

Information About International Adoption

Educational Materials For Prospective Parents

The information provided in this package is a collection of materials that we believe will be helpful to you in your adoption journey. Please retain these materials, as you will want to refer back to them.

Please read over each section so that you are familiar with all issues, even if you believe they do not affect you and your adoption.

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Adoption Educational Materials

Introduction to international adoption

Statistics in adoption

- 500,000 people turn to adoption each year.
- 140,000 children find permanent homes with American families each year.
One third of the nation is touched by adoption within their immediate families.

How adoption has changed America

Because it is now so open and visible, adoption is helping redefine the understanding of what it means to be a family. Adoption is:

- Altering views on race.
- Creating a new type of extended family, one that includes the birth family.
- Becoming a bellwether for the understanding and acceptance of all non-traditional families.
- Altering views of nurture vs. nature, biology's role in creating the parent-child relationship, the nature of adult-child bonding, the importance of "blood" relationships, and an array of related issues.
- In a far more visible way than either the decline of two-parent homes or the growth in the Hispanic population, adoption is reshaping American views of our nation as more multiracial, multicultural and multiethnic, especially as the availability of white infants declines and people adopt more children from abroad and from foster care. The impact is most pervasive for children growing up today, who no longer think families are only formed when mommies and daddies make babies who look something like them.
- Creating a new type of extended family, because more and more adoptive parents, and adoptees, form ongoing relationships with birth parents and other members of biological families right from the start or in subsequent years. This phenomenon, which is more widespread than most people realize, is akin to the people who make up extended family relationships.
- In ways that affect members of other nontraditional families (foster, step, single, gay, older parents and even grandparents raising their children's children), adoption is making journalists, teachers, lawyers, doctors, social workers and other professionals rethink how they deal with families and family issues - and, more fundamentally, how they perceive the place of non-traditional families in our society.

Why should you understand adoption?

The modern family has changed dramatically in the last half century. Even so, society has yet to really understand and accept non-traditional families, including adoptive families. The media, which simultaneously mirrors and shapes the attitudes of society, perceive adoption as a small niche within our country. The fact is, each year 140,000 children find permanent homes in American families through adoption. The rise in international and transracial adoptions is helping to transform America into a more multicultural and multiethnic society.

Adoption has become only one in a mix of non-traditional families - divorced, step, multi-racial, single, gay, families headed by grandparents and those with parents or children of a different race, ethnicity or nationality. Indeed, because adoptive families include all these variations, adoption provides a valuable prism through which to view, and better understand - the changing realities of the modern family. By understanding adoption, we lay the groundwork for understanding all families.

The 2000 U.S. Census estimated there were 84 million children living at home. Of that number:

- Approximately 2.1 million (2.5%) were adoptees still living at home, 1.6 million were under 18, and 4.4 million were stepchildren.

- Together adopted and stepchildren accounted for 8% of children still living in the home.
- Some 4.5 million children were growing up in households headed by grand-parents.
- Some 62% of children under 18 lived with two biological parents, nearly 3% of whom lived with unmarried parents.

A brief history of international adoption

By **Heather Salerno**, *The Journal News* (Original publication: November 10, 2002)

International adoption dates to post-World War II, when U.S. parents took in large numbers of orphaned European and Japanese children. The wars in Korea and Vietnam also prompted adoptions from those countries. The boom occurred in the early 1990s, when poverty and social upheaval was rampant in Latin America, the former Soviet Union and Eastern Europe.

Reports of heartbreaking conditions in Romanian orphanages resulted in a spurt of adoptions there. The fall of Communism opened the door for orphans to be adopted from Russia and other former Soviet republics (Last year, 13 times as many children were adopted from Russia as were when it was newly independent in 1992). China became popular in the mid-to-late 1990s, after the Chinese government established adoption guidelines and a central administration to process applications. For many families, adopting abroad has more appeal than adopting at home: It is often easier that way to adopt an infant.

Most adoptive parents want a healthy newborn, but at home, the wait can be years. Adopting from overseas generally takes 12 to 18 months (depending on the country), and nearly half of internationally adopted children are infants.

Older parents and single parents, who may be rejected by some domestic agencies that place infants, are often welcome to adopt children in other countries. For many parents, adopting abroad may mean creating an interracial family. This choice means they often must contend with racial stereotypes and other criticism. Some people question the decision to go abroad when hundreds of thousands of children await adoption at home.

The reality is there are few infants of any race available for adoption at home. The 100,000 children in foster care waiting for an adoptive family are generally school-age boys and girls who have often been bounced around the chaotic system, and may have a history of emotional and mental difficulties.

"These children have had very hard lives," says Rita Soronen, executive director of the Dave Thomas Foundation for Adoption, which focuses on children in this country's child-welfare system. "They require a lot of patience."

Another reason parents go overseas is to avoid challenges from birth parents. Many children available for adoption in nations like China were abandoned or are orphans, and the birth family is unlikely to disrupt an adoption. Though few domestic adoptions are contested (less than 0.1 percent each year), they get tremendous play in the media, and make prospective adoptive parents wary.

International adoption programs may provide less of a financial gamble, too. "With domestic adoption, there is more of a risk. You will most likely be supporting the birth mother, helping with living and medical expenses, and if the birth mother changes her mind, that money is lost," says Suzanne Nichols, a White Plains attorney who specializes in adoptions from Hungary.

But when it comes to what is most important for parents — a child — some agency directors say international adoption is more of a sure thing.

"International offers a level of security that domestic doesn't necessarily give," says Timothy Sutfin, Executive Director of the Long Island-based New Beginnings Family and Children's Services.

Sutfin's agency has placed more than 2,200 children, most born overseas, with New York area parents since 1983. With international adoption, he says, "There is a child on the other end." Yet adopting abroad has more bureaucratic pitfalls.

All adoptions require extensive paperwork, but international ones involve demands from two governments. Dossiers — the set of legal documents that accompany international adoptions — must include information requested by the foreign country, and approval from the U.S. Immigration and Naturalization Service.

With the implementation of the Child Citizenship Act of 2000, parents no longer must apply to the INS to naturalize a child as a U.S. citizen, but depending on the type of visa issued, parents may have to readopt their child in an American court.

Another hazard is that adoptions can be delayed at any time by the United States or the child's birth nation. Romania has temporarily halted inter-country adoption so the government can eliminate corruption in its adoption system.

Conversely, the U.S. government has voiced its own concerns about baby-selling and child abduction. The INS was so convinced of a "seriously flawed" process in Cambodia that the agency suspended U.S. adoptions last December, leaving children already matched with American parents in limbo.

Before parents are matched with a child, however, they must meet the criteria established by the other country.

Many nations require one or both parents to spend time there — a minimum of two weeks in countries like Kazakhstan — which boosts already high costs. Countries can reject parents because they are too old or too young; others consider more than one divorce by each parent unacceptable. Korea and Thailand are among those that ban unmarried couples from adopting. Gay men and lesbians are barred from adopting in China and Panama.

"It's hard," says Mary Durel, Adoption Director at Family Service of Westchester in White Plains, "but we have to respect the cultures we are adopting from."

Adoption terminology

Adoptee: A person who was adopted. Some people prefer the terms adopted child or adopted person.

Adoption: The complete transfer of parental rights and obligations from one parent or set of parents to another. A legal adoption requires a court action.

Adoption agency: An organization, usually licensed by the state, that provides services to birth parents, adoptive parents and children who need families. Agencies may be public or private, secular or religious, for profit or nonprofit.

Adoption assistance: Monthly federal or state subsidy payments to help adoptive parents raise children with special needs.

Adoption attorney: A lawyer who files, processes and finalizes adoptions in court. In some states, attorneys may also arrange adoptive placements.

Adoption consultant or adoption facilitator: Individual whose business involves connecting birth parents and prospective adoptive parents for a fee (only allowed in a few states). In international adoption, a facilitator may help adoptive parents complete the adoption in the child's country of origin.

Adoption plan: Birth parents' decision to allow their child to be placed for adoption.

Adoption tax credits: Nonrefundable credit that reduces taxes owed by adoptive parents who claim adoption expense reimbursement on federal taxes (and in some states with similar legislation, on state taxes). You may be able to take a tax credit of up to \$10,390 for qualifying expenses paid to adopt an eligible child. The adoption credit is an amount that you subtract from your tax liability.

Also, up to \$10,390 paid or reimbursed by your employer for qualifying adoption expenses under an adoption assistance program may be excludable from your gross income. (However, you cannot exclude this adoption assistance if your employer is an S corporation in which you own more than 2% of the stock or stock with more than 2% of the voting power.) An adoption assistance program for this purpose is a separate written plan set up by an employer to provide adoption assistance to its employees. See Adoption assistance program under For Employers, later, for more information.

You may claim both a credit and exclusion for expenses of adopting an eligible child.

See <http://www.irs.gov/taxtopics/tc607.html>

Adoption triad: The three major parties in an adoption: birth parents, adoptive parents and adopted child. Also called adoption triangle or adoption circle.

Agency adoption: Adoptive placements made by licensed organizations that screen prospective adoptive parents and supervise the placement of children in adoptive homes until the adoption is finalized.

Birth parent: A child's biological parent.

Closed adoption: An adoption that involves total confidentiality and sealed records.

Confidentiality: The legally required process of keeping identifying or other significant information secret. Also, the principle of ethical practice that requires social workers and other professionals not to disclose information about a client without the client's consent.

Consent to adopt or consent to adoption: Legal permission for the adoption to proceed.

Decree of adoption: A legal order that finalizes an adoption.

Dossier: A set of legal documents used in international adoption to process a child's adoption or assignment of guardianship in the foreign court.

Employer benefits: Compensation to workers through employer-sponsored programs, e.g., financial assistance, reimbursement of adoption expenses and/or provision of parental or family leave. For a list of employers who provide benefits, call the National Adoption Center at 800-to-adopt.

Finalization: The final legal step in the adoption process; involves a court hearing during which the judge orders that the adoptive parents become the child's legal parents.

Foster parents: State- or county-licensed adults who provide a temporary home for children whose birth parents are unable to care for them.

Home study: A process through which prospective adoptive parents are educated about adoption and evaluated to determine their suitability to adopt.

Identifying information: Information on birth parents or adoptive parents that discloses their identities.

Independent adoption: An adoption facilitated by other than an adoption agency.

INS. (BCIS): U.S. Immigration and Naturalization Service, a federal agency under the Justice Department that oversees all visas issued to allow entry into the U.S. www.bcis.gov

Interstate Compact on the Placement of Children (ICPC): An agreement regulating the placement of children across state lines.

Legal guardian: A person who has legal responsibility for the care and management of a person (such as a minor child) who is incapable of administering his or her own affairs.

Legal risk placement: Placement of a child in a prospective adoptive family when the child is not yet legally free for adoption.

Open adoption: An adoption that involves some amount of initial and/or ongoing contact between birth and adoptive families, ranging from sending letters through the agency to exchanging names and/or scheduling visits.

Photo listings: Photos and descriptions of children who are available for adoption.

Placement: The point at which a child begins to live with prospective adoptive parents; the period before the adoption is finalized.

Post placement supervision: The range of counseling and agency services provided to the adoptive family after the child's placement and before the adoption is finalized in court.

Private adoption: See independent adoption

Private agencies: Nongovernmental adoption agencies licensed by the state.

Public agencies: Social service agencies run by state or county governments that deal mainly with children in foster care.

Readoption: For a child adopted in another country, a second adoption in a U.S. court.

Relative adoption: Adoption by a biological relative of the child.

Relinquishment: Voluntary termination of parental rights. Some prefer the phrase making an adoption plan.

Reunion: A meeting between an adopted person and birth parents or other birth relatives.

Search: An attempt to locate and/or make a connection with a birth parent or biological child.

Semi-open adoption: An adoption in which a child's birth parents and adoptive parents may meet once or twice but exchange primarily non-identifying information.

Special-needs children: Children whom agencies consider difficult to place because of emotional or physical disorders, age, race, membership in a sibling group, history of abuse or other factors.

Transracial adoption: An adoption in which the child and parent(s) are not of the same race.

Waiting children: Children in the public child welfare system who cannot return to their birth homes and need permanent, loving families to help them grow up safe and secure.

Adapted from the National Adoption Information Clearinghouse (www.calib.com/naic).

Handy guide to constructive adoption language

For every term that conveys a negative adoption message, there is a more constructive and realistic alternative.

Negative Language

Real parent, natural parent

Own child

Illegitimate

Given up, taken away

Give away, give up, put up

To keep

Unwanted, abandoned

Adoptable/available child

Reunion

Adoptive parent

Foreign adoption

Track down

Surrender

Hard to place

Foreign child

Is adopted

Blood relatives

Positive Language

Birth or biological parent (two words)

Birth or biological child

Born to unmarried parents

Termination of parental rights

Make an adoption plan

To parent

No equivalent language, please do not use

Child in need of a family

Meeting, making contact with

Parent (except when relevant to the story)

International/intercountry adoption

To locate, contact

Adoption agreement

Child with special needs

Child from another country

Was adopted

Genetic relatives

Child health considerations

Certain health risks are inherent when adopting foreign children. Generally, children come into care because of abandonment, poverty, illness or death of parents, or family dysfunction (including alcoholism, drug abuse, child abuse and/or neglect). Children may have experienced poor prenatal and/or postnatal care, early neglect, and a lack of health care services, including immunizations. Specific health problems may include malnutrition, parasites, minor congenital defects, developmental delay, tuberculosis, hepatitis (A, B, or C), and HIV/AIDS. Children also can be affected by living in institutions during critical developmental periods or over long periods of time. Reputable agencies will provide prospective parents with as much information as possible on a child's background and medical history; however, they cannot guarantee the accuracy or completeness of this information. Medical evaluation (including lab testing) in developing countries does not match U.S. standards. The birth parents' medical and genetic histories are not always known, especially for abandoned children.

Most foreign countries have developed child welfare systems, but most struggle to provide a minimum standard of care for dependent children. Children who spend formative early periods or many years in large institutions with few caretakers will usually show the effects of lack of stimulation and

institutionalization. In institutions, it is the strong children who survive. It should be noted that some children exhibit remarkable recovery from developmental delays after they have proper nutrition and medical care and are in a family setting. Some children show long-term delays and will require rehabilitative therapies to help correct the damaging effects of institutionalization. Loving care notwithstanding, other children who have suffered prolonged neglect and abuse in orphanages may require expert help over long periods.

You should educate yourself about the impact for children of the conditions detailed above—all are factors that can affect a child's physical, developmental, and emotional growth. Learn what resources are available to you in your community should the child you adopt need some professional help to address and hopefully make up for early delays. Talk to other families who have adopted from different countries and orphanages to see how their children are doing after arrival and several years thereafter.

Adapted from the National Adoption Information Clearinghouse (www.calib.com/naic).

General medical issues: *Health and Developmental Issues of Internationally Adopted Children [2004.January.05]*. When evaluating a child who is newly adopted from abroad, the healthcare provider who first encounters the adoptive family in the office setting, is essentially creating a medical history from the limited pre-adoption medical information from the country of origin, the parent (s) experience with the child since adoption and information collected during a thorough initial medical and developmental evaluation hopefully performed within the first few weeks after the child's arrival.

Pre-adoption medical information

Most children adopted internationally do have pre-adoption medical abstracts that are quite limited. (1) There is rarely pre-natal care for orphans/foundlings and the transfer of information from birth mothers in maternity hospitals to orphanages in most countries is almost non-existent. In Russia, women often deliver babies at home or in a hospital and they leave the hospital quickly, relinquishing the child to the state. Because most children adopted from China are abandoned and found in public places, there is no pre-natal or birth/delivery information available. Orphanage staff make their best guess about the age of the child although sometimes, there is a "date of birth" note pinned to the child's clothing. This is in contrast to South Korea, with its excellent foster care system, where there is full disclosure of medical information, good pre-natal care, and opportunities to make inquiries about medical conditions in order to complete any missing information about the child's medical and developmental course while in foster care.

On the whole, the flow of information about children about to be adopted from all countries abroad continues to improve. That said, there are a number of health issues common to children who have been living in orphanages and enough medical experience has been accumulated since the mid to late eighties when international adoption began to grow in the U.S. making this information quite accessible and easy to know in the context of a primary care general medical practice.(2) From the most recent official Immigration and Naturalization statistics by end of 2002 (3) There were 20,099 children adopted from abroad with 5,053 from China and 4, 939 from Russia. Other popular countries for Americans to adopt from in 2002 were Guatemala, South Korea, Ukraine, and Kazakhstan. International adoption reflects the "geopolitics" of the world, thus resulting in the shifting of numbers and countries from year to year.

Latent tuberculosis infection (LTBI)

From data from a retrospective cohort study of 504 internationally adopted children in 1997 and 1998 done by this author, (4) 10.4 % of children adopted from China had LTBI and 30% of children adopted from Russia had LTBI. This clearly reflects the endemicity of TB in China and Russia and should reinforce the need for such testing regardless of BCG status. (5) These children had negative chest films and were prescribed isoniazid (INH) once a day for nine months which in children is quite tolerable and safe. Per this author's experience, INH without sorbitol causes less diarrhea and would be the preferred product to ensure compliance for nine months. Liver enzymes were acquired at baseline, but were not followed unless there were symptoms to warrant those studies.

Hepatitis A, B, C

Hepatitis A is a fairly mild infectious disease in children transmitted mainly in food and water in most countries outside of the U.S. It can cause irreversible, even fatal damage to the liver in adults, but it doesn't have a carrier state or a chronic state which is how it differs from Hepatitis B and C. It would not be necessary to test for Hepatitis A unless the child has transaminase elevations and/or was symptomatic with liver disease i.e., jaundice. Hepatitis A is preventable, with a two-vaccine series, administered six to twelve months apart, and is recommended for all families traveling abroad to adopt children from orphanages as it is highly transmissible in households and while traveling outside the U.S. (6)

Hepatitis B and C, on the other hand, both have a chronic carrier state that can potentially cause chronic active hepatitis, cirrhosis and cancer of the liver. In the study cited above (4) 2.8% of the children evaluated were positive for Hepatitis B surface antigen. 3.3% were positive from China and 2.6% were positive from Russia. Hepatitis B vaccine is required for school entry in the United States and should be given to adults/parents traveling abroad to adopt children due to the high risk of acquisition of this infection from their children who could be potential carriers of this infection. (7,8) Anecdotally, in the 5 years since Saiman et al. (4), this author has seen less children with carriage of Hepatitis B. More reliable testing abroad, testing of children at an older age, and more widespread vaccination in the orphanage probably all contribute to the change in prevalence in the carrier state of adoptees.

Hepatitis C serology was obtained in 98% of the study participants (4) and 4 were found to be antibody positive, but all were negative for viral RNA and 2 children remained positive after 1 year of age; one is 8 years of age and has normal transaminases and negative PCR and the other is lost to follow-up. In the practice of adoption medicine most recently, more and more pre-adoption reports from Russia include Hepatitis C tests with positive results. Reports of blood transfusions are also more common. This is obviously important information for parents to be aware of during the adoption process. Hepatitis C infection cannot be diagnosed in a child under the age of one year no matter what tests are performed and transfusions in children living in orphanages anywhere in the world should be seen as highly risky for Hepatitis B, C, and HIV infection.

HIV

This is a rare disease in adoptees, but HIV has an evolving epidemiology. This author undertook a study of HIV prevalence in adoptees in Spring of 2001 in preparation for a presentation at the Medical Institute of the Joint Council on International Children's Services (www.jcics.org) in April, 2001 in Washington, D.C. Seventeen adoption centers in the U.S. participated and about 7,300 children were tested for HIV on arrival in the U.S. Fifty-nine children were ELISA positive for HIV and 12 children (0.16%) were found to have HIV infection. Of the 12, there was 1 child from Russia diagnosed in 1998, 4 from Cambodia, 4 from Romania, 1 from Panama, and 2 from Viet Nam. 10/12 (83%) of the children were negative at time of referral for adoption and then were found to be infected on arrival in the U.S. Much has changed since the author collected this data. China instituted mandatory testing in Summer/Fall 2002 for all children referred for adoption in orphanages in China reflecting the HIV crisis in China revealed in Elisabeth Rosenthal's New York Times series on the epidemic of HIV in China (9). HIV testing in Cambodia was moved from the Aurore lab to the illustrious Pasteur Institute and included PCR testing (Cambodia has since closed to international adoption completely). Adoption from Romania is in moratorium since the study and the children who tested positive from Romania were adopted in the early 90s when there was no testing for HIV in that country. The author has no children infected with HIV in 10 years of practicing adoption medicine and evaluating about 2, 400 children in person.

Syphilis

Syphilis has turned out to be a rare diagnosis in children adopted from abroad. Though we see a lot of medical reports from Russia (10) that syphilis is epidemic, we rarely see the disease. This author typically sees "syphilis exposure" on about 10-15% of Russian pre-adoption medical abstracts. The vast majority of these children are reportedly treated with Penicillin injections for at least two weeks and in some cases for 30 days. This is likely why it is rare in Russia. It is rare in adoptees from China (11,12). Out of 2,400 kids seen in my office personally since the early 90s, I have three affected families with 5 infected children. Two children had congenital syphilis and were treated effectively on arrival with no long-term

sequelae. Three sisters recently were diagnosed in November 2003 and were likely sexually abused by their stepfather in the Russia hospital and were treated with Penicillin for 14 days and did well.

Parasites

In Saiman et al, 87/461 (19%) of children tested had evidence of Giardia lamblia by either antigen detection and/or parasite identification. Being born in Eastern Europe was a risk factor for the acquisition of Giardia. The next most common parasite was Dientamoeba fragilis. A handful of children had bacterial pathogens such as Campylobacter, Shigella and Salmonella. Frequent refractory cases of Giardia led this author to use 30 mg per kg of metronidazole benzoate for 14 days instead of 15 mg per kg for 5 days. A pharmacy in Cheshire, Connecticut (1-800-861-0933) was found to be the best source of anti-parasite medication suspensions with palatable flavors/textures leading to excellent compliance. In spite of the controversy around whether to treat children with asymptomatic Giardiasis, this author has always opted to treat for two reasons:

- Children in orphanages fail to thrive and Giardia may contribute to malabsorption of nutrients leading to poor growth and development.
- Giardia is quite transmissible in a household especially when the patient is not toilet trained.

Helicobacter pylori and reflux esophagitis

From time to time the author has encountered a newly adopted child with recurrent episodes of reflux, vomiting and irritability. Though there are few studies of this entity in orphans (13), this author has encountered children with these symptoms and some have tested positive for H. pylori antigen in the stool; treatment of this entity according to established regimens with several antibiotics and ranitidine (H2 antagonist) has been successful with patients becoming miraculously symptom free.

Lead poisoning

Thirteen percent of Chinese adoptees had elevated blood lead levels on arrival. Rarely was lead elevated in adoptees from other countries (14). Only one child, a 14 month old toddler adopted from China in this author's practice of 10 years, had to be treated with 20 days of Chemet for lead poisoning with a level of 48 ug/dl. She did well and was developmentally normal. It is assumed that lead poisoning in China comes from lead containing gasoline and coal burning used for industry and home heating and cooking.

Immunization records of adoptees

As immunization becomes more widespread and systematic in orphanages, and vaccines become more effective, health professionals are faced with a new dilemma regarding the recent arrivals: to immunize from the beginning regardless of records or to use antibody titers and available schedules to create a unique immunization plan. This has been an unfolding issue. In a study published in 1998 involving a small number of adoptees, "only 35% of Chinese, Russian, and EE adoptees exhibited protective titers to diphtheria and tetanus" (15). In similar studies (16, 17, 18, 19) over the last few years, there is increasing evidence that using antibody titers may be a more judicious approach to this issue.

The most recent of these studies (19) involved this author's practice and studied the records of 113 children adopted from abroad through May 2003; as high as 97% of children had acceptable titers of diphtheria, 96% for tetanus, 94% for polio, and 77% for Hepatitis B. These data are quite impressive as compared to older studies and support the use of antibody titers for children over one year of age (avoiding the issue of residual maternal antibodies) along with a compulsive review of intervals for vaccines. It has been the thinking of adoption medicine specialists that vaccines done in Guatemala, South Korea, India, and Thailand are performed most uniformly in keeping with U.S. guidelines and are likely acceptable for younger children. It is this author's recommendation to consider repeating vaccines for children under one year of age, if they are adopted from Russia and China and to use the schedule along with antibody titers per the Redbook, to create an individualized schedule for children over one year of age from these countries. (20)

Alcohol related neurodevelopmental disorders

There is no way to establish accurate data for the prevalence of FAS or FAE in adoptees because of the lack of accurate family history. We do know that there are no education programs warning pregnant women about the deleterious effects of alcohol on the unborn child and that drinking during pregnancy is quite common almost everywhere in the world, including the U.S. where there are public warnings. It is essential that families understand that exposure to alcohol cannot be diagnosed, but rather surmised from

a child's development and behavior and that the diagnosis of the facial features of FAS is challenging. The diagnosis of the facial features of FAS is the focus of photo and video evaluations for pre-adoption assessments for families adopting children from Russia and Eastern Europe.

Malnutrition, failure to thrive, rickets, iron deficiency anemia, zinc deficiency, scabies, eczema

Undernutrition and the absence of crucial elements, especially micronutrients like iron, zinc, calcium, and vitamin D are rampant in orphanages. Children living in orphanages abroad commonly have rickets (vitamin D, calcium deficiency), iron deficiency anemia, zinc deficiency, and eczema due to poor nutrition. Due to these conditions children do not grow optimally and fail to thrive. (21)

Rickets causes low muscle tone, box-like shaped heads, frontal bossing, and bowing of the lower extremities. (22) Rickets resolves swiftly with re-nourishment and physical activity, but some children continue to have low muscle tone chronically and may require physical therapy. Children with severe rickets may be misdiagnosed with muscle diseases and cerebral palsy.

Iron deficiency anemia is easily treated with iron and should be distinguished from alpha and beta Thalassemia which are commonly found in Asian children and are not diseases.

Zinc deficiency is likely a cause for frequent respiratory infections in orphanages as well as refractory eczema and acrodermatitis enteropathica (23).

Children in orphanages with poor skin integrity are at risk for scabies and bacterial infections such as impetigo; these are easily managed on arrival in the U.S., but scabies is commonly missed as it often doesn't appear in its classic form; it also leads to "acropustulosis" which is misunderstood and managed ineffectively with repeated treatment of scabies, rather than simple moisturization and patience.

Developmental delays and long-term issues

Development is the most important long-term issue in adoptees from abroad, but it is impossible to do this topic justice in a survey article of this nature. Most children adopted from abroad are delayed on arrival in the U.S. and have amazing recovery. (24,25) Per this author's experience, only about 60% of these children will qualify for Early Intervention (EI) which is provided free through the Department of Health in each county for children less than 36 months of age and provides physical therapy, occupational therapy, speech and language therapy in the home for families with children who qualify. Pediatricians should be aggressive about using the Denver II for each well-child visit and referrals for EI should be proactive. Children frequently show later signs of delay when they are challenged in a school environment and these delays usually involve language. If delays are not managed appropriately, children can develop behavioral problems which unnecessarily can undermine self-esteem. Children who are adopted need the support of their pediatricians, school teachers and their peers to understand their special identity issues as well. (26)

There are increasingly more academic long-term studies that healthcare professionals have undertaken in the last few years to provide resources for families through international adoption. The International Adoption Project at the University of Minnesota began in 2000 and has registered more than 3,000 families. The website <http://education.umn.edu/icd/iap> (27) includes a newsletter with articles focused on long-term medical and developmental issues.

Recommended screening tests and evaluations

Antibody titers for children over one year of age who have a credible vaccine record from the country of origin:

- diphtheria antibodies
- tetanus antibodies
- polio neutralizing antibodies for type 1, 2, 3
- chicken pox antibodies
- measles, mumps, rubella (depends on the country and reliability of these vaccines)

HIV-1,2 ELISA

Hepatitis B serology (Hep B surface antibody, Hep B surface antigen, Hep B core antibody total)

Hep C EIA

Hep A total with reflex to IgM in case of acute infection

Syphilis serology (RPR, FTA-ABS)

Lead Level (venous)

Complete Blood count with differential and platelets

Hemoglobin electrophoresis

Thyroid screen

- TSH

- Free T4

- Total T4

Rickets screen

- Alkaline phosphatase

- Calcium

- Phosphorus

Liver Enzymes

- ALT

- AST

Kidney Function tests

- BUN

- Cr

Audiology evaluation for all children adopted from abroad (unknown birth history and possible prematurity).

Vision screening by a board certified pediatric ophthalmologist for all children adopted from abroad (unknown birth history and possible prematurity).

Dental visit with a pediatric dentist should be done by 18 months of age (poor nutrition, rickets, exposure to sugar in the bottle with bottle propping)

TB skin test (TST) on arrival and again 6 months from the time of arrival (If the BCG site is not healed wait until it is healed and if more than a few months is needed for healing, consider having a chest x-ray; then do the TST when the BCG scar is completely healed. Consider repeating HIV, Hep B, C 6 months after arrival (lengthy incubation periods and exposure just at the time of departure).

Full developmental assessment on arrival and every few months to determine the need for Early Intervention

http://www.orphandoctor.com/medical/general/health_issues.html

Fetal alcohol syndrome

Historical perspectives

Historically, since ancient Greek and Roman times, and throughout the middle ages, alcohol was suspected to be a cause of injury to the fetus (teratogenic) as it lay innocently inside the womb. In fact, the children of women who were known alcoholics, were often cast away and abandoned by society. The bible instructed women not to drink when they became pregnant. [Clarren & Smith 1978] Bridal couples in Carthage were forbidden to drink wine on their wedding night in order that defective children might not be conceived. [Jones & Smith 1973a]

In modern times, a French group of researchers is credited with the first recognition of an effect on infants due to alcohol exposure during pregnancy. [Lemoine et al. 1968]

Independent of the French, Kenneth L. Jones and David W. Smith from the University of Washington School of Medicine in Seattle, Washington described a syndrome associated with alcohol ingested during pregnancy. [Jones & Smith 1973b] The children were born to women who were chronically alcoholic during pregnancy. The infants diagnosed with fetal alcohol syndrome (FAS) were found to have a pattern of altered growth and development with similar facial features. The craniofacial abnormalities consisted of microcephaly (small head), short palpebral fissures (small eye openings), epicanthal folds (extra skin folds close to the nose at the inner aspects of the eyes), and mid-facial hypoplasia (middle area of the face appears flattened). There were many other abnormalities of the systems of the body including pre-natal and post-natal growth deficiency, problems with joints, kidneys, genitals, cleft palate, and congenital heart anomalies. Not all the initial cases reported, had all of these abnormalities, but the facial features were consistently identified. With a seven year follow-up of the original children identified by the Washington group [Jones et al. 1974], over 60% of the children had intellectual impairment usually accompanied by microcephaly.

Shurygin published a study in a pediatric journal in Russia in 1974 which also described the effects of alcohol during pregnancy. Dr. Streissguth came across this study a few years after her group had described FAS. This study looked at a unique situation where mothers gave birth to children before and after the advent of their alcoholism. The children born before the mothers became alcoholic did not have alcohol related disorders, but rather suffered from the adverse environmental conditions of their life; the children born to the mothers when they were drinking during the pregnancy clearly had what appeared to be the devastating complications of alcohol related disorders. [Shurygin 1974; Streissguth 1997a]

Pathophysiology and teratology of pre-natal alcohol toxicity

The effect of alcohol on the growing and developing embryo and fetus is still not completely understood. The exact mechanisms by which alcohol induces malformations may be as a result of a direct toxic effect or it may be a combination of ethanol and acetaldehyde, its metabolite. [Abel 1984; Campbell & Fantel 1983 Dreosti et al. 1981; Sreenathan et al. 1982] The timing of the toxic event and the peak alcohol concentrations may work together to exert a teratogenic effect. [Schenker et al. 1990a] It is essential to look at alcohol as a teratogen to understand the actual physical effects of alcohol on the embryo and the fetus. A teratogen is a substance that interferes with normal development during gestation in utero. Teratogens can cause four main results: death, malformations, growth deficiencies, and functional deficits. When genes and teratogens interact, they cause very unique changes. The genetic make-up of both the mother and the developing embryo/fetus influences how and whether that child will be affected by the teratogen, in this case, alcohol. Between 25% and 45% of

children born to mothers who drink during pregnancy will have FAS. [Gilliam et al. 1988; Streissguth 1997b] There are numerous animal studies that demonstrate brain damage from exposure to alcohol. [Clarren et al. 1988; Miller 1993; West et al. 1981] Postmortem findings have been reported as case studies on fetuses, infants, and children of mothers who used alcohol during pregnancy. The neuropathologic anomalies include micrencephaly, leptomenigeal glioneuronal heterotopias, holoprosencephaly-arrhinencephaly, agenesis of the corpus callosum, and dysgenesis of the cerebellum and brain stem. [Swayze et al. 1997a] Magnetic Resonance imaging (MRI) of children, adolescents, and adults with classic FAS has shown a high incidence of midline brain anomalies. [Swayze et al. 1997b].

Prostaglandins may also be involved in the pathophysiology of alcohol toxicity. [Challis & Patrick 1980] It has been postulated that alcohol may interfere with prostaglandin metabolism and may interfere with the normal balance and regulation of placental blood flow. The placenta is the organ created early in pregnancy for delivering oxygen and nutrients to the developing embryo and fetus. When there is decreased blood flow to the embryo or fetus, there will be insufficient oxygen and essential nutrients. Chronic hypoxia (decreased oxygen) has been implicated in the etiology of alcohol related disorders. [Lewis & Woods 1994a] The actual amount of alcohol necessary to produce malformations seen in alcohol related disorders is unknown. It is still not clear whether one can predict particular abnormalities, whether behavioral or physical, based on the trimesters when alcohol has been consumed. Alcohol probably has its effects throughout pregnancy. Evidence does suggest that short-lived, high concentrations of alcohol as occurs in binge drinking, can be especially deleterious. [Ernhart et al. 1987; Lewis & Woods 1994b; Schenker et al. 1990b; FDA 1981] The lowest harmless dose of alcohol during pregnancy is unknown and subsequently, complete abstinence is recommended.

Guidelines in defining alcohol related disorders

The first attempt to establish uniformity in terminology for Fetal Alcohol Syndrome was addressed by the Fetal Alcohol Study Group of the Research Society on Alcoholism (RSA) in 1980 and again in 1988, without complete consensus. In 1989 Sokol and Clarren [Sokol & Clarren 1989a] provided a set of guidelines with minor modifications of the original 1980 definition. The diagnosis of Fetal Alcohol Syndrome (FAS) in its strictest definition can only be made when there is a documented history of alcohol exposure and the patient has signs of abnormality in each of three categories:

Prenatal and/or postnatal growth retardation (weight and/or length or height below the 10th percentile when corrected for gestational age).

Central nervous system involvement (including neurological abnormality, developmental delay, behavioral dysfunction or deficit, intellectual impairment or/ or structural abnormalities, such as microcephaly (head circumference below the 3rd percentile) or brain malformations found on imaging studies or autopsy).

A characteristic face, currently qualitatively described as including short palpebral fissures, an elongated midface, a long and flattened philtrum, thin upper lip, and flattened maxilla.

Children who have only some of the characteristics of FAS (central nervous system effects without all of the characteristic facial features or growth deficiency), have been categorized as having Fetal Alcohol Effects (FAE) or Possible Fetal Alcohol Effects (PFAE). [Sokol & Clarren 1989b; Streissguth 1997c] The Fetal Alcohol Study Group of RSA was not able to find any acceptable way to use these terms; Sokol and Clarren have recommended that the use of the terms FAE or PFAE should be "strongly discouraged". They have instead recommended "Alcohol Related Birth Defect (ARBD)". Aase, Jones, and Clarren criticized FAE in a commentary "Do We Need the Term "FAE"?" because of its indiscriminate use which they felt led to overdiagnosis. [Aase et al. 1995] In 1996, the term alcohol-related neurodevelopmental disorder (ARND) was introduced by the Institute of Medicine. [Institute of Medicine et al. 1996a] Ann Streissguth uses alcohol-related neurodevelopmental disorder (ARND) interchangeably with FAE. [Streissguth 1997d]

For the sake of simplicity and uniformity, this chapter will use the term "alcohol related disorder" (ARD) as a general description which will encompass Fetal Alcohol Syndrome (FAS) and alcohol-related neurodevelopmental disorder (ARND) or Fetal Alcohol Effect (FAE). A child who fits the criteria established by the Fetal Alcohol Study Group of the Research Society on Alcoholism (RSA) for Fetal Alcohol Syndrome (FAS) will be specifically referred to as having FAS. If a child has some of the classic facial features of FAS, is of normal size, and has some central nervous system and behavioral manifestations, ARND or FAE will be used. The Institute of Medicine has recently attempted to sort out the complexities of the diagnostic criteria for alcohol related disorders. [IOM et al. 1996b] They have even provided a diagnostic category for children without confirmation of maternal alcohol exposure; establishing clear diagnostic criteria is an evolving work in progress associated with controversy and challenging issues which may be clarified with a more complete understanding of the pathophysiology of

alcohol toxicity and perhaps the development of more definitive biochemical, molecular, or radiologic indicators of the effects of alcohol.

Incidence of FAS worldwide

The worldwide estimated incidence of FAS is 1.9 per 1,000 live births based on a survey of published prospective and retrospective studies from Australia, Canada, Finland, France, Sweden, Switzerland, England, and a number of cities in the United States. [Abel & Sokol 1987a] Incidence estimates vary considerably depending on the methodology of the studies and particularly on the study sites. Based on this incidence rate, an estimate of the numbers of children born with FAS can be calculated. If there are 4 million births each year in the U.S. and an incidence rate of 1.9 cases of FAS per 1,000 births, we could predict the birth of 7,600 children with fetal alcohol syndrome each year ($0.0019 \times 4,000,000$). The economic impact of FAS is staggering; in the U.S., the economic cost associated with FAS-related growth retardation, surgical repairs of organic anomalies (cleft palate, cardiac anomalies), treatment of hearing deficits, and the management of mental retardation, learning problems, and behavioral disorders is \$321 million per year. [Abel & Sokol 1987b]

Families who are adopting from Eastern Europe and the Former Soviet Union need to know that the use of alcohol during pregnancy is rampant. There are no public health programs to educate women about the deleterious effects of drinking during pregnancy. Poverty and deteriorating social conditions in the last few years have led to increasing substance abuse in all age groups. [Associated Press/Chicago Tribune 1995; Davis 1994; Garrett 1997b] The Environmental and Health Atlas of Russia edited by Murray Feshbach, a prominent Sovietologist on faculty at Georgetown University, is an excellent source of statistics regarding the social, economic, and health issues of FSU. Alcoholism in FSU has skyrocketed in the last decade. In 1993 the number of alcoholics in FSU rose by 40.8 percent. There was a stunning increase in alcoholism among women by 48.1 percent. Eighty to ninety-four percent of girls ages 15-17 years drank sometimes and 17 percent drank often.

[Feshbach 1995a] Adolescent pregnancy and pregnancy among middle aged women is on the rise in FSU. Abortions are difficult to obtain; women attempt their own abortions and die of the complications.

[Feshbach 1995b] It is not uncommon to note as many as ten pregnancies on medical abstracts for adoption evaluations from FSU. Women who drink do not have adequate nutrition and are unable to obtain consistent pre-natal care; premature births are epidemic in Former Soviet Union. Miscarriages are common as well.

In a retrospective chart review of 131 pre-adoption evaluations which included accompanying videos, conducted at Winthrop-University Hospital from 1994 through 1997, seventeen (13%) medical abstracts included a documented history of maternal alcohol ingestion during pregnancy. Using the strictest criteria defined by the Fetal Alcohol Study Group for the Research Society of Alcohol which required documentation of maternal alcohol ingestion, there were 2 (1.53%) children with FAS. Fifteen (11%) children were exposed to alcohol and were at risk for FAE. There was a suspicion of FAS by video evaluation in 28 (21.4 percent) children. Out of the 28 suspected FAS cases, there were 5 (17.8 percent) children with a documented history of maternal alcohol abuse on the medical record. Some of these children did not quite fit the classic FAS picture. It is unlikely that children adopted from abroad who may appear to have the classic features of FAS will have a documented history of maternal alcohol ingestion.

Extrapolating from the number of actually diagnosed FAS cases, would result in a rate of 15 per 1,000 births which is eight times the worldwide rate of 1.9 per 1,000. The 95% confidence limits for 15 per 1,000 live births are as follows: lower limit is 1.9 per 1,000 and the upper limit is 54.1 per 1,000. The birthrate in Russia is 1.4 million births per year. With an incidence of FAS of 15 per 1,000 live births, there could potentially be 21,000 children with FAS born each year ($0.015 \times 1,400,000$) in the Former Soviet Union.

Diagnosis of alcohol related disorders

Included in this section of this chapter are two photographs of children who were living in an orphanage in Moscow at the time they were observed by this author in August 1997. Both children had a documented history of maternal alcohol abuse in their medical histories. They had growth failure for all growth parameters (height, weight) including head circumferences below the 3rd % (microcephaly); they were already considered mentally retarded by extensive evaluations of the doctors who examined them in the

orphanage. This was confirmed by a detailed discussion between the author and the orphanage director in August 1997. The three year old boy's parents were both alcoholics who occasionally came to visit him at the orphanage in a drunken state. In order to really understand the subtleties of diagnosing the classic features of FAS, the reader should be looking at the photographs while reading this section. The faces of these children clearly have all of the classic features of FAS: small eye openings with epicanthal folds, a flattened midfacial area, and a thin upper lip, with a long, flat philtrum.

It is essential to understand that the diagnosis of FAS is not always so easy. It is often completely overlooked in newborns [Little et al. 1990]. Many healthcare providers have not had training in the recognition of FAS. The face of an infant with suspected FAS may not appear to have the classic features early on in infancy, but as the muscles and bones mature, the facial features can become more apparent. Some of the classic features may be indistinguishable from certain ethnic characteristics. Asian and Native American children have epicanthal folds and a flattened midfacial area. There are some very Asian looking Russian children because of Russia's close proximity to Asia and the obvious mixing of cultures over the centuries. Russians living in Ulan-Ude, just north of Mongolia, look like Asian Caucasians. African American children do not have a thin upper lip, but the absence of this characteristic should not rule out FAS. [Streissguth 1997e] There are also other syndromes that resemble FAS like fetal hydantoin syndrome (exposure to dilantin (phenytoin), an anti-convulsant medication during pregnancy).

Most importantly, the facial features may just not be classic! The effect of the alcohol is quite variable as discussed in the section on definitions and terminology. Children may outgrow the facial features of FAS as well as their growth failure. Weight gain occurs quite often, although linear growth may remain limited [Streissguth 1997f]. Some children may be born with a normal head circumference, but as they grow, their head circumference growth velocity is not normal and their microcephaly evolves by the time they are one year of age. This is actually commonly seen on Russian pre-adoption growth charts, but it would be impossible to distinguish this late onset microcephaly as a result of alcohol exposure from malnutrition and deprivation in the orphanage and intrauterine infections (syphilis, cytomegalovirus, rubella, toxoplasmosis, herpes simplex). There are diagnostic tools to help professionals to learn how to identify FAS. According to Dr. Streissguth, Jon Aase views the diagnosis of FAS as detective work. [Aase 1990; Aase 1994] He has produced a videotape guide to teach the diagnosis of FAS.

A photographic screening tool developed by Astley and Clarren [Astley & Clarren 1996] uses computer analysis of standardized photographs to make the diagnosis of FAS. For the diagnosis of children adopted from abroad, this tool has limited utility because the quality of the photographs would most likely never meet the stringent requirements of the computer software. It is extremely challenging to make the diagnosis of FAS from video and photographs provided with a pre-adoption review. The videos are poorly produced and are often copied numerous times, losing most of the quality and acuity. Photographs are taken too far away or taken at angles that really do not allow clear inspection of the face; the photos are often copied or faxed before they are presented to prospective parents. The ethnicity of children adopted from abroad could hardly be accounted for with this simple computerized photographic screening tool.

Cognitive and behavioral manifestations of alcohol related disorders

What are the central nervous system and behavioral manifestations of alcohol related disorders? The behavioral and cognitive effects of alcohol related disorders can be mild, moderate, or severe. There is no way to predict the severity based on the physical appearance of the child. There are no tests to predict the future effects for a newly diagnosed infant. In a recent survey of FAS case reports by Mattson and Riley, between 1973 and 1996, the mean IQ was 65.73 (SD=20.2) with a range of 20 to 120 [Mattson & Riley 1997a]. The average IQ for individuals affected by alcohol is in the mental retardation range, but there is a tremendous variation. Children with ARND or FAE appear to have higher IQ scores than children with classic FAS, but these scores are still in the mentally retarded range for the most part. [Mattson & Riley 1997b] Even if the IQ is in the normal range, children with alcohol related disorders can have severe and complex cognitive deficits and unusual behavioral manifestations. Some of these problems include jitteriness, disturbed sleep/wake cycles, hypotonia, hypertonia, poor state regulation, poor habituation, head

banging and/or body rocking (self-stimulation behaviors), poor fine motor or gross motor control, hyperactivity, poor eye-hand coordination, poor balance, poor tandem gait, central auditory dysfunction, delayed or perseverative language, attentional impairments, learning disabilities, deficits in receptive and expressive language, poor impulse control, poor concentration, memory impairments, difficulties with judgment, difficulties with abstract reasoning, inability to generalize from situation to situation, difficulties with abstractions such as time and space and cause and effect, and poor adaptive functioning. Over time as the child grows from infancy through childhood to adolescence and adulthood, some or all of these cognitive and behavioral manifestations can become apparent, but are commonly misdiagnosed. If alcohol is not suspected, the child is mislabeled and treated inappropriately. [Streissguth 1997g; Mattson & Riley 1997c]

Birth defects associated with alcohol related disorders

What are the possible multisystem manifestations (birth defects) associated with alcohol related disorders? Twenty to fifty percent of children with FAS or FAE demonstrate a variety of physical anomalies [Committee on Substance Abuse and Committee on Children with Disabilities 1993] (see Table 1) including abnormalities of the face (cleft lip and/or palate), heart (ventricular septal defect, atrial septal defect, patent ductus arteriosus, Tetralogy of Fallot) skeleton (joint abnormalities, digit abnormalities), hearing deficits (conductive and neural), teeth (small teeth and faulty enamel), eyes (microphthalmia, myopia, strabismus, hypoplasia of the optic nerve) [Stromland & Hellstrom 1996], genitals (hypospadias, hypoplastic labia majora), and kidneys (hydronephrosis, horseshoe kidneys) [Taylor et al. 1994] This study looked at the renal sonograms of 84 patients with alcohol related disorders and found significant renal abnormalities in three (3.6 percent) patients. They do not recommend renal sonograms, but this author disagrees because there are just not enough patients screened in this study.

Understanding 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 (oligophrenia); or had terrifying prognoses such as perinatal encephalopathy, muscle tone abnormalities (e.g., spastic quadraparesis, pyramidal syndrome, myotonic syndrome), hypertension-hydrocephal syndrome and intrapartum spinal trauma. What do these diagnoses really mean and are they correct?

The use of medical terminology differs among countries. The best example is perinatal encephalopathy, a diagnosis listed in close to 100% of children referred from Russia. To most physicians in the United States, perinatal encephalopathy is an ominous condition which denotes a child at high risk of cerebral palsy and mental retardation. In Russia, the diagnosis may be made if the attending physician feels there is evidence from the history or physical exam that the child was “stressed” at some point in the pregnancy, delivery or post-partum period. In other words, the child – in their minds – is at risk for neurologic damage. A course of therapy is then 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 does not 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 contain evidence that suggests the diagnosis is incorrect.

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

is questioned, seek assistance from a physician who has experience interpreting adoption medical information.

The videotape

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

A video captures only a tiny fraction of your child's life. The bright lights, additional attention and conflicting commands from caregivers often confuse a child – portraying them either 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 dinner time in your home.

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

The embassy physical

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

Growth and developmental milestones

Growth and development proceed on the basis of biological, not chronological, age. Subtract the number of months your child was premature from his/her chronological age to determine the corrected gestational age. The corrected gestational age, not chronological age, should be used for plotting growth and evaluating development. For example, a child born at 28 weeks gestation is three months premature (a full-term baby is born at 40 weeks gestation.)

Six months after birth, this child should be plotted at the three-month point on growth curves and should have reached three months on a developmental checklist. As a general rule, you can stop correcting for prematurity by a child's second birthday.

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

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

Development can be altered by too much or too little attention. The Korean child who is continually carried by a foster mother may not have gross motor skills (sitting, crawling, etc.) that are age appropriate for children born in the United States. These delays rapidly correct when a child is given a chance to explore the environment on his/her own. Too little attention, the usual situation in institutionalized care settings, leads to significant delays in all areas of 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 mentioned in 17% of women studied and fetal alcohol syndrome in 2.4 of referral documents. It may be possible to diagnose fetal alcohol syndrome using growth and development information and pictures/videotapes, but the diagnosis can be missed early in life even by experts. It is almost impossible to diagnose milder degrees of alcohol impairment, sometimes referred to as fetal alcohol effect, prior to arrival in this country. If you are 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.

Blood tests in the country of origin

Pre-placement blood testing is variable. A defined battery of tests is not currently required for visa approval for the majority of orphans. In some cases, testing may be ordered by the Embassy for the Embassy's physician when a specific communicable disease is common in the community or suspected in your child. Some agencies or countries have a set testing protocol for children prior to referral. Therefore, blood tests may have been performed on your child. If not, five questions should be asked prior to requesting blood tests for specific diseases.

Can the test be done?

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

Will the test be performed correctly?

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

Will the results be reported accurately?

Outright dishonesty, while rare, does occur.

Will blood drawing place the child at risk of catching the disease for which you are testing?

Disposable needles and syringes are often difficult to obtain and sterilization 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 Hepatitis B virus (Hepatitis B surface antigen) at two months of age may actually be positive at a later point in time. With HIV, the most commonly used test does not identify the virus, but only tests for the protective antibody. A child infected with HIV may not reliably produce the antibody until 18 months of age.

Should the child be tested prior to 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.

Above Information from: http://www.peds.umn.edu/iac/for_families/before/understandingmedinfo.html

Adopting an institutionalized child: what are the risks?

By Dana Johnson, M.D., Ph.D.

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

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

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

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

What are the chances that my child will be normal on arrival?

Let me be blunt. The chance of an institutionalized child being completely normal on arrival in your home is essentially zero! Here's why:

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

- An orphanage is a terrible place to raise an infant or young child. Lack of stimulation and consistent caregivers, suboptimal nutrition and physical/sexual abuse all conspire to delay and sometimes preclude normal development. All institutionalized children fall behind in large

and fine motor development, speech acquisition, and attainment of necessary social skills. Many never find a specific individual with whom to complete a cycle of attachment. Physical growth is impaired. Children lose one month of linear growth for every three months in the orphanage. Weight gain and head growth are also depressed. Finally, congregate living conditions foster the spread of multiple infectious agents. Intestinal parasites, tuberculosis, Hepatitis B, measles, chickenpox, middle ear infections, etc., are all found more commonly in institutional care settings.

Will I be able to determine the nature and severity of my child's immediate health needs prior to arrival?

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

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

If my child isn't normal on arrival, when will he/she catch up?

This is a question that no one can answer with certainty. We do know that your child will progress far better in your home than he/she would have in the orphanage, and that most children make tremendous gains in growth and development during the first years with their adoptive families. Unless a child is truly neurologically impaired, gross and fine motor skills as well as strength respond well to improved nutrition and a stimulating environment.

However, many children, especially those who spent considerable time within institutional care settings, continue to show delays in language and social skills, behavioral problems, and abnormalities in attachment behavior even after several years in their adoptive home. In most situations, areas of delay respond to appropriate treatment, but resolution of the problem may take time and expert guidance. In some situations, therapy will improve but cannot correct the fundamental problem; e.g., fetal alcohol exposure. In these situations, the challenges will be life-long. © 2003 by the International Adoption Clinic at the University of Minnesota. The first clinic of its kind in the United States providing for the health needs of internationally adopted children through its clinic services, research and education.

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Since my child will likely have medical and/or developmental needs, will I be able to locate appropriate therapeutic resources within my community?

Your child's most important resource is you and your family. Your commitment to your child's well-being is the single most important factor in success. However, despite what you may have heard, love alone may not be enough. Expert help is frequently needed to rehabilitate a child who has suffered prolonged neglect and abuse within an orphanage.

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

covered, at what level, and for how long. Careful investigation of these areas may help you decide if adopting an institutionalized child is an option for your family.

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

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

If you decide to proceed, you can lower your chances of adopting such a child by obtaining appropriate information from your agency and having it reviewed by a knowledgeable physician prior to accepting a referral. An important part of this process is being prepared to say no if you recognize that the needs of a certain child exceed your capabilities. Be aware, though, that you will never have all the information you need to eliminate this risk. Don't drive yourself wild in an endless search for that one final piece of information that will guarantee a correct decision. The best decision you can hope to make is one that is well-reasoned, based on the information that is available, accompanied by the "leap of faith" that is a mandatory part of all conscious decisions to parent. If you cannot knowledgeably assume this risk, international adoption—particularly of an institutionalized child—may not be for you.

Will we be satisfied that we made the choice to adopt a child from an orphanage?

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

IN SUMMARY:

- Don't expect your child to emerge from an orphanage unscathed. © 2003 by the International Adoption Clinic at the University of Minnesota. The first clinic of its kind in the United States providing for the health needs of internationally adopted children through its clinic services, research and education.
- 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.

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Institutional living and environmental issues in adoption

Developmental concerns

Developmental concerns are to be expected in children who have been institutionalized, neglected or abused, severely malnourished or generally lacking in developmental stimulation. Developmental expectations may vary across cultures (i.e. infants may be swaddled, never placed on the floor), which will limit a child's developmental progress. Nutrition and developmental stimulation do help a great deal, but may not completely resolve the delays.

It is important for parents to understand that "developmental delay" does not always mean "with food and love, it will all get better." Most international adoptees DO achieve typical development, but some do not. As a rule of thumb, most infants who are delayed make 2 months of developmental progress (at least) in 1 month. My approach is to discuss Early Intervention on the first visit and to strongly recommend this if a

child is severely delayed or if parental support seems indicated. Most parents welcome the option of a developmental assessment and ongoing monitoring and therapy if indicated.

For school-aged children, a non-verbal assessment may be helpful in determining a child's optimal school placement. Learning difficulties and attentional concerns are particularly common in children with a history of institutionalization, alcohol exposure or malnutrition. This is particularly true for children over three years of age.

Language delays are particularly difficult to assess in international adoptees. Unlike other immigrant children who continue to speak their primary language, international adoptees lose their first language in parallel with gaining a second one. It does help to understand the proficiency of a child's language in their primary language before adoption, but this is rarely feasible. Functional receptive language is relatively easily acquired at most ages, but more robust language in the school age child may take years to fully develop. While English as a Second Language (ESL) services may be helpful, such measures are often insufficient for older adoptees who may have a primary language disorder (Gindis, 1999)

Emotional and behavioral concerns

A child's emotional health post-adoption is related to a number of factors, including the child's temperament, parental temperament, pre-adoption environment, abuse and health as well as post-adoptive adjustment. It is very difficult to determine true concerns vs. "within the range of normal" during a single office visit.

Some common behaviors of concern to parents include self-stimulatory behaviors (i.e. head banging, rocking) that can be expected to diminish with time. Gorging on food or refusal to eat is relatively common as well. Sleeping patterns may be erratic given time zone changes, sleeping alone vs. in an institutional setting and having the option to do something other than lying in bed. Parents appreciate an explanation of goals for eating and sleeping behaviors, but should be encouraged to provide this structure with some flexibility.

In general, particularly younger adoptees typically form a strong relationship with their new parents within a week of meeting them. Indiscriminate friendliness is common in older international adoptees, but is both disturbing to families and a safety risk for the child.

Depression (manifest at an age-appropriate level) is not uncommon. For example, imagine your adjustment after relocating to a completely new world with different sounds, smells, people, practices and language.

Some of the most common parental concerns include "attachment disorders" and "sensory integration disorders." Health professionals may be discussing developmental delay, failure to thrive, language delays, pervasive developmental delays (PDD/autism), post-traumatic disorders (PTSD) or mental retardation.

Sadly, emotional neglect, physical abuse and sexual abuse are not uncommon in orphanages around the world. These are not diagnoses to be made on an initial visit, but require continued monitoring and often the assistance of other professionals.

Lisa Albers, MD, MPH
April 12, 2002

What are "attachment," Reactive Attachment Disorder and attachment therapy?

"Attachment" is a theoretical construct developed by Bowlby and Spitz early in the twentieth century to describe a relationship between an infant and a primary care taker, manifest in certain behaviors. The initial theory resulted from their observations of infant behavior in the setting of profound maternal and sensory deprivation. Clinicians and researchers since this time have described infants who do not present with a pattern of 'secure attachment' with their primary caretaker (or caretakers) as being at significant

risk for later impairments in social relationships, attachments, trust and intimacy. (Bowlby, 1951; Spitz 1945).

A range of appropriate and inappropriate attachment behaviors have been described as infants learn to explore the world with gradually less proximity to a familiar caregiver. Ideally, during one's early days, weeks and months of life, an infant's caregiver provides him or her with a secure environment that serves as a safe and secure base from which to explore the outside world. Interactions between an infant and one or more caretakers occur multiple times per day and thousands of times during infancy. Any single interaction is not critical, but the general quality of interactions over time does impact a child's perception of the world with respect to where he or she can or cannot get his needs met. In addition, it is unlikely that early experiences can be "erased" but there is not felt to be an "absolute" critical period beyond which all children are likely to have "attachment problems" if they have not formed a positive attachment relationship.

As is typical of many behavioral diagnoses, extreme difficulties with attachment have been defined as a disorder by clinicians and researchers. "Reactive Attachment Disorder of Infancy or Early Childhood" is described in the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV-TR). According to the DSM-IV-TR, "Reactive Attachment Disorder" (or "RAD") is a term used to describe a child who displays "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 and is associated with grossly pathological care."

Children who present with disordered attachment patterns, as manifest by specific behaviors, have often been abused, neglected, traumatized or generally deprived of critical developmental experiences with positive adult attachment figures.

Children who have missed these early childhood experiences during critical times may develop patterns of extreme defensiveness with interpersonal relationships, excessive social inhibition, hypervigilance, and ambivalent responses relating to people. In addition, more extreme behaviors such as aggression, defiance, destructiveness, rage, depression, and indiscriminant attachments to others (without depth or meaning) may be seen.

Clinicians and researchers are currently facing an increasing demand to address the needs of children who have suffered early attachment difficulties leading to behaviors consistent with the diagnosis of Reactive Attachment Disorder, but unfortunately, therapies for these disorders are not proven. Attachment therapy is not a single therapy, but ideally a multidisciplinary informed approach to assisting families with children who present with severe attachment-related difficulties.

Ideally, "attachment therapy" is a collective set of therapeutic interventions ranging from individual, family and group therapeutic approaches to the more controversial "holding therapy approaches." Of note, no "holding therapies" have been reported in peer reviewed journals.

Lisa Albers, MD, MPH

April 12, 2002

www.aap.org/sections/adoption/meddevinfo.htm

Impact of foster care and orphanages

While neglect and abuse are sometimes part of the history of children adopted from foster care and orphanages, the more severe impacts - Sensory Integrative Disorder and Attachment Disorder - are not as well known. It is important to note that the American Academy of Pediatrics reports that 12% of *all* children, including non-adopted children, have some sort of sensory integrative dysfunction. These are part of a broad category of developmental delays owing to lack of stimulation in severely overcrowded and understaffed institutions or in multiple placements of foster children. In practical terms, infants, babies and toddlers who are confined to cribs and who have little contact with human touch may suffer sensory deprivation, resulting in a failure of the brain to integrate some neurological pathways. Similarly, foster children who are subject to multiple placements without addressing the psychological impacts, can exhibit

similar problems. This early deprivation for both populations could lead to behavioral and medical problems. Early intervention is essential to a good long-term prognosis. *Development Assessments of International Adoptees* (www.calib.com/naic/pubs/r_devev.cfm)

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Grief and loss in adopted children

By Susan Ward, hannahandhermama.com

As adoptive parents, our children's adjustment and confidence in their world depends upon our ability to identify their grief, assist them through their grief issues, and help them grow from that grief. This parenting responsibility begins when we adopt, and continues as we guide our children into adulthood. As parents, adoption agencies, and social workers, we view adoption as happy, joyful. A child without a family now has one. A family yearning to share its love can now open its heart. The topic of grief is not a topic generally discussed when considering adoption. It's not a regular topic in adoptive parenting classes. And books and web-sites seldom discuss an adopted child's possible feelings of loss, trauma, and grief. Intellectually, we understand that babies and children experience feelings of discomfort, loss, and confusion during the first weeks and months after being adopted. Practically, though, do we allow and even create opportunities for newly adopted children to grieve their losses and their past? And throughout our children's lives, do we acknowledge and assist them with their grief? If we adopt babies, we may mistakenly assume that our child's life begins with us. If we adopt an older child, we may wrongly assume that their past is now their past. Adopted children, however, bring multiple issues of loss with them into their adopted families, no matter what age they were adopted. Childhood grief is often based on different issues than those that impact adults. Donna O'Toole, grief counselor and author of *Helping Children Grieve and Grow*, writes, "Especially for children, a loss may be based on safety, comfort, and familiarity, rather than on what adults speak of as love or affection." *Helping Children Grieve and Grow* lists six categories of childhood loss: relationship loss (usually people and animals); loss of objects that give comfort (toys, blankets, clothing); loss of a secure, familiar environment; loss of self (ways of being and doing that define us uniquely); loss of skills, abilities, and competencies; and loss of familiar habits and routine. Adopted and foster children, no matter what their age, embark upon their newly changed lives facing most of these categories of loss. They've lost their caregivers, their clothes and bedding, their familiar smells, tastes, and sounds; the way they do things; their ability to feel comfortable with their lives and language, and their daily routines. Theresa Anderson, family counselor specializing in issues of adoption, attachment, and grief says, "Grief is THE core issue that adopted children deal with...grief and terror. Think about international adoption... You can't take a child from home, put them into an airplane, cross the world, surround them with 1,000's of people at the airport, have them met by strange people, smells, textures, foods, and voices, and not expect them to be traumatized." As adoptive and foster parents, we cannot overlook our children's grief because it is not easily seen or identified. In *Helping Children Grieve and Grow* Ms. O'Toole writes, "Children usually don't tell you they are grieving. You can tell by what they say and do." Examples of possible reactions of grieving children include anger, sadness, hyperactivity, changes in appetite, hoarding food, inappropriate emotional response, headaches, difficulty making decisions, regressive behaviors, and clinginess.

Children's responses to grief, though, may not fall within a list of observable reactions. Ms. O'Toole writes, "When children feel overwhelmed by intense feelings they may naturally make their world safe by distancing themselves physically or emotionally, by pretending or by denying the reality of the loss." Ms. Anderson comments that trauma and loss can, and often does, interfere with a child's general development. She adds, "Children often cover trauma and grief with being perfect, with controlling others, or with being mad." In *Our Own: Adopting and Parenting the Older Child*, Ms. Maskew writes, "Experienced parents recommend that you take the initiative in talking with your child about losses and grief. You cannot go around the pain and loss, you must go through it." Also, she reminds parents of the need to teach children about emotion words and expressions. "Kids who have been traumatized or abused or who simply did not have a stable early life may never have learned how to identify their feelings and their effects." Even if we acknowledge and assist our children with grief and loss in the early years they live with us, that doesn't mean their grieving is over and done. The issues of loss, grief, and trauma that our children face upon adoption, do not disappear once they have adjusted to their new lives. Adoption-related grief issues are re-visited throughout their lives. Ed Entmacher, a North

Carolina psychiatrist who works with children and families says, "Grieving over adoption issues doesn't happen easily or neatly. It has to be revisited over and over into adolescence and adulthood." As an adoptive parent, read about grief and loss in children. Help your child to accept and grow from their grief. It's part of being an adoptive family.

Advantages of older child adoption

To think that when we adopt, we have choices... international adoption or domestic. Agency or private adoption. Boy or girl. Newborn or older child. Parents of biological children have none of these choices. When considering adoption, many people assume "the younger the better" and overlook the advantages of older child adoption (in the adoption world, an "older child" is generally considered to be age two or over at the time of adoption). However, there are advantages of adopting an older child that should be contemplated as you consider your adoption options in older child adoption:

- You can learn more about an older child as to their abilities, interests, and personalities than you can with a baby.
- You have more history (childhood illnesses, developmental milestones, skills, talents) that can be evaluated by specialists and doctors before you accept a referral.
- You can match (to a degree) your interests and personality with your child-to-be.
- Certain disorders, such as Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) cannot be diagnosed in babies, only in older children.
- Older children can be less demanding than a baby. Depending on their age, an older child can do things by themselves regarding dressing, bathing, eating, chores, and playing on their own.
- Older children can interact and play with you. You can DO things right from the beginning with your child: take hikes, plant bulbs, bake cookies, roller blade.
- With an older child, you are given an extraordinary window into their past lives. They may have special memories of grandparents, or favorite foods and games from their country of birth. You can help them retain and synthesize their memories of their past lives. Their past provides an extra peek inside the emotions and personality of your child.

There are, of course, disadvantages to older child adoption, just as there are disadvantages and advantages to adopting babies. No matter what age you adopt, it's a bit like most of life---lots of wonderful moments mixed in with enough challenges to make sure we appreciate the good times!

What to expect when you adopt an older child

While all older adopted children are different, there are a few things you might anticipate if you're adopting an older child. The following summary examples are meant to be reference points rather than specifics of how all children act. First week: During the first week in your home your child will be excited, overwhelmed, sad, and happy. This abundance of emotions may result in tantrums and/or behaviors several years younger than your child's actual age.

Your child will probably alternate between happily doing what is asked of her, and staunchly refusing to do anything. Some families experience a honeymoon period where the child acts completely agreeable; other families are tested from day one. If your child is internationally adopted, she may begin saying phrases i.e., "thank you" and "hello" and beginning to count, within a day or two home. Bedtimes may be horrific; tantrums, refusing to stay in room, many requests for attention, etc. Many children are very traumatized by the move to their new home. It might be expressed by poor behavior, meanness, overly quiet, changes in eating habits, and more. Daily interactions with your new child will provide you with smiles, excitement, frustration, and amazement that your child is finally home with you.

Recommendations: -Establish house rules from day one. -Have them do chores from day one. -Keep a very regular daily schedule.-Provide very little stimulation. Stay home, only a handful of toys in their room, limited visits from friends and family, no presents.-Give them many ways to spend their excess energy; swimming, running, kicking a ball. -Begin your attachment and bonding immediately with hugs, tickles, hair brushing, dancing together, and reading together. First month: If your child didn't test and push you the first week, it may happen during the first month. The initial excitement and newness has worn off and your child may begin to feel unsure about how permanent her placement is with you. Telling her it's forever isn't enough; read books on adoption, show them your love, and realize that time is a factor. During the first month, many children begin to grieve for the life they've left; birth parents, foster parents, teachers, friends, foods, language, smells, clothes, and more. If adopted internationally, your child will be understanding a lot said in English, but her expressive language may still be very limited. You may be beginning to feel comfortable with your new life, but your child may not.

Recommendations: -Be very consistent about enforcing rules and consequences. -Realize that your child may be one age chronologically, and much younger emotionally. -Keep close supervision on your child's interactions with other children. Don't assume they know how to play appropriately with other children. -Provide opportunities for your child to talk about her life before living with you. -Create family rituals i.e. Friday night pizza or Wednesday board game night. For some families, six months is a turning point in regards to improved behaviors and growing love and acceptance that this truly IS their forever family. Internationally adopted children may be conversationally competent at this point, but will still have an accent and will not yet have complete fluency. If you've worked hard on creating a solid bond with your child, and she doesn't have attachment issues, she will now be more comfortable giving and receiving honest affection. She will be more confident about your commitment to her, but she will have times where she still grieves.

Recommendations: -Slowly allow your child to make more choices. -Find ways to help your child make connections between her past and her present; conversations, journal writing, lifebook, etc. -Realize that some children will still need to fill the deficit of love from their past. They may benefit from lots of cuddle time, playing toddler games, or being fed a bottle. -Begin to introduce additional activities into your child's life, all while being observant as to how she reacts to new stimuli. Parenting an older adopted child, like parenting children of any age, brings rewards and challenges into your life. During the first six months, remember to balance your excitement and emotional commitment to your new child, with her worries and hopes.

International adoption: post institutionalized issues

By Susan Ward

Depending on what country prospective parents live in, the adoption options are often diverse. Domestic or international. Foster-adopt or adopt. Public agency or private agency. Open or closed adoption. Each choice provides advantages and challenges. Parents who adopt internationally may face issues and behaviors not seen in biological children, or in children adopted domestically. Many children living in orphanages develop what are called post institutionalized (PI) issues and behaviors.

Doctors in America, Canada, Australia, and other western developed countries are often unfamiliar with post institutionalized issues. In America, for example, orphanages were eliminated nearly 30 years ago, so the doctors familiar with PI issues have generally been in practice for a long time.

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.

Listed below are behaviors associated with PI children. Some children have almost none of these; other children have quite a number of them. If you're considering, or have adopted from an orphanage, be aware of these potential behaviors. 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.

Head banging - Banging their head on the floor or wall when frustrated, irritated, or angry.

Poor transitions - Inability to change from one activity to another.

Not asking for help - Proceeding with a frustrating activity without asking a parent or adult to help.

Trouble going to sleep - Difficulty falling asleep. Difficulty staying asleep. Nightmares and uneasy sleep patterns.

Easily over-stimulated - Agitated and/or overwhelmed by any activity outside the daily routine.

Poor cause and effect thinking - Developmentally behind peers in understanding that certain behaviors and actions incur consequences, natural and/or logical.

Overly-cute - Attention-seeking behaviors to gain attention of adults and peers.

Overly affectionate - Asking for attention, hugs, food, attention, and kisses from strangers.

Poor language skills - Language skills are often behind their peers, even when accounting for the time it takes to acquire their second language.

Not toilet trained - Orphanage children are not taught to pay attention to their body's needs and signals, but are seated on the toilet at regular intervals.

Sensory integration disorder - Overly sensitive to sounds, smells, textures, movement.

Reactive attachment disorder (RAD) - Inability to trust and attach. Manipulative, controlling, sometimes violent behaviors.

No pain - Upon falling, bumping, or tripping, they show no indication of pain: no tears.

Susan Ward, founder of Heritage Communications, maintains [Older Child Adoption Online Magazine](#).

Sensory integration dysfunction:

Sensory Integration Dysfunction is the inability of the brain to correctly process information brought in by the senses. Sensory Integration Dysfunction (SID/DSI) or sensory processing deficits can come in many different forms. No two children will be affected in the same ways. SID/DSI was first noticed in children with autism or who had autistic traits, but is also seen in children with other disabilities such as cerebral palsy or ADD/ADHD or can be present by itself. Children can have mild, moderate or severe SI deficits. SID/DSI is treatable with therapy and a sensory diet set up by an occupational therapist who is trained in SI. You should look for a therapist who is certified in praxis testing (SIPT certified) and Wilbarger trained. If you go to Sensory Integration International you can request a listing of trained therapists in your area.

Children with SID/DSI can be either hyposensitive or hypersensitive to outside stimuli. For example, a child who is hyposensitive to touch will constantly be crashing into things seeking extra stimulation while the hypersensitive child will avoid being touched or touching things when at all possible. SID/DSI can also include children who have processing deficits in one or more areas. Visual and auditory processing deficits are noticed in children with cerebral palsy quite often. When a child has a visual processing deficit, it does not mean that they cannot see. It means that they have a hard time finding the words for objects they are viewing or, if asked to get an object, they might look right at it and then say they can't find it. This is because they are seeing it but their brains are not processing that they are seeing it. Auditory processing deficits are the same, the child hears what you say but the brain does not process it so the child understands or it takes several minutes for what you have said to "click" with the child. One way

to help with auditory processing deficits is to break down instructions, giving them one thing at a time to do. Let them finish the first task before you give them another instruction. Listening or music therapy can also help with auditory processing deficits. Below is a list of other behaviors exhibited by children with SID/DSI:

- Loves to spin, swing and jump - this will seem to calm them down after several minutes.
- Complains of how clothing feels - does not like tags left in their clothing and have to have their socks on just so, or a certain kind of sock.
- Picky eaters - get stuck on one certain food and is basically impossible to get them to eat anything else.
- Oversensitivity to smells. Or undersensitivity - may sniff people, objects, food.
- Oversensitivity to sounds--will frequently cover ears. Or undersensitivity.
- May have an exceptionally high pain tolerance
- May tire easily
- Unusually high or low activity level
- Resists new situations
- Problems with muscle tone, coordination, motor planning
- Can be very impulsive or distractible.
- Persistently walks on toes to avoid sensory input from the bottom of the feet. This can also be a sign of cerebral palsy if the child is unable to bring their feet down flat when asked or trying.

These are just a few of the symptoms that children with SID/DSI can exhibit.

Additional resources and reading

Books

Adopting the Hurt Child: Hope for Families with Special-Needs Kids; by Gregory C. Keck, Regina M. Kupecky (Pinon Press, 1998)
The Adoption Triangle; by Arthur D. Sorosky, Annette Baran, and Reuben Pannor (Corona, 1989)
Being Adopted; The Lifelong Search for Self; by David M. Brodzinsky, Marshall Schechter, and Robin Marantz Henig (Anchor, 1993)
Birthmothers: Women Who Have Relinquished Babies for Adoption Tell Their Stories; by Merry Bloch Jones (Chicago Review, 1993)
How It Feels to Be Adopted; by Jill Krementz (Knopf, 1988)
Journey of the Adopted Self; by Betty Jean Lifton (BasicBooks, HarperCollins, 1995)
Let's Talk About It: Adoption; by Fred Rogers (Paper Star, 1998)
Raising Adopted Children; by Lois R. Melina (HarperCollins, 1998)
Real Parents, Real Children; by Holly van Gulden and Lisa M. Bartels-Rabb (Crossroad, 1995)
Talking With Young Children About Adoption; by Mary Watkins, Susan Fisher (Yale University Press, 1995)

Organizations

Adoptive Families of America (AFA)

2309 Como St
St Paul, MN 55108
(800) 372-3300

<http://www.AdoptiveFam.org>

American Adoption Congress (AAC)

1000 Connecticut Ave, NW, Suite 9
Washington, DC 20036
(202) 483-3399

Child Welfare League of America (CWLA)

440 First Street, NW, Third Floor
Washington, DC 20001
(202) 638-2952

<http://www.cwla.org>

North American Council on Adoptable Children (NACAC)

970 Raymond Ave, Suite 106
St Paul, MN 55114-1149
(651) 644-3036

E-mail: NACAC@aol.com

Adoptive Families Today <http://www.adoptivefamilies.com/>

Adoptive Families Today is a support group located in Illinois for prospective adoptive parents, adoptive parents, adoption professionals and all those interested in adoption

National Adoption Information Clearinghouse <http://naic.acf.hhs.gov/>

This website has a lot of information on a variety of topics related to adoption including publications on gay and lesbian parenting and adoption laws.

The National Council for Single Adoptive Parents <http://www.adopting.org/ncsap.html>

This organization provides support to single adoptive parents and publishes a handbook for single adoptive parents.

The Evan B. Donelson Adoption Institute <http://www.adoptioninstitute.org/>

The Adoption Institute has set out to improve information available about adoption, and has published many studies relating to adoption & outcomes for children.

Stars of David: Jewish Adoption <http://www.starsofdavid.org/>

This site provides information and a support network for Jewish and partly Jewish adoptive families.

FamilyNet <http://www.hrc.org/familynet>

This site is sponsored by the Human Rights Campaign Foundation and contains information about legal issues, adoption, parenting, and other topics of concern to gay, lesbian, bisexual, and transgendered (GLBT) families.

Adoption Tax Credits**IRS Website** <http://www.irs.gov/>

Search the IRS website for the forms and information related to the Adoption Tax Credit.

Adoption Learning Partners e-learning course: *Understanding the Adoption Tax Credit*

<http://www.adoptionlearningpartners.org/>

Learn more about the Adoption Tax Credit through this interactive e-learning course that will take you step-by-step through the process of applying for the tax credit.

Adoption Publications and Catalogs**Adoptive Families Magazine** <http://www.adoptivefamilies.com/>

This monthly magazine features articles regarding adoption.

Tapestry Books <http://www.webcom.com/~tapestry>

This catalog specializes in adoption-related books for adults and children.

Perspectives Press <http://www.perspectivespress.com/>

This publisher has books on infertility, adoption, and parenting.

Rainbow Kids <http://www.rainbowkids.com/>

A publication for families adopting internationally.

Our Chinese Daughters Foundation <http://www.ocdf.org/ocdf/index.htm> China tours, newsletters and adoption services.

Asia for Kids <http://www.afk.com/>

This catalog of books, CD-ROMS, tapes, games, clothes, etc. are resources for teaching Asian languages and cultures.

Proud Parenting Magazine <http://www.proudparenting.com/>
This magazine is dedicated to GLBT parents and their children.

International Adoption Related Information

US Department of Citizenship and Immigration (*formerly INS & BCIS*)

<http://uscis.gov/graphics/formsfee/index.htm>

Site contains the forms you'll need to complete and international adoption.

The CDC Travel Health Information <http://www.cdc.gov/travel/>

Provides up-to-date information on health concerns for international travel, including information on any vaccines necessary for travel to various countries.

Joint Council on International Children's Services (JCICS) <http://www.jcics.org/jcics.html>

Joint Council on International Children's Services advocates on behalf of children in need of permanent families and promotes ethical practices in intercountry adoption.

International Concerns for Children <http://www.fortnet.org/ICC/>

Offers current, monthly updated information on reputable, ethical, proven intercountry adoption agencies.

General Adoption Information

<http://www.adopting.com/info.html>

Adoption Information by Country

<http://www.adopting.com/countries.html>

Resources for Special Needs

<http://www.adopting.com/special.html>

Web: News Groups, Chats and Email Groups

<http://www.adopting.com/mailing.html>