as otitis or tonsillitis. Because of these differences, the usual antibiotics prescribed for simple childhood infections are not effective in tuberculosis.

Children are exposed to tuberculosis when they inhale the contagious sputum droplets of an infectious contact (usually an adult in their environment). These sputum droplets are spread by coughing, laughing, or even singing, so it is not difficult to see why infected adults, who can typically generate a more vigorous cough, are considered highly contagious and young infants are not. In populations where TB is endemic, infected adults may work in orphanages or nurseries or be part of a foster family. In other circumstances, TB may be passed from an infected mother to her child immediately after birth. These children are often extremely ill and many do not live beyond the early days of infancy, especially if poor nutrition and lack of medical care contribute to the severity of illness.

In TB infection, the usual focus is the lung, but untreated TB may spread more widely. For these reasons, the symptoms of TB may range from the relatively healthy child with mild wheezing or coughing to the more severely affected child with widespread disease involving the brain, lungs, bones, or kidneys. Children with very poor nutritional status and children who acquire TB very early in life are at increased risk for widespread disease.

After exposure to tuberculosis, the body's immune system develops a delayed hypersensitivity response, which is reflected in a positive TB skin test. The skin test remains positive even after appropriate treatment for TB. Thus, a positive TB skin test may mean either a previous exposure (infection without active disease), the presence of the actual disease, or a past infection that is now cured. Differentiating between these possibilities is clearly very important.

All adopted children from abroad, whether they appear healthy or ill, should receive the Mantoux (needle prick) intradermal skin test for tuberculosis. This test, known as a PPD, is more sensitive and specific than the multiple puncture test (Tine). Undernourished children may fail to respond to the Mantoux test even though they may have been exposed to TB. This type of negative reaction is called anergy and is related to the inability of the immune system to respond appropriately to the skin test. One way to control for the possibility of anergy is to place a Candida (yeast) skin test at the same time the Mantoux test is given. In children whose immune system is appropriately active, the Candida skin test will be positive, and a negative Mantoux test will then accurately reflect the child's never having been exposed to TB. Depending on the country of origin, 3-9% of international adoptees will have a positive skin test.

BCG and Subsequent Tuberculosis Testing

What is BCG vaccine?
BCG stands for Bacille Calmette-Guerin vaccine. This is a live-virus vaccine that is recommended by the World Health Organization (WHO) for use in countries where tuberculosis (TB) is a serious threat. BCG vaccine is recommended to be given shortly after birth in order to prevent complications of tuberculosis infection. It does NOT prevent getting TB disease in the lungs. It prevents babies and young children from having TB spread from lungs to the central nervous system or other parts of the body. BCG helps to prevent TB meningitis, a serious and sometimes fatal threat to babies and young children.

What countries are using BCG vaccine?
BCG is generally not used in the United States or Western European countries. However, it is widely used in Eastern Europe (e.g. Russia, Ukraine, Kazakhstan), Central and South

American (e.g., Guatemala, Peru and Columbia), African nations (e.g., Ethiopia, Liberia), China, India, Philippines and Vietnam.

What does a BCG vaccine look like?
A brand new BCG vaccination will often be located on a baby's upper outer left or right arm. At first, a BCG scar will look red, puffy and a bit moist or gooey. Occasionally, a BCG can appear to ooze small amounts of fluid periodically during the first few months after administration. However, once a BCG vaccine site heals, it looks like a very small flesh-colored scar. In about 1 to 2% of babies (1 or 2 of every 100 babies), the BCG site will develop an abscess or cause swollen lymph nodes in the baby's armpit. Most of these abscesses will resolve or heal on their own without any treatment. However, on rare occasions, a child may develop a secondary bacterial infection and require an oral antibiotic treatment. If your child's BCG site is extremely reddened, puffy, or oozing thick, colored or foul-smelling drainage, have your doctor or nurse practitioner examine your child.

Should children who have been given a BCG be tested for TB?
YES, because BCG does not prevent pulmonary TB. We have seen numerous cases where children with BCG vaccines have had positive findings of lung (pulmonary) TB disease. Contrary to rumor and myth, having received one BCG vaccine does NOT mean a person will always have a false positive test. However, timing of the TB test is important for babies or children who have been given BCG. Persons with fresh, reddened or oozing BCG vaccine sites have a high probability of having a false positive TB Mantoux skin test. However, once a BCG vaccine site appears to be well healed and flesh colored, a false positive test is unlikely. **Babies or young children who have had one BCG vaccination in the past that appears to be well-healed should be tested with a TB Mantoux test. A reading of 10 mm or more of reddened induration (thickening or lump) should be considered positive.**

Children with a positive TB test should have chest films taken, to be sure they do not have active lung TB disease. Most children who test positive will have a latent TB infection. Latent TB means that a child was exposed to TB germs in the air, breathed in the germs and became infected without yet activating TB disease in the chest. In order to prevent the TB germ from activating into lung disease, a child with latent TB should be treated for nine months with Isoniazid (INH). Activation of the TB disease is more likely to occur in infants and toddlers, as compared to older children and adults. About 40% of infants and toddlers with latent TB infection will develop actual TB disease in their lungs or lymph systems, as compared to about 15% of teens and adults who will eventually develop TB disease in the lungs or lymph system.

HIV INFECTION

Although HIV is a worldwide epidemic, it fortunately has affected few international adoptees. Even though the risk is small, testing remains very important because of treatment options now available. Two groups of laboratory procedures are used to evaluate the presence of HIV infection: tests that identify antibody directed toward HIV (ELISA antibody test) and tests that directly identify the presence of the virus (growing the virus in viral culture or polymerase chain reaction [PCR], which identifies the genetic material of the virus). The ELISA antibody test is the least expensive and easiest procedure available, but it may not be the most appropriate test in young children for the following reasons:

- Under 18 months, the ELISA antibody test reflects the mother's passively transmitted antibodies. Thus, the test may be falsely positive if the mother is HIV positive but the infection has not been transmitted to the baby.
- The ELISA test may also be falsely negative. More children are being reported who test negative on the ELISA but are still proven to be infected when culture or PCR is done.
- The ELISA turns positive later than the culture or PCR. For example, if a child is exposed to HIV via a contaminated syringe, blood product, or vaccine three weeks before placement, his or her ELISA will not be positive (too soon), but the viral culture or PCR will be positive.

Consequently, the AAP recommends that children younger than 18 months of age have a direct test for the virus (culture or PCR) rather than the ELISA antibody test alone. Children who are HIV-positive should be evaluated by a specialist in pediatric AIDS.

RPR or VDRL for syphilis

Although the risk of syphilis is low (less than 2 percent), appropriate screening is necessary to identify children who require treatment. Children who have a positive Venereal Disease Research Laboratory (VDRL) test or rapid plasma reagin (RPR) test should be evaluated according to the recommendations of the AAP's Committee on Infectious Diseases. Many treatments delivered abroad are incorrect or fail to eradicate the spirochete in sites such as the central nervous system. If treatment regimens administered abroad are not fully described as to the type of penicillin, dose in units or in milligrams per kilogram, number of doses and duration of therapy, the child should be reevaluated fully and re-treated if necessary. Statements such as "syphilis treated in mother" (or-infant) are too vague and should not be considered as indicative of adequate therapy.

Cytomegalovirus in International Adoptees

Cytomegalovirus (CMV) is a common virus world-wide. In many underdeveloped countries, virtually 100% of the population has had CMV. Infection rates are higher, and exposure to the virus occurs at an earlier age in:

- developing countries
- lower socioeconomic groups in industrialized nations
- Asian populations

We are not presently culturing the urine of internationally adopted children for cytomegalovirus (CMV), because approximately 30-50% of adoptees are excreting the virus, the same percentage that we would expect to find in infants or toddlers in daycare in the U.S. Ordinarily, CMV acquired after birth is benign. However, special problems may arise for women who acquire their first CMV infection during a pregnancy, or for any person whose immune system is compromised after steroid use, chemotherapy or transplantation.

Infants born to women who acquired a primary infection with CMV during pregnancy may have severe sequelae, such as blindness, deafness or mental retardation. Immunocompromised hosts may have severe infections themselves, including pneumonia. In these populations, we recommend checking antibodies to CMV. If the antibody test is positive, then the patient has

acquired CMV in the past and the risk of severe complications is low. If the antibody test is negative, then the patient should understand that CMV may be acquired from any of several sources: blood products, sexual partners, or infants or toddlers of any country of origin, including the U.S. Since there is no vaccine to prevent the transmission of CMV from an excreting infant to a caregiver, we recommend good handwashing and excellent personal hygiene when handling urine, diapers, or toys or other objects that may have come in contact with the child's oral secretions. Children present virtually no risk of transmitting the virus after they have been toilet-trained.

Post-Arrival Evaluations

Identifying medical problems common to internationally adopted children

No matter how healthy your internationally adopted child appears, he or she should see your physician within the first few weeks after his or her arrival-or sooner if there appear to be problems. Physicians evaluate the health status of children using a medical history, physical examination, and laboratory tests. In children adopted from abroad, the history may be limited or fabricated and the physical examination rarely identifies the problems common to international adoptees-most of which are infectious diseases by and large diagnosable only by appropriate lab tests. For that reason, a battery of screening tests is absolutely necessary to fully evaluate the health of your child.

SCREENING TESTS

- Hepatitis B profile, to include HBsAg, anti-HBs, and anti-HBc

  All patients who are positive for hepatitis B surface antigen are evaluated for the presence of hepatitis Be antigen, delta agent and elevated transaminase levels

- HIV-1 and HIV-2 testing by ELISA in children greater than 18 months of age and by ELISA and culture in children less than 18 months of age.

- Mantoux (intradermal PPD) skin test with Candida control

- Stool examination for ova and parasites

  Symptomatic children, especially those from India, also receive stool cultures for *Salmonella, Shigella, Yersinia, and Campylobacter*

- RPR or VDRL for syphilis

- Complete blood count with erythrocyte indices

- Dipstick urinalysis

- A developmental exam is essential for all international adoptees, but especially for those who have been institutionalized.
- A lead level and antibodies to hepatitis C should be checked in children from Eastern Europe, Russia and China
- Children from China should be screened for hypothyroidism due to high incidence of dietary iodine deficiency.
- Vision and hearing screening can be done as directed by the primary physician.

Immunizations

We have recently found that approximately 60% of children who were reported to have received three or more DPT/OPV vaccines in China, Russia or Eastern Europe have no antibodies to these diseases. This means that either the vaccines used were outdated or improperly stored, the child lacked an appropriate immunologic response after vaccination, or the vaccination certificate was fraudulent.

We recommend testing for diphtheria and tetanus antibodies in any child who has reportedly received three or more DPT vaccines. If antibodies are absent or low, or if the child has received fewer than three DPT vaccines, we would advocate *starting the immunization sequence over again*, according to the recommendations of the American Academy of Pediatrics for children not immunized in the first year of life.*

*2000 Red Book; *Report of the Committee on Infectious Diseases*; American Academy of Pediatrics; Elk Grove Village, IL; p. 52.

Physical & Sexual Abuse

Unfortunately, institutional care settings are a magnet for adults who prey upon children. If physical or sexual abuse is suspected, it is in the best interests of the child and the family to seek the advice of physicians and therapists who have expertise in this area. Indications for an evaluation may include unexplained scars or bruises, a positive history or x-ray evidence of fractures, genital/rectal scarring or tears, and sexual behavior that is not age-appropriate. It is also not unusual for the child to share stories of past abuse with the parents once she/he forms a trusting relationship with them.

Bony Fractures, Physical Abuse & Rickets

Related to the question of physical abuse, it is our observation that a number of Chinese children have arrived with bony fractures. Rickets is a common diagnosis on Chinese medical forms. Our studies have confirmed that the older a Chinese child is on arrival, the greater the

risk for rickets. Thus, fractures may be due either to the nutritional disorder or to abuse.. Any child who arrives with bony fractures, swelling or tenderness should be evaluated for fractures and rickets. Not only is this important in terms of the child's well-being, it is also important for the adoptive family's safety, to document that these fractures occurred prior to the child's arrival.

ASSISTANCE IN INTERPRETING MEDICAL RECORDS

For further help, please feel free to contact the International Adoption Clinic at the University of Minnesota. Referral information may be faxed, and we will review videotapes and pictures if you wish to send them. Please include daytime and evening telephone numbers and your home address in your correspondence, and return postage or a prepaid envelope if you would like your videotape or pictures returned. You may want to contact us prior to sending or faxing materials to ensure that we will be available to review them. There is no fee for our services, but we do accept tax-deductible donations for our work. Checks should be made out to "University Children's Foundation."

Dana E. Johnson, M.D., Ph.D.
Box 211 (use box number for U.S. mail)
C432 Mayo Building (use room number for UPS, Federal Express or Airbourne Express deliveries)
420 Delaware Street SE
Minneapolis, MN 55455
(612)-626-2928
(612)-624-8176 [fax]
johns008@maroon.tc.umn.edu [e-mail]

Also visit the International Adoption Clinic on the Adopt INFO page of the Internet:

http://www.cyfc.umn.edu/Adoptinfo/index.html

Links and Resources

At the University of Minnesota

International Adoption Project (a joint effort of National Institutes of Health, U of MN Department of Pediatrics, U of MN School of Public Health, U of MN Institute of Child Development, U of MN Department of Family Social Science and MN Department of Human Services)
International Adoption Project

Confucious Institute (family Chinese language classes)

Local Resources

Minnesota Organization on Fetal Alcohol Syndrome (MOFAS)
www.mofas.org

North American Council on Adoptable Children (NACAC)
970 Raymond Avenue, Suite 106, St. Paul, MN 55114-1149
Tel: 651-644-3036; 800/470-6665 (for adoption subsidy questions only)
Fax: 651/644-9848
www.nacac.org
Focuses on the needs of waiting U.S. and Canadian children. NACAC provides legislative advocacy, research and policy analysis, the quarterly newsletter Adoptalk, grants for the development of replicable local training and support services, and an annual national conference.

National Resources

Other Adoption Medicine Professionals (links to American Academy of Pediatrics Section on Foster Care and Adoption)
Other Adoption Medicine Professionals

Adoptive Families of America, Inc.
2309 Como Avenue, St. Paul, MN 55108
Tel: 612-645-9955; 800-372-3300
Fax: 612-645-0055
Supports, educates and advocates on behalf of all kinds of adoption-built families. Publishes the bimonthly magazine Adoptive Families, sells essential adoptive parenting resources, has a helpline and more.

International Concerns Committee for Children
911 Cypress Drive, Boulder, CO 80303
Tel: 303-494-8333
Offers information on adoptable domestic and foreign children, has an overseas orphanage sponsorship program, and publishes an annual Report on Foreign Adoption. Also matches waiting children with prospective families.

Joint Council on International Children's Services
7 Cheverly Circle, Cheverly, MD 20785
Tel: 301-322-1906
Fax: 301/322-3425
www.jcics.org
The oldest and largest organization of licensed international adoption agencies in the world; parent/advocacy groups are also an important part of the membership. Joint Council member agencies agree to adhere to its Standards of Practice, a code of ethical adoption practices. Write for a list of agencies and resources.

National Adoption Information Clearinghouse
330 C St. SW, Washington, DC 20447
Tel: 703-352-3488; 888-251-0075
Fax: 703/385-3206
www.calib.com/naic
Provides information about all aspects of adoption, including adoption publications, referrals to adoption-related services, searches of its computerized information databases, and copies of state and federal laws relating to adoption.

National Resource Center for Special Needs Adoption, Spaulding for Children
16250 Northland Drive, Suite 120, Southfield, MI 48075
Tel: 248-443-0306
Fax: 248-443-7099
www.nrcadoption.org
Publishes books on adoption issues and refers parents to agencies and health professionals with expertise in special needs adoption.

Parent Network for Post-Institutionalized Children
P.O. Box 613, Meadow Lands, PA 15347
Tel: 724-222-1766
www.pnpic.org
Provides information, parent support and educational seminars on parenting children adopted from institutions.

Pre-Adoption Medical Review: An Evolutionary Process

What we have learned over the last two decades in adoption medicine.

By Jerri Jenista, M.D.

Sixteen years ago, I received a long-awaited and exciting phone call from my social worker.

"It's a girl. Do you want her?" I still have my copy of the reply telegram, "Yes! Send Baby Girl Jenista home immediately!"

Eventually a tiny passport-sized photograph arrived in the mail from India with the child's birth-date but no other information, medical or otherwise.

When Lousia arrived, at the age of 6 weeks weighing 5 pounds, her complete original medical record accompanied her. I was alarmed but not surprised to read in the daily notes that she was a premature baby with a birthweight of 3 pounds who had been tube fed until the day before she was put on the plane. Soon after arrival, she was hospitalized for failure -to- thrive, drug resistant *Salmonella* infection, and suspected sepsis. After suffering several complications including an axillary nerve palsy from the IV board, a gastrointestinal bleed induced by the antibiotic, and hypoxia (lack of oxygen) from a hospital-acquired respiratory syncytial virus infect-ion, Louisa went home to be tube fed until she was 10 pounds (at 6 months old). However, except for chicken pox and a broken arm, she's never been sick since.

At the time, no one considered Louisa a baby with "special needs" and there certainly was no thought of accusing the adoption agency of hiding medical information. Among the other 12 children who arrived from the same nursery at the same time, diagnoses of chronic hepatitis B, cerebral palsy, and profound deafness were subsequently made, again with no consideration that the agency or social worker was "at fault" for these adverse outcomes.

In 1999, we (the medical and adoption communities) would be horrified that the adoptive parents were not "fully informed" of their child's condition before arrival. What has changed over the last 16 years? Were the parents of the "old days" more willing to take risks? Did the adoption agencies not know what they were doing? Were the children being adopted somehow different than today's internationally adopted child? I think the answer to all of these questions is "yes".

In 1982, when I was applying for my first child, there were only a handful of agencies doing international adoption in the United States. By 1987, the first year for which the International Concerns Committee for Children (Boulder, Colorado) has statistics, there were 103 placing and local service (homestudy) agencies working in 20 countries. Most agencies had very strict requirements as to family characteristics. There were few countries with well organized adoption laws and prospective parents had little choice about the age or sex of the child they wished to adopt. Adoption fees were low (Louisa's was $3,500) but the waits were long (often two to three years from application to arrival).

Adoptive parents had al-most no control over the adopt-ion process; it was definitely a "don't call us, we'll call you" relationship with the adoption agency. By the time a family finally received a referral, there was little thought to refusing the child. The only adoption magazine at the time, OURS Magazine (now *Adoptive Families)*, mostly carried stories of the long wait with a happy outcome or how the family overcame unexpected special needs in their child, also to an eventual happy ending.

A mother who wrote of her experience disrupting the placement of a two-year old from Korea was roundly criticized in the Letters to the Editor as being insensitive to cultural issues and to the normal behaviors of toddlers. (Many years later, I realize that the woman was probably describing a child who had what we refer to today as "attachment disorder".) Another article discussed the serious implications of turning down a referral, warning prospective parents that it was unlikely that they would be considered for

another child.

Although there were a half-dozen well-established professional staff, most agencies were small, typically run by adoptive parents, existing on a shoe-string budget and the work of volun - teers. It was not at all unusual for an adoptive parent to defer some expenses by working in the office answering phones or typing homestudies. Without word processors, fax machines, and cheap long distance telephone rates, all paperwork was slow and information was virtually unobtainable in a reason-able time frame.

A few agencies had handouts about what to expect when the new baby arrived (most adoptees were baby girls under the age of 12 months). These usually gave a typical schedule of sleeping and feeding practices in the native country and often included a few words in the child's first language. Medical issues except for lactose intolerance, lice, scabies, and malnutrition were almost never mentioned. Agencies placing from Korea issued warnings that Mongolian spots on the buttocks were not evidence of child abuse and that the wide nasal bridge of Asian faces could make a child appear cross-eyed when he was not. Lori Wedeking, a public health nurse in Minnesota, published a series of brief medical articles in OURS Magazine. But no one had any statistics.

A diligent parent who searched a medical library would have found a few articles on malnutrition, hepatitis B, and measles in adopted Korean children, a study on the health condition of Vietnamese orphans arriving during the war, and a few case reports of interesting medical problems in indi-vidual children from Latin America. When I published an article "Medical Problems of Foreign-Born Adopted Children" (AJDC 1987;141: 298-302), discussing the issues noted in 128 children in a single pediatric practice, it was the largest (and only) series reported.

In 1981, the American Academy of Pediatrics published a two-page discussion of general recommendations for the care of internationally adopted children but there were no other professional standards available for the practicing physician. In 1986, the first dedicated international Adoption Clinic opened at the University of Minnesota. In 1987, that clinic presented the first conference for social workers on the medical issues in adoption, concentrating almost exclusively on nutrition and infectious diseases. In 1985, I surveyed all 330 Michigan families adopting inter-nationally; the majority reported that the most useful sources of medical information were the few records that accompanied the child and the advice of other adoptive parents.

It should be no surprise, an then, that little medical information or education was provided to adoptive families. Agencies truly did have little idea of what they were doing, mostly because no one was counting children or following them long -term to see what really happened. They only exception was Holt International Children's Services who carefully kept track of every child possible and collaborated with academic researchers on studies of nutritional and cognitive outcomes in Korean girls.

And what of the children themselves? Until the mid-80's, there were only 3,000 to 5,000 international adoptions each year and most of those children cam from excellent foster care in Korea. Children were available for adoption because of extreme poverty, illegitimate birth, or parental death or because they had conditions not treatable in the native country. Although there must have been birth-parents with mental illness or drug or alcohol problems and child who had been abused or neglected, this information was almost never reported, probably because no one thought to ask.

Did those children have problems that were unrecognized and/or more severe than expected? The answer is yes. In my review of almost 3,000 children adopted from one Indian nursery, at least 5 % of children had a permanent handicap such as blindness, deafness, mental retardation, or cerebral palsy. In the late 80's all series reported from Michigan, Minnesota, Maryland, Washington State, Sweden, Australia, and else where reported high rates of missed medical and developmental diagnoses in children from every source country. Research studies of children adopted to various western European countries hinted at behavioral and language problems in a significant proportion of children.

Adoption conferences and parent magazine began to discuss a few problems, especially developmental disabilities and emotional and behavioral problems. At the same time, adopt-ion of children from foster care in the United States began to increase dramatically. Media stories focusing on these formerly abused and neglected children resonated with families who had adopted internationally. *Adoptive Families* magazine began to carry stories about domestic adoption issues, in-stead of concentrating solely on international adoption, realizing that there were many shared experiences among these families.

What began as a

gradual evolution toward more medically informed adoption workers and families took an abrupt leap in 1990 to 1991 when over 3,000 Romanian orphans were adopted by North Americans. Suddenly, the adoption and medical communities were presented with a large group of very high risk children adopted by poorly informed or prepared parents. These Romanian children were products of a society that had been suffering for many years before they were born. Thus, they presented with high rates of prematurity and low birthweight combined with every possible consequence of institutional living including multiple infectious diseases, malnutrition, growth retardation, global developmental delay, abuse, neglect, and poor or absent medical care for congenital anomalies and other treat-able conditions.

Not surprisingly, studies from every country in Europe and North America with Romanian children began to report series of children with multiple short and long term medical issues. Even in the late 90's, we are only just beginning to get a feel for the extent of the long-term developmental and behavioral issues some of these children face.

Add in an influx of families willing to pay very high fees, facilitators and new Agencies with little or no experience in adoption or child welfare, and vast new sources of children from the former Soviet Union and China and suddenly the "tone" of international adoption has changed. In 1999 in the United States, there were 164 agencies placing from 46 countries and 76 local service agencies working in international adoption. This does not count the "newcomers" to international adoption – the large number of un-licensed facilitators and private legal firms. Adoptions have increased to almost 16,000 per year the costs have risen dramatically. Fees of $20,000 are considered the "norm". Perhaps there are problems to be worried about!

The agencies have definitely changed. The adoption practices of the "old days" were not so wonderful. Lawsuits, just as in domestic adoptions, were inevitable and have probably induced better and quick-er reform. The good agencies and workers are trying hard to educate their families about adoption risks through many modalities including the homestudy process, adoption seminars, handouts, medical and clinic referrals, and personal counseling. Even the not-so-good (and the downright sleazy) agencies now require that their clients sign waivers releasing the agent of all responsibility for bad outcome. If nothing else, this should indicate to a prospective parent that perhaps there are problems to be worried about!

Because there are so many more children available now for adoption and because there are so many more agencies for parents to choose from, adoption workers can no longer sit around and count the families waiting on their lists. Instead, they must recruit for parents and must provide appropriate services to keep them.

One downside that I see to this competition is that there is considerably less time to educate parents. When they were a captive audience, the parents would listen to whatever the agency had to say, as limited as it might have been. Now if a family does not want to "wait" to go through an extensive pre-adoption training or feels that the agency works too slowly, they pick up and apply else-where. (The exact issue of avoiding an agency who "makes" you do more pre-adoption work was a main topic of discussion at a recent parent group meeting I attended.)

Adoptive parents have clearly changed. The legal threats in domestic adoption, open adoption records, and the perceived high medical risks of domestic adoption have encouraged more families to turn to

Why Children Are Available for Adoption

	Russia	Romania	Los Angles	Maryland	San Francisco
Involuntary termination of parental rights	25%				
No available caretaker		7%		30%	24%
Neglect	6%		71%	51%	30%
Physical abuse		.5%	14%		25%
Abandonment	3%	19%		23%	9%
Failed Placement	< 1%				7%
Child disability	4%	11%	6%	4%	
Sexual abuse	< 1%		9%		5%

international adoption. The adoption regulations of some countries, such as China, have selected for families who are wealthier, older, and more educated than in the past. Resources for accurate (and inaccurate!) information have abounded including more parent groups, Internet websites, e-mail discussion groups, and a proliferation of mag-zines and books and adoption conferences. Armed with more knowledge and more choices and faced with high fees, adopting parents are much more demanding consumers now than a decade ago. Knowing that there are vast numbers of waiting children, that more medical information is available, parents have begun to demand (and get) more extensive information.

The medical professionals who deal with adopted children have also changed. We are now better organized and we too, have new and better ways to share information among ourselves. A new body of research on all aspects of adopted children's health is now being developed. Many of us have visited the orphanages and/or have professional friends who work in the sending countries. Currently, we have more than 2 dozen clinics and over 200 hundred physicians and nurse practitioners who work in inter-national adoption in North America. Thus we, the medical community, are much better prepared today to assess the pre-adoption medical records for a prospective family. We have two decades of hands-on practice with actual children and have learned what problems are the most common and will last the longest.

Finally, I believe the children we are seeing for adoption today are at far higher risk than the referrals of the past. Although the majority of children world-wide are still available because of extreme poverty, parental death and illegitimate birth, we have seen, since the early 90's many more children who have suffered numerous social and medical insults. These children are much more similar to the children being adopted from foster care in the United States. Thus, we see children who were born premature and/or low birthweight, whose mothers may have abused drugs and/or alcohol. We see children whose parents have had their parental rights terminated because of abuse and neglect, children who have been separated from their siblings and relatives, children who have lived in homeless shelters and hospitals for prolonged periods.

As a matter of fact, if you look carefully at children entering foster care in the United States and compare them to children being referred for adoption from Romania, Russia, you find that the two groups are very similar. We would expect families adopting foster children to receive extensive pre-adoption education and post-adoption support services. We are only just beginning to realize that families adopting children of similar background from other countries need the same services.

What have we learned over the last two decades in adoption medicine? Everything about adoption has changed: Who is adopting, which children are available, and who is placing those children in families. The knowledge about medical and social issues has increased dramatically as have the resources to find this information.

Prospective parents today should be as fully informed a possible about their potential child's medical condition. It is the responsibility of the agency or facilitator and physician to make sure that information is made available to families in a useable format. In addition, it is the responsibility of families to become informed about the kinds of risks they are taking on in each kind of adoption.

Innumerable studies have shown that the majority of adopting parents are happy with the children they are raising, despite unexpected medical and other issues. However, that doesn't mean we can't do a better job at in-forming and supporting families than in the past. I am sure that my mother was happy with the nice clean clothes that she hung up to dry in our backyard every day in the 1950s. But does that not mean that I am going to give up my gas dryer which give me just as nice clean dry clothes with less effort and less time. Similarly, we've done adoptons "the old way." Now it is time to do them the right way- with all parties committed to full disclosure of information with families before placement.

Every day families ask me, "If you were adopting today and had the same information about the child we are considering, would you go forward?" And my answer is, "I don't know." Back then, we depended on luck. Today, we have knowledge. Given the choice, I think I'd rather be smart than lucky. But I might have missed the opportunity to adopt The World's Cutest Baby (who still lives at my house and is still very cute).

Dr. Jenista runs an adoption practice and is also the editor of Adoption/Medical News, a newsletter for parents and professionals on the medical issues in adoption. She may be contacted at 551 Second St., Ann Arbor, MI 48103. 734-668-0419 voice or 734-668-9492 fax.

AdoptiveFamilies

Post-Adoption Checkups

by Deborah Borchers, M.D.

Q: Which medical tests should our newly adopted child have now that she's home?

Traveling to adopt my children, I witnessed firsthand the conditions in which they spent their early lives. As a mom, I saw the caretakers' love. As a pediatrician, I saw crowded living quarters and lack of sanitary conditions. Before we came home, I treated lice and scabies passed to my daughter from her caretakers. But by the time of her first doctor visit in the U.S., my daughter was clean, free of skin diseases, and had begun to adjust to her new surroundings.

Most pediatricians treating newly adopted children can't judge potential risk factors based on firsthand observation. They must rely on what parents tell them about their children's early lives.

After a child's placement in an adoptive home—whether via a domestic or an intercountry adoption—there should be a review of all medical records, a complete physical examination, and diagnostic testing, all taking into consideration the child's past. Since children change between the time of adoption and the first medical evaluation, healthcare workers need to be reminded about the child's previous home and circumstances. With these in mind, healthcare workers should take the following steps:

Evaluate birth history and past medical history. In cases where these are unavailable, physicians must evaluate a child's potential exposures from available information. Children exposed to drugs or alcohol prior to birth should be evaluated for blood-borne pathogens and sexually transmitted diseases, as should children born in countries where risks of those diseases are higher. This should include testing for syphilis, hepatitis B, hepatitis C, and HIV. Children who have been significantly malnourished, have been in institutional care, or who have lived in northern latitudes (where they may not have been exposed to much sunshine) should be tested for rickets. For children adopted domestically at birth, review of birth records should include attention to testing done on the birthmother, with repeat testing if records are unavailable or unreliable. All children adopted from another country should have a repeat of any pre-adoption testing.

Assess risk for diseases. Children who have lived in conditions of poverty are at risk for infectious diseases as well as diseases related to environmental toxins and inadequate nutrition. Risk of exposure to tuberculosis is much higher in orphanages and other institutions, as well as in particular areas of the United States. Any child who has been adopted abroad should be evaluated for giardia and other stool parasites. A complete blood count should be done to check for anemia. Non-Caucasian children should have a hemoglobin electrophoresis to evaluate abnormalities in the structure of the blood hemoglobin. All children beyond the newborn stage should also have a test done for lead toxicity. A urinalysis can detect kidney disorders and urinary tract infections.

Perform metabolic screens. In the U.S., all states require testing at birth for metabolic disorders that, if

left untreated, will result in mental retardation. Physicians should verify that this testing has been done, or, if results are unavailable, repeat the test. Children under the age of one who have been adopted internationally should have a metabolic screen sent to the Department of Health of the state in which they live.

Validate immunizations. If records cannot be validated, most immunizations can be repeated without harm to the child. Where records exist, in order to verify them, blood testing may be done to examine for antibody protection from previous immunizations. The same should be done for children who arrive from other countries with a written immunization record. With few exceptions, immunization records of internationally adopted children should not be accepted as written. Vaccines given to orphanages may be old or not refrigerated properly.

Do hearing and vision screening. The American Academy of Pediatrics recommends hearing screening for all newborns and an eye exam in the first six months of life. Whatever your child's age, screening early for problems will ensure that she is fully able to respond to her new environment.

Carry out developmental evaluations. Children who have lived in foster homes or institutions are at risk for developmental delays. It's worth assessing a child's psychological needs, too. Is there reason to believe there is a history of abuse or neglect? Its effects may not surface until months or years after your child comes home, so this aspect of your child's health warrants ongoing assessment.

Deborah Borchers, M.D., FAAP, is the mother of two daughters adopted internationally.

Questioning Medical Myths

Make sure your infant or toddler is getting the care he needs.
By Mary Allen Staat, Dee Daniels, and Michelle Dickey

New parents often contend with conflicting or erroneous medical advice. Here are a few misconceptions we've encountered in families adopting internationally:

Misconception: All immunizations should be given because we can't be sure if children have been appropriately immunized.
In cases where there is incomplete documentation or none at all, blood testing after your child arrives home can help sort out whether he is protected against vaccine-preventable diseases. The vast majority of children will not need to have immunizations repeated.

Misconception: All infants should be placed on a special formula for lactose intolerance.
While lactose intolerance occurs more frequently in children of Asian, Native American, African, and Latino ethnicity, it is still relatively uncommon in infants and young children. It is best to continue with the formula used in your child's birth country or to use a milk-based formula in order to smooth the transition to your family. Intestinal symptoms can often be attributed to parasites or a change in environment, and not necessarily to the formula used.

Misconception: Only children with diarrhea should be tested for parasites. While diarrhea is a frequent symptom of protozoal parasites, it is not common in children with intestinal parasites. They may have poor growth, abdominal pains, cramping, diarrhea, constipation, foul smelling stools, irritability—or no symptoms at all. And a child may not recognize as abnormal symptoms he has lived with for a long time. Parasite testing is recommended for all internationally adopted children.

Misconception: Repeat testing for infectious diseases is not needed if tests were done in the child's birth

country. Most children will have birth country documentation of testing for HIV, hepatitis B, syphilis, and sometimes hepatitis C and tuberculosis. Because several of these have long incubation periods, testing soon after arrival and again six months later is important to assure that your child did not become infected shortly before coming home.

Misconception: Tuberculosis testing should not be done if a child has received a tuberculosis vaccine. The BCG vaccine can cause a tuberculin skin test (TST) to be reactive. However, because tuberculosis is such a serious disease, it is recommended that all internationally adopted children be tested and the history of BCG vaccine be disregarded when reading the TST.

Mary Allen Staat, M.D., M.P.H., is Director of the International Adoption Center at Cincinnati Children's Hospital Medical Center. Dee Daniels, R.N., and Michelle Dickey, M.S., are nurse practitioners there.

List of Recommended Post-Arrival Medical Evaluations

Adapted from an article by Deborah Borchers, M.D.

Evaluate Birth History and Past Medical History

1. Blood-borne pathogens and sexually transmitted diseases, including syphilis, hepatitis B, hepatitis C, and HIV.
2. Children who have been significantly malnourished, have been in institutional care, or who have lived in northern latitudes (where they may not have been exposed to much sunshine) should be tested for rickets.
3. Repeat testing for children adopted domestically at birth if records are unavailable or unreliable, and for all children adopted from another country.

Assess Risk for Diseases 1. Children from orphanages or institutional care should be tested for tuberculosis.
2. Any child who has been adopted abroad should be evaluated for giardia and other stool parasites.
3. A complete blood count should be done to check for anemia. Non-Caucasian children should have a hemoglobin electrophoresis to evaluate abnormalities in the structure of the blood hemoglobin.
4. All children beyond the newborn stage should also have a test done for lead toxicity.
5. A urinalysis can detect kidney disorders and urinary tract infections.

Metabolic Screens

1. In the U.S., all states require testing at birth for metabolic disorders that, if left untreated, will result in mental retardation. Physicians should verify that this testing has been done, or, if results are unavailable, repeat the test. Children under the age of one who have been adopted internationally should have a metabolic screen sent to the Department of Health of the state in which they live.

Validate Immunizations

1. If records cannot be validated, most immunizations can be repeated without harm to the child.
2. Blood testing may be done to examine for antibody protection from previous immunizations.
3. With few exceptions, immunization records of internationally adopted children should not be accepted as written. Vaccines given to orphanages may be old or not refrigerated properly.

Hearing and Vision Screening

1. The American Academy of Pediatrics recommends hearing screening for all newborns and an eye exam in the first six months of life. Whatever your child's age, screening early for problems will ensure

that she is fully able to respond to her new environment.

Developmental Evaluations

1. Children who have lived in foster homes or institutions are at risk for developmental delays.
2. It's worth assessing a child's psychological needs, too. Is there reason to believe there is a history of abuse or neglect? Its effects may not surface until months or years after your child comes home, so this aspect of your child's health warrants ongoing assessment.

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Preparing while you wait for adoption travel: Getting Yourself Immunized Now

Monday, 31 May 2004 00:00

As families collect the mounds of paperwork to prepare for international adoption, some prospective parents find ways in which to prepare themselves for parenthood. Besides reading books about parenting, taking a class on infant CPR, fixing up the child's room, cleaning out the garage and attic, and meeting other parents through support groups, there are some unexpected ways to better anticipate the travel abroad by protecting yourself now for exposures that may occur when you travel.

Most trips to adopt internationally last no more than three weeks. Even so, during that short time new parents are exposed to a myriad of infectious diseases that are rare in most parts of the United States, due to better health conditions in the U.S. It makes sense to be prepared and to be protected while you travel, rather than risking that you will be significantly ill just as you become a new parent. Some of the recommended vaccines require multiple doses spread out over up to six months to confer full immunity. If families prepare to travel before they have a referral, there is less concern about all that needs to be done once they have a date to travel abroad.

It is recommended that all adults and children traveling abroad to developing nations have an updated panel of all routine immunizations, as well as additional ones that are necessary just for travel.

For all adults traveling internationally, it is recommended that they have three **Hepatitis B** vaccines to fully protect them from acquiring Hepatitis B. This disease, which is spread in manners similar to HIV, is contagious through blood and body fluids, particularly sexual transmission. Testing for children still in the country of their birth is not reliable, and some children who have tested negative abroad have tested positive once in the U.S. Family members have then been needlessly exposed. All newborns in this country begin this series of shots shortly after birth, and many states now require the full series of shots for school entry. Adults employed in occupations with the risk of exposure to body fluids (particularly health care workers) should be already vaccinated through their place of employment. The vaccine is given three times, the second one at one month after the first dose, and the third shot four to six months after the first dose. Although the risk of exposure for families while traveling is probably low, this is an important vaccine that should be given in the event of an accidental exposure to an adult or child with Hepatitis B, especially if that child becomes a member of your family (since it may take more than four months for an adult to become immune from the vaccine).

Families who travel abroad are also at significant risk of contacting **Hepatitis A**, another form of hepatitis that is preventable by a vaccine. This disease is much more contagious than is Hepatitis

B, and is spread through contaminated water, contaminated food, or the mouth or fecal excretions of a person infected with this virus. Thus, it can be communicated by sharing food, drinking unsafe water (ice in drinks, as well as water that is not boiled or bottled), eating food washed in unsafe water (including lettuce, uncooked vegetables and unpeeled fruits), and even by changing the diaper of an infected infant without using good hand washing. This vaccine is effective for a short term if given one month prior to travel abroad. If multiple trips are planned, it is suggested that an individual have a booster 6 to 12 months after the initial dose, as this will avoid the need for a repeat booster prior to all future trips. This vaccine should not be given to children less than two years of age. The Hepatitis A vaccine has replaced the need for the gamma-globulin shot, which was formerly given to most adults prior to international travel.

Although wild type **polio** has been eradicated in North America (some vaccine acquired polio has been seen from the polio vaccine that is given by mouth in individuals who have a compromised immune system), polio is still seen in developing nations. It is recommended that all adults traveling to a developing nation receive an inactivated polio vaccine (IPV) to lessen the risk of acquiring polio abroad. This should be done even if the polio vaccine was given during childhood, as it will serve as a booster dose. The oral polio vaccine (OPV) should not be given to adults because of the risk of acquiring polio from the vaccine itself in individuals whose immunity may have waned. If children are traveling abroad for adoption, they should also receive an additional dose of the polio vaccine, preferably as IPV. This means that they should have a total of five doses of polio vaccine by age 4 rather than the recommended four doses. Adults that receive a booster before travel do not routinely need a dose before each trip.

Diphtheria and tetanus are still seen in other countries. Adults are reminded to have a Td booster every ten years to give continuing protection against these diseases. If an injury that is at risk for tetanus occurs more than five years after one's tetanus shot, a booster is needed at that time. Since none of us can predict what injuries may occur while we are abroad, it is recommended that adults have a tetanus shot booster if it has been more than five years since the last shot. This lessens the chance that a tetanus shot may be needed while overseas.

Measles, mumps and rubella are childhood illnesses that were once common, and have lessened in frequency due to the MMR vaccine, now given during childhood. Due to several outbreaks of measles in children returning from China, the recommentations have been updated as of 5/2004:

Born before 1957: likely had disease, so no vaccines officially recommended. If you are unsure, immune compromised or want to be certain, an antibody level (rubeola titer, not rubella, which is the GERMAN measles) can be drawn.

Born after 1957: TWO doses of the live virus measles vaccine or an antibody level (as above) to demonstrate immunity. There was a killed virus vaccine given in the early 1960's, and this likely did not give long term immunity. My recommendation is for families to be certain that they are immune,(via the two doses of the vaccine or blood test) and if not immune then get the vaccine. The vaccine has a certain percentage of failure to the measles component, so that's why the two

doses are recommended. The second dose catches the people who missed making antibody the first time.

For children traveling: CDC recommendations include a dose of MMR (Measles/Mumps/Rubella) at 12-15 months. A second dose (for vaccine failure) is given at 4-6 years old. If a child has not received the second dose prior to travel to China (such as a child between 1-6 years old), it can easily be given earlier. The timing of the second dose is very arbitrary and not necessarily related to any medical reason. In fact, the two doses can be given as closely as 6 weeks apart.

There is now an effective shot to protect against **chicken pox**, which can cause significant illness in adults. The shot, given in two doses (the second 6 weeks after the first), is thought to be fairly protective against this disease, lessening the illness if an individual does acquire chicken pox. A blood test can be done if an adult's history is unclear, although the shot is not harmful if given in someone who had the disease and did not know it. This shot, as well as the MMR, should not be given in pregnant women.

For individuals traveling during the fall and winter months, it is recommended that they have the **influenza vaccine** which is offered each fall.

The recommendations regarding malaria prophylaxis vary depending upon the length of the visit, the ultimate destination (particularly rural versus urban), and the hours of exposure (whether you will be out after dark). Given that most adoption trips are relatively short in length, many doctors do not recommend that you take these medications, which have significant side effects, and must be taken for long time prior to travel, during the trip itself, as well as upon return home. For updates about malaria, it is suggested that you contact the CDC Malaria Hotline at (404) 332-4555, the CDC automated fax line at (404) 332-4565 or the CDC web site http://www.cdc.gov.

There are also vaccines for cholera, typhoid and yellow fever, but these are not univerally recommended for all international travelers due to expense, side effects, low availability, and mostly the low risk of exposure in most travel for international adoption. Again, for information about the particular area of the world where you will be traveling, contact the CDC at the above numbers or through the International Traveler's Hotline at (404) 332-4559. Many cities also have an international travel center with physicians who are knowledgable about travel abroad.

By Deborah A. Borchers, M.D., F.A.A.P.

 This information is provided for adoptive parents, according to the current guidelines of the Centers for Disease Control and the American Academy of Pediatrics. It is intended to encourage prospective adoptive parents to immunize early, but not to take the place of a primary care physician familiar with each family member. All immunizations should be given by trained medical personnel in a health care setting. Dr. Borchers is a general pediatrician and adoption medicine specialist in Cincinnati Ohio, and may be reached at 513/753-2820.

Written August 25, 1998, revised May 8, 2000.

Medical Testing Recommended for International Adoptees

Written by Deborah A. Borchers, M.D., F.A.A.P.

It is suggested that families make an appointment with their child's health care provider within one to two weeks after your arrival home. This will allow you to have their child examined for any contagious illnesses, evaluated for any conditions that need additional medical referrals (chronic problems), and allow the child's physician to review the child's immunization status.

Some physicians may see a child, in his/her clean, middle-class attire, and tell parents that testing is not necessary. *This is not true*. Children adopted from other countries may have any and all of these illnesses with absolutely no symptoms, namely no cough for TB, no diarrhea for parasites, no jaundice for hepatitis B, no developmental concerns specific to lead poisoning alone, and no growth failure for thyroid dysfunction. Physicians need to look at these children as if they were with birth parents in native attire in the country of birth. Most physicians would not balk at doing tests for such a child.

A good reference for physicians is a book that should be on the desk of all pediatricians, the Red Book, a publication of the American Academy of Pediatrics. This book, updated every three years, has a chapter which details the testing for all children who have been adopted from other countries, particularly with reference to infectious diseases. Most of the tests listed here are in this book and are recommended by numerous US experts in international adoption medicine.

Recommended blood, urine and screening tests

Your child should have several blood tests after she arrives home

- A **Hepatitis B profile** is needed to evaluate children for acute or chronic hepatitis B. This should include the **Hepatitis B surface antigen , Hepatitis B core antibody and Hepatitis B surface antibody (HBsAg, anti-HBc or HBcAb, and anti-HBs or HBsAb).** These basic tests will show if a child has hepatitis B, has been exposed or has had the vaccine, or is a carrier of the disease. If any of the tests are positive, the doctor may recommend further testing to delineate the extent of the illness. Unfortunately, the test results are commonly misinterpreted. If a parent has a question about the interpretation of the testing, contact a specialist in gastroenterology or infectious diseases, or the Hepatitis B Coalition (612-647-9009) or Hepatitis B Foundation (215-884-8786) for more information. Since the incubation period of this illness is 3 to 6 months, it is recommended that children be retested six months after their arrival home to be sure that theydo not have this illness, particularly if they received any blood tests or vaccinations while in the country of birth. It is necessary to do all of the tests listed above (and not just the Hepatitis B surface antigen commonly done by most

doctors as a screen), as up to 60 percent of children with Hepatitis B may be missed with only doing the usual blood screen. All children with Hepatitis B infection should also be examined for Hepatitis D and have liver function tests. In addition, all children with either acute or chronic Hepatitis B infections should be referred to a pediatric liver or infectious diseases specialist for long term care.

- **Hepatitis C** has also been seen in some adoptees, and it is recommended by that all international adoptees be screened for the antibody to this virus. As with Hepatitis B testing, children should be retested for Hepatitis C antibody 6 months after arrival home. Antibody acquired from a child's birth mother may persist until a child is 15 to 18 months old. If the initial antibody for Hepatitis C is positive, repeat testing should be done at that age along with a PCR test for the virus itself.
- **HIV testing by ELISA for HIV-1 and HIV-2** is recommended for all children. This illness, although rare in many countries from which children are adopted at present, is recommended for parental piece of mind and for early identification of HIV. Some countries at higher risk of HIV exposure include Cambodia, Thailand, Haiti and Romania. If a child is less than 18 months of age, it is recommended that s/he also have a **HIV PCR test**. This is because the HIV test is not as reliable for children less than 18 months of age. Because it is estimated that the incidence of HIV will be increasing in the near future, it is also recommended that this testing be repeated 6 months after arrival home. Live virus vaccines (MMR, Varivax for chicken pox, and the Oral Polio Vaccine) should not be given to a child until the HIV test results have been reviewed by a physician.
- **A stool examination for ova and parasites, giardia antigen and bacterial infections** is recommended for all international adoptees, not just (but especially) for those with diarrhea. Families need to contact the laboratory that process the stool specimen to see if special handling instructions are necessary with collecting this specimen. Children living in impoverished orphanages are at a higher risk, as are children who are significantly malnourished. It is not necessary for children to have diarrhea for them to have illnesses diagnosed by these tests. Most doctors will obtain three specimens, collected 48 hours apart, to make completely sure that the children have no infection, particularly if they are symptomatic. Children living in an orphanage setting may pass several parasites at one time. If a parasite is found, it is recommended that the stool examination be repeated after treatment. Some assymptomatic parasite infections found in international adoptees will resolve without any treatment. There are also numerous cases of children adopted internationally who have tested negative for parasite infections just after being adopted, but have passed large worms months to years later.
- A **complete blood count** to check for anemia is recommended. A **hemoglobin electrophoresis** is also recommended for children of Asian, African and Mediterranean descent who are anemic to identify thalassemia (a blood condition similar to sickle cell anemia) and sickle cell anemia, both genetic blood disorders. All children should also have a **lead level**, as several international adoptees have had elevated lead levels leading to anemia. Behaviors associated with lead poisoning include pica (eating dirt and other non-food items)

and irritability. Left untreated, lead poisoning may result in developmental delays. If a child is found to be anemic or have lead poisoning, repeat testing should be done to monitor for improvement in these conditions.

- A **blood test for syphilis** (usually a RPR or VDRL) is recommended to evaluate the child for syphilis, which could have been acquired from his/her birth mother. If this test is positive, further blood tests are necessary. A spinal tap to check for Neuro-syphilis which could cause developmental problems may also be recommended.. If a child has a medical history that states "syphilis treated in child", make sure that the child has a full evaluation anyway and do not assume that the treatment was adequate.
- A screen for **hypothyroidism** (a TSH) is recommended now for all children adopted internationally Low thyroid disorders have been diagnosed in a significant number of international adoptees, and the reason is not yet known. Symptoms may include a low resting heart rate, fatigue, and being overweight (gaining weight easily). Most birth children born in the US are screened for this disorder before discharge from the hospital of birth. In children adopted by six to twelve months of age, physicians should consider doing the **metabolic screen** which is done on all newborns in the state in which the child now lives. This test, done free of charge, screens for some very rare conditions which need immediate treatment.
- A **PPD test** should be placed on a child's arm to screen him/her for tuberculosis. Many children born in other countries have received a vaccine shortly after birth called the BCG. This vaccine is supposed to protect against tuberculosis, and the children may have some reaction to the PPD after receiving this vaccine. However, it is still strongly recommended that all international immigrants be screened for exposure to tuberculosis, regardless of whether they have received the vaccine. This test can safely be done on children as young as five or six months, and can be done just after a child arrives home as long as the BCG scar is not freshly healing. It should be read (looked at to see if it is positive or negative) in 48 to 72 hours by a health care professional, not just a parent. Because these children are children at high risk for disseminated tuberculosis (spreading beyond the lungs, potentially to the kidneys and brain), a positive result is one where the injected area is raised above the skin 10 millimeters or more. **The interpretation of this test does not change even if the child had the BCG vaccine.** Some physicians will do an additional skin test at the time of the PPD to evaluate if the child's immune system will allow him/her to react to the test. Regardless of whether this control test was done, children need to have a repeat PPD test six months after arrival. If positive, a chest x ray is recommended. If the x ray is negative, the child should be started on Isoniazid, an anti-tuberculosis antibiotic, which should be taken without fail for the next nine months. Even if a child was reportedly treated for a positive TB test in the orphanage, the treatment should be repeated.
- A dipstick urinalysis should be done on a urine specimen to evaluate for any blood, protein or infection in a child's urinary system that may need further evaluation.
- For children that received DTP immunizations in the country of birth, a physician may choose to do blood testing for **Diphtheria and Tetanus antibody levels** to see if the vaccines were effective. This test is unreliable if the immunizations were given within six

months prior to the blood test. Due to problems with inadequate storage, inadequate reaction to the vaccines, or potentially falsified records, many adoptees show no immunity to these two portions of the DTP shot, despite having reportedly received three or more of these shots. A physician should not assume that the immunizations were effective, and doing this test is one way to verify immunity. **Most physicians now believe that the immunizations should be repeated, as this presents low risk to the child.**

Summary of blood testing recommended by medical adoption experts

- Hepatitis B screen, including Hepatitis B surface antigen, Hepatitis B surface antibody, Hepatitis B core antibody.
- Hepatitis C screen.
- HIV ELISA and PCR screen.
- Stool examination for ova and parasites, giardia antigen, and bacterial culture. Three specimens, obtained 48 hours apart, are strongly recommended, particularly for children formerly in an orphanage.
- Complete blood count; hemoglobin electrophoresis is recommended for children who are anemic and at risk for abnormal hemoglobins, such as children of African, Asian or Mediterranean descent.
- Lead level.
- Blood screen for syphilis.
- TSH to rule out low thyroid levels; consider the state metabolic screen.
- A PPD to evaluate for tuberculosis. A test of 10 mm is considered positive and should necessitate further evaluation and treatment.
- A urinalysis dipstick.
- Diphtheria and Tetanus antibodies may be done if vaccines were given to verify immunity.
- Calcium, phosphatase, alkaline phosphatase and rickets survey if there is a suspicion of rickets.
- · Six months after arrival home children should have repeat testing for Hepatitis B, Hepatitis C, HIV and tuberculosis (with a repeat PPD test).

Other recommended evaluations

- In addition to blood and urine testing, it is strongly recommended that children have other medical screens for problems for which he/she is at high risk. Some of these problems may have no apparent symptoms at the time of his/her adoption, but statistics show that these children are at increased risk for concerns in these areas.
- A **hearing screen** by audiometry or BSER (terms familiar to physicians) is recommended for all children adopted from other countries. In many countries, the health care for these children is marginal. Many previously institutionalized children have had ear infections diagnosed after arrival in the United States, and it is assumed that these children may have

previously had (undiagnosed) infections while still in their orphanage. Early intervention with children with hearing impairment is necessary to ensure proper language development and hearing augmentation, so it is helpful to have this screen done soon after arrival home, preferably once all ear infections have been treated.

- Likewise, a **vision screen** and evaluation by an ophthalmologist (an M.D.) is recommended. Crossed eyes is a common problem in institutionalized children. In many countries there is no knowledge of birth history, so it is not known if the birth mother had any infections that could compromise the child's vision long term. These infections could include Toxoplasmosis (a parasite infection often passed through cat feces) and Rubella (German measles). Similarly, a family history of eye problems is not known, so the ophthalmologist should screen for any hereditary eye problems.
- A **developmental screen** is recommended to evaluate a child's developmental level at the time of her arrival home. In some states this information may be useful in helping a family to qualify for a special needs adoption subsidy. This can be done by a physician or nurse through a test known as the Denver Developmental Screening Test (DDST), easily administered in the doctor's office, or through agencies in your county. These agencies, often associated with the local county Board of Mental Retardation and Developmental Disabilities, include a program known as **Early Intervention.** This program is available (free of charge) to all children less than three years old who have developmental concerns. Specialists in the program help to facilitate the development of children identified at an early age as having developmental delays. Despite the name, a referral to this program does not mean that a child is retarded. In many counties, the parent can initiate the referral. Most children born in other countries may qualify for at least some services by being at risk, namely by being previously institutionalized in an orphanage. The therapists in the program assist parents by working with their child in their home or in a school setting. Referrals may be made at any time a parent has a concern about their child's development, not just necessarily at the time of his/her arrival home.

Immunizations

Some children born in other countries will have received immunizations prior to their adoption. Others may receive immunizations at the time of their medical evaluation for their US visa. Generally, the timing falls into one of three categories:

Immunizations given to children while in orphanages should be repeated. According to multiple adoption medicine specialists, blood testing performed on children in similar institutional care in Eastern Europe, China and other countries demonstrated that the children did not have full antibody protection against the diseases for which they had been immunized, despite records that reflected a full set of immunizations. There are strong questions about the proper storage and administration of the vaccines, as well as whether the records are even accurate reflecting that the shots were even given. All live virus vaccines, such as the MMR (Measles, Mumps, Rubella or German Measles) and

Chicken Pox vaccine should be repeated (once the HIV test is shown to be negative). Blood testing should also include testing for the Hepatitis B Antibody (as mentioned earlier), as this will show if a child has antibody to Hepatitis B. Most of the vaccines used these days have such low side effects that it is safe to repeat them, even if a child actually received the vaccines overseas.

Immunizations given to children in foster homes in Korea are thought to be more reliable, and probably do not need to be repeated. When in doubt, it is suggested that these children also have testing done to see if these shots were effective. Again, it is completely safe to repeat most vaccines, with no risk to a child.

Immunizations given to children at the time of the medical evaluation for the visa are considered to be the safest and most reliable of the vaccines. The record needs to be presented to your doctor so that s/he can then time the administration of future vaccines using that information.

Written by Deborah Borchers, M.D.

Written August 25, 1998, revised May 8, 2000.

Dr. Borchers is a general pediatrician and adoption medicine specialist at the Eastgate Pediatric Center in Cincinnati, Ohio (513/753-2820). These tests are in agreement with recommendations by the American Academy of Pediatrics Committee on Infectious Diseases as well as a consensus of physicians in the US with expertise in international adoption. This article may be reprinted and shared with parents, social workers and physicians.

GRIEVANCE PROCEDURE:

The Grievance Procedure is established to resolve areas of disagreement between prospective clients/adoptive clients/birth parents and agency personnel. The agency is responsible for grievances which involve disagreements with agency policy, procedure or practice.

If a client has a grievance, they should first discuss the disagreement with their social worker. Should a resolution not be reached, the client should file a written grievance requesting resolution of a disagreement with the agency. The written request must include a statement of the issues or concerns and the relief sought by the client. The request for a grievance meeting must be sent directly to the director of social services or executive director.

Within 30 days of receipt of the written request, the agency will convene a meeting to address the grievance. Persons in attendance at the meeting may include the placing social worker, social worker supervisor, executive director, and client. The presence of individuals at this meeting must be approved by the agency to insure protection of data practices. At least one supervisor who has the authority to influence the implementation of agency policy, procedure and practice must be present.

At the conclusion of this meeting, one of the following may occur:

1. If the grievance is resolved to the client's satisfaction, the resolution must be documented and signed by the client and the agency representative. A written decision must be finalized within twenty (20) days.

2. If the grievance is not resolved to the client's satisfaction, the client may request a meeting with the Board of Directors. This meeting is contingent on the Board's approval. Prior to the meeting, the client(s) must sign a release of all information to be reviewed by the Board prior to the meeting. If the client(s) unwilling to give such a release, the Board will be unable to meet with the client.

3. Should a meeting with the Board of Directors not be approved, the Client is expected to end the grievance procedure.

4. If a meeting with the Board of Directors is granted and a resolution is agreed upon, the resolution must be documented and signed by the client(s) and the agency representative. A written decision must be finalized within thirty (30) days.

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CLINICAL REPORT

Understanding the Behavioral and Emotional Consequences of Child Abuse

Guidance for the Clinician in Rendering Pediatric Care

AMERICAN ACADEMY OF PEDIATRICS
John Stirling, Jr, MD, and the Committee on Child Abuse and Neglect and Section on Adoption and Foster Care

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
Lisa Amaya-Jackson, MD, MPH

NATIONAL CENTER FOR CHILD TRAUMATIC STRESS
Lisa Amaya-Jackson, MD, MPH

ABSTRACT

Children who have suffered early abuse or neglect may later present with significant behavior problems including emotional instability, depression, and a tendency to be aggressive or violent with others. Troublesome behaviors may persist long after the abusive or neglectful environment has changed or the child has been in foster care placement. Neurobiological research has shown that early abuse results in an altered physiological response to stressful stimuli, a response that deleteriously affects the child's subsequent socialization. Pediatricians can assist caregivers by helping them recognize the abused or neglected child's altered responses, formulate more effective coping strategies, and mobilize available community resources. *Pediatrics* 2008;122:667–673

www.pediatrics.org/cgi/doi/10.1542/peds.2008-1885

doi:10.1542/peds.2008-1885

Key Words
child abuse, posttraumatic stress disorder, foster care

Abbreviations
PTSD—posttraumatic stress disorder
HPA—hypothalamic-pituitary axis

INTRODUCTION

Early maltreatment can significantly alter a child's normal developmental arc and leave the victim with significant long-term impairments. Health care professionals who provide care for maltreated children must consider the consequences of previous abuse for the child's ongoing development and adaptation when faced with a variety of long-term behavior problems regardless of whether children reside with their birth families, foster families, or adoptive families.

An increasing body of evidence documents the robust relationship between adverse experiences in early childhood and a host of complications, both medical and psychological, that manifest throughout childhood and later in adult life. The Adverse Childhood Events Studies have demonstrated that child abuse, neglect, and other circumstances that disrupt the parent-child relationship are significantly associated with many leading causes of adult death, such as stroke, cancer, and heart disease, and with heavy health service utilization. These disparate consequences, including depression and suicide, hypertension and diabetes, cigarette smoking, alcohol and other substance abuse, and fractured bones, bear compelling testimony to the vulnerability of children to stressful experience.[1]

Pediatricians see children before, during, and after adverse events. In the office, clinicians deal daily with children who are suffering the effects of trauma, including separation and loss, physical and sexual abuse, parental neglect, and witnessing violence. Many of these children, especially those for whom the stress is particularly severe, chronic, or pervasive, will have difficulty overcoming their persistent physiological and psychological responses to their earlier stress. Lingering symptoms of posttraumatic stress disorder (PTSD) or disrupted attachment can present as difficulties with sleep, anxiety, oppositional behavior, violent behaviors, and school failure.[2,3]

The child's problematic behavior may continue long after abuse or neglect have ceased, despite consistent and attentive parenting by foster or adoptive parents or birth parents who have successfully changed their own behaviors. Desperate caregivers may seek the pediatrician's help in diagnosing and treating a suspected "medical condition" or "chemical imbalance." Unless health care professionals recognize the relationships of these common behavior problems to their remote antecedents, their interventions will be at best inefficient and at worst ineffective or even counterproductive. The primary health care professional holds the first, perhaps most critical link for caregivers and

children: to help them understand that the child's unsatisfactory response to stress may have originated as a biologically based adaptation to the child's abnormal world and that persisting problem behaviors are the consequence. Pediatricians can help caregivers understand that there are healthy strategies and interventions that can help children reduce these excessive responses to environmental stress and assist children in resuming a normal developmental trajectory.

WHEN TRAUMATIC STRESS WILL NOT GO AWAY

Children who have survived acute events such as house fires, automobile accidents, major medical illness, or natural disasters frequently complain of disordered sleep, intrusive "flashback" memories, and altered emotional responses to everyday situations. These are classic symptoms that arise from experiencing a single traumatic life event. Such severe stress reactions are particularly common after incidents of interpersonal violence (such as domestic violence, child abuse, and terrorism). In cases of child abuse or neglect or other exposure to violence, in which the stresses are often prolonged and unavoidable, long-term stress reactions are common and can be especially devastating. In patients suffering from the aftereffects of significant early stress, the offending stimulus, sometimes minor, seems to echo the previous abuse and to produce an equivalent, dramatic emotional reaction that is often inappropriate to the provocation. Stimuli that produce such reactions are known as traumatic reminders and may take many forms. Reaction to an old trauma may be brought forth by a smell, sound, or other sensory input or may be triggered by an action, place, or date. In this reaction, the brain is engaging in what seems to be an exaggerated form of pattern recognition, a common form of learning in which similar patterns of stimuli call forth a similar neuroendocrine (and, thus, behavioral) response.[4,5]

Symptoms can be grouped into 3 main behavioral clusters: (1) reexperiencing through intrusive thoughts, dreams, and "flashback" recollections; (2) avoidance of reminders and numbing of responsiveness, including social withdrawal, restricted range of affect, and constriction of play; and (3) physiological hyperarousal in the form of hypervigilance and exaggerated startle response, attention and concentration problems, and sleep disturbance. When disordered stress responses persist long after the trauma, the condition is termed PTSD.[6,7] It is uncertain why some children develop PTSD after trauma but others do not, although severity and chronicity of the initiating stress seem to play a part, as do such host factors as social support and genetic variation.[2]

Diagnostic criteria for PTSD are the same in children as in adults. These may be summarized as: (A) exposure to a traumatic event that involved serious threat of death accompanied by intense fear and horror; (B) a tendency to persistently reexperience the traumatic event (through intrusive thoughts, dreams, and "flashback" recollections); (C) numbing of general responsiveness; and avoidance of stimuli that trigger this reexperience (seen as social withdrawal, restricted range of affect, and constriction of play); and (D) persistent symptoms of arousal (hypervigilance, exaggerated startle, and other physiological measures), (E) duration of above symptoms for more than 1 month and causing clinically significant distress or impaired functioning.[6] In children, these characteristics may manifest in developmentally different ways, such as traumatic play or extreme emotional lability, with "hair-trigger" explosive responses to minor provocations.[8–11]

Research has shown anatomical changes correlated with a history of PTSD symptoms, including smaller brain volumes and size differences in limbic structures.[12–14] Similarly, end-organ responses along the hypothalamic-pituitary axis (HPA) are altered by prolonged exposure to cortisol, a glucocorticoid critical to the body's stress response. Abuse victims have demonstrated abnormalities of the HPA response.[14–18] These observations underscore the premise that the exaggerated behavioral responses seen in complex PTSD have strong—and durable—anatomical and physiological underpinnings. Indeed, complex traumatic stress suffered early in life may be thought of as having both behavioral and developmental consequences.

Caregivers of a child with very difficult behaviors need to hear that the fault is neither entirely theirs nor entirely the child's. They need to learn that their child is dealing with a physiological response unfamiliar to them and to learn new and more effective ways of responding themselves. Although love and consistency are essential, they are not always enough.

THE SIGNIFICANCE OF EARLY STRESS: PSYCHOLOGY OR PHYSIOLOGY?

It is hardly remarkable that the seeds of adult dysfunction are sown in early childhood stress. We have long known, for example, of the lifelong effects of early malnutrition or of exposures to toxins such as lead or alcohol. What is remarkable, however, is the realization that many of the dysfunctional behaviors have their origins not in some random organic dysfunction but, rather, in the otherwise healthy brain's physiological adaptations to the abnormal world in which the developing child finds himself or herself. These adaptations, although initially useful, have not prepared the child for existence in the larger, more normal world outside the home. Behaviors that may have been useful, even life-saving, in a violent or neglectful home (such as hypervigilance or extreme passivity) become the problem behaviors identified at school or in child care (often interpreted as "attention deficit" or "daydreaming"). Once clearly established and internalized, however, the child's typical response to a stimulus (his or her definition of "normal") can be very hard to change.

The past 2 decades have seen remarkable progress in the understanding of neurodevelopment.[19,20] Once thought of as an enigmatic "black box," the brain is now seen as a complex of specialized, interactive organs, constantly developing through interaction with the environment and each other. Nowhere is this development more dramatic than in the first 3 years of life as the young brain undergoes sweeping structural change as it senses and adapts to the environment in which it finds

itself. Neurons develop myelin sheaths and proliferate, developing myriad connections with others throughout the cranium. With experience, some are strengthened, developing more connections with other neurons. Others are cut back through a process known as apoptosis, the "pruning" of unused connections. Significant apoptosis is seen as early as 4 years of age, continuing until the typical adult brain has lost nearly half of the neuronal connections it possessed at age 3.

It is now understood that this pruning is experience dependent—use strengthens neural pathways, and idleness marks others for demolition. As neurophysiologists remark, "neurons that fire together wire together." Although the 3-year-old's brain is optimized for learning, an adult's brain becomes optimized for performance. Use and disuse of specific pathways alter the neuronal structure through a variety of mechanisms, including changes in sensitivity and the number of synaptic connections.

These changes act to adapt the brain structurally to its environment. By allowing experience to alter its structure, the brain can grow to become the best brain for a child's given surroundings. It is, in other words, learning. A more visually complex environment, for example, may favor a larger visual cortex, whereas a child born blind might devote more cortical area to hearing. Similarly, a brain grown in a more threatening world may benefit from a highly developed fight-or-flight response, with appropriate modifications to the limbic system and HPA.[16,21] For instance, the amygdala, a vital part of the limbic system and necessary in emotional regulation, demonstrates a biphasic response to circulating stress hormones.[22] It becomes more sensitive to stress initially but shrinks when chronically exposed to high circulating concentrations of the stress hormone cortisol, adapting by becoming less sensitive. The hippocampus, a cortical region essential to the proper encoding and retrieval of memory, is similarly affected.[23] These structural changes, by affecting the brain's (and, thus, the individual's) response to stimuli, result in an altered behavioral response to stress.[10,16] The more chronic the stress, the more likely and longer lived the physiological changes.

WAR OF THE WORLDS

Unfortunately for the child, a brain specifically adapted for one type of extreme environment is seldom optimized to perform in another. This, in itself, would not be an insurmountable problem. However, children raised in abusive, violent, or neglectful homes are often denied the very tools that would help them adapt to new and different surroundings. Abused or neglected children often suffer impairments in their language abilities and cognitive skills.[24] One recent study found 36% of preschoolers in foster care to be developmentally delayed and found no difference between the developmental effects associated with reported physical abuse, sexual abuse, or neglect.[25] These deficiencies may reflect prenatal insults or postnatal contributors, such as malnutrition or toxic exposures, but almost certainly correlate with inadequate parental care during sensitive periods in early brain development, providing children with less exposure to language and fewer opportunities for cognitive development.

One of the most important tasks of early childhood is learning to discriminate states of affect.[26] Lacking good models, abused and neglected children may grow up unable to explain (or, indeed, to understand) the difference between such feelings as sadness and anger. In extreme cases, this is termed alexithymia (an inability to "read" emotion). Without this important perception, the ability to perceive the intentions of others, or to monitor one's own response, is lost and social learning is severely impaired.

The brain is most easily altered, or adapted, early in its life. Although there are thought to be few true "critical periods" after which alterations become impossible, early childhood may be thought of as a "sensitive period" for many forms of cognitive—and most emotional—learning, after which it becomes difficult to establish new patterns of thinking or reacting.[19,20] Thus, the abused or neglected child is asked to adapt to a new and different world but is given inadequate neural and behavioral tools with which to do so.

POSITIVE FEEDBACK (OF THE NEGATIVE KIND)

A child's hypervigilance and inability to regulate emotional states after maltreatment can result in challenging behaviors in interactions with others. Victims of previous abuse or neglect are far more often identified as "problem children" than are their peers and show higher rates of diagnosis with attention problems and violent and oppositional behaviors.[27] Caregivers and teachers often respond to these behaviors in the traditional fashion: warnings become more brusque (and often louder) and discipline more strict (and often more punitive).

Although such responses from adults usually gain the desired result in normal children, they become problematic when the listener is hypervigilant for threats and has difficulty controlling his or her own emotions. To a child who is physiologically adapted to a high-threat environment, a minor slight or stern admonition can sound like the prelude to real danger. When the child's exaggerated emotional response calls forth an even stronger response, the child may mistakenly assume that his or her initial reaction was warranted. Such responses inadvertently confirm the child's mistaken impression that the world in general is a high-threat environment. This is, in effect, positive feedback in that it reinforces the preceding behavior—behavior that has negative consequences for the child and for all those around him or her. With reinforcement, neural adaptation (learning) continues. Thus, although maltreated children's threat-adapted neuroanatomy can be said to determine their behavior, that behavior (via the responses of those around them) would be expected, in turn, to determine the further growth of their anatomy.

ATTACHMENT ISSUES

The child's sense of the parents' availability and responsiveness to protect him or her and see to his or her needs—a building block of secure attachment[28]—is a

critical mediator of developmental success, especially under conditions of traumatic stress.[29] An attentive caregiver may help the child learn the give-and-take nature of social communication and teaches the child to recognize and regulate his or her own emotions in a continuous "dance" of interaction.[30,31] With such a benefactor, the infant is secure to learn and explore. When the parent is frankly abusive, the resultant attachment can be confused and disorganized, but even less-severe mistreatment can affect attachment. When the caregiver is absent, preoccupied, or inconsistent, it also becomes difficult for the infant to feel safe. Observers describe neglected infants as more demanding, anxious, or more difficult to console, and they can present special challenges to their already compromised parents. Unless the cycle is broken, the challenged parents are likely to respond with anger or by further distancing themselves from the demanding child, and another positive feedback cycle begins to reinforce maladaptive behaviors.

INTERVENTIONS

Across this continuum of outcome possibilities, current caregivers—be they birth parents, foster parents, or adoptive parents—are almost certain to face major challenges in appropriately responding to the child's mental and physical health needs. A previously neglectful birth parent who has stopped using drugs or left a violent domestic situation may now be able to be consistent and attentive but may find the child unresponsive to his or her best efforts. When a previously maltreated child presents with behavior problems, especially when those problems are resistant to intervention, maladaptive physiological responses may contribute to a child's presentation. In fostering or newly adoptive parenting situations, it is not enough to merely provide a loving and consistent environment; the new parents must be helped to see that the child who has suffered abuse or neglect might indeed see, and respond to, that environment differently than might another child who has not suffered abuse.[32] Too often, maladaptive physiological responses are misinterpreted by teachers and parents and the child is dismissed as willfully "mean" or "disrespectful" and punished accordingly, which reinforces the response.

As abused children grow and develop, earlier trauma is revisited and reconsidered. Often, a child who has learned to live with these abnormal responses will experience added challenges in addressing them as an adolescent. Physiological changes and the onset of formal operational thought can complicate adjustment issues, and problematic behavior can resurface in new and often more dangerous forms. Here again, caregivers need preparation to help children respond constructively.

Therapy must be directed to reshaping the child's perceptions and emotional responses while helping the caregivers address their own behaviors. Failure to do so can result in serious long-term consequences that range from violent behavior to dangerous risk taking to impaired domestic relationships.[33,34]

A child's primary health care professional plays a critical role in identifying for caregivers and children the psychological and biological signs and symptoms of child traumatic stress. A careful psychosocial history should be taken whenever a child presents with behavioral symptoms, with attention paid to early abuse, neglect, or abandonment, especially during the first 3 years of life. Domestic violence, drug abuse, or parental mental health diagnoses are "red flags" that should raise concerns. If an accentuated stress response is suspected, the physician can help caregivers understand that the child's problems are more than simple "defiance" or willful misbehavior. Guidance can include discouraging aggressive responses to aggressive behaviors, including corporal punishment, and explaining how noise and anger can further aggravate the child's runaway stress reaction. Furthermore, physicians can clearly state that there are evidence-based treatments that mental health professionals use to help children and adolescents with traumatic stress reactions and assist them in resuming a more normal developmental path. This information can be shared with the caregivers, starting them on the road to better understanding and ability to obtain trauma-specific services. It is important for parents to know that treatment research has demonstrated that one of the most important factors influencing children's psychological adjustment is the degree of support they receive from their parents and other guardians.[35,36]

The best available evidence from controlled trials supports treating child abuse trauma reactions and related symptoms with trauma-specific psychotherapy that emphasizes cognitive-behavioral approaches. Cognitive-behavioral approaches used in treating abused children include education about child abuse and common reactions of children; teaching safety skills, stress-management techniques, and emotion-regulation skills; facilitating a coherent narrative of the traumatic event; and assisting appropriate emotional and cognitive processing (correcting untrue or distorted ideas about how and why the trauma occurred). Dyadic or conjoint parent work is emphasized as well, recognizing that the child's caregivers bear responsibility for continuing the work of therapy on a day-to-day basis.[37–40] This is especially important with younger and preverbal children.

Some children may not be ready immediately to construct a narrative about their trauma. When coping skills have been put into place, however, conversation between the child and a skilled therapist about the trauma has been a critical ingredient in studies that have provided the strongest research evidence. In fact, studies of adult rape victims have suggested not only that telling the story of the trauma is critical to treatment but also that organization of the trauma narrative and a client's emotional engagement in talking about his or her story can predict symptom reduction.[41,42] Art therapy may be a venue for some children to express their experiences nonverbally.[43]

Given the biological nature of the stress response, medications are often considered to assist children in regulating symptoms of physiological hyperarousal (such as nightmares, sleep difficulties, and high anxiety) and can be prescribed by child psychiatrists, pediatric primary health care professionals, or other pediatric medical subspecialists such as developmental/behavioral pediatricians. Pharmacologic approaches should be considered whenever the behaviors symptomatic of the uncontrolled stress response

interfere with the child's ongoing socialization. The evidence base for psychopharmacologic approaches to treating children and adolescents who suffer from PTSD symptoms is emerging, and although medication can often help ameliorate the stress response in youth, it is important to note that the research on these psychopharmacologic approaches lags behind the research in adults.[44] The same can be said about the promising efforts to prevent PTSD pharmacologically by using medications to blunt the acute stress response.[45–47] Such prevention, of course, would be more feasible after a single trauma, such as a criminal act, than for chronic stress. However effective in reducing symptoms, psychopharmacologic intervention should be considered an adjunct to, rather than a substitute for, psychotherapy.

Effective intervention may involve a variety of professionals working together. A skilled therapist can help the child learn to recognize and regulate his or her emotions and can help the family to respond in a way that makes the situation better instead of worse. Neuropsychological testing can aid in identifying the child's cognitive strengths and weaknesses, helping to anticipate future difficulties and indicating possible solutions, particularly in the area of school performance. Psychiatric or pediatric physicians may prescribe medications to help control extreme behaviors, and educators can tailor educational interventions that respect the child victim's special challenges. Social service workers can help the family obtain needed respite care or other support. By providing a "medical home" for the child, the pediatrician can serve as the facilitator for the intervention team.

CONCLUSIONS

In pediatric office practice, physicians and nurses are often asked to treat common behavioral problems. Children with a history of abuse, neglect, or abandonment may present to the pediatrician with symptoms including anger, aggressive behaviors, depression, or difficulties sustaining attention. In many cases, the children are no longer exposed to direct threat but present with residual behaviors that can be linked to neurophysiological responses to previous maltreatment. When the children are in foster or adoptive care or when a birth parent's circumstances have improved, caregivers may be attentive and consistent in their attempts to address a child's maladaptive behaviors but still find typical behavior-modification strategies unsuccessful. In many cases, the child's exaggerated reactions to stressful stimuli can cause the caregivers to act in ways that reinforce the child's misbehavior.

When attentive and consistent parenting seems ineffective, the physician would do well to remember that early maltreatment (physical or sexual abuse, neglect, or exposure to violence and fear) can deprive the child of the tools needed to adapt to a larger social environment. In addition to denying the developing child necessary social interactions, early maltreatment can alter the normal child's neural physiology, significantly changing the expected responses to stress and affecting the child's ability to learn from experience.

The pediatrician can assist directly and in cooperation with other professionals. Pediatricians should continue to advocate for timely evaluation of children entering the foster care system, as recommended by the American Academy of Pediatrics.[48] Given the risks posed by early neglect and abuse, these examinations should include developmental and cognitive screening in addition to the usual medical assessment,[49] although many foster children do not receive these comprehensive evaluations.[50] Ongoing education for the caregivers of previously maltreated children, especially for foster parents, is essential and can be better guided by the results of a comprehensive evaluation.

Using their therapeutic relationship with the child and family, physicians can work to educate the caregivers, helping them understand that their child's behavioral responses may well be different from those of other children in the same situation and that the differences may reflect a physiological difference rather than willful misbehavior or an egregious failure on the part of the caregivers. If such timely educational interventions can change caregivers' perceptions, they can relieve stress and begin to stabilize the family, with the ultimate goal of decreasing turnover in foster care. A change in perception might also open the door to ongoing counseling on referral from the primary health care professional.

Although many patients with a significant history of trauma will need to be followed by mental health professionals, the pediatrician still plays an important role in management. By providing a medical home, the pediatrician can work longitudinally with caregivers and continue to treat symptoms that are obstructing therapy. Pediatricians can facilitate access to community resources, work closely with the child's school to address behavioral challenges to learning, and help coordinate care among specialists in other disciplines.

Lisa Nalven, MD, MA
Elaine E. Schulte, MD
Moira A. Szilagyi, MD, PhD

STAFF

Mary Crane, PhD, LSW

REFERENCES

1. Felitti VJ, Anda RF, Nordenberg P, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 1998;14(4):245–258
2. Holbrook TL, Hoyt DB, Coimbra R, Potenza B, Sise M, Anderson JP. Long term trauma persists after major trauma in adolescents: new data on risk factors and functional outcome. *J Trauma.* 2005;58(4):764–771
3. Lansford JE, Dodge KA, Pettit GS, Bates JE, Crozier J, Kaplow J. A 12-year prospective study of the long-term effects of early child physical maltreatment on psychological, behavioral, and academic problems in adolescence. *Arch Pediatr Adolesc Med.* 2002;156(8):824–830
4. Bremner JD, Vythilingham M, Vermetten E, et al. Cortisol response to a cognitive stress challenge in posttraumatic stress disorder (PTSD) related to childhood abuse. *Psychoneuroendocrinology.* 2003;28(6):733–750
5. Elzinga BM, Schmal CG, Vermetten E, van Dyck R, Bremner JD. Higher cortisol levels following exposure to traumatic reminders in abuse-related PTSD. *Neuropsychopharmacology.* 2003; 28(9):1656–1665
6. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed, Text Revision. Washington, DC: American Psychiatric Association Press; 2000:xxxvii, 943
7. Cook A. *Complex Trauma in Children and Adolescents*. Los Angeles, CA: National Child Traumatic Stress Network; 2003. Available at: www.nctsnet.org/nctsn_assets/pdfs/edu_materials/ComplexTrauma_All.pdf. Accessed January 16, 2008
8. Yehuda R. Post-traumatic stress disorder. *N Engl J Med.* 2002; 346(2):108–114
9. Eth S, ed. PTSD in children and adolescents. In: Oldham JM, Riba MB, series eds. *Review of Psychiatry.* Series Vol 20. Washington, DC: American Psychiatric Association Press; 2001: 1–200
10. Pfefferbaum B. Posttraumatic stress disorder in children: a review of the past ten years. *J Am Acad Child Adolesc Psychiatry.* 1997;36(11):1503–1511
11. Pynoos R. Traumatic stress and developmental psychopathology in children and adolescents. In: Oldham JM, Riba MB, Tasman A, eds. *Review of Psychiatry*. DC: American Psychiatric Association Press; 1993:205–238Vol 12. Washington
12. Teicher MH, Andersen SL, Polcari A, Anderson CM, Navalta CP. Developmental neurobiology of childhood stress and trauma. *Psychiatr Clin North Am.* 2002;25(2):397–426
13. Teicher MH, Dumont NL, Ito Y, Vaituzis C, Giedd JN, Andersen SL. Childhood neglect is associated with reduced corpus callosum area. *Biol Psychiatry.* 2004;56(2):80–85
14. De Bellis MD, Keshavan MS, Clark DB, et al. Developmental traumatology, part II: brain development. *Biol Psychiatry.* 1999; 45(10):1271–1284
15. Anderson CM, Teicher MH, Polcari A, Renshaw PF. Abnormal T2 relaxation time in the cerebellar vermis of adults sexually abused in childhood: potential role of the vermis in stress-enhanced risk for drug abuse. *Psychoneuroendocrinology.* 2002; 27(1–2):231–244
16. Gunnar MR, Donzella B. Social regulation of the cortisol levels in early human development. *Psychoneuroendocrinology.* 2002; 27(1–2):199–220
17. Tarullo AR, Gunnar MR. Child maltreatment and the developing HPA axis. *Horm Behav.* 2006;50(4):632–639
18. Bugental DB, Martorell GA, Barraza V. The hormonal costs of subtle forms of infant maltreatment. *Horm Behav.* 2003;43(1): 237–244
19. Institute of Medicine, Committee on Integrating the Science of Early Childhood Development. *From Neurons to Neighborhoods: The Science of Early Child Development.* Shonkoff J, Phillips D, eds. Washington, DC: National Academies Press; 2000
20. Siegel DJ. *The Developing Mind: Toward a Neurobiology of Interpersonal Experience*. New York, NY: Guilford Press; 1999
21. De Bellis MD, Chrousos GP, Dorn LD, et al. Hypothalamic-pituitary-adrenal axis dysregulation in sexually abused girls. *J Clin Endocrinol Metab.* 1994;78(2):249–255
22. McEwen BS. Glucocorticoids, depression, and mood disorders: structural remodeling in the brain. *Metabolism.* 2005;54(5 suppl 1):20–23
23. Landfield PW, McEwen BS, Sapolsky RM, Meany MJ. Hippocampal cell death. *Science.* 1996;272(5266):1249–1251
24. Rossman BBR. Longer term effects of children's exposure to domestic violence. In: Graham-Bermann SA, Edelson JL, eds. *Domestic Violence in the Lives of Children: The Future of Research, Intervention, and Social Policy*. Washington, DC: American Psychological Association; 2001:35–65
25. Zimmer MH, Panko LM. Developmental status and service use among children in the child welfare system: a national survey. *Arch Pediatr Adolesc Med.* 2006;160(2):183–188
26. Beeghley ME, Cicchetti DA. Child maltreatment, attachment, and the self system: emergence of an internal state lexicon in toddlers at high social risk. In: Hertzig M, Farber E, eds. *Annual Progress in Child Psychiatry and Child Development*. Philadelphia, PA: Brunner/Mazel; 1996:127–166
27. Wodarski JS, Kurtz PD, Gaudin JM Jr, Howling PT. Maltreatment and the school-aged child: major academic, socioemotional, and adaptive outcomes. *Social Work.* 1990;35(6): 506–513
28. Bowlby J. *Attachment and Loss*. 2nd ed. New York, NY: Basic Books; 1982
29. Lieberman AF, Amaya-Jackson L. Reciprocal influences of attachment and trauma: using a dual lens in the assessment and treatment of infants, toddlers, and preschoolers. In: Berlin LJ, Ziv Y, Amaya-Jackson L, Greenberg MT, eds. *Enhancing Early Attachments: Theory, Research, Intervention, and Policy*. New York, NY: Guilford Press; 2005:100–124
30. Greenspan SI. Comprehensive clinical approaches to infants and their families: psychodynamic and developmental perspectives. In: Meisels SJ, Shonkoff JP, eds. *Handbook of Early Childhood Intervention*. New York, NY: Cambridge University Press; 1990:150–172
31. Carlson EA, Sroufe LA. Contribution of attachment theory to developmental psychopathology. In: Cicchetti D, Cohen DJ, eds. *Developmental Psychopathology. Volume 1: Theory and Methods*. New York, NY: John Wiley & Sons; 1995:581–617
32. James B. *Handbook for the Treatment of Attachment Trauma Problems in Children*. New York, NY: Free Press; 1994
33. Styron T, Janoff-Bulman R. Childhood attachment and abuse: long-term effects on adult attachment, depression, and conflict resolution. *Child Abuse Negl.* 1997;21(10):1015–1023
34. Alexander P. The differential effects of abuse characteristics and attachment in the prediction of long-term effects of sexual abuse. *J Interpers Violence.* 1993;8:346–362
35. Deblinger E, Stauffer LB, Steer RA. Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. *Child Maltreat.* 2001;6(4):332–343
36. Cohen JA, Deblinger E, Mannarino AP, Steer RA. A multisite randomized controlled clinical trial for multiply traumatized

children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry.* 2004;43(4):393–402
37. Chaffin M, Hanson R, Saunders BE, et al. Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems. *Child Maltreat.* 2006;11(1):76–89
38. Lieberman AF. Child-parent psychotherapy: a relationship-based approach to the treatment of mental health disorders in infancy and early childhood. In: Sameroff AJ, McDonough SC, Rosenblum KL, eds. *Treating Parent-Infant Relationship Problems.* New York, NY: Guilford Press; 2004
39. Hembree-Kigin TL, Bodiford McNeil C. *Parent-Child Interaction Therapy*. New York, NY: Plenum Press; 1995
40. Kolko DJ, Swenson CC. *Assessing and Treating Physically Abused Children and Their Families: A Cognitive-Behavioral Approach*. Thousand Oaks, CA: Sage Publications; 2002
41. Amir N, Stafford J, Freshman MS, Foa EB. Relationship between trauma narratives and trauma pathology. *J Trauma Stress.* 1998;11(2):385–392
42. Jaycox LH, Foa EB, Morral AR. The influence of emotional engagement and habituation on outcome of exposure therapy for PTSD. *J Consult Clin Psychol.* 1998;66(1):185–192
43. Murphy J, ed. *Art Therapy With Young Survivors of Sexual Abuse: Lost for Words*. Philadelphia, PA: Taylor & Francis Inc; 2001
44. Donnelly CL, Amaya-Jackson L, March JS. Psychopharmacology of pediatric posttraumatic stress disorder. *J Child Adolesc Psychopharmacol.* 1999;9(3):203–220
45. Stahl SM. Is psychopharmacologic "inoculation" effective in preventing posttraumatic stress disorder? *J Clin Psychiatry.* 2005;66(1):5–6
46. Vaiva G, Ducrocq F, Jezequel K, et al. Immediate treatment with propranolol decreases posttraumatic stress disorder two months after trauma. *Biol Psychiatry.* 2003;54(9):947–949
47. Pitman RK, Sanders KM, Zusman RM, et al. Pilot study of secondary prevention of posttraumatic stress disorder with propranolol. *Biol Psychiatry.* 2002;51(2):189–192
48. American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. Health care of children in foster care. *Pediatrics.* 1994;93(2):335–338
49. American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. Developmental issues for young children in foster care. *Pediatrics.* 2000;106(5):1145–1150
50. Leslie LK, Hurlburt MS, Landsverk J, Rolls JA, Wood PA, Kelleher KJ. Comprehensive assessments for children entering foster care: a national perspective. *Pediatrics.* 2003;112(1 pt 1):134–142

RECOMMENDED READING

American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. *J Am Acad Child Adolesc Psychiatry*. 2005;44(11):1206–1219

Cohen JA. Posttraumatic stress disorder in children and adolescents. In: Sadock BJ, Sadock VA, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. Vol 2. 8th ed. Philadelphia, PA: Lippincott, Williams & Wilkins; 2005:3286–3291

ATTACHMENT DISORDER SYMPTOM LIST

1. Compulsive need to control others, including caregivers, teachers, and other children.

2. Intense lying, even when caught in the act.

3. Poor responses to discipline: aggressive or oppositional – defiant.

4. Lack of comfort with eye contact (except when lying).

5. Physical contact: wanting too much or too little.

6. Interactions lack mutual enjoyment and spontaneity.

7. Body functioning disturbances (eating, sleeping, urinating, defecating).

8. Increased attachment produces discomfort and resistance.

9. Indiscriminately friendly, charming; easily replaced relationships.

10. Poor communication: many nonsense questions and chatter.

11. Difficulty learning cause/effect, poor planning and/or problem solving.

12. Lack of empathy; little evidence of guilt and remorse for others.

13. Ability to see only the extremes; all good or all bad.

14. Habitual disassociation or habitual hypervigilance.

15. Pervasive shame, with extreme difficulty reestablishing a bond following conflict.

Internationally Adopted Children: Important Information for Parents

Congratulations on the adoption of your child! As you begin your new life together, it is important that you help your child have a healthy future.

Evaluating Your Child's Health Upon Arrival Home:

Children adopted internationally are at risk for diseases related to their early life experiences, and many being adopted today have complex special health needs. Because of these factors, a medical examination soon after arriving in the United States is very important. This may be done by your child's doctor or a specialist in adoption medicine. If your child has special health needs, he or she may also need to see one or more medical specialists — but a general overview visit and a primary healthcare provider to coordinate care between multiple services is a good place to start.

What to Expect During the First Medical Visit:

The examination should include a review of your child's medical history and a physical examination. Your child may need immunizations as well. Your doctor will order recommended laboratory tests (see "Important Information for Your Child's Doctor" below) which are very important to ensure a healthy start and future for your child. Even if your child appears healthy, some medical conditions don't show signs or symptoms until later, when they may be more difficult and complicated to treat.

The following is more information about what your child's doctor should do. Remember to bring all your child's medical records with you, particularly ones you received before the child's adoption.

- **Review risk factors from your child's history.** This includes drug or alcohol exposure before birth, infectious diseases, any hospitalizations or surgeries, any available birth family history, difficult life experiences, and environmental risks.

- **Review immunization records.** As a part of the medical evaluation for your child to receive a United States visa, you agreed to have your child immunized as soon as possible. It is important for parents and doctors to be aware that vaccines given in orphanages may have been stored incorrectly, inadequately recorded, or given at inappropriate times and intervals in a child's life. Therefore, vaccine histories should not be accepted as written. Most vaccines may be repeated safely. As another option, your child's doctor may order blood testing to determine what immunity your child has to some vaccine preventable diseases, and then vaccinate as needed.

- **Order recommended tests**. This includes testing for anemia, lead, rickets, thyroid function, syphilis, viral diseases, tuberculosis and intestinal infections; developmental, vision and hearing screening; dental and mental health examination. Recommended laboratory tests that were previously done overseas should be repeated. Even if your child does not seem to be sick, the recommended screening tests are important for the health and well-being of your child, your immediate family, and other people with whom your child may have contact.

Important Information for Your Child's Doctor:

Children adopted internationally often have lived in conditions of poverty with limited nutrition, limited stimulation, various traumatic events, and environmental and infectious disease hazards. As such, a comprehensive evaluation is recommended by the American Academy of Pediatrics (AAP) to evaluate for diseases that may be present, with no initial signs or symptoms.

Below is a list of testing that is recommended for this child, regardless of the absence of symptoms or test results from the child's birth country.

Growth & Nutritional Issues

- Measure length, height, weight (unclothed), and head circumference (for ALL children). Use standard CDC or WHO growth charts to determine growth percentiles.
- Growth should be monitored with further work-up done if there is not catch-up growth by 6 months after arrival in the home.
- CBC to evaluate for anemia, blood disorders. Hemoglobin electrophoresis should be done for children at risk for hemoglobinopathies.
- Lead level for environmental risks.
- TSH (in some countries the soil is deficient of iodine).
- Newborn metabolic screen up to 2 years.

Infectious Diseases

- PPD or currently recommended testing for tuberculosis exposure. This should be done even if the child was immunized with the BCG vaccine.
- Hepatitis B virus serologic testing: Hepatitis B surface antigen (HBsAg).
- Hepatitis C virus serologic testing R HIV serologic testing.
- Testing for tuberculosis, Hepatitis B, Hepatitis C, and HIV should be repeated after the child has been home 6 months. Some children may not respond initially if the incubation period is inadequate or if they are malnourished.

- Syphilis serologic testing: RPR or VDRL, and FTA-ABS or TPPA R Stool examination for ova and parasites (3 recommended, best collected 48 hours apart) with specific request for Giardia and Cryptosporidium testing.
- Stool bacterial culture (if diarrhea present).
- Serologic testing for other parasites such as Trypanosoma cruzi, lymphatic filariasis, Strongyloides, Schistosoma species may be indicated for certain children.
- Evaluate immunization status by checking antibody titers for vaccines previously given (e.g., diphtheria, tetanus, polio neutralizing titers) OR repeat immunizations. Exceptions may include children from foster homes in Korea.

Other Recommended Screenings

- Screen of development and behavior, mental health needs, trauma history.
- Assessment of vision and hearing.
- Oral health assessment, with referral to a dentist.
- Referrals for early intervention, speech/OT/PT if indicated.

Additional Information & Resources:

- Care Considerations for Adopted Children (HealthyChildren.org Parent Webinar)
- Respectful Ways to Talk about Adoption: A List of Do's & Dont's
- Parenting After Trauma: Understanding Your Child's Needs
- Caring for Your Adopted Child: An Essential Guide for Parents (AAP Book)
- Adoption Medicine: Caring for Children and Families (AAP Book)

Last Updated

4/25/2019

Source

Specialized Resources

The U.S. Department of State

Office of Children's Issues
SA-29, 4th floor
2201 C Street, NW
U.S. Department of State
Washington, DC 20520
202-736-9130
Web site: travel.state.gov

The Office of Children's Issues provides general information about international adoption and U.S. visa requirements. The Office can make inquiries of the U.S. consular sections abroad regarding the status of a specific adoption case and can clarify documentation or other requirements; they can ensure that foreign authorities or courts do not discriminate against U.S. citizens. They cannot locate a child for adoption, become directly involved in the adoption process in another country, or order that an adoption take place or that a visa be issued.

International Adoption Medical Kit

Johns Hopkins Hospital has made available a medical kit for traveling adoptive parents.
The kit includes:

- Antibiotics for the child
  - Includes a weight chart for proper dose
- Ointments for scabies and lice
  - Includes photos for infections and rashes and proper use of medication
- Eye infection cream
- Digital thermometer
- General first aid materials
- Tylenol
- Benadryl

Johns Hopkins realizes that the weights that have been given of the children may be inaccurate, so they will provide information on a variety of weights.
To purchase this kit, please contact:
Evelyn Robinson at 410-955-3000.

Videotape

"Visible Differences: Transracial Parenting through Adoption" is a 28-minute parent preparation video that is a thoughtful, provocative, passionate, and tender exploration of the issues of transracial parenting through adoption. The video can be ordered by phone or mail from Pact: An Adoption Alliance, 4179 Piedmont Avenue, Suite 330, Oakland, CA 94611 (510) 243-9460. The price is now $25 for individuals, agencies and social workers.

Adoption and Ethnic Heritage Books and Materials

Adoptive Families of America
c/o New Hope Communications
42 W. 38th St, Suite 901
New York, NY 10018
800-372-3300
http://www.adoptivefamilies.com/books.php

Pact: An Adoption Alliance
4179 Piedmont Avenue, Suite 330
Oakland, CA 94611
(510) 243-9460 (voice)
(510) 243-9970 (fax)
www.pactadopt.org

Perspectives Press
P.O. Box 90318
Indianapolis, IN 46290-0318
(317) 872-3055
www.perspectivespress.com

Tapestry Books
PO Box 6448
Hillsborough NJ 08844
800-765-2367
www.tapestrybooks.com

Multicultural Kids
P.O. Box 6204
Buffalo Grove, IL 60089
800.711.2321
www.multiculturalkids.com

Celebrate the Child
1821 Enterprise Drive "S"
Harvey, LA 70058
504.340.6191
www.celebratethechild.com

Financial Matters

Employee Adoption Assistance Benefits
Many employers help their employees when they adopt by reimbursing adoption expenses with a cash benefit of several thousand dollars. If your employer does not offer

this benefit, call Adoption and the Workplace at the National Adoption Center (800-TO-ADOPT) for materials to guide you in requesting this benefit from your employer. There are also links to employers that offer adoption benefits.
http://www.adoptionfriendlyworkplace.org/

"How to Make Adoption an Affordable Option"
This comprehensive booklet, published by the National Endowment for Financial Education, is available online at www.nefe.org/adoption, click on "What it costs" to locate general articles about the adoption tax credit, military subsidies, loans, and the federal family and medical leave act.

A Child Waits Foundation
1136 Barker Road, Unit 12
Pittsfield, MA 01201
866.999.2445
Website: www.AchildWaits.org
Email: achildwaits@poboxes.com
Non-profit charitable foundation that makes low cost loans to families adopting internationally, based on financial need. No interest is charged on loans, except for a very small amount to cover possible inflation, and there is ample time to pay back the loan. Grants are available in special circumstances, especially to families that could probably not afford to adopt from overseas without the assistance of a grant, and families adopting older and special needs children.

Adoption Expense Tax Credit
The Hope for Children Act is now public law, which took effect beginning January 1, 2002. H.R. 622, incorporated into H.R. 1836, the Economic Growth and Tax Relief Reconciliation Act, has increased the adoption tax credit for qualifying expenses to $10,630 so far, with a small increment each year. To learn more about the tax credit go to http://www.adoptionlearningpartners.org/courses/taxcredit.cfm

Adoption Education

Adoption Learning Partners
By phone: 800-566-3995
8:30 am – 5:00 pm CST
By Email: info@adoptionlearningpartners.org
Website: www.adoptionlearningpartners.org

Adoption Learning Partners is a web based education series which seeks to improve adoption outcomes for all members of the adoption circle by providing a vibrant, innovative, educational resource on the Internet. The vision of Adoption Learning Partners is to offer highly valuable, timely, web-based educational resources for adoptive parents, adopted individuals, birth parents and the families that love them. Many courses are free or charge a small fee for a certificate of completion.

Courses include: With Eyes Wide Open, Conspicuous Families, Adoption Tax Credit, The Journey of Attachment, Finding the Missing Pieces, Let's Talk About Adoption. New courses have been added at regular intervals.

Specialized Therapy Resources

Note: This list of resources is provided for informational purposes only. Joint Council does not endorse or recommend any individual resource, and there are many more available beyond those listed here.

American Occupational Therapy Association
4720 Montgomery Lane
P.O. Box 31220
Bethesda, MD 20824-1220
Phone: 301-652-2682 Fax: 301-652-7711
www.aota.org

Attachment and Bonding Center of Ohio
Gregory Keck, Ph.D.
12608 State Road, Suite 1
Cleveland, OH 44133
Phone: 440-230-1960
Fax 440-467-1498
E-Mail: abcofohio@webtv.net
Website: www.abcofohio.net

The Center specializes in treating children who have experienced developmental interruptions. Dr. Keck, author of Adopting the Hurt Child: Hope for Families with Special-Needs Kids, and his staff also treat individuals and families who are experiencing a variety of problems in the areas of adoption, attachment, substance abuse, sexual abuse, and adolescent difficulties.

ATTACh
Association for Treatment and Training in the Attachment of Children
95 W. Grand Ave., Suite 206
Lake Villa, IL 60046
Phone 847-356-3506
Fax 847-356-1584
Website: www.attach.org
Email: info@attach.org
ATTACh is an international coalition of professional and lay persons who are involved with children who have attachment difficulties. They provide clinical education, training, and research on attachment; offer family support, including an open referral service to qualified professionals; and have an annual conference on attachment and bonding

Attachment Center at Evergreen
Dr. Foster Cline
32065 Castle Court, Suite 325
Evergreen, CO 80439
Phone: (303) 674-4029
Toll Free: (866) 674-4029
Fax: (303) 674-4078
E-mail: info@attachmentexperts.com
Web Site: http://www.attachmentexperts.com
The Attachment Center provides education and training on attachment therapy for parents, placing agencies, therapists, and the general public. The goal of treatment is to help both child and family understand the problems, develop strong attachments, and modify thoughts, feelings, perceptions, behaviors, and relationships -- so that the child can have a more satisfying and productive life, the parents can be happier and more effective in their role, and society can be safer.

The Theraplay Institute
3330 Old Glenview Road, Suite 8
Wilmette, Illinois 60091
Phone: 847-256-7334
Fax: 847-256-7370
Website: www.theraplay.org
E-mail: info@theraplay.org
Theraplay is an engaging, playful treatment method which is modeled on the healthy interaction between parents and their children. It is an intensive, structured short-term approach, which actively involves parents. Theraplay's goals are to enhance attachment, self-esteem, trust, and joyful engagement and to empower parents to continue on their own the health-promoting interactions of the treatment sessions.

Sensory Integration International
PO Box 5339
Torrance, CA 90510-5339
Phone: (310) 787-8805
Fax: (310) 787-8130
Scheduling Number: (310) 787-8253
E-mail: info@sensoryint.com
Web Site: http://www.sensoryint.com/index.htm

SII was founded by a group of occupational therapists dedicated to helping people with disabilities related to sensory integrative problems. They bring together professionals, individuals, families, and researchers who want to know more about sensory integration. They offer workshops to introduce parents and teachers to sensory integration and its connection with learning and behavior, train occupational and physical therapists in the evaluation and treatment of sensory integrative dysfunction in children, and offer publications and a resource system to connect parents and teachers with therapists and programs providing sensory integration services.

Center for Adoptive Families
10230 New Hampshire Ave., Suite 200
Silver Spring, MD 20903
Phone: 301-439-2900
Fax: 301-439-9334
E-mail: caf@adoptionstogether.org
Website: http://www.adoptionstogether.org/CAF/

CFA's mission is to strengthen adoptive families. They offer support groups to parents, group counseling for children and adolescents, an annual Kids' Connection Conference, training for educators and community members about adoption, and other counseling and support programs.

Center for Adoption Support and Education
Maryland office:
11120 New Hampshire Ave., Suite 205
Silver Spring, MD 20904
Phone: 301-593-9200
Fax: 301-593-9203
Email: caseadopt@adoptionsupport.org
Virginia office:
King's Park Professional Building
8996 Burke Lake Road, Suite 201
Burke, VA 22015
703-425-3703
Fax-703-425-3704
Email address: caseadopt@adoptionsupport.org
Website: www.adoptionsupport.org

C.A.S.E. provides post-adoption counseling and educational services to families, educators, child welfare staff, and mental health providers in Maryland, Northern Virginia, and Washington, D.C. In addition, C.A.S.E. is a national resource for families and professionals through its training, publications, and consultations.

Recommended Books, Newsletters and Magazines

Books

Suggested below are organized according to the articles in the Adoptive Parent Preparation Manual. Most of them can be ordered through Tapestry Books, whose excellent catalog is available by calling 800-765-2367. (Used copies of most books listed here can be found through the Barnes and Noble web site.) Tapestry Books has a fine selection of books for children of various culture and ethnicities, with good descriptions of each book.

Article 1: Issues of Separation and Loss in Adopted Children

Helping Children Cope with Separation and Loss
by Claudia L. Jewett (Harvard Common Press, 1994)
Provides many practical techniques for easing a child through the normal stages of grieving.

A Child's Journey through Placement
by Vera Fahlberg, M.D. (Perspectives Press, 1991)
Includes an excellent section on behavior management, which will especially benefit parents whose children are making painful transitions.

Real Parents, Real Children: Parenting the Adopted Child
by Holly Van Gulden (Crossroad, 1997)
Explains many adoption issues, including how children grieve for their birth parents and ways that adoptive parents can help them come to a healthy resolution of this grief.

Article 2: Easing Your Child's Separations From You

Twenty Things Adopted Kids Wish Their Adoptive Parents Knew
by Sherrie Eldridge (Random House, 1999)
Written by a woman who was herself adopted, this book shows adoptive parents how to free their kids from feelings of fear, abandonment and shame.

Touchpoints, Three to Six: Your Child's Emotional and Behavioral Development
by T. Berry Brazelton, M.D. and Joshua D. Sparrow, M.D. (Perseus Publishing, 2001)
Offers solutions to difficult behaviors resulting from separation anxiety and other emotional needs. Focuses on children ages three to six.

How to Raise an Adopted Child
by Judith Schaffer and Christina Lindstrom (NAL/Dutton, 1991)
This book addresses many concerns of parents and children as they grow. It is meant to be re-read and consulted over the years.

Article 3: Effects of Long-Term Institutionalization on Children

Don't Touch My Heart: Healing the Pain of an Unattached Child
by Lynda G. Mansfield and Christopher H. Waldmann (Piñon Press, 1994)
Provides insights into beneficial therapies and gives encouragement to families of children who have an initial inability to trust due to early abuse and neglect.

Waking The Tiger: Healing Trauma
by Peter A. Levine (North Atlantic Books, 1997)
This book explores the physiological effects and causes of trauma, then offers an original. scientific approach to healing trauma in children and adults.

Article 4: Promoting Attachment and Brain Development in Your Child

Becoming Attached
by Robert Karen, Ph.D. (Oxford University Press, 1994)
Explores our first relationships and how they shape our capacity to love, then offers strategies to promote attachment and healthy relationships.

Attaching in Adoption: Practical Tools for Today's Parents
by Deborah D. Gray (Perspectives Press, Inc. 2002)
A valuable resource for parents of children with attachment problems. Explains the meaning of their child's behaviors and provides tools for developing interventions for their unique child.

Your Baby and Child
by Penelope Leach (Alfred A. Knopf, 1997)
A popular parenting book by a psychologist who emphasizes building a strong bond with your child by responding fully to his or her needs.

Article 5: How Do Children Change?

Toddler Adoption : The Weaver's Craft.
By Mary Hopkins-Best (Perspectives Press, 1997)
This practical book covers many aspects of adopting and parenting children from one to three, and even younger. Includes forming attachments, behavior management, and more.

Raising Adopted Children: A Manual for Adoptive Parents
by Lois Ruskai Melina (HarperCollins, 1986)
This guide to the special parenting issues of adopted children is especially strong in its coverage of research on adopted children and its positive results.

Article 6: Appropriate Discipline: Alternatives to Physical Punishment

Parenting with Love and Logic
by Foster Cline and Jim Fay (Piñon Press, 1990)
A fun and enlightening book that presents principles of teaching responsibility that build parent-child bonds.

The Parent's Guide
by Stephen McCarney and Angela Bauer (Hawthorne Educational Services, 1992)
This valuable guide presents alternative approaches to each and every behavior problem, so parents can explore what works for their particular child.

Good Kids, Difficult Behavior: A Guide to What Works and What Doesn't
by Joyce E. Divinyi
Presents simple, effective tools for changing difficult behavior through the adult's thoughtful prepared responses. Gives positive parenting techniques that support the child.

Article 7: What if Your Child Rejects You during the Attachment Process?

Building the Bonds of Attachment: Awakening Love in Deeply Troubled Children
By Daniel Hughes
Helps parents to strengthen their bond with attachment-resistive children with playfulness, acceptance, and avoidance of approaches that increase the child's fear, shame and despair.

Parenting the Hurt Child: Helping Adoptive Families Heal and Grow
by Gregory C. Keck and Regina M. Kupecky (Piñon Press, 1995)
Written by two of the foremost authorities on attachment problems, this book gives encouragement and useful tools to parents whose children resist attachment.

Article 8: Coping with Difficulties and Delays as You Wait for Your Child

Launching a Baby's Adoption: Practical Strategies for Parents and Professionals
by Patricia Irwin Johnston (Perspectives Press, 1997)
From psychologically preparing for your new baby through the practical matters of adding a new household member, this book will help ease the transition to a new baby.

Child Behavior
by Frances Ilg, M.D., with Louise Bathes Ames and Sidney Baker (HarperCollins, 1992)
Has sections on how to handle typical childhood problems (eating, sleeping, etc.). Recommended as a quick reference book for parents to consult again and again as their child grows.

The Adoption Resource Book
by Lois Gilman (HarperCollins, 1992)
Covers all aspects of adoption and raising an adopted child. Includes checklists of procedures and paperwork, and questions to ask at each step along the way.

Article 9: Dealing with an Unexpected Diagnosis in Your Child

Can This Child Be Saved? Solutions for Adoptive and Foster Families
by Foster Cline, M.D. and Cathy Helding (World Enterprises, 1999)
Despite the title, this book offers encouragement and effective help to parents of children with difficult behavior and emotional problems, who may not respond to conventional approaches. Practical techniques, clearly explained.

When Love is Not Enough: How Mental Health Professionals Can Help Special Needs Adoptive Families
by Marian Sandmaier (Child Welfare League of America, 1988)
Helps families to prepare for adoption and maximize the adjustment primarily of children with special needs. The complex emotional needs of the entire family are taken into account.

That's My Child
by Lizanne Capper (Child Welfare League of America, 1996)
This book explores the different avenues of support available to parents of children with disabilities.

Article 10: Your Child's Life Book: An Introduction to His Adoption Story

Lifebooks: Creating a Treasure for the Adopted Child
by Beth O'Malley (Tapestry Books, 2000)
This book presents information on what life books are, why they are so important, and how to proceed with them from just about any standpoint. There is a 58 pg. chapter on the "Essentials."

The Complete Lifebook Workbook
by Jim Mooney (Tapestry Books, 1996)
An example of one way a life storybook might be organized. Many of the pages have a fill-in-the-blanks format. Information is also included to normalize many of the reasons that children might be adopted.

Article 11: The Importance of Your Child's Cultural and Racial Heritage

Are Those Kids Yours? American Families With Children Adopted from Other Countries
by Cheri Register
Based on research and interviews with adoptive parents and adult adoptees, this book explores the challenges of raising a child of another race and culture, and explains how to do it well.

Inside Transracial Adoption
by Beth Hall and Gail Steinberg (Perspectives Press, 2000)
With insight, honesty and humor, the authors guide readers through the complexities of transracial adoption, clarifying the issues and offering critical tools to help families navigate the challenges they confront. Good age appropriate ideas for kids from infancy through adulthood.

Pact's Booksource:A Reference Guide to Books on Adoption and Race for Adults and Children
by: An Adoption Alliance (Federal Grant, 2001)
A catalog for families, educators and adoption professionals to provide age appropriate support for children. A huge collection of books that help adopted children and children of color encounter characters that resemble them in obvious and subtle ways.

Article 12: Adoption as a Lifelong Process

Being Adopted: The Lifelong Search for Self
by David Brodzinsky, Marshall Schecter, and Robin Henig (Doubleday, 1993)
This book by some of adoption's foremost researchers explores the inner world of adoptees
as they develop, mature, and seek answers to questions of loss and identity.

Telling the Truth to Your Adopted or Foster Child: Making Sense of the Past
by Betsy Keefer and Jayne E. Schooler (Bergin and Garvey, 2000)
Explains why the full truth, with all its details, can help heal the hurt child. There are clear guidelines and examples that adoptive parents can follow.

Twenty Life Transforming Choices Adoptees Need to Make
by Sherrie Eldridge
More than 70 adoptees share their unique challenges and offer inspiration to other adoptees who may be confronting similar issues.

Article 13: Older Child Does Not Equal Adoption Disordered

Adopting the Older Child
by Claudia L. Jewett (Harvard Common Press, 1978)
This book is still the classic volume for families adopting (or considering adopting) an older child. Filled with caring advice on handling the transition from "honeymoon" period to testing phase to full integration into the new family.

Our Own: Adopting and Parenting the Older Child
by Trish Maskew (Snowcap Press, 1999)
In this book, parents considering older child adoption can find answers to many of their questions and concerns. The book covers both domestic and international adoption. It is full of great stories from adoptive families and backed up by research and interviews with adoption professionals.

The Challenging Child
by Stanley Greenspan (Addison-Wesley, 1996)
An optimistic and reassuring book that describes the five "difficult" types of children and how to live happily with them.

Newsletters

Adopted Child
No longer published; back issues available
www.raisingadoptedchildren.com
Phone: 208-882-1794 or 208-883-8035
Monthly Newsletter

Adoption/Medical News
Subscription - $36/year
Back issues can be ordered ($10/issue non-subscribers, $4/issue subscribers)
P.O. Box 1253
State College, PA 16804
Email: pqidc@aol.com
www.adoptionmedicalnews.com
Phone: 814-364-2449
Fax: 814-364-2616
Newsletter published ten times per year:

The Post
Parent Network for the Post-Institutionalized Child
P.O Box 613
Meadowlands, PA 15347
Phone: 724-222-1766
Email: info@pnpic.org

Magazines

Adoptive Families
42 West 38th Street, Suite 901
New York, NY 10018
Phone: 800-372-3300 or 646-366-0830
Fax: 646-366-0842
Email: letters@adoptivefam.com
Bimonthly magazine

Adoption Today
246 S. Cleveland Avenue
Loveland, CO 80537
Phone: 888-924-6736 or 970-663-1185
Email: louis@adoptinfo.net
www.fosteringfamiliestoday.com
Quarterly magazine