Reality Check

Common Health and Developmental Issues of Internationally Adopted Children

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Written by

Jody Temple White

and

Jill Barnhart

A collaborative effort between

International Family Services and University of Alabama - International Adoption Clinic

Special thanks to Richard Price, Michelle Henley, Rachelle Staley for their help with writing, editing and insight.

Published by International Family Services

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IFS is pleased to present you this training course. We hope you find it helpful as you prepare to add a very special child to your family.

Introduction to International Family Services

Welcome

It is a pleasure to present this book to you. It represents thousands of combined hours of research, personal experience, and training. International Family Services (IFS) wants families to be as prepared as possible as they enter into and complete the adoption process. This material is thorough and realistic. As you read it, we encourage you to write down any questions and concerns and review them with your social worker or program director.

International Family Services History

International Family Services (IFS) was founded in 1991 by Carol and Bob Mardock with the first adoptions coming out of Romania. By 1994, IFS had grown to two offices, located in Texas and Pennsylvania, and had completed over 125 adoptions from three countries, Romania, Vietnam and Russia. IFS has continued to grow, adding offices in Arizona, Oregon, California, Kansas, Missouri, Alabama and Michigan. Now, the international adoption programs include countries such as China, Russia, Kazakhstan, Guatemala, India and others. With over 3,000 children placed in permanent homes across the country, IFS continues to work hard to help families navigate the international adoption process.

IFS Adoption Programs:

- China
- Russia
- Guatemala
- India
- Kazakhstan
- Ukraine

IFS Mission Statement

International Family Services, Inc. (IFS) is a U.S. 501(c)(3) non-profit humanitarian aid organization who mission is to:

- Place orphaned and abandoned children in permanent and loving families;
- Assist prospective adoptive families navigating the international adoption process;
- Provide financial support and aid to orphanages and child welfare organizations who support and care for those children who may never be placed in permanent homes;
- Educate and empower adoptive families to successfully transition the child into the family and community;
- Serve with respect and dignity, honoring individual choices and cultural differences.

IFS Code of Conduct

IFS is committed to high ethical standards and has instituted a Code of Conduct Statement which applies to all programs we offer. This Statement is adhered to by all IFS staff, directors, adoption coordinators and Family Hope coordinators.

IFS will:

- Provide all information regarding a child's medical, social and behavior history to families as we receive it.
- Advocate for each child with the goal of finding permanent and loving homes.
- Relay any critical information in a timely manner.
- Work with families to help complete the adoption as quickly as possible.
- Keep all family information confidential unless given written permission.

IFS will not:

- Intentionally push or pressure families into making an adoption decision, but may institute a timeline for the sake of the child.
- Knowingly withhold critical and/or sensitive information regarding the medical, social and behavioral history of the child.
- Provide medical recommendations, evaluations or other medical advice to families regarding child referrals.

NOTES

Prospective Adoptive Parents Responsibilities:

Prospective Adoptive Parents will:

- Be honest and truthful with any and all information needed to complete the adoption.
- Be respectful and considerate of IFS staff and other IFS representatives throughout the adoption process.
- Complete all required training and education as directed by IFS Staff.

Prospective Adoptive Parents will not:

- Share confidential or identifiable information about their referred child on any web site, chat room or other public forum without written permission from IFS.
- Discuss specific details of their adoption, prior to its completion, in any public forum or with any media without written permission from IFS.
- Be in direct contact with orphanage staff, foreign representatives or other foreign officials unless given permission by IFS.

Goals and Objectives of the Course

The goals and objectives of this course are to:

1. Provide families with a general overview of:
    - the possible needs, risks and conditions of institutionalized children
    - the impact of institutionalization on children
2. Provide resources and information to families about:
    - Basic child development issues
    - Assessing the referral
    - Assessing current and future development and treatment needs
3. Provide broad developmental milestones using relevant research and real-life examples from adoptive families.

About This Course

This course was written for Prospective Adoptive Parents (PAPs) and contains valuable information appropriate for children of all ages. A basic understanding of possible concerns related to adopted children can help shed light on issues which may appear over time. Some of the children being adopted through IFS programs have spent time in the foster care system and others have lived in an orphanage. This course touches on both types of care, but many of the studies discussed pertain to life in an orphanage, sometimes referred to as an institution.

While this course contains extensive information taken from various reputable adoption specialists and sources, it is not intended to be a substitute for a medical evaluation or treatment plan. Once the child is home, IFS recommends that parents take the child to the family's pediatrician and, if possible, to an international adoption medical clinic. An adoption clinic does not replace the pediatrician, but the clinic will work along side the pediatrician to complete the necessary testing, immunizations and other evaluations. IFS does not give medical advice or medical recommendations, therefore, this course compiles and summarizes various adoption-related articles, books and other resources, along with material written specifically for this course by licensed therapists at University of Alabama's at Birmingham International Adoption Clinic. All sources are cited and a complete list of references and resources can be found in the reference section of this book.

PROSPECTIVE ADOPTIVE PARENTS: A married U.S. citizen of any age and his or her spouse of any age, or an unmarried U.S. citizen who is at least 24 years old at the time he or she files the advance processing application and at least 25 years old at the time he or she files the orphan petition. The spouse of the U.S. citizen may be a citizen or an alien. An alien spouse must be in lawful status if residing in the United States (http://uscis.gov/graphics/services/appen.htm#b)

General Overview of International Adoptions

What is an international adoption?

Over 20,000 inter-country adoptions take place each year, adding to the more than 200,000 foreign-adopted children already living in the U.S. There are two ways to bring an adopted child into the United States. The fastest and easiest way is to adopt an orphan who automatically becomes eligible to enter the United States as an immediate relative. Only U.S. citizens (if married, only one parent needs to be a U.S. citizen) are eligible to immigrate a child as an orphan. The second way is to adopt a child and reside with that child in the child's country for two years prior to petitioning for the child (www.uscis.gov).

Children Available for International Adoption

There is an extensive amount of paperwork involved in classifying a child as legally available for international adoption. Governments must follow specific protocol before this classification is given. Each country has its own waiting period before the child can be adopted by foreigners. This waiting period allows time for native citizens to adopt the child, possible family members to come forward and/or to ensure the authenticity of the orphan status.

An **orphan** available for international adoption, as defined by the U.S. immigration law, is a foreign child who does not have any parents because of the death or disappearance of, abandonment or desertion by, or separation or loss from, both parents (www.uscis.gov) .

A child may become an orphan due to the **relinquishment**, either voluntary or court regulated, of his or her birth parent's rights. Relinquishment, according to U.S. Immigration law, occurs when a foreign-born child with a sole or surviving parent who is unable to provide for the child's basic needs, consistent with the local standards of the foreign sending country, and who has, in writing, irrevocably released the child for emigration and adoption (www.uscis.gov).

Who is involved in an international adoption?

While the choice to adopt is very personal and private, once the decision has been made, many entities become involved. Each entity has its own responsibility, purpose and role, but information is shared between them. During the adoption process, families will deal with entities in the United States and in the foreign country. They include:

United States Entities:

Placement agency – agency contracted by the adoptive family to facilitate entire adoption process.

Adoption Coordinator or **Program Director** – Agent, usually an employee of the Placement Agency, serving as placement agency liaison between prospective adoptive parents, foreign country program coordinator, home study agency and social

ORPHAN

Under U.S. immigration law, an orphan is a foreign child who does not have any parents because of the death or disappearance of, abandonment or desertion by, or separation or loss from, both parents (www.uscis.gov) .

RELINQUISHMENT

An orphan can also be a foreign-born child with a sole or surviving parent who is unable to provide for the child's basic needs, consistent with the local standards of the foreign sending country, and who has, in writing, irrevocably released the child for emigration and adoption (www.uscis.gov).

worker. Responsibilities usually include coordinating the entire adoption process including agency documentation, dossier preparation and travel preparation with the prospective adoptive family.

Home study (HS) agency – agency that performs home study and post placement assessments. The HS agency may be the placing agency or an outside agency licensed to conduct home studies. The HS agency is hired by the adoptive family.

Social worker – agent that performs home study and post placement assessments for HS agency.

United States Citizenship and Immigration Services – authority issuing legal immigration status and visas to children adopted internationally.

Adoption medical clinic - a clinic specializing in adoption-related issues that works with families to assess the medical and developmental risks of a specific child, both pre- and post-adoption.

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Foreign Entities:

The following entities may be involved in an international adoption. The actual entities involved vary among countries.

Ministry of Health – agency appointed by some foreign governments to oversee child welfare. Responsibilities include administering and enforcing adoption laws, policies, regulations and approving requests for adoption.

Ministry of Education – agency appointed by some foreign governments to assist the Ministry of Health in child welfare issues including international adoptions

CCAA – China Center of Adoption Affairs is the agency appointed by the Chinese government whose responsibilities include overseeing, processing and approving requests for adoption in China.

CARA - Central Adoption Resource Agency is the agency appointed by the Indian government whose responsibilities include overseeing, processing and approving requests for adoption in India.

Foreign Program Coordinator - agent serving placement agency in assisting prospective adoptive parents with the adoption process prior to and while the parents are in the foreign country.

Translator – agent serving placement agency translating documents from English to foreign language. May also serve as translator for prospective adoptive families while in foreign country.

Foreign Judge - appointed authority in foreign country courts to approve and handle official adoption proceedings.

Foreign Adoption Attorney – trusted authority, usually assigned by the placement agency, to handle legal aspects of international adoption. Prepares and submits legal documents to foreign governments and courts. May serve as voice of prospective adoptive parents in foreign courts if power of attorney is given.

Orphanage Director – Responsible for day-to-day operations of the orphanage. Serves as the "guardian" of the children. May have input on children available for adoption as well as in approval process of

prospective adoptive parents. Serves as liaison between governing bodies as the voice of the children.

Orphanage Doctor - Responsible for the health and well-being of the children in the orphanage. Agent responsible for providing medical history and diagnosis as well as any necessary medical care while the child is under the guardianship of the foreign country.

Document registration office - office which registers adoption documents in Guatemala.

US Embassy/Consulate - entity which issues immigrant visas, and invitation letters and verifies adoption documents prior to a family's or child's return to the United States.

Embassy Certified doctor - a foreign doctor certified to conduct exit medical examinations on the child prior to the child's entrance into the United States

Family Court - In Guatemalan adoptions, the adoption case is heard in Family Court. The judge, foreign social worker, attorney, child, care giver and bio mother (if applicable) are all present. (PAP's are not present at Family Court.)

PGN - Solicitors General's office in Guatemala. Responsibilities include: final court and processing all adoption related documents.

Civil Registrar - office which registers the adoption and provides revised birth certificates and other necessary documents.

Secretary of State - The SOS certifies or apostilles dossier documents for acceptance in foreign courts. The certification or apostilles verify the authenticity of the notary information by attaching a certificate to the notarized document.

Foreign Consulate - Foreign consulates in the U.S. will authenticate paperwork and issue entry visas for adoptive families. Papers being authenticated must first be certified by the Secretary of State, unless adopting from India. India documents may go directly to the Secretary of State.

International Adoption Process

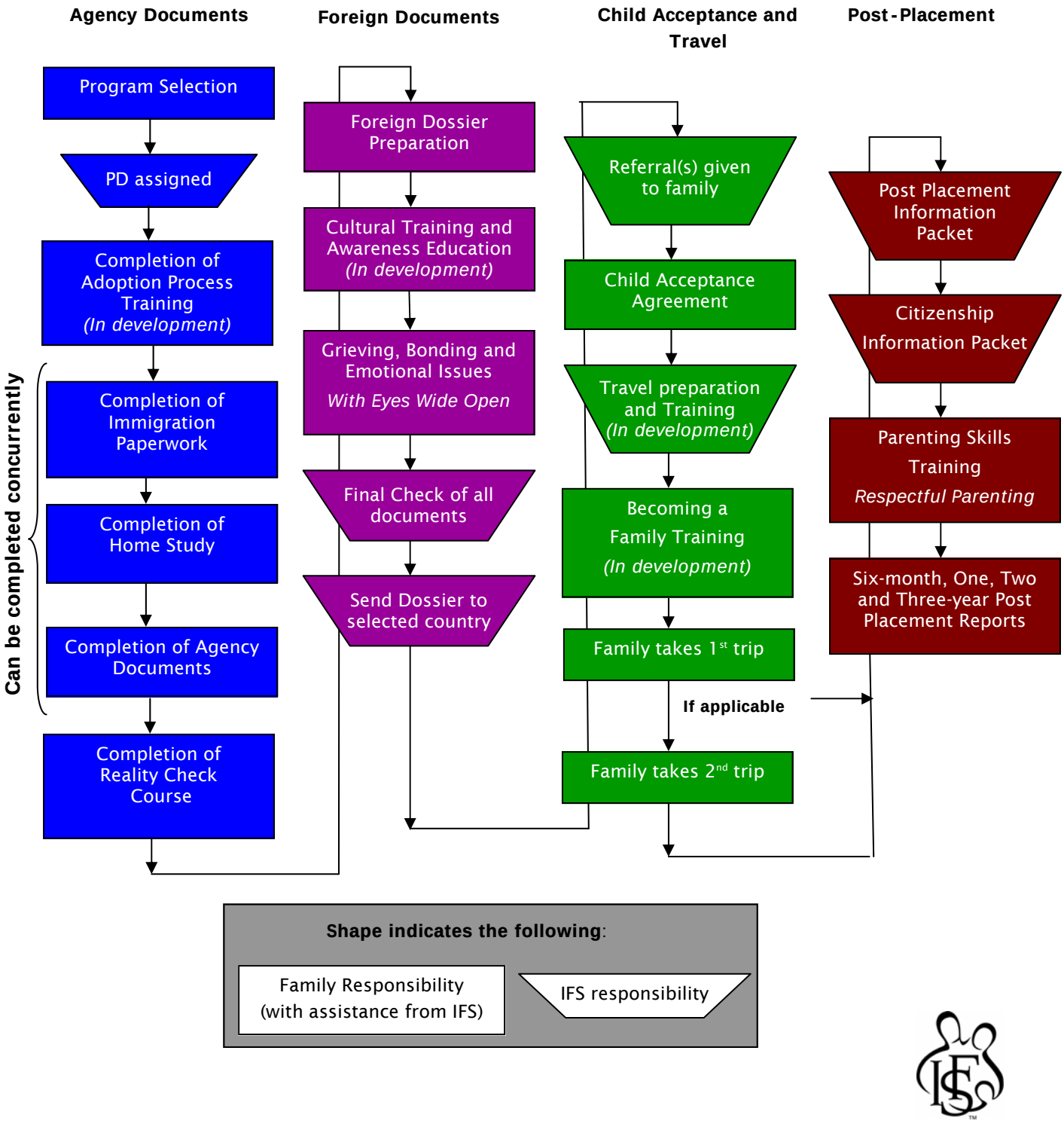
The international adoption process contains many parts including United States government clearance, Citizenship and Immigration Services (CIS) clearance, foreign paperwork, travel and post-placement reporting and registration. Changes, delays, paperwork, waiting and last-minute requests are the nature of international adoptions. It can be an emotional roller coaster as families work with U.S. adoption agencies and the governments to navigate through the complexities of the process. IFS has extensive knowledge and history in the facilitation of international adoptions, but even with this experience there are still issues that surface and need to be resolved. IFS works diligently with families and the governments to ensure a successful adoption. Most adoptions do complete, but, unfortunately, there are no guarantees that every adoption will be finalized.

A basic flowchart of the adoption process is shown in Graphic 1. This chart provides a general overview of the adoption process. It is not intended to be a detailed list of the many possible particulars of every adoption proc-

ess. All IFS contracted families are required to complete each phase of the process including necessary training and paperwork.

Graphic 1

IFS International Adoption Process



Part One: Health and Medical Risks and Concerns

Introduction

The adoption journey is an exciting, emotionally-driven adventure. Families enter into this journey for a variety of reasons. Some have dealt with infertility, others want to add to their family, and others want a child of a specific gender or age. Regardless of the motivation, each family will experience a broad variety of emotions throughout the process. Even though this is a very exciting time, most families experience episodes of frustration, grief, anxiety and worry during the process.

One main concern many families have is that, typically, prospective adoptive parents (PAPs) do not receive a lot of background information on their adopted child. This fact alone may cause greater worry about the health and development of the child. While nothing can be done to change the child's past experiences, PAPs can take a proactive approach to understanding basic child development issues, including typical patterns and differences in adopted children, and adoptive issues in general, in order to help meet the needs of the child today and on into the future.

With All the Risks Involved, Why Do an International Adoption?

Adoptive parents have been brought into the child's life for a reason, and it is up to the parents to prepare themselves so that they can support, love and nurture the child in the best way possible. This course is designed to equip, prepare and educate Prospective Adoptive Paarents. Some of the information may seem scary and at some point the question may come up, "Why would someone choose to adopt when there are so many inherent risks?" Each person has to answer this question for himself or herself, but in the following excerpt taken from the 2003 article titled, "Adopting An Institutionalized Child: What Are the Risks?" written by Dr. Dana Johnson, M.D., Ph.D. Professor of Pediatrics, Director of the International Adoption Clinic and Director of the Division of Neonatology at the University of Minnesota, the question is addressed:

> "...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." (http://www.peds.umn.edu/iac/risks.pdf)

Dr. Johnson goes on to make the following recommendations to PAPs:

- "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."

This course was written to address some of these common concerns and to bring awareness to some of the potential issues families may face when adopting a child internationally. Although this course was written to address various issues pertaining to adopted children, PAPs should remember that many of these issues are not exclusive to internationally adopted children. Biological children can also have similar challenges. When it comes to raising children, whether adopted or biological, there are no guarantees about health, development, disease or illness.

Child Issues

Needs of children awaiting adoption

Every human being has basic fundamental needs which must be met in order to live and thrive. Generally, children adopted internationally have not had these needs consistently met, which can lead to the variety of issues and concerns discussed in this course. Maslow's Hierarchy of Needs (Graphic 1.1) is a theory in psychology proposed by Abraham Maslow in his 1943 paper *A Theory of Human Motivation*, and later extended. The basic idea of this hierarchy is that higher needs come into focus only after all lower needs have been met. Growth forces result in upward movement on the hierarchy, whereas regressive forces push needs down in the hierarchy. Maslow's Hierarchy of Needs is an excellent theory which sets a good foundation for the discussion about the needs of internationally adopted children. Each level of the pyramid is described below with a brief summary of how it pertains to institutionalized children.

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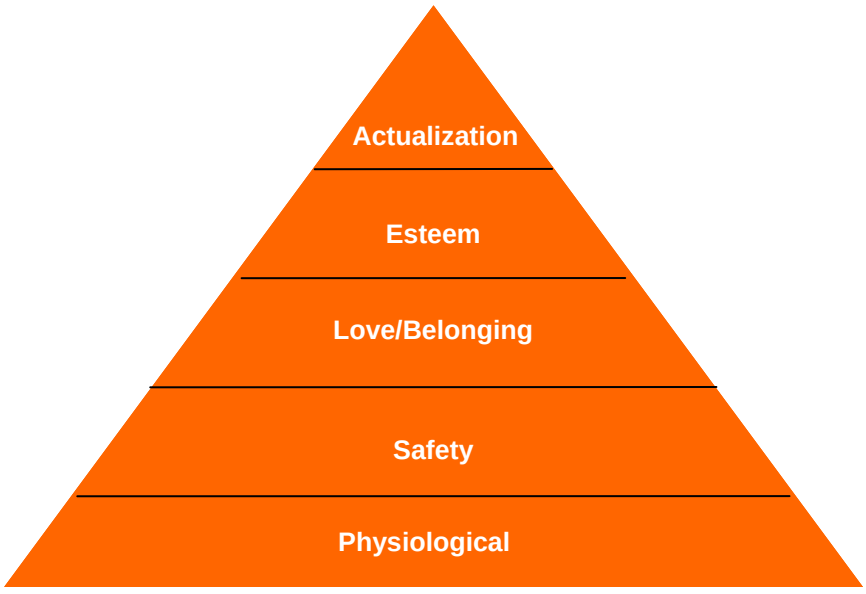
Graphic 1.1

Maslow's Hierarchy of Needs



Physiological Level

Physiological needs such as food, drink, sleep, shelter, fresh air and proper temperature keep our bodies in balance. If these needs are not met, then all of the other desires and capacities are pushed onto the back burner. These needs are the foundation of our existence.

Typically, sleep is the most common area of difficulty for institutionalized children transitioning to a home environment. Keeping the child in close proximity and comforting the child immediately may help to ease some of the sleep issues during the initial transition.

In orphanage environments, food and clean drinking water are not as plentiful as in American households. This may be one of the reasons adoptive children may hoard food and drink during the transition from the orphanage to the new home. While this behavior is inappropriate, the root of the behavior may stem from a basic insecurity. According to Maslow's theory, the child is instinctively protecting herself by taking the food. Once this need is consistently met and the child feels the security that she will have enough food, the behavior will typically diminish. Remaining consistent and giving continual reassurance to the child will build security and help the child understand that her basic needs will be taken care of on a regular basis. The withholding of food, water or other basic necessities as a form of punishment will intensify the child's insecurity and may cause increased hoarding and detachment.

Tips to Curb Food Hoarding:

- Keep meal times routine and consistent
- Allow the child to keep food in his or her room in proper storage containers
- Give the child his or her "own" drawer filled with healthy snacks or food and allow them to eat as they want or need
- Explain about food safety

Safety Level

Once the physiological needs of food and shelter are met, humans need safety. Safety includes feelings of security; stability; dependency; protection; freedom from fear, anxiety, and chaos; need for structure, order, law, and limits.

Children from orphanage environments may experience new and unexplainable fears. For example, loud sounds or music, pets, unknown adults or being left alone commonly cause them to be afraid. The children may seem hyper-vigilant, having a difficult time relaxing, calming themselves and sleeping. These children have a feeling that they must keep themselves safe because they are unsure of their surroundings.

Most institutionalized children have had limited exposure outside the orphanage, and while there are many new and exciting things to experience, this new environment can prompt new fears as well. Fears are expressed in numerous ways. Sometimes children show it by being overly aggressive or withdrawing, by being possessive over toys, clothes or people, increased clinginess or needing to stay in close proximity to the parent, and acting out for unexplained reasons. Staying tuned in to the child's progression through the pyramid of needs can help shed light on the child's behavior.

Love and Belonging Level
Once safety and physiological needs are met, humans naturally gravitate toward achieving fulfillment of love and the need to belong.

When the adopted child begins to feel secure and safe, more confident his basic needs will consistently be met, he is more receptive to forming natural and healthy attachments with his adoptive parents and other family members. This attachment process takes time and is discussed in further detail later in this book. The bonds are strengthened as the child's needs are consistently met and he becomes comfortable and secure in his new life. The child feels, maybe for the first time, as though he is part of a family.

Sometimes moving into the Love and Belonging level signals the end of what is often called the "honeymoon" period. Families have reported that once the children feel that they belong and are loved, new behaviors and attitudes, both positive and negative, sometimes appear. If this occurs, it is important to remember that the child may be testing the limits and the boundaries, just as any child does. As mentioned before, consistency and unconditional love are critical components in helping the child through this phase.

Self-Esteem Level
Once we humans are less distracted by physical and safety needs, we are more able to build a positive self-esteem. Self-esteem is simply how we see ourselves, what we think of who we are. Many other factors shape our self-esteem, including personality, the words and actions of others towards us, and a growing sense of competence, accomplishment and personal power.

Having a positive self-esteem is an essential building block for any child. Unfortunately, the adopted child comes with baggage which can greatly affect how she views herself. This can be a confusing time for the child, especially if she is older and has memories of her former life. Active listening and allowing the child to talk openly, without judgment, about her past may help her work through this time. There are numerous books and websites available to help adoptive parents in opening the discussion about the child's past experiences and adoption and ways to help build the child's self-esteem.

Self-Actualization Level
Self-actualization (a term originated by Kurt Goldstein) is the *instinctual* need of humans to make the most of their unique abilities. Maslow described self-actualization as:

> *"A musician must make music, the artist must paint, a poet must write, if he is to be ultimately at peace with himself. What a man can be, he must be. This need we may call self-actualization.* (*Motivation and Personality*, 1954) "

While other needs can be met fully, self-actualization is seen as "growing" or as a continuing driving force. This driving force is what motivates humans to continue learning and trying new things.

Special Needs of Adopted Children

Taken from *Twenty Things Adopted Kids Wish Their Adoptive Parents Knew.* Copyrighted material by Delta Publishing and used with permission of author Sherrie Eldridge. www.adoptionjewels.org.

Emotional Needs:

- I need help in recognizing my adoption loss and grieving it.
- I need to be assured that my birth parents' decision not to parent me had nothing to do with anything defective in me.
- I need help in learning to deal with fears of rejection – to learn that absence does not mean abandonment, nor a closed door that I have done something wrong.
- I need permission to express all adoption feelings and fantasies.

Educational Needs:

- I need to be taught adoption is both wonderful and painful, presenting lifelong challenges for everyone involved.
- I need to know my adoption story first, then my birth story and birth family.
- I need to be taught healthy ways of getting my special needs met.
- I need to be prepared for hurtful things others may say about adoption and about me as an adoptee.

Validation Needs:

- I need validation of my dual heritage (biological and adoptive).
- I need to be assured often that I am welcome and worthy.
- I need to be reminded often by my adoptive parents that they delight in my biological differences and appreciate my birth family's unique contribution to our family through me.

Parental Needs:

- I need parents who are skillful at meeting their own emotional needs so that I can grow up with healthy role models and be free to focus on my development, rather than taking care of them.
- I need parents who are willing to put aside preconceived notions about adoption and be educated about the realities of adoption and the special needs of adoptive families face.
- I need to hear my parents openly express feelings about infertility and adoption, thus producing a bond of intimacy between us.
- I need my adoptive and birth parents to have a noncompetitive attitude. Without this, I will struggle with loyalty issues.

Relational Needs:

- I need friendships with other adoptees.
- I need to be taught that there is a time to consider searching for my birth family and a time to give up searching.
- I need to be reminded that if I am rejected by my birth family, the rejection is symptomatic of their dysfunction, not mine.

Spiritual Needs:

- I need to be taught that my life narrative began before I was born and that my life is not a mistake.
- I need to be taught that in this broken, hurting world, loving families are formed through adoption as well as birth.
- I need to accept the fact that some of my adoption questions will never be answered in this life.
- I need to be taught that I have intrinsic, immutable value as a human being.

Anyone who has worked with children or spent any time with children, know how resilient they are. Adopted children are no different. They are survivors which, up until they joined their adoptive families, survival has most likely been their driving force. As the child passes through each level of the pyramid, their focus changes and their parents will get to see glimpses of the child's unique abilities and personality. It is up to the parents to continually nurture and support the child's growth, so the child can learn and know how valuable they are and how they "fit" into this world.

There is no timeline for how long it takes for any child to go through the first few levels described above. It is a process which takes time, patience and understanding. Some of the levels may be harder for some children than others due to past experiences, the child's temperament, the child's age, the length of institutionalism and various other factors. If there is concern about specific areas of development or behavioral issues, families should seek help from qualified professionals. Counselors or therapists trained in adoption-related issues can be excellent resources for both the child and the parents.

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A. H. Maslow. *A Theory of Human Motivation.* Psychological Review, 50, 370-396. (1943)

A. H. Maslow. *Eupsychian Management.* (1965). Note that the Andy Kay featured in this book is the Andy Kay of Kaypro.

M. A. Wahba & L. G. Bridwell. *Maslow reconsidered: A review of research on the need hierarchy theory.* Organizational Behavior and Human Performance, 15, 212-240. (1976).

FOSTER HOME

a household in which care is provided to a child who has been orphaned or removed from the home of his or her natural parents (as for reasons of abuse, neglect, or delinquency) Source: *Merriam-Webster's Dictionary of Law, © 1996 Merriam-Webster, Inc.*

Orphanages and Foster Care

Children available for international adoption live in a variety of environments. Most of the countries permitting international adoptions operate orphanages, and most internationally adopted children come from orphanages. However, some children live in foster or group homes. Having a general understanding of the various types of living situations is important as prospective adoptive parents prepare for their child's arrival into the family.

A residential **foster home** is much like any other family home. Children experience life in a family unit where the caregivers do not rotate and genuine sibling relationships are built. The home functions where the adults are "parents" and siblings are "brothers and sisters." The children generally have their own room and belongings and are treated as members of the family. While there are routines as in any family, schedules are generally more relaxed than in a group or orphanage environment. Children in residential foster homes will typically form a bond with the family. This is the closest version of what is considered a "traditional" family environment.

Group foster homes are larger and have more children than a residential home. Consistent caregivers serve as "house parents" and live in the facility. Occasionally, other caregivers come for a weekend or several days to offer relief to the house parents. In this environment, children experience life as a large family unit. Schedules are generally more structured to accommodate the larger group. Children share rooms but still have their own belongings. Attachments are made with the house parents as "mother" and "father." Sibling attachments and bonds are generally formed with the roommates; however all the children refer to each other as brothers and sisters. These attachments are healthy and show that the child has the ability to attach and should be able to transfer that attachment to the adoptive parents. While making the new attachments may be easier for these children, the grieving may be harder as they leave people they love and are bonded with.

Life in an Orphanage

Created by Lenore Grabel, Executive Director of Adoption Journeys of Arizona, Inc. Used with permission.

- The daily routines are structured. There are consistent expectations of behavioral parameters for children, and discipline is strict.
- Caretakers vary.
- Children's experiences are limited.
- Children become independent and self-sufficient many times beyond their developmental ages.
- Children develop survival skills.
- Infants do not have their needs met consistently.
- Infants, much of the time, do not receive recognition or attention for expressing needs. They can move through stages of development without building trust in primary caregiver.
- Infants are placed on potties at early ages—generally no diapers used in Russia and children are potty trained as soon as they sit up on their own.
- Feeding techniques conform to orphanage routines—protocols for feeding fit orphanage schedules; bottles propped, children are expected to drink from cups at younger ages than might be expected in a family setting.
- Children fed by caretakers to fit feeding schedules; many times children are fed very quickly and not allowed to enjoy eating on their own at the ages that are developmentally appropriate.
- When food is gone, there is no more. Children may not know what a kitchen looks like.
- Children experience group dynamics regularly—they live in groups with others their age. During the daytime, infants are kept in playpens together, sleep in rooms at night with others. Hierarchies and attachments are formed among the children more than with the caretakers.
- Schedules are not adjusted to children's needs. Everyone is placed on a schedule that fits the orphanage structure and caretaker capabilities.
- Children are not reinforced consistently for their accomplishments, meeting their developmental milestones or their behaviors.
- Children may not have learned "correct" emotions as they do in a family setting, where they learn from reinforcement, interactions and responses of their parental caretakers.
- Children become used to caretakers coming and going. This may instill feelings of separations, and loss as regular life experiences.
- Children may not be taught "cause and effect" relationships.
- Lack of one-on-one teaching experiences at the appropriate developmental milestones affects their levels of understandings.
- Children's immune system can be affected by diet, as well as, by their emotional connections.

In an **orphanage** environment, life is more like a residential school with limited resources. Many caregivers rotate frequently and typically do not live at the facility. The caregivers view themselves as the authority figure, but not as a parent. Children may bond with their caregivers, but it is usually not the intimate bond between a parent and a child. Friendships are made with the other children, instead of a sibling bond. Children sleep in large rooms with many beds. The child's bed may be their only consistent possession. Clothes and the limited toys are typically shared by all. Any belongings the child may have as their own are often taken by other children or by caregivers to be shared. Schedules are very structured. Even the kindest of caregivers are burdened by the multitude of children and are ill-equipped to truly meet individual emotional needs. Meals and snacks are served in mass as the caregivers struggle to feed large groups of hungry and rowdy children as quickly as possible. There is no time to respond to individual needs; if children do not eat fast enough, the food is taken away. In some orphanages, baths are given quickly, so fundamental hygiene skills are not developed or enforced. The child's basic physical needs are met, however emotional and developmental needs are not.

ORPHANAGE

A public institution for the care and protection of children without parents. Source: *The American Heritage® Dictionary of the English Language, Fourth Edition*

It is important for prospective adoptive parents to understand the environment their child may come from. Children from orphanage environments are used to structure and routine. They have lived in an environment where they have had to do whatever they can to get what they need. Unfortunately, this sometimes means lying, stealing, manipulating or fighting. These negative behaviors usually fade with time once the child understands that these behaviors are unnecessary and not allowed by their adoptive parents.

Whatever environment the child comes from, patience and understanding will be key to his or her adjustment. Finding out as much as possible about the current living situation of the child will help during the initial transition. This topic is thoroughly discussed in the course "*With Eyes Wide Open: A Preparation Guide to International Adoption*" written by the Children's Home Society of Minnesota. IFS contracted families are required to complete the course as part of the IFS Family Training Program. For more information and to register, visit http://www.ifservices.org/family-training.php.

References:

www.orphandoctor.com

Additional Resource on Malnutrition:

http://www.emedicine.com/ped/topic1360.htm

Affects of Malnutrition on Children

Malnutrition of children in orphanages is, unfortunately, a common issue. Diets are usually unbalanced and portions are small with limited nutrients. Infants may receive milk or diluted formula which reduces the concentration of nutrients. Bottle propping is common as there are not enough caregivers to hold all the babies during feeding times. Infant diets are often supplemented with inappropriate offerings such as potatoes, kefir (yogurt), rice and congee.

Micronutrients such as iron, zinc, calcium & vitamin D are usually absent from the children's diet. These nutrients are crucial for active, growing infants, toddlers and school age children. When iron is missing, anemia may result. Cognitive abilities can be diminished if iron deficiency lasts for a long period. Zinc deficiencies can result in respiratory infections and eczema. Vitamin D and calcium deficiencies may result in weak bones and low muscle tone. The timing, duration, and severity of malnutrition work together as contributing factors to illness, disease and growth failure. Using growth charts can be very helpful and it strongly encouraged by adoption specialists and pediatricians.

For a copy of a growth chart, visit,

http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/charts.htm

References:

Miller, LC, Kiernan, MT, Mathers, JI, et al. Development and Nutritional Status of Internationally Adopted Children. *Arch Pediatr Adolesc* Med. 1995, 149: 40-44

Bhutta, ZA, Black, RE, Brown, KH, et al. Prevention of Diarrhea and Pneumonia By Zinc Supplementation in Children in Developing Countries: Pooled analysis of randomized control trials. J Pediatr. 1999; 135:689-697

Aronson, JE, Johnson, DE, Melikova, M, and Alonso, M (1999) Catch-Up Brain Growth in Children Adopted from Eastern Europe and Russia. Abstract in press. The Ambulatory Pediatric Association, May 1999, San Francisco

Galler, JR and Ross, RN (1993) Malnutrition and Mental Development. In RM Suskind and L. Lewinter-Suskind (Eds), Textbook of Pediatric Nutrition. (pp. 173-179). New York: RavenPress, Ltd.

Other Conditions Affecting Waiting Children

Life in a third world country is not easy. Being an orphan in these countries is even harder. Studies show that for every three to four months spent in an institution, the child experiences a one month delay in his or her development. Based on the study, every child who has spent over four months in an institution has some type of delay. Additionally, children adopted abroad usually have some other type of condition affecting them.

The most common conditions affecting waiting children are influenza, colds, and ear and skin infections. In addition to the child adjusting to the transition from orphanage to home, the child's immune system needs time to adjust to the new environment as well. Some families have commented that their adopted child seems prone to catching every germ and has a constant runny nose for the first few months at home. An international adoption clinic, doctor or pediatrician can help assess if there is cause for concern.

Head lice is another parasite common in orphanages and is highly contagious. Lice are typically found behind the ears and at the neckline in the back of the head. With large infestations, the child may even have sores on their scalp from scratching. Over the counter shampoos and medications will usually treat this problem. Several treatments may be required before the lice are completely gone.

Another common condition is scabies, which is caused by little mites burrowing under the skin causing intense itching. These mites are not visible to the naked eye. Papules or tiny raised red spots may be found on the palms of hands and soles of feet. Armpits, face, and the waist are other

areas of infestation. Scabies is also highly contagious, so all family members should be treated. Treatment usually involves a prescribed medicated cream.

More advanced conditions may not be apparent until the child is seen by a United States physician. Doctors should screen all children adopted abroad for conditions such as lead poisoning, anemia, rickets, iodine deficiency and parasites. Lead poisoning exposure may come from many sources such as leaded gasoline exhaust, ceramic ware, and even traditional medicines used abroad. Anemia, rickets and iodine deficiency are usually the results of poor nutrition and an unbalanced diet. While children can be genetically prone to anemia, it is usually caused by not having enough iron in the diet. Rickets is a result of Vitamin D, calcium and phosphorous deficiencies. A good source of Vitamin D is fish oil and ultra-violet rays. Iron and iodine are particularly important in brain development. Iodine deficiency can also cause problems with the thyroid such as hypothyroidism. Anemia, rickets and iodine deficiency can usually be treated over time with a balanced diet and vitamin supplements. Licensed nutritionists can help families with an appropriate dietary plan to help offset these deficiencies.

Parasites are another condition affecting waiting children. Intestinal parasites (giardia lambilia) may cause diarrhea, abdominal distension, chronic belly pain and flatulence. Lab testing is recommended according to American Academy of Pediatric guidelines. Many children need to be checked on multiple days due to the way the parasite sheds. Consultation with an adoption clinic or pediatrician is recommended for the diagnosis and treatment of this condition.

Chronic conditions such as syphilis, tuberculosis, HIV, and hepatitis are usually screened before the child becomes available for adoption. The results should be noted on the child's medical report. However, a thorough screening should be performed again by a pediatrician or other medical professional once the child is home. Physicians knowledgeable in international adoptions recommend the following medical screenings:

- Hepatitis B profile
- Hepatitis C antibody
- HIV-1 and HIV-2 testing
- Mantoux (intradermal PPD) skin test
- Stool examination for ova and parasites
- RPR or VDRL for syphilis
- Complete blood count with erythrocyte indices
- Lead level
- Thyroid screen
- Vision and hearing screening

For more information on these chronic conditions, visit **Center for Disease Control at www.cdc.gov or American Academy of Pediatrics website at www.aap.org**

Data on Institutionalized Children

Medical Diagnoses in Internationally Adopted Children

- Anemia 30-40%
- Intestinal parasites 50%
- Hepatitis B 3-5% China
- Hepatitis C < 1 %
- Scabies 25%
- TB exp Russia 25%
- TB exp China 9 %

Medical Diagnoses in Internationally Adopted Children

- Congenital Syphilis (exp) < 1%
- Malaria <1%
- Congenital Heart Disease 3%
- Craniofacial Abnormalities 3%
- Kidney abnormalities <1%
- Lead poisoning (China) 13%

Referenced from Dr. Aronson's adoption center and other adoption centers across U.S. www.orphandoctor.com

There is a wealth of information available about each one of these chronic conditions. The following is a list of resources PAPs can use for additional research and information on these and other conditions.

References:
http://www.orphandoctor.com
http://adoption.com
http://www.peds.umn.edu/iac/

Immunizations

All internationally adopted children are required, in accordance with United States Immigration law, to have received some basic immunizations in their country of origin prior to arriving in the United States. While there are some international standards regarding vaccinations and immunizations, there have been instances where children have been given vaccinations which were either stored improperly or beyond the expiration dates. In addition, malnourished children absorb the vaccinations differently. For these reasons, the child is at risk, so the Center for Disease Control suggests that children adopted internationally be re-immunized once they arrive in the United States.

The Center for Disease Control web site (http://www.cdc.gov/node.do/id/0900f3ec8000e2f3) has extensive information about vaccinations and immunizations. The Center for Disease Control's recommended immunization schedules, one following a traditional schedule and the second as a "catch-up" schedule is included in this book. For a printable version of these schedules or to get more information, visit http://www.cdc.gov/nip/recs/child-schedule.htm.

NOTES

Relevant Environmental Toxins

One of the main environmental toxins that affects waiting children is lead. Lead is a neurotoxin that can cause brain damage. It can also damage bones, interfere with growth, intensify anemia, and affect kidney function. Children are especially vulnerable to the harmful affects due to the rapid development of their brains. Even the lowest level of lead can interfere with brain development affecting behavior and cognitive abilities.

Traditional Immunization Schedule

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2005

Vaccine \ Age	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4–6 years	11–12 years	13–18 years
Hepatitis B[1]	HepB #1	HepB #2			HepB #3				HepB Series			
Diphtheria, Tetanus, Pertussis[2]			DTaP	DTaP	DTaP		DTaP			DTaP	Td	Td
Haemophilus influenzae type b[3]			Hib	Hib	Hib	Hib						
Inactivated Poliovirus			IPV	IPV	IPV					IPV		
Measles, Mumps, Rubella[4]						MMR #1				MMR #2	MMR #2	
Varicella[5]						Varicella			Varicella			
Pneumococcal[6]			PCV	PCV	PCV	PCV			PCV	PPV		
Influenza[7]					Influenza (Yearly)				Influenza (Yearly)			
Hepatitis A[8]	Vaccines below red line are for selected populations								Hepatitis A Series			

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form are available at www.vaers.org or by telephone, 800-822-7067.

Range of recommended ages
Only if mother HBsAg(–)
Preadolescent assessment
Catch-up immunization

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip
American Academy of Pediatrics www.aap.org
American Academy of Family Physicians www.aafp.org

Continued on next page

Symptoms of lead poisoning are subtle and non-specific making it difficult to diagnose. Conditions of lead poisoning can include constipation, irritability, moodiness, learning difficulties, and in serious cases, seizures. The pediatrician should be alerted to the fact that the child may have been exposed to lead from a number of sources prior to arriving in the United States. Screening for lead poisoning should be done during the child's initial health assessment.

The Center for Disease Control website states that "potentially dangerous levels of lead have been reported in internationally adopted children, particularly those from China, Cambodia, Russia, and other countries in Eastern Europe. Lead exposure in other countries can result from a variety of sources, including leaded gasoline exhaust, ceramic ware, and traditional medicines." Additional sources leading to lead exposure are smelting emissions, mining, and coal burning. Many of the areas above use coal indoors for cooking and for heat during the winter, especially China. For more information on lead poisoning, visit http://www.cdc.gov/lead/.

Traditional Immunization Schedule page 2

Footnotes

Recommended Childhood and Adolescent Immunization Schedule

UNITED STATES • 2005

1. **Hepatitis B (HepB) vaccine.** All infants should receive the first dose of HepB vaccine soon after birth and before hospital discharge; the first dose may also be administered by age 2 months if the mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB may be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be administered at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

   Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) at separate sites within 12 hours of birth. The second dose is recommended at age 1–2 months. The final dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9–15 months.

   Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks.

2. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.

4. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11–12 years.

5. **Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.

6. **Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9):1-35.

7. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], and diabetes), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53[RR-6]:1-40). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2004;53(RR-6):1-40. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

8. **Hepatitis A vaccine.** Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12):1-37.

Air pollution is another environmental toxin that affects children adopted abroad. Many countries do not have the same air quality control standards of the United States. Poor air quality is especially a problem in the winter when anything combustible is burned for heat, releasing toxins into the air. Respiratory problems such as asthma and bronchitis may be-

Catch-up Immunization Schedule

Recommended Immunization Schedule
for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind
UNITED STATES • 2005

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 wks	4 weeks	4 weeks	6 months	6 months[1]
Inactivated Poliovirus	6 wks	4 weeks	4 weeks	4 weeks[2]	
Hepatitis B[3]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 mo	4 weeks[4]			
Varicella	12 mo				
Haemophilus influenzae type b[5]	6 wks	4 weeks if first dose given at age <12 months 8 weeks (as final dose) if first dose given at age 12-14 months No further doses needed if first dose given at age ≥15 months	4 weeks[6] if current age < 12 months 8 weeks (as final dose)[6] if current age ≥ 12 months and second dose given at age <15 months No further doses needed if previous dose given at age ≥15 mo	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[7]	6 wks	4 weeks if first dose given at age <12 months and current age <24 months 8 weeks (as final dose) if first dose given at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose given at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥ 12 months No further doses needed for healthy children if previous dose given at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	

Continued on next page

come worse due to the air. These conditions are usually treatable and manageable once the child arrives in his or her new home.

References:

http://www.cdc.gov/node.do/id/0900f3ec8000e044

American Academy of Pediatrics. Screening for Elevated Blood Lead Levels. Pediatrics. 1998; 101: 1072-1078.

Aronson JE, Johnson DE, Hostetter MK, et al. Lead Poisoning in Children Adopted from China. Ambulatory Pediatric Association. Pediatric Academic Society's Meeting. San Francisco, California. Abstract #45, May 1999.

Aronson JE. Why is Lead a Problem? International Adoption and Health. The Yale-China Review. 1998; 6: no.1, 30-31.

Risk Factors Associated with Adopted Children

Maternal substance abuse

The use of alcohol, illegal drugs, and cigarette smoking during pregnancy is a risk regardless of the country. The long-term residual effects of this type of abuse during pregnancy include low birth weight, small head circumference, lower APGAR scores, learning disabilities, Attention Deficit

Catch-up Immunization Schedule page 2

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS

Vaccine	Minimum Interval Between Doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria	4 weeks	6 months	6 months[8] if first dose given at age <12 months and current age <11 years 5 years[8] if first dose given at age ≥12 months and third dose given at age <7 years and current age ≥11 years 10 years[8] if third dose given at age ≥7 years
Inactivated Poliovirus[1]	4 weeks	4 weeks	IPV[1,9]
Hepatitis B	4 weeks	8 weeks (and 16 weeks after first dose)	
Measles, Mumps, Rubella	4 weeks		
Varicella[10]	4 weeks		

Footnotes

Children and Adolescents Catch-up Schedules UNITED STATES • 2005

1. **DTaP.** The fifth dose is not necessary if the fourth dose was administered after the fourth birthday.
2. **IPV.** For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years. If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.
3. **HepB.** All children and adolescents who have not been immunized against hepatitis B should begin the HepB immunization series during any visit. Providers should make special efforts to immunize children who were born in, or whose parents were born in, areas of the world where hepatitis B virus infection is moderately or highly endemic.
4. **MMR.** The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
5. **Hib.** Vaccine is not generally recommended for children aged ≥5 years.
6. **Hib.** If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.
7. **PCV.** Vaccine is not generally recommended for children aged ≥5 years.
8. **Td.** For children aged 7–10 years, the interval between the third and booster dose is determined by the age when the first dose was administered. For adolescents aged 11–18 years, the interval is determined by the age when the third dose was given.
9. **IPV.** Vaccine is not generally recommended for persons aged ≥18 years.
10. **Varicella.** Administer the 2-dose series to all susceptible adolescents aged ≥13 years.

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.org or call the 24-hour national toll-free information line 800-822-7967. Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Web site at www.cdc.gov/nip or call the National Immunization Information Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

Disorder or Attention Deficit Hyperactivity Disorder, and sensory integration issues. Alcohol and smoking are the most common forms of maternal substance abuse, however, illegal drug use has become a growing concern. The timing, amount of exposure, abuse of multiple drugs, poverty, poor nutrition and inadequate prenatal care are a few of the issues that cloud the effects of prenatal drug abuse on children. All of these factors together may have subtle but significant impairments on a child's ability to manage their emotions, focus and maintain attention.

A child who is prenatally (in the womb) exposed to alcohol can have a varied combination of permanent developmental and behavioral effects. Fetal Alcohol Syndrome Disorder is generally recognized as the leading cause of mental retardation worldwide and "the long term effects of alcohol on fetuses are more powerful then those of other drugs, including cocaine" (Diane Malbin). This is crucial to understand as adoptive parents because alcohol is the most abused drug in the world.

For more information on Fetal Alcohol Syndrome, visit

University of Washington: Fetal Alcohol and Drug Unit. http://depts.washington.edu/fadu/

FASLinks. http://www.acbr.com/fas/

Fetal Alcohol Syndrome (**FAS**), Fetal Alcohol Effects (**FAE**), Partial Fetal Alcohol Syndrome (pFAS), Alcohol Related Neurodevelopmental Disorders (**ARND**), Static Encephalopathy (alcohol exposed) (**SE**) or Alcohol Related Birth Defects (**ARBD**) are all names for a spectrum of disorders caused when a pregnant woman consumes alcohol.

Fetal Alcohol Syndrome is a diagnosis that initially was only given to children who showed a narrow set of characteristic signs. These included characteristic facial features, pre natal or post natal growth delay and evidence of central nervous system involvement (developmental delays, small head size, hyperactivity etc). As more and more research has been done on these children and those who had only a few of the characteristic features but many developmental and behavioral symptoms, physicians have realized that alcohol ingested while a child is in utero affects children in many characteristic ways. The term Fetal Alcohol Spectrum Disorder (FASD) began to be used as an umbrella term used to describe the range of disabilities caused by prenatal exposure to alcohol.

The effects of being exposed to alcohol are extremely varied making diagnosis difficult at times, especially when a family may have no history of the child's birth family and the effects of living in an orphanage have also impacted a child. Alcohol effects the way the brain develops and different parts of the brain are affected based on when the birth mother drank and how much, making the list of possible effects long and complicated.

Some helpful facts are that FASD is permanent, but children who have the best outcomes in life are those who are diagnosed early and live in stable family environments. Children can have a wide range of symptoms that appear at times to worsen as a child ages. School difficulties increase as more and more abstract information is presented and school demands increase. Social skill seems to worsen over time as peers mature and the child with FASD has difficult perceiving the social demands and may appear immature. Unlike a person who had mental retardation where all skills are delayed in a similar manner, a person with FASD usually has big difference in level of functioning in different areas. Social skills may be like a six year old and speech skills like a nine year old. In addition, children with FASD are extremely variable in there performance, one day they will "get it" and then next day not remember or be able to access this information.

When a family is reviewing a potential adoptees referral they should have it evaluated by a physician with significant experience in international adoption. This is especially true if there is documented or suspected maternal history of drinking during pregnancy and/or poor growth. Once a child is home they should be evaluated for the existence of facial features and neurodevelopmental signs associated with fetal alcohol spectrum disorder. There is a myriad of information on the web, but it is very difficult for adoptive parents to sort through given the sketchy history of most internationally adoptive children's birth parents. However, given the vast difference in long term success that accompanies early diagnosis, it is imperative to seek out information and seek professionals who are familiar with this diagnosis in the post-institutionalized

child. If your child is affected by alcohol there is hope, found primarily in understanding the way each child's brain is uniquely wired and teaching to his/her strengths. Excellent resources for understanding this invisible disability are:

Fetal Alcohol Syndrome: Support, Training, Advocacy and Resources website. www.FASSTAR.com.

Malbin, MSW., Diane. *Fetal Alcohol Sydrome, Fetal Alcohol Effects: Strategies for professionals.* Hazelden Publishing, 1993.

Klienfeld, Judith and Siobhan Wescott. *Fantastic Antone Succeeds: Experiences in educating a child with fetal alcohol syndrome.* University of Alaska, 1993.

Drug addicted babies will often have tremors, be inconsolable at times and have troubled sleep patterns. Dr. Linda Mayes of the Yale University Child Study Center in New Haven, Connecticut reports the difficulty some drug exposed infants have in achieving a quiet state may also affect their intellectual development. It can affect critical components of learning such as responding to new stimuli, focusing and sustaining attention, and processing information.

Children exposed to illegal drugs may have minimal frustration tolerance, may be more easily excitable, have more difficulty screening distractions, and startle easily. Common symptoms of babies exposed to cocaine are hyperactivity, poor feeding, rapid heart rate, and excessive sudden movements. The Center for Disease Control in Atlanta, Georgia conducted a study finding that cocaine abuse during the early stages of pregnancy can also lead to urinary tract defects in unborn child.

Judith Schaffer of New York State Citizen's Coalition for Children advises parents control the environment of drug exposed infants to avoid overexcitement. Watch for eye aversions, sneezing, and color changes as clues to overexcitement. She also strongly recommends using comfort techniques such as swaddling the infant in cotton blankets with arms close to the body and the use of pacifiers. Gentle rocking up and down instead of side to side may also help to comfort the child.

Cigarette smoking is also considered a form of substance abuse. Babies exposed to cigarette smoking prenatally, generally, have low birth weights and may experience some growth retardation. Long-term learning disabilities have also been linked to maternal cigarette smoking as well. Women who stopped smoking early in the pregnancy have a better chance of delivering a normal birth weight baby.

Exposure to pre-natal substance abuse is a risk in every country. Placement agencies are required to share with prospective adoptive parents all information pertaining to the referred child and the child's birth parents, but unfortunately, the information isn't always available or known. Some

NOTES

children have facial features or behaviors which may indicate some level of exposure, but currently, there is no way to test to what degree the child has been affected. Each child is different in how he or she presents the symptoms, making the diagnosis much more difficult and elusive.

References:

NIDA Notes, Volume 13, Number 4, November, 1998
www.Adoption.com – Encyclopedia of Adoption

Genetic Risks

Children inherit many traits from their birth parents. Physical characteristics, talents, intelligence, and temperament are examples. Some health and emotional traits are also linked to heredity. It is important to remember while children may be genetically predisposed to certain conditions or traits, it may or may not become apparent. Researchers are constantly discussing whether conditions are genetically predisposed or if environment is responsible. Studies have shown that both play a vital role in the child's health and development.

Intelligence and general mental ability is shown to have strong heritability. Research suggests that environment has a strong influence on the child's intellectual development during the early years. Genetics appears to "kick in" as the child becomes older. Studies have also shown that both environment and genetics play a part in a child's temperament. Social ability and openness to experience have shown strong genetic influences. However agreeableness and conscientiousness show stronger environmental influences.

References:

www.Adoption.com – Encyclopedia of Adoption

Emotional Risks

Adopted children face one of life's hardest lessons: that painful and sad things happen to good people. They discover very young that life is not always fair. Many may feel that what has happened to them is their own fault. Attachment and loss are two major factors prospective adoptive parents will help their child deal with. No matter how old the child, he can have issues with attachment and loss. Much has been written about the emotional aspects of adoption on children. IFS urges each family to continue to educate themselves on this topic. This information will help PAPs further understand this important piece in the positive development of their adopted child. A list of books, websites and other resources has been provided in this book.

Attachment and Bonding

Attachment is a key foundation in relationships. When we feel attached to someone, we spend more time with them. A relationship develops whether it's with family, friends, co-workers, or pets. The ability to attach is normally laid during infancy. Infants are aroused by a physical need (hunger, fatigue, comfort, etc.) and cries for help. The caregiver responds to the cry by filling the need. This continues, and infant's needs are consistently satisfied. As a result, the infant becomes attached to the care-

giver and knows that he or she can trust the caregiver to help when needed. This is a typical attachment cycle.

In an orphanage, caregivers do the best they can, but many times the caregivers are caring for a large number of children who all require individualized attention. The ratio of caregiver to child can be anywhere from one to ten or more. Due to these circumstances the scenario played out in an orphanage environment may actually go like this, the infant is aroused by a physical need and cries for help. The caregiver is not consistently able to meet the child's need so the infant learns that his needs

Recommendations For Fostering Attachment During the First Six to Nine Months Home

The following excerpt was taken from the article titled, "Fostering the Parent-Child Attachment Relationship" written by Mary Chesney, RN, CPNP, MS International Adoption Clinic, University of Minnesota For the complete article, visit http://www.peds.umn.edu/iac/for_families/transition/attachment.html.

Our list of recommendations is based on the collective years of experience of our team of adoption health care specialists and has evolved over time. In presenting these recommendations, I would like to acknowledge the collaborative contributions of my clinic colleagues, Dana Johnson, MD,PhD, Angela Sidler, MD, Stacene Maroushek, MD, Kay Dole, OTR, Sandy Iverson, RN, CNP, Mary Jo Spencer, RN, CNP, and Maria Kroupina, PhD.

- We recommend a low-keyed arrival scene as you return home from your child's country of origin. It is usually best to avoid having a large crowd greet you. Your child should stay in your arms and should not be passed to others.
- Develop daily routines and rituals, and stick to them as much as possible. In keeping mealtimes, bedtimes and playtimes consistent, your child will begin to feel that each day has a predictability and structure to it. This is comforting for the child who is experiencing a period of incredible change and transition from orphanage to adoptive family.
- We recommend that parents, as much as possible, be the only persons to feed, change, bathe, dress, rock to sleep, or comfort their child. We think it is helpful for your newly adopted child to practice having needs consistently met by you, the parent.
- When extended family members or friends bring gifts for your child, we recommend that you have your child sit with you and that you hand the gift to your child or assist your child in opening the gift. You may want to say something like "Look, Annie. Grandma brought you a present. You may open it now."
- In the beginning, you may want to advise relatives and friends ahead of time that they should ask your permission to pick up your child or do an activity with your child. Each time they ask permission, your child is hearing them reference you as the important decision-maker for activities that involve your child. This may provide your child with practice in referencing you before embarking on a new experience.

Continued on next page

may not be satisfied and he may stop "alerting" caregivers of his needs. This cycle continues and eventually the child can come to believe that he can not trust anyone else to provide for his needs. He begins using self-soothing behaviors, such as sucking fingers, rocking or banging. This puts the child's ability to attach to a caregiver at risk and a foundation has been laid for the child to have potential attachment issues.

Signs of an attachment issue in infants include independence at very young ages, a child that does not cry or alert to a need, and a child that shows no emotion at all. Older children may hoard food, seek help from any adult other than the parent, be overly clingy, show indiscriminate friendliness, act out, appear manipulative or distrustful, or seem insincere or without conscience.

The good news is that over time loving, supportive parents can usually repair the foundation with consistent responses to the child's needs. In time the child learns that in her new environment her needs will be met by the same person all the time. For the first time, the child begins to form a healthy attachment.

Attachment and Bonding Resources:

The Attachment and Bonding Center of Ohio
http://abcofohio.net

Attaching in Adoption
written by
Deborah Gray

Continued from previous page

- In large group gatherings, like adoption shower parties, let guests know ahead of time that you will be holding your child and that you will not be passing your child around from person to person. Overall, we advise avoiding large group gatherings during your child's first few months home. A previously institutionalized child does not need trips to Disneyworld or a day of shopping at the mall. What he or she needs more than anything is lots of concentrated one-on-one time with a warm, loving and sensitive parent.
- Spend as much one-on-one time with your child as possible. Your child does not need to be surrounded by lots of toys. In fact, being surrounded by too many toys and an overly stimulating environment may be overwhelming. Instead, choose one or two toys and get down on the floor with your child, and play with the toys in an interactive manner with your child. Use lots of facial expressions and face-to-face gestures like peek-a-boo or rubbing noses together. Watch your child for cues that he or she may be getting overwhelmed or tired, and then switch to a soothing, comforting activity such as rocking your child.

We believe that all of these steps may assist your child in seeing you as the essential "gatekeeper(s)" through which all good things in life come. The goal is to help your child realize that you are the one(s) to meet his or her needs, to be trusted, and with whom to seek close contact.

There has been a lot of attention around the subject of attachment and bonding. One type of attachment issue is reactive attachment disorder (RAD). According to Mary Strickert author of *The International Adoption Guidebook*, "RAD is a condition in which a child has great difficulty forming lasting, loving relationships. Usually resulting from neglect or abuse, the child has not formed a bond with a parent or primary caregiver and is left unable to sustain a healthy relationship with anyone. Conditions that can damage a child's ability to attach usually occur within the first two to three years of the child's life (www.adoption.com). " As stated previously, there is strong evidence showing if a child has bonded with one primary caregiver, it is likely he can transfer that attachment to the new caregiver or parent.

Attachment and bonding do not happen overnight. It takes time for a child to know that she can trust and depend on her adoptive parents. If a child is able to bond to one person, the child should be able to appropriately bond to others over time. Some adoptive parents feel very attached to the child before the child even comes home. This is very normal and completely appropriate. Unfortunately, the child doesn't always reciprocate the attachment and bonding as quickly as the parents may want or expect. When this happens, parents can sometimes feel discouraged, hurt or scared. In this situation, it is important to remember that given time, consistency, unconditional love and sometimes therapy, the child can make good progress towards making appropriate attachments with the key people in their lives.

For more information on culture shock, grief and loss refer to the resource section in the back of this book.

References:
www.Adoption.com – Encyclopedia of Adoption
Adaptations made from the State of Alabama, Department of Human Resources, GPS Course for Foster/Adoptive Parents.

Culture Shock and Loss

Prospective adoptive parents will experience culture shock when visiting the foreign country to adopt their child. Children will experience culture shock the minute they leave their known environment. This environment, regardless of how bad it was, did provide some level of security, comfort and care. The child is leaving everything that is familiar and is experiencing many things for the very first time. Being outside, riding in a car, going to restaurants, and staying in a hotel in the native country may be new to the child, not to mention riding in the airplane. Once home, the child will be immersed in a new language, smells, food, music, clothes, and endless other experiences. Material items we take for granted everyday, such as a telephone ringing or the television, may be new and unusual to the child.

The child has left behind everything he was accustomed to and is entering a new world. Imagine yourself taking such an incredible leap. In some cases, the caregivers have prepared the child for the change, but many times it happens without a lot of warning to the child, making the shock even greater. Parents need to understand and be sensitive to the culture shock the child may be experiencing. Even though the change is positive,

the child is still dealing with profound loss. Grief, loss and culture shock manifest differently in each child. Infants and young children may be overly fussy and sensitive. Older children may act out or withdraw. In all cases, allow the child time to mourn the losses and begin assimilating to his or her new culture. Limiting large parties and visits for at least a month or two until the child begins to feel comfortable in their new environment can help to absorb some of the shock. Express to family and friends that they are not meeting the "real child" in the first few months and to relax and be patient while the child adjusts and transitions to the new environment and lifestyle.

Experts suggest the following can be symptoms of culture shock:

- Wanting to withdraw from the local people
- Excessive sleeping
- Obsessing over missing favorite foods
- Craving for news from home country
- Doubts about being in the new culture
- Wishing you were somewhere else
- Feeling physically ill (from emotional stress)
- Blaming others for your negative feelings
- Reluctance to leave the house to socialize
- Excessive daydreaming about home country
- Criticism of local people and new culture
- General sense of anxiety and discomfort
- Sense of dread, fear, paranoia
- Lethargy, depression, lack of vitality or energy

List taken from the book titled, "Cross-Cultural Connections" by Duane Elmer

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Issues of loss will resurface from time to time. It is important to allow the child to have these feelings. However, be careful that the child moves through the grief and does not become depressed. Validate the child's feelings and let them know it's okay to miss their friends and feel sad. Do not under any circumstances get upset or angry with the child, or make them feel guilty for their feelings. The child's world has been turned upside down. It is the prospective adoptive parent's job to comfort, understand, and demonstrate what home and family is all about.

Duane Elmer, author of "Cross-Cultural Connections," suggest that "virtually everyone [traveling or living abroad] experiences culture shock to some degree regardless of what country they come from. However, people process culture shock symptoms differently. Some externalize and express their thoughts and emotions. Others internalize - hiding their real thoughts and feelings and try to tough it out hoping it will get better. Thus, in the early stages of exposure to a new culture, it is good for peo-

ple to talk about what they are observing, thinking and feeling. Regular debriefing times are necessary to reveal the emotional state of people. (Elmer, 47)" This advice is particularly relevant to families adopting older children. These children need to have the opportunity to share their emotions in their native language. Finding an interpreter, friend or counselor early on who speaks the child's language can be beneficial in helping the child work through the culture shock. Infants and toddlers also show signs of culture shock and grieving, although they are not able to verbally express their feelings.

References:

www.Adoption.com – Encyclopedia of Adoption

Elmer, Duane. *Cross-Cultural Connections.* 2002. Intervarsity Press, Downers Grove, Illinois.

Behavioral Risks

Every human being develops certain behaviors over time. Some behaviors are positive and others are negative. Numerous factors play into how these behaviors are developed. Environments, past experiences, temperament, and personalities are some of those factors. When the adopted child comes home, PAPs will begin to notice certain behavioral patterns emerging, especially as the child becomes more familiar and comfortable in his new environment. These behaviors are compounded due to cultural differences. Some of these behaviors may be negative and difficult to understand. The following list was adapted from the book titled "*Self-Awareness, Self-Selection and Success: A Preparation Guidebook for Special Needs Adoptions*" written by Wilfred Hamm. The list provides some common behavioral issues with both domestic and internationally adopted children. It is presented in two parts: understanding the behavior and then coping with it.

For more information on these and other behaviors, visit

www.fosterparentcollege.com

Hoarding or Gorging Food

Understanding the Child's Behavior:

- The practice is especially common in children adopted from third world nations.
- It could indicate long-term or serious deprivation not just of food but also of emotional nurturing: Food equals love to the child.
- It is not understood as stealing, but as a survival mechanism.
- The child may also consume huge amounts of food, never seem to be satisfied and may even beg food from friends and classmates.
- Children may also "gorge" on things – clothing, toys.

Coping Strategies:

- Relax and do not worry! This behavior usually goes away by itself.
- Give the child time, at least a year, to become secure and comfortable in his or her new environment.
- Try to ignore hoarding as much as possible. Gently point out that it is not necessary, that food is readily available upon request.
- Give the child lots of emotional reassurance. Frequent hugs, kisses and words of praise may help reduce anxiety.

- Do not use food as a tool of discipline or primary sign of approval.

Bedwetting

Understanding the Child's Behavior:

- The practice occurs most frequently in boys and is fairly common in the general population. As many as 20 percent of all children under ten have at least an occasional episode.
- In the special needs child, bedwetting may be part of a general regression to younger age behavior.
- It can be a release of tension and anxiety, fear of separation or difficulty experienced in early toilet training.
- The many stresses associated with moving to a new family may trigger bedwetting.
- Bedwetting may be an angry or hostile response to a child's feelings of loss and lack of control over life circumstances.
- Bedwetting is an excellent attention-getting technique.
- It may be part of a large "I cannot cope, do not expect anything from me" syndrome, which is a sign of depression.
- It runs in some families and usually ends in puberty, if not before.

Coping Strategies:

- First, try to get as much background on the child from current caregivers.
- Check with a good pediatrician or urologist to be certain it is not a physical problem, especially in a child over five years. There could be a chronic bladder infection.
- Give the child complete responsibility for cleaning up (if age appropriate) – changing sheets, washing bedclothes, etc., without shaming him.
- Waking the child before the adults retire or waking the child before dawn each morning may be helpful.
- The less attention paid to this the better, especially with a school-aged child.
- Be patient. Almost nobody carries this problem into adulthood. Praise progress, even it if is small.
- Make the child feel safe.
- Expect accidents – encourage new efforts. Reward good behavior.

School Problems

Understanding the Child's Behavior:

- Almost all children in the foster care system (or orphanage) have experienced several moves and changes. This usually also means a change in schools. The emotional, and even physical, disruption often brings educational deficits and achievement lags.
- Children suffering severe stress and anxiety do not have the energy and attention to focus on schoolwork.
- The school setting sometimes provides a handy arena to work out an-

ger at events beyond the child's control.

- Disruptive behavior provokes attention from everyone – classmates, teachers, parents.
- Lack of achievement accomplishes the same end. Besides, success can be scary and may bring with it long-term responsibility and parental expectations of doing well.
- Life has taught many children to be more comfortable with failure than success and to identify themselves as problems. Children live up to the labels they are given.

Coping Strategies:

- Relax. This in an almost universal problem in older child adoption. Talk to other parents.
- Be sure to get all available information on the child's past performances, test scores and grades.
- Recognize that it is almost impossible to change patterns of performance quickly. Set reasonable goals that both the parents and the child feel are achievable.
- Meet the teachers and principal. Take an active role in designing the child's education. Insist on what you know is best for the child. Visit the school regularly.
- Do not be afraid to experiment. Perhaps the child needs a great deal of structure or feedback, an earlier bedtime, a physically active playtime before school, a change in television habits, or a special tutor.
- Place the child in the grade that will allow success and achievement. This may mean "holding back."
- Stand up for the child in disputes. Do not assume the child is guilty every time a call comes from the school or teacher. Be his or her advocate.
- Back up the school on what matters – for example, getting work done, getting along with others, and attendance.
- Reinforce all progress immediately. Be proud of the child's accomplishments and the let the child know it.

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Lying and Stealing

Understanding the Child's Behavior:

- Dishonesty is also quite common in children adopted from the foster care system or orphanage.
- Like other behavior problems, dishonesty may abate over time, although it is important to recognize that it may never go away entirely, and will reappear during stress.
- Lying and stealing, if severe and repeated, may indicate inner rage at being unable to exert control over one's life and environment.
- Lying is a self-protective device and a way to avoid punishment and embarrassment. Some children do it more out of habit and fear than anger or necessity. Self-confidence and self-esteem lead to reduced

need for self-protection.

- The concepts of "truth" and personal ownership may hold little meaning for children who have been promised so much and had so little. Conscience development may be quite delayed. Do not expect the child to act his or her biological age.
- This behavior indicates the child has not developed trust in adults or has not had an opportunity to value truth-telling.
- The child may have no skill in handling difficult situations.

Coping Strategies:

- Here especially, it is important to be patient. Try to imagine yourself in the child's place, with his or her anger and fear. Do not be harsh or self-righteous.
- Make it safe to tell the truth and do not try to trap the child in a lie. Build his or her trust and the need to lie will be reduced.
- Realize that the child almost never knows why he or she lies or steals, so do not ask the child to explain. Forgive and move on.
- Be firm, fair and consistent. Use of logical consequences are often effective.
- Set a good example and praise truth-telling. Your child will eventually conform to your norms.
- Do not jump to conclusions or always assume guilt. This leads to scapegoating and reduces incentives to honesty.
- Reinforce and look hard for the positives. Children stop lying and stealing more readily when they feel loved as they are.

Physically Aggressive Behavior

Understanding the Child's Behavior:

- Many children waiting for adoption have had harsh and damaging life experiences. Some have been victims of child abuse and most feel deeply hurt by their biological parents.
- Inability to control one's life and the pain of repeated rejection breeds frustration and anger. Physical aggression is one sure outlet for pent-up feelings.
- Beneath the anger lurks fear and distrust of adults. Aggressive behavior keeps people at a distance and does not let them see inside.
- This behavior always gets attention and that may be part of the reason for it
- Self-esteem of foster children is generally poor. They feel they "deserve" punishment, are never somehow good enough and will frequently provoke scolding and spanking.
- Some children are merely reflecting the environment they have experienced. Domestic violence is a major issue worldwide.

Coping Strategies:

- Be realistic about what you can expect. Changes in basic behavior pat-

terns can take a lot of time.

- Break the problem down into smaller pieces. For example, try to make the child go one day (then two, three, etc,) without a physical confrontation.
- Give the child concrete strategies to use instead of physical aggression. For example, yell, tell, walk outside, punch pillows or punching bags, draw or write in a journal. Reward her at once for using alternatives to fighting.
- Help the child build an understanding of the causes or triggers for his or her anger, so the child can try to control them.
- Consider what are acceptable ways to express anger. Discuss with the child what he or she is allowed to do when angry. Focus on appropriate ways to deal with anger rather than what is not allowed.
- The child needs appropriate physical affection.
- Give the child a regular outlet to reduce stress and expend excess energy.
- When the child is aggressive, he or she is out of control. Parents should remain in control and discipline should be consistent and immediate, not long-term.

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Sexual Acting Out or Involvement

Understanding the Behavior:

- Millions of children are the victims of inappropriate adult sexual behavior. This sexual abuse may be mild or severe, but it always has an impact.
- Children in foster care (and orphanages) are more vulnerable to sexual abuse and exploitation. The traditional taboos are not present and parental protections and family safety are not available.
- Often older children in the foster home or institution "initiate" younger kids. Sexual activity may be learned and shared at a very young age.
- Without sufficient care or comfort, sexual activity is a reliable means of temporarily getting closer and feeling good.
- In some cases, sexual activity has been a powerful indicator of approval and the only consistent proof of adult affection.
- The child usually blames him or herself for inappropriate behavior, feels guilty and unworthy and seeks punishment or confirmation of being "bad."

Coping Strategies:

- All children should be clearly told what is considered acceptable sexual conduct. Social standards are important and must be reinforced.
- Sex, in all aspects, should be a comfortable topic for parent-child discussion.
- Be calm. To a great extent, the parents' handling of a sexually acting out child will set the tone of improvement in the situation.
- Be absolutely clear about what is known or believed to have happened.

Do not mince words or hide emotions, but do not patronize the child if he or she was the victim. Stress that the child is safe.

- If the child is acting out with other kids, again be firm and clear. Do not equivocate, use correct descriptive terminology and state that the behavior is not permitted ever. This confrontation session should be held with other family members present. They should be completely aware of the situation and not afraid to add additional information.
- If the child has acted out with a family member, state that everyone in the family is aware and will be watching. Restrict contact between perpetrator and victim.
- Family counseling should help everyone gain a better perspective, but be certain counseling does not weaken the responsibility of the child for his or her appropriate behavior.
- It will be hard, but try to put this behind you and build a better, more open relationship. The child needs self-forgiveness, as well as, forgiveness from others.

Withdrawal and Rejection

Understanding the Child's Behavior:

- Children waiting for adoption have typically faced many rejections, first by biological relatives, later, perhaps by foster parents or other children. These traumatic experiences have left the child hurt and afraid to love. After all, loving someone has proven to be dangerous since the person always leaves you.
- To avoid pain, foster children sometimes make themselves hard to love by withdrawing, detaching themselves from others, seeming to be emotionally vacant.
- In severe cases, withdrawal may be a sign of anger turned inward and of depression.
- Family relationships include both giving and receiving love. Some children believe they are unworthy of love and that their own love has no value. It seems easier and safer to risk nothing by neither responding to nor initiating a personal relationship and seeming to reject family ties.

Coping Strategies:

- Be patient. It took time to develop a fearful attitude and time will be required to overcome the past. Take it easy and relax.
- Sometimes it helps to talk about the past. Help the child put his or her past in some perspective. This may help him or her understand that they are not to blame for difficulties.
- Be positive. Withdrawn and rejecting children need constant reinforcement. Try to find concrete ways to build their self-esteem.
- Shower the detached child with expressions of love. Hugs, touch, kisses, gifts, notes and greetings make it easier to trust in the love the parents keep offering.
- Get the child involved in choosing and planning family activities and

fun. This says that his or her needs and wishes are important and valuable to the whole family.
- Do not let the child isolate him or herself. Arrange for a shared bedroom, a team-style family chore system or family involved recreation.
- If no improvement is seen in six months, consider counseling for the family and the child.

Impulsiveness

Understanding the Child's Behavior:
- The child seems to be in constant trouble because he or she lacks good judgment.
- The child does not understand connections between cause and effect.
- No structure was provided for the child. Outside control was inconsistent or missing.
- This often indicates re-nurturing is needed.

Coping Strategies:
- Be sure to keep rules to the minimum. Rules should be simple and direct.
- Parents should become the outside control (provide structure) long enough for the child to learn inner control.
- Be patient, but persistent.
- Adjust your own expectations to that of a much younger child.

The above material was taken from Self-*Awareness, Self-Selection and Success: A Preparation Guidebook for Special Needs Adoptions* by Wilfred Hamm, Thomas Morton and Laurie M. Flynn. This copyrighted material was used with permission from the publisher, North American Council on Adoptable Children. www.nacac.org.

Other Behavioral Issues

Some of the behaviors, sometimes referred to as Post-Institutionalization (PI), listed above can be contributed to the affects of institutionalization. According to Susan Ward, author of the article titled, "International Adoption: Post-Institutional Issues" states, "PI behaviors are caused from lack of stimulation, little affection, very structured days, limited movement, few choices, not being taught proper emotional outlets, and more. Institutions-- orphanages, are preferable to living with an abusive or neglectful family. However, they are not conducive to providing children with the support, and nurturing that comes from living in a caring, loving, knowledgeable family environment (www.olderchildadoption.com)."

Some other PI behaviors are listed below. Some of them are overcome by time and minimal interventions by parents. Others require assistance from professionals.

Rocking. Repetitive rocking back and forth when agitated, nervous, or tired. This is typically a self-soothing technique. International adoption specialists can give PAPs tips and techniques for managing this behavior.

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Head banging. Banging their head on the floor or wall when frustrated, irritated, or angry. Again, this is sometimes a self-soothing technique, but may also indicate some sensory integration issues.

Poor hygiene. Personal hygiene skills are often behind their peers due to not having adequate training, experience or examples of how take care of oneself.

Inability to make decisions. Institutionalized children have not been taught to make decisions about even the most simple of tasks. So when given the opportunity to make choices, for example, what to eat, what to wear, what they like, can be an overwhelming experience to the child. PAPs should limit the number of things to choose from, so the child can learn how to make appropriate choices.

Easily over-stimulated. PI children can become easily agitated and/or overwhelmed by any activity outside the daily routine. They are used to having a consistent schedule and routine, so anything outside of that routine can make the child feel unsafe or "off-balance."

Poor cause and effect thinking. PI children are typically developmentally behind peers in understanding that certain behaviors and actions incur consequences, natural and/or logical.

No pain. Upon falling, bumping, or tripping, PI children may show no indication of pain: no tears. This may indicate some sensory integration issues.

Summary

While these risks and behaviors can seem daunting and overwhelming, studies have shown how institutionalized children have made remarkable progress in overcoming and managing their delays or disabilities. Adopting a child, whether domestically or internationally, comes with inherent risks, but in a recent article published in The Journal of American Medical Association, author Dr. Laurie Miller discussed a recent study completed by Juffer and van Ijzendoorne where they reported their findings from a meta-analysis of studies on behavioral problems and mental health referrals of international adoptees. The authors of the study compared internationally adopted children with nonadopted children or domestically adopted children. The study "convincingly demonstrates that international adoptees, have more behavioral problems than nonadopted children, although the effect sizes were small. On the other hand, when compared with domestic adoptees, international adoptees had fewer total, externalizing, and internalizing behavioral problems and fewer mental health referrals" (Miller). The study also found that "internationally adopted children who resided with their adoptive families for more than 12 years had fewer total behavioral problems than those living with their families for less time...Notably, age at adoption did not relate to behavioral problems, a finding of critical importance as the number of *older* children (often defined as over two years of age) needing adoptive families continues to increase" (Miller).

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Part Two: Developmental Risks and Concerns

Introduction

Part One of this course focused on the general health and medical risks which may be present in children who are internationally adopted. Many of the early studies conducted by physicians specializing in the field of adoption medicine were based upon medical issues such as vaccination protocols and appropriate lab tests. However, what physicians and other professionals involved with international adoption now realize is that health is just one concern. Delays in a child's motor, sensory, emotional, language and cognitive development, as a result of living in an orphanage, are often predictable and usually treatable, yet many times the delays are overlooked. When the delays are ignored, they rarely just go away, instead they may continue to effect children into their school years and possibly beyond. **It is important to note that each child is an individual and while this course presents general trends, it should not replace professional assessment to determine how all of these factors, additional medical diagnoses and social emotional adjustment may have affected the child.**

For more information on University of Alabama's International Adoption Clinic, visit http://adoption.chsys.org

Now, in Part Two, we focus on possible developmental delays typically found with waiting children. This section of the course was written by Jill Barnhart, occupational therapist at the University of Alabama's (UAB) International Adoption Clinic. Ms. Barnhart and the other therapists in the clinic regularly train Prospective Adoptive Parents (PAP) regarding the risks and issues facing internationally adopted children, but the clinic's main focus is on the children. Over the course of over three years, the clinic has conducted developmental evaluations on children at various stages in the adoption process. Newly arrived children, ages six months to 15 years, and children adopted as babies and toddlers experiencing challenges now that they are in school, are both seen regularly by UAB therapists and clinicians. The therapists have learned that there are predictable developmental challenges from early orphanage life, some of which fade once a loving home is provided, some of which require short-term specialized therapy or intervention and some of which result in life-long learning challenges. These delightful and courageous children have been the best tutors.

Part Two is designed to help adoptive parents with a basic understanding of how the possible risks and delays can manifest in day-to-day life. The University of Alabama's (UAB) Adoption Clinic has created a list of common comments of parents of internationally adopted children. Each comment is followed by a remark from a licensed therapist at the UAB clinic. The remarks following each comment come from recent research and day-to-day clinical experience.

Recent research looks at children who have been internationally adopted from orphanages throughout the world. This is a relatively new group.

Until the 1990s, the largest group of internationally adopted children was from Korea. These children were adopted on average at age six months after living their first months in foster families with access to medical care. As a result they had few, if any, developmental delays. The focus for these adoptive families was on transracial parenting. In the early 1990's, Romania, and subsequently Russia and China, became open for international adoption. Many children began to be adopted from these countries and the children often received substandard basic health care and neglectful orphanage care. In addition, the average age at adoption increased to two years. Children were staying in these environments much longer prior to adoption.

The second source of information comes from the day-to-day clinical practice at the University of Alabama at Birmingham's (UAB) International Adoption Clinic. As mentioned previously, this clinic sees hundreds of children annually and prepares PAPs with solid information on what to expect and the treatment options. For more information about the International Adoption Clinic, visit http://adoption.chsys.org.

Assessing developmental delays and other issues pertaining to the needs of an adopted child is like putting together a puzzle. There are many pieces, which need to be evaluated, explored, and identified before a complete treatment plan can be created and implemented. Understanding the full impact of institutionalization on children is an ongoing study, but much has been learned already which can help adoptive families when dealing with emotional and developmental delays.

The following information is applicable to PAPs adopting a child of any age. PAPs should read this section in its entirety because it discusses some basic developmental milestones which are a foundation for the child's future development. If the proper foundation has not been laid, it could contribute to other developmental delays which may show up later in life.

"With animals it has been shown that if they are raised in a more stimulating environment (mazes, toys, etc.) they make more connections in their brain and their brains are bigger."
Bruce Duncan Perry MD, PhD
www.childtrauma.org.

General Factors Affecting A Child's Development

Overall, after factoring out health risks such as prematurity, prenatal malnutrition, and prenatal alcohol exposure, there are three crucial factors that influence a child's development within an orphanage: level of stimulations, attention of caregiver, and the variables of stage of life, number of moves and time spent.

Level of Stimulation

The first factor is the level of stimulation in a child's environment. Many children in orphanages are in bleak surroundings. They have little visual stimulation, seeing primarily blank walls and the rails of their crib. They have limited variety in the sounds they hear, and insufficient time being touched and carried.

The degree of environmental deprivation correlates to the amount of developmental delay. In general, the more sparse the living environment, the more developmental delay. It is interesting to note in environments where toys are provided, but no one is interacting with the child and the toy (helping the child explore and applauding their efforts), the effect of the stimulation is diminished.

Attention of Caregiver

The second factor affecting a child's development is the attention of a primary caregiver, a person for the child to bond or attach to. There are two primary reasons for the lack of attention from a caregiver. First, the ratios between children and caregivers are usually very high making it difficult for caregivers to get even basic tasks completed. Second, even in a "good" situation, there may be little nurture. This lack of a primary caregiver has been shown to affect the way children grow (children without this are typically smaller) and the way they develop motor and language skills.

Stage of Life, Time Spent and Number of Moves

The third factor affecting a child's development involves variables, which are interrelated. These variables include:

1. The amount of time the child spent in the orphanage
2. The number of moves the child experienced prior to adoption
3. The stage in life the child experienced the deprivation

It has been shown the longer a child is in an orphanage the greater the developmental delay. Also, the greater the number of moves (i.e. baby hospital to orphanage to hospital for illness to new orphanage to adoptive home equals four moves versus orphanage to adoptive home equals two moves) the greater the delay. Studies have shown babies who stay in a home environment, even if it is a deprived and neglectful, usually suffer less developmental delay then those who are in an institution from birth. A child removed from a home later in life after the brain had a chance to form many of its crucial connections will often have less developmental delays.

Even though developmental delays may be part of the issues the child faces, adoptive parents and families are critical in helping the child overcome the delays. Dr. Dana Johnson states, "Adoption, whether formal or informal, has always been a superior method of assuring survival for children whose parents are unwilling or unable to care for them. However, adoption can also affect child development in profound ways. Data collected over the past three decades support adoption as a superior means of promoting normal development in children permanently separated from birth parents. Out of calamity and loss, children recover and progress to become functionally and emotionally competent adults. For children suffering severe neglect or abuse in early life, an adoptive family is a remarkable environment for healing emotional and physical trauma and reversing developmental deficits."

More Information on Motor Skills:

Why Motor Skills Matter: Improve Your Child's Physical Development to Enhance Learning and Self-Esteem
Written by Tara Losquadro Liddle

General Development of Gross Motor skills

6 to 9 months

- *On stomach, will hold weight on one hand while reaching*
- *Sits unsupported and reaches for toys*
- *Rolls from back to stomach & pivots*
- *Crawls forward with stomach on floor*
- *Maintains balance on hands and knees*

9 - 12 months

- *Creeps forward on hands and knees*
- *Pulls to standing, using stable support*
- *Lets go of support and stands alone*
- *Walks holding on to furniture*
- *Walks with help*

12 - 18 months

- *Stands alone in the middle of floor*
- *Walks backwards and sideways (1 - 3 steps)*
- *Climbs up stairs, one hand held, creeps upstairs*
- *Rises to standing position alone*
- *Walks alone*

18 – 24 months

- *Walks down stairs with support*
- *Jumps in place*
- *Runs length of the room without falling*

Reference:
Barnhart, Jill, University of Alabama, International Adoption Clinic
Johnson, Dana. "Adoption and the Effect on Children's Development." Early Human Development (2002). Article located on http://www.peds.umn.edu/iac/pdf/adoption%20and%20the%20effect%20on%20childrens%20development.pdf

Parent Observations Of Their Newly Adopted Infant or Toddler

"My baby is amazing, when we got her she wasn't even sitting and now she is walking, all in one month!"

For families who adopt young children, it is common to discover at adoption that they are delayed in their motor skills (sitting, crawling and walking). This is primarily because children in orphanages spend a great deal of time in their cribs lying on their backs. While this may be a safer position for young babies, babies need time on their stomachs to develop normally. In addition, when children do get out of their cribs, they are often placed in walkers at a young age. This keeps them off what may be a dirty floor and allows some freedom of movement, keeping babies happier. Unfortunately, the result is poor development of motor skills.

Typically, when children are four months old they begin to push up on bent arms and raise their head, when placed on their stomach. This strengthens their neck and shoulders until they can hold their body up while reaching for a toy. This skill then expands until they can scoot backward, then forward and eventually crawl. This takes five to six months. However, for this to occur, babies need three things:

1. Time on their stomach
2. Space to move
3. Encouragement from a caregiver.

The progression more commonly seen in babies in orphanages throughout the world is weakness or irritability when placed on their stomach, limited time spent in crawling (one month) or not crawling at all and then walking on time developmentally. While this can seem encouraging, lightning fast catch-up, skipping these important steps causes two things to happen. First, children do not have the underlying muscle strength to develop advanced skills such as running, walking down stairs, jumping or balancing on one leg (see 18-24 months skills). Secondly, that early time spent in crawling is what prepares the human body for understanding right and left and eventually for writing. Difficulty with developing handwriting is common for children who have spent their early months in orphanages (see *"She's having really difficult time writing"*).

Fortunately, development in these areas is usually correctable. First, if possible, encourage the normal progression of skills; PAPs should encourage the child to crawl for a couple of months and not facilitate walking, even though this means delaying walking. Secondly, when children are first home, they need ample time to play on their hands and knees this can happen by spending time crawling through tunnels, crawling up and down stairs and use indoor and outdoor playground equipment. Giving children plenty of opportunities to play, run, swing, climb and safely explore is great therapy for children regardless of his or her developmental delays. Parents can have the child evaluated by an International Adoption Clinic to help determine if there are developmental concerns. **Physical** or **occupational therapists** can provide ideas and tips on ways to strengthen the child's trunk, hips and shoulders.

"I don't know why, but when I tried to give her Cheerios she just screamed, and she will only suck her bottle if I make the hole bigger"
One of the first things babies do when they are born is suck. Babies are created to be fed one at a time and at a certain rate while breast-feeding. This is mimicked in the bottles and nipples available commercially. Unfortunately, this is difficult to do with a roomful of babies. Orphanage workers throughout the world have had to come up with creative ways to feed many children in a short time. This often includes enlarging the hole in the nipple so the formula is consumed faster and children do not need to suck as long or as forcefully. In addition, bottles may be tied to a crib. Some children, when adopted, are able to adapt to eating from a regular nipple with little difficulty. For others, when a new nipple is introduced they may cry, get tired quickly or simply not be able to get liquid from the bottle through the smaller hole. Parents should gradually try to transition to a regular nipple (fast flow size). If the baby is having difficulties, try a variety of types of nipples. It is important to gradually decrease the size of the hole because the muscles used in sucking are the same mus-

PHYSICAL THERAPIST

The physical therapist establishes a plan of care and manages the needs of the patient/client based on the examination, evaluation, diagnosis, prognosis, goals, and outcomes of the planned interventions for identified impairments, functional limitations, and disabilities (www.apta.org).

OCCUPATIONAL THERAPY

Occupational therapy is skilled treatment that helps individuals achieve independence in all facets of their lives. It gives people the "skills for the job of living" necessary for independent and satisfying lives (www.aota.org).

cles eventually used in talking. This transition should take place within the first few weeks home.

In addition, children in orphanages are sometimes given cereal through a bottle for the first year or bland porridge types of food may be their main staple. This feeding commonly occurs with an orphanage worker spooning the food in rapidly with a large spoon. This pace combined with a lack of variety and texture can result in a child being overly sensitive to foods with differing textures and flavors. Some parents say "My child cries if Stage 3 baby foods or Cheerios are given." Children are remarkably adaptable and this initial sensitivity usually fades within one to two months when parents gently and repeatedly try adding texture to the child's diet. If the child is not eating a typical variety of foods by this point, it is important to be seen by an Occupational Therapist or Speech Therapist who specializes in pediatric feeding for more ideas to reduce sensitivity and increase the variety of foods the child can eat.

The opposite problem can also occur; some children have less sensitive mouths, hold food in their mouths, drool and may lose interest in food quickly. One technique used in helping children with less sensitive mouths is to feed them foods that are very cold, spicy or have more intense flavors. Lastly, there have been multiple studies that show in animals that both smell and taste develop pre-natally and are affected by what the birthmother eats. These experiences have been shown to affect taste (and smell) preferences later in life. Trying foods and flavors more typical of birth culture may help some eating issues. Older adoptees and children who lived in home environments (foster care) may miss their culture's food so again adding more traditional foods from their culture can also help with eating.

"Substantial recovery from the delay is possible in the short term – if removed from the depriving environment"
O'Conner et al

An international adoption clinic or your local pediatrician can provide guidance on the amount and types of food the child should be eating. Texas Children's Hospital provides two informative articles about feeding an infant (ages zero to one) and child (ages one to six). These articles provide helpful tips and strategies that can be used to help when transitioning the children into a home environment. Following are the links to both articles:

Feeding Guidelines 1-6 years - http://www2.texaschildrenshospital.org/internetarticles/uploadedfiles/140.pdf

Feeding guidelines 0-1 year - http://www2.texaschildrenshospital.org/internetarticles/uploadedfiles/138.pdf

"He's not talking because he switched languages. I'm sure he'll catch up, he did not say much in his first language either."

Children who are internationally adopted are most commonly delayed in language development. Parents are often told that language will catch up without being given any idea of how fast it should catch up. Communication has several facets and not all are equally delayed in children who are internationally adopted. One facet of communication is **receptive language**, which is the ability to understand language. **Expressive language** is the ability to communicate with words or gestures. Typically, expressive language is the area where children are the most delayed at the time of adoption and this is also the area where catch-up is the slowest. Gestural communication is more typically age appropriate for internationally adopted children. Receptive language may also be delayed especially in children who have had frequent untreated ear infections, which may cause some mild hearing loss (easily treatable). All children should have a hearing evaluation within a month of arriving home.

RECEPTIVE LANGUAGE
the ability to understand language and expressive language

EXPRESSIVE LANGUAGE
the ability to communicate with words or gestures

Children who are internationally adopted are often speech delayed in their first language. Studies completed on children in the 1950s living in orphanages in the United States found that this area of communication was the most delayed of all the developmental areas. This has been re-demonstrated by a study done in Russia by Russian psychologists. They discovered that in an orphanage environment, 60% of children age 24 – 30 months had no expressive language (typically children have 15-20 word by 18 months of age) and 86% of 3 – 3 1/2 year olds used one word sentences (typically children use two word phrases at age two). When children have a documented speech delay in their referral information, it is usually accurate (Gindis, 1999).

In Sharon Glennen's PhD, CCC-SLP article "Orphanage Care and Language" the reasons for these language delays are clearly outlined. From personal observation, she noted that children have limited exposure to language while in the orphanage environment. Dr. Glennen noted that these infants and young children are often carried facing away from the caregiver with little or no interaction and are typically given simple verbal commands like "come here" and "sit down." During meals, caregivers do not talk to young children, and toddlers eat together with no adult and therefore have few adult language models. Also, during playtime, children are grouped by age, so there are few language models from older children. The limited number of language interactions leads to the expressive language delays seen in many post-institutionalized children. However, many children have excellent non-verbal language skills; they use gesture and imitate easily and well. If children do not have non-verbal skills, it may indicate a more significant language delay.

For More Information on Speech and Language Delays and Questions to Ask, visit
http://pages.towson.edu/sglennen/index.htm

www.asha.org

While delays are expected, internationally adopted children are often not provided speech therapy intervention because the typical rate of catch-up has not been widely studied. Pediatricians and therapists may think the child "will catch up" with time. Again Dr. Glennen of Towson University completed the first attempt to determine typical rates of catch-up for in-

ternationally adopted children. Average acquisition for vocabulary and length of sentences can be found at http://pages.towson.edu/sglennen/InfantToddlerLanguageDev.htm . There are two general rules. First, if a child is delayed in nonverbal communication skills, he or she will likely have more difficulty acquiring English and thus close monitoring of language acquisition is recommended. Secondly, children should catch up by double their age at adoption. Therefore, if a child is adopted at 12 months old, they should be "caught up" by age two. These are very rough guidelines, and if there is a concern, seek a speech evaluation and refer the **speech therapist** to the above website.

Speech acquisition in older adopted children has additional considerations. This topic is covered later in this section.

"He is in constant motion and does not have any fear." OR "He is overwhelmed easily and will cry when the vacuum cleaner starts."
Children who have spent their early years in an orphanage are not touched and moved as often as children raised in a home. Think about babies in healthy birth homes; they are bathed and lotioned, often daily, carried around as their parents do daily tasks, hugged and kissed and thrown into the air to get that magical smile. This is just part of normal, nurturing care; however, these commonplace things are forming critical circuits in the brain from birth. As they happen over and over again the circuits are strengthened and work more and more efficiently to carry information to other parts of the brain. Touch and movement are basic needs and in their absence the brain may begin to process information from the senses differently. At times, touch that is pleasurable to most, may feel irritating or painful to children who have not experienced it. In some children, touch is so unpleasant they never touch objects and as a result their fine motor skills (reaching, grasping, etc.) are delayed.

To begin to understand this feeling, picture yourself sitting outside in the grass, with your hands behind you. Now imagine your child coming up behind you and touching your hand. You would be flooded with warm emotions and pleasant sensations. Now picture yourself in the same position, but a spider walks over your hand. Your touch sensors would be activated and a flight response would take over in a fraction of second. This can be what this mis-wiring feels like; pleasant touch can feel like a spider. On the opposite end of the spectrum the child might not even feel they are being touched if they do not "see" it also. Fortunately, young children are very adaptable and for most children this "calms down" and these differences disappear within the first three months home. But, it can be helpful in those early days home to know that your child's responses may not be willful behavior but rather reactions, out of his or her control, to information taken in through his or her senses.

Touch is often hypersensitive as described above, but strangely, these same children often do not feel pain. This is termed **pain agnosia**. It is a

SPEECH THERAPIST
Work with the full range of human communication and its disorders, including: treating speech, language and swallowing disorders in individuals of all ages, from infants to the elderly, and evaluate and diagnose speech, language and swallowing disorders (www.asha.org).

PAIN AGNOSIA
The loss of the ability to feel pain

result of having painful experiences repeatedly and not being comforted. This again will often fade quickly as children learn that caring and responsive parents will comfort them when they are hurt. Children will also frequently demonstrate oversensitivity to loud sounds or be overwhelmed in noisy environments. Naming these sounds (telephone, vacuum, etc.) and limiting loud and noisy environments can help with this transition. Visually, children also may be easily overstimulated, especially by many bright colors and patterns in their rooms and on their bedding. Having plain sheets and using calming colors can be helpful.

Lastly, children may have a lower threshold for responding to movement. As a result they move more often, play "harder" and at times cannot anticipate danger. This is amplified by the fact that some children do not have smooth communication from their muscles and joints to their brain, thus, they do not always know where their body is in space. In addition, movement can actually "calm down" the sensitivity to touch, sound and vision, causing them to seek out movement experiences.

If these differences in responding to the environment continue after two to three months, or if this fearfulness seems to be effecting his or her development, your child may have a sensory processing disorder that can be treated by an occupational therapist. Trained pediatric therapists are a good source of information about **sensory integration** issues or there are many books written about this topic. For a list of books and resources on this topic refer to the "Recommended Reading" section in this book.

"She doesn't seem to know how to play with toys and will only pick up hard plastic ones."
At times, when children are first adopted they don't appear to know how to play with toys. They may actually be fearful of some toys, especially stuffed animals, those that make loud noises or ones that move on their own (see the previous section). Also, at times children may not want to pick up or touch toys because touching them feels unpleasant. In this situation, activities to decrease the touch sensitivity can help with play. Institutionalized children, typically, have not had exposure to a variety of toys. This limited access and the fact that children are not taught how to play or interact with toys can contribute to this concern. Children learn by watching, and in an orphanage there are minimal opportunities for children to watch caregivers or other children play with the toys. As parents interact lovingly and individually with their child, gently playing and teaching through modeling, most children will be able to progress in play. If they do not, an evaluation may be recommended.

SENSORY INTEGRATION
the ability to organize and process sensory input and then use it to respond appropriately to a particular situation (Trott, 1).

Sensory Integration Books:

The Out of Sync Child and ***The Out of Sync Child Has Fun*** written by Carol Stock Kranowitz

Sense Abilities: Understanding Sensory Integration by Maryann Colby Trott

Sensory Integration Network
www.sinetwork.org

Parent Observations Of Their Newly Adopted Pre-Schooler or Kindergartener

"He is so smart, I can just tell."
Many children who are internationally adopted are very resilient and thrive in their new homes once they are loved and provided stimulation. An excellent study (Ruetter) completed on children adopted from Romania in

the 1990s, when the institutional environment was at its worst, showed that children adopted at age two or younger showed rapid improvement and had almost caught up to peers (adopted but not institutionalized) by the age of four. This study focused on cognitive testing and the children involved had not yet begun school.

At the University of Minnesota, ongoing research is being completed by a team of professionals known as the International Adoption Project. This team surveyed 2,299 children in 1,857 families; these were internationally adoptive families who had been home between three to eleven years. They asked these families a series of questions regarding "risk factors" they believed their child experienced prior to adoption. These included prenatal alcohol exposure, malnourishment of the birth mother, prematurity, over six months of institutionalization, and emotional and physical neglect and abuse. Based on the responses to these questions children were considered to have been well cared for, adequately cared for, or poorly cared for. Interestingly, when looking at how the children are currently doing in a variety of areas there was not one risk factor that was found to be worse than others; rather it was the combination or number of risk factors that resulted in children having greater ongoing emotional and/or developmental issues. In addition, the number of risk factors increased greatly as the amount of time spent in an institution increased, thus 35% of children who spent over two years in an institution had been poorly or very poorly cared for.

The results regarding school performance include the following:

- 16% of children surveyed were considered **gifted and talented**. This number jumped to 24% in children who had been extremely well cared for (0 or 1 risk factor), and dropped to 8% of those poorly cared for
- 27% of 10-12 year olds and 44% of teenagers had received an **award for academic excellence.**
- 33% were felt to be **excelling in all or most subjects.**
- 17% were felt to be **falling behind in some or all subjects**. This number jumps to 44% in children who were poorly cared for prior to adoption and 42% in children who spent two years in an institution
- Only 15% of children from families or foster care were felt to be **falling behind in some or all subjects** and 11% in children who spent less than six months in an institution.

Overall, the greater the number of risk factors, the more difficulty children had in school. The reasons some children struggle in school are varied, but in general children adopted over the age of two, children with delayed language skills in their first language and/or children with non-existent or very poor school opportunities will require additional support in some aspect of school.

Other Educational Resources:

All Kinds of Minds: A Young Student's Book About Learning Abilities and Learning Disorders written by Dr. Mel Levine

www.Allkindsofminds.org

Handwriting without Tears website
www.hwtears.com

"It has been so hard for him to learn the alphabet."
Often children who are adopted as preschoolers have a difficult time learning letter names and mastering reading a few years later in kindergarten. While there can be many reasons for this, the most common is simply lack of exposure to letters and writing. The article "Teaching your child the ABC's of Reading" by Melissa Fay Greene (*Adoptive Families* magazine Jan/Feb 2003) outlines this dilemma and gives great advice. It's content is summarized below:

Children in a language rich environment begin acquiring letters one at time, "M" for McDonalds as they drive by, "j" for Jonathan as they hang their coat in pre-school, "D" for Daddy as they play with tub letters. It is estimated that the average American child is exposed to hundreds of hours of pre-reading experiences before kindergarten. They are interested in books because books are associated with pleasure and if Mom and Dad are often reading they want to imitate. Many internationally adopted children do not have these early pre-reading experiences. They have no method yet of making sense of what seem like random squiggles (much like our view of Chinese characters or Arabic script). Letters require rote memorization and are very tricky because orientation matters (b versus d), the capitals often do not reflect the lower case, and they can be written very differently and still be the same letter. After this arduous task the child next needs to learn the sounds of letters.

Graphomotor and Scissoring Development

12-18 months	Holds crayon and scribbles on paper
18- 24 months	Imitates vertical crayon stroke & circular scribble Holds crayon with thumb and fingers
24-30 months	Snips with scissors Holds pencil with thumb & fingers Imitates drawing horizontal line
30-36 months	Snips on line using scissors Imitates cross & circle

So how do we help children do this? Children learn by touch and movement as well as seeing letters. Use multiple experiences to help the child understand the concept of the letter. Making letters in clay, paint, and foam in the bathtub and using their bodies all help with developing the concept. Surround them with letter puzzles, blocks, trains or magnets - whatever is motivating. Reading together must be a daily occurrence and while reading parents

Other Resources for Reading Readiness:

Games for Reading: Playful Ways to Help Your Child Read written by Peggy Kaye

The Complete Letter Book: Multisensory Activities for Teaching Sounds and Letters written by Michele Borba and Dan Ungaro

should at times point out the words being read and begin to help the child understand that those squiggles tell the story. Most of all make learning language and letters fun!

"She has a really difficult time writing and doesn't consistently use the same hand."

Internationally adopted children, at times, may experience delays in fine motor skills. These delays may include how accurately the child picks up objects, does simple puzzles and manipulates toys. Usually after living in a home, being exposed to toys, and the praise and encouragement of a parent, the child's fine motor delays improve quickly. However, even when a child has normal fine motor skills, they often have a difficult time with prewriting skills, writing (precision and legibility) or fluency (speed) in writing as they mature and develop. Scissoring skills are also difficult because they require holding one part of the hand stable (little finger) while moving the other (thumb side). There is a distinct motor pathway in the brain that is responsible for writing (or **graphomotor skills**). According to Dr. Mel Levine (www.allkindsofminds.org)

GRAPHOMOTOR SKILLS
Motor skills needed for writing.

FINGER AGNOSIA
Loss of the ability to feel where finders are if eyes are closed.

> "Graphomotor dysfunction can deter writing in several different ways. Some thwarted writers have trouble picturing the letters they're trying to form, while others can't recall fast enough the muscle movements needed to make specific letter symbols. Kids with these problems generally prefer printing to cursive writing (and should be allowed to print). A number of students have problems assigning specific hand muscles to particular parts of letter formation. Many of them may have the same kinds of impairments in speaking and so have had a hard time pronouncing certain words. Still others can't seem to track the moment-to-moment location of their fingers while they are writing, a condition known as "**finger agnosia**." Many students with graphomotor deficiencies develop awkward pencil grips, which can make the motor aspects of writing even more of a chore."

Finger agnosia is one area commonly seen in internationally adopted children. So if there is a delay, developing a plan for assisting the child is important. An Occupational Therapy evaluation is often helpful. The handwriting program, "Handwriting without Tears," which has a Readiness (prewriting) component, can be used in a school or home setting and is very successful at helping children learn to write well. In addition, for some children only learning to print is appropriate; for other types of challenges (especially motor planning) cursive writing, where a child does not have to pick up the pencil while writing, is often more efficient. For many, early introduction to keyboarding (computer skills) toward the end of second grade will help with longer assignments and getting thoughts on paper.

Parent Observations Of Their Newly Adopted School Age Child

"I hear that children learn language really quickly and they sound like any other kid in a short time."

It is true that that most children who are internationally adopted will make rapid gains in English and acquire basic functional English (required for day-to-day living) within one year. In addition, unless they are adopted after they reach puberty, there is rarely any accent. The task that is much more difficult is acquiring the necessary language skills to have academic success. The English required to function well at home and with friends is very different then the English needed to learn science and history, or to interpret literature. It is estimated that learning "cognitive-academic language" can take five to seven years. English as a second language programs can be very beneficial, but it might be wise to start children behind age peers in school. Children who are internationally adopted differ greatly from immigrant children in that they lose their first language very quickly. Thus, they do not have any language to "think" in as they learn, language and new concepts. Families should be prepared to provide daily assistance to the child for many years in school subjects, providing additional training, support and help with homework.

"Our daughter will be seven when she comes home, but she has not been in a school at all, what grade should she go in?"

One of the greatest challenges for children who are adopted close to or at school age is finding an appropriate school placement. There are no standard answers. Many schools use the same standards in placing internationally adopted children as they do with children who are recent immigrants. While this may seem logical, there are fundamental differences between internationally adopted children and recent immigrants. Non-internationally adopted immigrants usually thrive when placed in the chronologically age appropriate grades with English as a Second Language services. While there are similarities between the two populations, internationally adopted children have additional issues, as previously addressed, which results in the need for other special services beyond ESL.

Finding and implementing a good plan is made all the more difficult because most schools are unfamiliar with children adopted from a different country and may only have one or two children with this background in their school district. Typically, schools are also generally unaware of the recommendations made by experts in the adoption field. **It is the responsibility of the parent to familiarize themselves with the proper information to make good school choices, and parents need to be prepared to advocate for the child with teachers, administrators and other education professionals.** This may include seeking out appropriate testing methods, requesting additional testing and applying for special educational services beyond ESL. Some educational professionals may say – "We just need to have him or her repeat a grade," but studies indicate that this is not always the correct course of action.

Resources Relating To School Age Children:

www.bgcenter.com

http://pages.towson.edu/sglennen.htm

Our Own: Adopting and Parenting the Older Child written by Trish Maskew

The Complete IEP Guide: How to Advocate for your Special Ed Child written by Lawrence Siegal

Boris Gindis, PhD, is one of the leading experts in the field of school readiness and the adopted child. The following information is a summary from his online course *School Readiness and Placement of the Internationally Adopted Child*. Mr. Gindis states the best approach regarding readiness in children who are internationally adopted is a "bi-directional" approach, which is the idea that both the child and the school must adjust to each other to provide the best learning situation. This is very different than the prevailing view that children mature at a certain point (often age specific) to be able to handle the demands of school. Internationally adopted children may have had such cultural deprivation they will not be "ready" in the traditional sense for years. In addition, it is helpful to remember that school has both cognitive demands and social demands, and children may have very different abilities in these two areas.

What should parents do to help their children?

Before adoption, prospective adoptive parents can investigate services in the school the child will attend. Questions parents may want to ask the school staff may include:

1. What is the level of experience with international adoptees?
2. What has their previous experience been?
3. Do they recognize that these students are very different from other ESL students?
4. What is the quality of the ESL program (number of teachers, class size, diversity of language composition, etc.)?
5. What other support services are available to children in regular classrooms (chapter one services, reading recovery programs)?
6. What are the **Section 504** and special education services like? Does the school and the special education services work cooperatively and who will help design the **Individual Education Plan (IEP)**?

Pre-adoption, when the child has been identified, try to determine his or her language competency in their first language and their level of schooling, including what types of pre-academic or academic skills the child was learning. This may be invaluable information for current school placement and future treatment plans.

Once the child is home, parents can begin to assess his or her developmental age and general health. More specific language and cognitive testing in the child's first language may be helpful (however they need to take place with the first month of being home) and there is a small window of time to complete this. In addition, the child's social skills and ability to regulate their emotions, as well as cognitive and academic skills, must be taken into consideration.

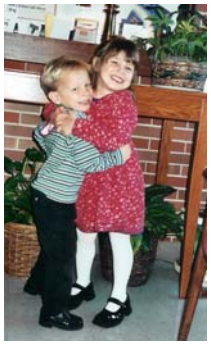
All these factors taken together can help determine the plan. If this sounds complicated, that is because each child brings a unique, and often difficult-to-unravel set of strengths and weaknesses to the school setting. Two general rules include:

SECTION 504

Section 504 is civil rights legislation for persons with disabilities prohibiting discrimination against individuals who meet the definition of disability (www.ldonline.org).

INDIVIDUAL EDUCATION PLAN (IEP)

IEP is a very important document for children with disabilities and for those who are involved in educating them. The document should improve teaching, learning, and results and includes the educational program that has been designed to meet that child's unique needs (www.ldonline.org).



1. Do not underestimate the enormity of the task of learning the language; starting children back a grade is often a good choice (usually helped along because physical size is often stunted and social and emotional skills are often also delayed).
2. Repeating grades in the first two years home may be helpful to allow for solidification of language and thinking skills. But, it is unwise to repeat a grade without seeking out some testing through an International Adoption clinic or clinicians familiar with the population to make sure the support needed for success is in place. Once a child is two grades behind, chronological age testing and the need for support services (occupational therapy, speech therapy, etc.) and possibly special education services has to be evaluated. Unlike many recent immigrants these children spent their beginning years of life in unimaginable circumstances and may require extensive support and creativity to learn.

NOTES

Assessment of Referred Child

Assessing the health and development of a child takes knowledge of health and developmental issues, experience and an unbiased perspective. IFS, nor any IFS staff, is qualified to give health or developmental assessments on referrals. IFS recommends that prospective adoptive parents take all available information to a qualified medical professional experienced in international adoptions, to get an assessment of the referral. For a directory of international medical clinics or doctors, who provide this service, please visit http://www.comeunity.com/adoption/health/clinics.html.

Dr. Dana Johnson, MD provides an insightful article, found on his website, titled "Planning for the Health Needs of Your Child." This article gives some tips for parents as they begin receiving referrals. IFS recommends that each parent read this very informative article. It is attached to this book, but can also be downloaded from http://www.peds.umn.edu/iac/downloads/index.html. This site also provides in-country assessment tools which can be helpful to medical professionals as they evaluate the needs of the child.

There are no guarantees with any child, each child is unique and special and each deals with their own life experience differently. Parents need to educate and empower themselves so that they can better help their children through whatever circumstances or issues they face. It is not always an easy road, but the good news is that there are experienced professionals, therapists and other people who can counsel, assist and further educate parents. This book provides a small sampling of the many resources available. IFS encourages each family to continue their education, not only about adoption issues, but also about parenting strategies and general child development.

Conclusion

Summary

- A orphan, available for international adoption, as defined by the U.S. immigration law, is a foreign child who does not have any parents because of the death or disappearance of, abandonment or desertion by, or separation or loss from, both parents (www.uscis.gov).

- There are many entities involved in an international adoption. Each entity has its own responsibility, purpose and role, but information is shared between them. During the adoption process, families will deal with entities in the United States and in the foreign country. The actual entities involved in the process vary among countries.

- Children available for international adoption live in a variety of environments. Most of the countries permitting international adoptions operate orphanages, and most internationally adopted children come from orphanages. However, some children live in foster or group homes.

- Malnutrition of children in orphanages is, unfortunately, a common issue. Diets are usually unbalanced and portions are small with limited nutrients. Infants may receive milk or diluted formula which reduces the concentration of nutrients. Micronutrients such as iron, zinc, calcium & vitamin D are usually absent from the children's diet. These nutrients are crucial for active, growing infants, toddlers and school age children.

- Maternal substance abuse, genetic, behavioral and emotional issues are all risks involved when adopting a child. This is primarily due to the fact that the information about the child and birth family are not available or unknown. Some of these risks are apparent at the time of adoption, while others become more evident later in life.

- Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effects (FAE), Partial Fetal Alcohol Syndrome (pFAS), Alcohol Related Neurodevelopmental Disorders (ARND), Static Encephalopathy (alcohol exposed) (SE) or Alcohol Related Birth Defects (ARBD) are all names for a spectrum of disorders caused when a pregnant woman consumes alcohol. These spectrum disorders are the leading cause of mental retardation.

- Attachment is a key foundation in relationships. When we feel attached to someone, we spend more time with them. The ability to attach is normally laid during infancy. Infants are aroused by a physical need (hunger, fatigue, comfort, etc.) and cries for help. The caregiver responds to the cry by filling the need. This continues, and infant's needs are consistently satisfied. As a result, the infant becomes attached to the caregiver and knows that he or she can trust the caregiver to help when needed.

- After factoring out health risks such as prematurity, prenatal malnutrition, and prenatal alcohol exposure, there are three crucial factors that influence a child's development within an orphanage. The three factors are level of stimulation, attention of caregiver and time spent in the institution.

- Children who are internationally adopted are most commonly delayed in language development. Communication has several facets and not all are equally delayed in children who are internationally adopted. One facet of communication is receptive language, which is the ability to understand language. Expressive language is the ability to communicate with words or gestures.

- Internationally adopted children, at times, may experience delays in fine motor skills. These delays may include how accurately the child picks up objects, does simple puzzles and manipulates toys. Even when a child has normal fine motor skills, they often have a difficult time with prewriting skills, writing (precision and legibility) or fluency (speed) in writing as they mature and develop.

- Boris Gindis states the best approach regarding readiness in children who are internationally adopted is a "bi-directional" approach which is the idea that both the child and the school must adjust to each other to provide the best learning situation. Internationally adopted children may have had such cultural deprivation they will not be "ready" in the traditional sense for years. In addition, it is helpful to remember that school has both cognitive demands and social demands, and children may have very different abilities in these two areas.

Key Terms

Resources by Topic

The following list contains some of the many books and websites on the various topics discussed in this book. IFS recommends that PAPs continue their education by reading and researching these and other topics. For additional adoption related books and materials, visit www.tapestrybooks.com or call 800-765-2367 to order a catalog.

Books for Children

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Zisk, Mary. *The Best Single Mom in the World: How I Was Adopted.* Morton Grove: Albert Whitman and Company, 2001.

Bonding and Attachment

Center for Family Development website http://www.center4familydevelop.com/

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Child Development and Health

Aronson, Dr. Jane. Orphan Doctor website http://www.orphandoctor.com

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Center for Disease Control www.cdc.gov

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http://www.adoption.com
International Family Services www.ifservices.org
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North American Council on Adoptable Children website http://www.nacac.org
Steinberg, Gail and Beth Hall. *Inside Transracial Adoption*. Indianapolis: Perspectives Press, Inc., 2000.
U.S. Citizenship and Immigration Services www.uscis.gov
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Grief and Loss and Culture Shock

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Kaye, Peggy. *Games for Reading.* Pantheon Books. 1st ed. 1984
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Siegal, Lawrence. *The Complete IEP Guide: How to advocate for your special ed child.* Berkley: Nolo.com, 2004.

Older Child Adoption

Borba, Michele and Dan Ungaro *The Complete Letter Book: Multisensory Activities for Teaching Sounds and Letters.* Good Apple, Inc. 1980
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Cline, F. and J. Fay. *Parenting with Love and Logic.* Colorado Springs: Pinon

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Maskew, Trish. *Our Own: Adopting and Parenting the Older Child.* Snowcap Press. 1999.
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Kranowitz, Carol Stock. *The Out-of-Sync Child Has Fun.* New York: Berkley Publishing Group, 2003.
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Trott, Maryann Colby. *SenseAbilities: Understanding Sensory Integration.* Therapy Skill Builders. Arizona: Therapy Skill Builders, 1993.

Special Needs Adoptions

Babb, L. Anne and Rita Laws. *Adopting and Advocating for the Special Needs Child.* Westport: Bergin and Garvey, 1997.
Hamm, Wilfred. *Self-Awareness, Self-Selection and Success: A Preparation Guidebook for Special Needs Adoptions*. Washington DC: NACAC, 1985.
Keck, Gregory and Regina Kupecky. *Adopting the Hurt Child: Hope for Families With Special Need Kids*, Colorado Springs: Pinon Press, 1995.
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Learning Disabilities Online. www.LDonline.org.
Siegal, Lawrence. *The Complete IEP Guide: How to advocate for your special ed child.* Berkley: Nolo.com, 2004.

Review Questions

The following questions pertain to this reading material. As part of requirements of applying to IFS for adoption services, **each** parent must complete the following questions and submit them along with a signed statement of completion to the Program Director. **For a printable version, please download and print the file titled, "*Reality Check* Review Questions and Statement of Completion".**

Please answer the following questions in essay form using a separate piece of paper..

1. Based on what you have learned in this course and your other reading on the topic, how to you plan to help your child through his or her grieving process? Be specific.
2. Based on what you have learned in this course, what might be some reasons your child may initially have difficulty bonding with you and what will you do to encourage the bonding? Be specific.
3. Explore what support services are available in your community. Explain how and why you might utilize the services.
4. What were the top three things you learned from this course and explain why each was helpful to you as you prepare to parent your adoptive child.
5. What other resources did you read and were they helpful to you as you prepare to be an adoptive family?

Statement of Completion

I, _____, hereby state that I read *Reality Check: Common Health and Developmental Issues of Internationally Adopted Children* provided to me by IFS.

I, _____, hereby state that I personally completed the attached Review Questions regarding the material contained in the *Reality Check: Common Health and Developmental Issues of Internationally Adopted Children*.

_____ _____

Printed Name Date

_____

Signature

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Borba, Michele and Dan Ungaro *The Complete Letter Book: Multisensory Activities for Teaching Sounds and Letters.* Good Apple, Inc. 1980.

Bhutta, ZA, Black, RE, Brown, KH, et al. Prevention of Diarrhea and Pneumonia By Zinc Supplementation in Children in Developing Countries: Pooled analysis of randomized control trials. J Pediatr. 1999; 135:689-697.

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http://www.cdc.gov/lead/.

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http://www.ifservices.org/family-training.php

http://www.nacac.org

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http://www.peds.umn.edu/iac/for_families/transition/attachment.html

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For information contact:
International Family Services
700 S. Friendswood Drive, Suite B
Friendswood, Texas 77546
Phone: 281-992-4677
Fax: 281-992-3179

www.ifservices.org

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 below.

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.

ABOUT THE MEDICAL INFORMATION IN YOUR REFERRAL

Medical Diagnoses In our study of over 300 potential adoptees from Eastern Europe, specific medical diagnoses were listed in over 90% of referral documents. However, many of these diagnoses were obscure (vegito-visceral syndrome), utilized arcane terminology (oliogphrenia) 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's brain was compromised 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 prescribed 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 doesn't want to appear to be placing too many "normal" children abroad or if 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 medical diagnoses listed in their child's medical history. **However, you should never completely ignore any diagnosis unless the records have evidence that suggests it 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 that diagnosis. However, acquisition of developmental milestones within an institutional care environment is usually delayed. In situations where there are questions as to whether a diagnosis is correct, seek assistance from a physician who has experience interpreting adoption medical information.

Growth and Developmental Milestones Growth and development proceed on the basis of biologic, not chronologic, age. Subtract the number of months your child was premature from his/her chronologic age to determine the corrected gestational age. The corrected gestational age, not chronologic 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 gestational age). Six months after birth, this child should be plotted at the three-month point on growth curves and have reached three months on a developmental check-list. 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 9-12 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 which is too small or too large may signal significant neurologic 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 development—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 noted in 17% and fetal alcohol syndrome in 2.4% of referrals. 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 considering 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.

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 a lifelong memory, videotapes can provide unique and invaluable medical information about your child. When viewing 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 as immobile, 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 dinnertime 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. 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.

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 or 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 procedures may be lax. Aside from mother-to-infant transmission of hepatitis, syphilis 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 the 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 antibody until 18 months of age.

- **Should the child be tested prior to arrival?**
  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 Hepatitis B (HBV), a viral disease which affects primarily the liver, is endemic in most countries placing children in the United States. The virus is transmitted from one person to another by percutaneous (needle stick or biting), mucus 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. The close confines of institutional care settings increase the risk of transmission.

When adults and older children are exposed to hepatitis B, most fight the infection effectively and clear the virus from their systems. However, the immature immune systems of infants and very young children may not identify this organism as an invader. These children do not clear the virus from their system and become chronic carriers of the hepatitis B virus—at risk for exposing others to the virus 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 prevalence in the country of origin: 8-10% in Asia, sub-Saharan Africa and parts of South America; 2-7% in Eastern Europe and Northern China; <2% in Western Europe and the United States. Generally, 3-6% of international adoptees seen in our clinic are positive for the hepatitis B virus. In certain situations, such as the children emigrating from Romanian orphanages in 1990-91, the incidence was much higher (20%).

Screening for hepatitis B after arrival is very important for the health of both your child and your family. An initial screening when the child first arrives in the U.S. and a second screening after the maximum incubation period of 12 weeks are recommended. The hepatitis B profile (see screening tests) rather than the simple testing for hepatitis B surface antigen should be utilized. In our experience, approximately 60% of the children with acute or chronic hepatitis would have been misdiagnosed if only the simple screening had been used.

The risk of transmission of hepatitis B to other family members has been examined. **Rates of infection ranged from 5 to 37%, with increasing infections seen when the adoptee was less than three years of age and within the first year of the child's arrival.** 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 now universally recommended for newborns in the U.S. and is mandatory for household members when a family adopts a child who is hepatitis B surface antigen positive.

The health status of chronically infected Korean adoptees is generally good. However, most Korean children acquired their infections perinatally, while children from Romania were more likely to have person-to-person transmission. Experience with Romanian adoptees indicates a higher risk of abnormal liver function associated with chronic infection. Delta hepatitis virus has been recognized in a number of hepatitis B surface antigen positive adoptees. 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 Intestinal and cutaneous 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 ubiquitous. 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 and 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 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 TM). 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 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.

The immune system may require up to three months to respond after an initial TB exposure. If your child has symptoms consistent with TB and the initial Mantoux skin test is negative, skin testing should be repeated within 6-12 weeks.

Prior BCG vaccination BCG, a vaccine made from the Calmette-Guerin bacillus—a weakened strain of a related mycobacterium—is administered to some infants in countries where TB is endemic. Most children from Eastern Europe and China have been vaccinated (look for a small scar usually on the left shoulder). Unfortunately, this vaccine does not provide complete protection. Individuals who have been vaccinated can still be infected with TB.

There is great confusion within the medical community about TB testing when a child has received BCG vaccine. You may hear that since your child was immunized with BCG, the TB testing cannot be performed or the BCG can be responsible for a "positive reaction." The American Academy of Pediatrics has now advised physicians that children who have received BCG vaccination can be screened with a Mantoux test. Interpretation of the test is the same as in non-immunized children.

What to do when the test is positive Positive Mantoux reactions of greater than 5 mm (1/5 inch) in an HIV-infected child or greater than 10 mm (2/5 inch) in the HIV-negative adoptee should be evaluated. Your physician should elicit an appropriate history, perform a physical examination and obtain a chest x-ray. In a child older than 5 years, the possibility of TB in the bones or kidneys should also be raised, especially in a symptomatic child with a positive Mantoux and a negative chest x-ray. At this juncture, the results of the history, physical examination, chest x-ray and sputum or other bodily cultures for TB will be used to differentiate between the possibilities of active tuberculosis or simple exposure (infection without active disease).

Because many physicians in the U.S. have not encountered TB, consultation with an infectious disease specialist is recommended for any child whose Mantoux skin test is positive. At the very least, the specialist will review the evidence for the diagnosis, will outline an appropriate course of drug therapy, and will be available to supervise the course of treatment.

HIV Infection While 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 which identify antibody directed towards HIV (ELISA antibody test) and tests which 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 cheapest and easiest procedure available, but 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 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/her ELISA will not be positive (too soon), but the viral culture or PCR will be positive.

Consequently, the American Academy of Pediatrics recommends that children less 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 and followed by a specialist in pediatric AIDS.

Syphilis While the risk of syphilis is low (< 2%), appropriate screening is necessary to identify children who require treatment. Children who have a positive VDRL or RPR should be evaluated according to the recommendations of the American Academy of Pediatrics 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 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 We are not presently culturing the urine of internationally adopted children for cytomegalovirus (CMV), because approximately 30-50% of adoptees are excreting this 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 acquire 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 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 coated with oral secretions. The child who is toilet-trained presents virtually no risk.

POST-ARRIVAL EVALUATION

Your child should see your physician within the first few weeks after arrival—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. A battery of screening tests is **absolutely necessary** to fully evaluate the health of your adopted child. Below are the tests recommended by the American Academy of Pediatrics and our suggested additions to the list. For further details, consult the *2000 Red Book: Report of the Committee on Infectious Diseases*, American Academy of Pediatrics.

Screening tests The International Adoption Clinic performs a variety of screening tests for internationally adopted children. These tests are essential for the health of your adopted child and your family. These tests should be done soon after the child's arrival in the United States. If some of the recommended tests have been done in the child's country of origin, they should be repeated once your child is home. In addition, testing for hepatitis B, hepatitis C, HIV, and tuberculosis should be repeated a second time after six months in the United States.

Recommended Screening Tests

- hepatitis B profile, to include HbsAg, anti-HBs and anti-HBc (Note: 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 or by PCR or culture in all children
- hepatitis C antibody
- 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
- lead level
- thyroid screen
- vision and hearing screening should be done for all adoptees.
- a developmental exam is essential for all international adoptees, but especially for those who have been institutionalized

Immunizations We have recently found that some children who were reported to have received three or more DPT/OPV vaccines in 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 at the time of vaccination, or the vaccination certificate is 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).

Physical and Sexual Abuse Unfortunately, institutional care settings are a magnet for adults who prey upon children. If you suspect that your child may have been physically or sexually abused within the orphanage, it is in your child's and family's best interests to seek the advise 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.

Reality Check

Review Questions
And
Statement of Completion

Please print a complete set of documents for each parent.

All documents must be completed, signed and returned to the Program Director.

Review Questions

The following questions pertain to the reading material contained in *Reality Check: Common Health and Developmental Issues of Internationally Adopted Children*. As part of requirements of applying to International Family Services for adoption services, **each** parent must complete the following questions and submit them along with a signed statement of completion to the Program Director**.**

Please answer the following questions in essay form using a separate piece of paper. Please attach this page to your answers.

1. Based on what you have learned in this course and your other reading on the topic, how to you plan to help your child through his or her grieving process? Be specific.

2. Based on what you have learned in this course, what might be some reasons your child may initially have difficulty bonding with you and what will you do to encourage the bonding? Be specific.

3. Explore what support services are available in your community. Explain how and why you might utilize the services.

4. What were the top three things you learned from this course and explain why each was helpful to you as you prepare to parent your adoptive child.

5. What other resources did you read and were they helpful to you as you prepare to be an adoptive family?

GO ONTO THE NEXT PAGE.

Statement of Completion

I _____ , hereby state that I read *Reality Check: Common Health and Developmental Issues of Internationally Adopted Children* provided to me by International Family Services.

I, _____ , hereby state that I personally completed the attached Review Questions regarding the material contained in the *Reality Check: Common Health and Developmental Issues of Internationally Adopted Children* book.

_____ _____

Printed Name Date

_____

Signature

Each Prospective Adoptive Parent must complete and sign his or her own Review Questions and Statement of Completion.

Once completed, please send the Statement of Completion and the Review Questions to your Program Director.