

## **Medical Care in the first Year of International Adoption**

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### **TRANSITION ISSUES FOR CHILDREN AND THEIR FAMILIES**

Persons caring for newly adopted children should respect the tremendous transitions that the child and their adopted family are experiencing.

The child experiences the loss of everything previously familiar to him or her.

A child's response to these life changes maybe puzzling or extremely challenging to the new parents, who had fallen in love with that same child who seemed delightful in their previous environment.

Most international adoptions involve long-distance traveling, which is overwhelming to both adults and children. For the child, it maybe the first time they have left the confines of an institutional care setting or small town. Airplanes, trains, buses, cars, big cities, escalators, and other technology are likely all new, and even frightening, to the child. Add to that 24 or more hours of traveling across multiple time zones, and, clearly, most children can be expected to be exhausted physically and emotionally by the time they arrive at their new homes.

Families can assist children to settle in by helping families by preparing low key arrivals with quiet time at home with the new family for at least the first several weeks. Although there are usually many friends and family members eager to welcome a new child home, the airport is not the time for a gathering of dozens of noisy well wishers. Adoptive parents should plan time off from usual activities, limit visitors to small groups and short stays of those who are likely to be important to the child (e.g. grandparents and other close relatives, close family friends) and commit to just "be at home" getting to know the child while allowing him or her to get to know them. Some children settle into their new homes and families quickly, as others take longer to adjust. Physicians should be available to write letters for parenting leave from work. This time is easily justified as necessary for attachment and bonding, the key determinants of the child's and family's long-term emotional health.

Because most internationally adopted children speak and understand a different language, communicating with the new family member is a critical consideration. Although initial communication is mostly nonverbal, children and their new parents may struggle with language barriers. Adopting parents should learn at least a few key phrases in the child's native language before adopting. Families can usually meet their child's basic needs by trial and error without translator, but it is often difficult for the child to share his or her fears, feelings, and questions. Thus, parents of school aged children should arrange for a translator to be available for at least several weeks after the child arrives home. Caution is warranted when working with translators as well. As with the use of translators and cultural interpreters, communication should involve a professionally trained translator who is free of cultural bias. Families enlisting the support of a translator should realize that children may perceive the person speaking their language as a sign that they are returning to their native country. Translators are essential when addressing topics that may be perceived as threatening, such as hospital admission, surgery, or a parent's expected prolonged absence.

### **GREIF AND LOSS**

Most children experience grief over the loss of significant care givers, peers, siblings, and the "home" that was familiar to them before adoption. Infants and toddlers who are grieving maybe cranky and irritable for no apparent reason and may sometimes cry inconsolably. Older children maybe profoundly sad, quiet, withdrawn, angry, aggressive, or defiant. Children may worry about caregivers, birth family, or

orphanage friends, wondering if they are safe and vice versa. Some children feel guilty for having left caregivers, peers, parents, or siblings behind.

Although the child's grief evokes sadness in adopted parents and may possibly contribute to difficult behaviors during the adoption trip home, grief is an emotionally healthy response to loss. A child's feelings of grief generally suggest that the child has had at least one significant previous interpersonal relationship.

As parents comfort the child, they gradually transfer that psychological attachment to his or her new parents, laying down a foundation for a solid future parent-child relationship. Parents can help children through this process by sharing pictures of the loved ones, allowing and encouraging letters or telephone calls the first year when possible, and providing language support to allow the child to talk about his or her feelings. Grieving typically lasts just days or weeks for extremely young children but maybe a process that takes many months or years for older children. Many years after adoption, children and adults may continue to grieve for the memories and loss of important people in their lives.

Most children work through their feelings informally by keeping a diary (or scrape books), talking with older adoptees, or reading and discussing books about the variety of adoption experiences. Sometimes, professional counseling is helpful with a therapist experienced with issues of grief, loss, and attachment. Parents should be encouraged to be flexible in their approach as they support their child's development of their own adoption story. Even as the child grieves over important losses, the parents and the child are adjusting to each other and building a new interpersonal relationship.

This "attachment" is a special and enduring relationship between a child and a significant person or persons, involving deep feelings of trust, pleasure, and security. Healthy parent-child attachment develops after many cycles of meeting the needs of the child by a loving, reliable, and nurturing care giver who is emotionally attuned to the infant. Attachment provides an internal working model for the infant to understand self, other people, and the world at large. The process of developing attachment stimulates biochemical and cellular changes in the brain, that are necessary for later cognitive functioning and interpersonal skills.

Children who spend their infancy and early childhood in child welfare institutions do not usually experience individual emotionally attuned care. They are thus at risk for alterations in their attachment behaviors and in their neurobiology. This can have profound effects on their later social, emotional, and cognitive functioning. The internal working model that a child develops as the result of institutional care taking is not one of safety, security, and trust but rather "it's every kid for him self or herself." Children with a history of institutional care learn to entertain themselves, comfort themselves, and meet their own basic needs at an early age.

Parents may find it easiest to think of their newly adopted child as "a psychological newborn in an older child's body" and then reorient their interactions with the child to promote better attachment. In practice, this means the parents may find themselves treating the child as if he or she were much younger psychologically, for example, rocking a school-aged child before bedtime or playing peek-a-boo with a kindergartener. Parents should plan to have as much quiet time at home alone with the child as possible and should aim to be the only one(s) to meet their child's physical and emotional needs. The child thus learns to trust the parent as the source of safety and nourishment.

New adoptive parents maybe impressed by a child's self-sufficiency, "braveness" when hurt, or ability to entertain himself or herself for extended periods. They should be careful to intervene, however, making sure the child sees that the parent is the active provider of food, comfort, and entertainment. These activities support the child's ability to use the parent as a secure base in the world. Parents should mirror

the child's emotional state and join the child in whatever activity he or she pursues, working to have the child develop pleasure in sharing his or her experiences with the parent.

Some children respond to the efforts of their new parents readily and begin to develop the foundations of strong attachments quickly, whereas others are much more threatened by their new parents' attempts to connect. When children resist their parents' offers of support, parents can use activities that the already child enjoys to create opportunities for small moments of connection and build on these overtime.

Most children love "roughhousing" play, and parents can engage their children in play that promote eye contact. Most children enjoy swinging; parents can push the child from the front. Games of peek-a-boo and hide-and-seek can create repeated joyful moments. Older children may enjoy similar pleasures by playing catch, ping-pong, tennis, and other reciprocal games. If children struggle to grant the status of "secure base" to their new parents within a few months of the adoption, some families may require work with therapists experienced in addressing attachment disturbances.

### **TRANSITION TO STARTING DAYCARE OR SCHOOL**

Once a child has developed a comprehension of their new world and is using the new parent(s) as a secure base from which to explore it, or, more commonly, when parents simply must return to work, the child can be transitioned into other care giving settings.

The child should be introduced gradually to the new caregivers, with the parent and child visiting together several times before the child is left alone. Initial stays without the parent should be short (approximately 30 minutes) and gradually increased to include a meal and nap time. Transition objects and photographs of the parent(s) and child together (in a child-safe photograph album, keychain, or the like) can help the child to realize that the parents are going to return and that this is not the whole world changing yet again.

Care givers need to be aware that this child may have greater transition needs than children who have been with their parents since birth. Most children do adjust to child care arrangements within a few months, but some struggle with insecurities and separation anxiety for years, often related to past experiences with separation and loss. When anxieties are severe or limit a child's first-year's ability to function, professional counseling with a therapist experienced in adoption and childhood trauma can be helpful.

Parents often ask about the risks, benefits, and timing of daycare placement. There is no research that has examined the outcome of the timing of childcare placement after international adoption.

Daycare poses the typical infection risks to these children. Additionally, it is thought that young children acquire language skills most appropriately when working with an adult (parent) one on one basis rather than in a classroom of toddlers who are all learning language skills. For parents who must return to work, it is advised that they find a small group setting. Children who have lived in institutional settings may find it easier to attend daycare or school rather than be in a more intimate family setting. In this case, children maybe better supported to develop healthy attachment relationships with their family and other primary care takers if they are cared for at home by a nanny or attend a small family-based daycare facility. The child may have continued attachment concerns overtime.

Generally, internationally adopted children transition to daycare settings similar to nonadopted children. For the child who has not bonded well with the parent, delay in daycare placement would be recommended. In addition, parents by adoption, like those by birth, are at risk for post adoptive depression or other difficulties in adjusting to the role of parenting their child. Community based support groups or mental health services may be indicated for parents as well.

## **SCHOOL ENTRY**

Entering school shortly after international adoption presents a particular challenge, because children may not have had any formal schooling in their country of origin. Language and academic skills may not be appropriate for the level of classroom functioning expected of a child their age. Parents are understandably eager to have their new children attending school at an age appropriate level, but some children need to start in a lower grade to learn basic academic skills. Some children need more time at home, learning to be a member of a family, before they are ready to venture out into the world. Ideally, parents and schools should work together to plan a gradual introduction to the school, with visits and half-day attendance until the child is ready for full-time attendance.

All children should have second language support arranged before starting school, which should last until parents, teachers, and the child think that he or she has completely learned the new language (typically at least several years.) Children older than kindergarten or first-grade age may benefit from a sliding grade level placement, starting out in a lower grade to allow for basic academic catch up and language learning but finishing the year with a class one or more levels higher, as achievement permits and age-appropriate social needs dictate. Careful attention should be paid to academic struggles, because children who have experienced severe deprivation in the past are at high risk for learning and cognitive disabilities.

For children adopted at school age, involvement in an English as a second language (ESL) program should be considered with the following caveats. ESL programs in the United States are primarily designed to support the educational progress of children maintaining their native language, while learning to converse and learn in a second language (typically English.) Internationally adopted children are often unskilled in their native languages, however, and are losing their native language while acquiring their new primary language. As a result, ESL services maybe useful to support children's adjustment to a new school setting, but these services alone cannot identify or remediate any fundamental speech and language delays.

For older children, an initial speech evaluation after adoption by a speech or language pathologist fluent in the child's birth language is ideal. If this is not possible, a skilled bilingual interpreter should assist in speech evaluation. Speech and language difficulties with articulation, grammar, and language processing are best identified in the birth language. Federal law mandates that all children older than 3 years of age are required to have an educational assessment in their primary language. Ideally, this is completed through and paid for by the school system, although parents may need to be involved in identifying an appropriate translator through local agencies, refugee support groups, universities, or professional translating services

## **EATING**

Most internationally adopted children are malnourished at the time of adoption, with as many as 68% fall than below the normal for height, weight and /or head size. Most children have not had access to appropriate quality and quantity nutrition before adoption, often eating food of marginal nutritional value on a schedule unrelated to their hunger and without the option to eat when they are hungry. Most children learn poorly adaptive behaviors under such circumstances, such as eating as much as they can whenever the opportunity arises and eating quickly before food is taken away by caretakers or other children. When these same children move into the care of parents this previously adaptive behavior can be alarming. Many new adoptive parents are extremely concerned about the huge volumes of food that their children eat and the rapid pace of the child's eating. They worry that the child may become ill and that they may become obese.

The recommended approach to this feeding behavior is to let the child have access to as much healthy food as they want as often as they want it. Children need to learn that they are now in a situation where there is enough food and what it feels like to be satiated. Many children have never felt this sensation and

do not associate it with a reason to stop eating however overtime learn that they can trust the new parent(s) to provide food in ample volume and frequency and that they can stop eating when they feel satiated. If parents restrict the child's intake, the child may continue to feel the need to "hurry up and eat more before Mom takes it away," and the long term habit of eating when ever there is the opportunity may continue. When allowed to eat freely, most young children begin to trust that their parents are going to provide food and slow down their intake within several months of joining the family.

Older children may be too self-sufficient (e.g., children who have previously lived on the streets or without any adult caretakers) may hoard food even when parents do not restrict their dietary intake. It is important for new parents to realize that this was an adaptive behavior that helped the child to survive before adoption; they should not punish the child for behaving in this way. It is helpful to have plenty of healthy (and non messy) foods always readily available to the child, such as bowls of fruit or pretzels on tables throughout the house. Some children benefit from having a backpack with healthy snacks that they can carry with them whenever they wish. Parents may need to work to gain the cooperation of schools and other caregivers with this plan. Most children begin to trust their new parents within several months of having plentiful food; however, occasionally, it may take many months, or even years, for some children to trust their parents to provide food. Professional counseling with a therapist experienced in childhood trauma and deprivation can be helpful if a child's eating does not normalize within several months of joining their new family.

Although most new internationally adopted children eat huge amounts of food, some children may struggle with eating. Some children may be sensitive to tastes or textures that they perceive as unpleasant. Others have swallowing and chewing coordination problems. Both of these difficulties maybe related to feeding practices typical of many institutional care settings. In many orphanages around the world, infants are fed with propped bottles, often with large holes cut in the nipple to accommodate porridge flowing out of the bottle. Children eat while lying supine in bed, trying to gulp quickly to keep from choking on the thick sludge. Older infants and toddlers are often fed the same porridge from a bowl with a large serving spoon used to shovel the cereal from the bowl directly to the child's mouth. Children are frequently gagged by the spoon and must keep gulping so not to choke. Eating in an orphanage is rarely pleasant or social, because caregivers, who often have 20 or more children to feed, simply do not have the time to feed children slowly or playfully. Any of these experiences can cause the child to develop poorly coordinated suck and swallow reflexes or severe tactile defensiveness in the mouth and on the face.

For most children, gentle and loving feeding practices over come these struggles within a few weeks. Parents should use a small soft spoon to feed the child and start with foods with textures and tastes that the child finds acceptable. Many parents find that foods similar to those a child received before adoption are a good starting point, even if these are things that would usually be fed to a much younger child. The texture and variety of foods can gradually be increased as the child is able and willing to tolerate the change. Gentle but firm (not tickly) touch on the face and hands during mealtime and at other times can help the child to learn to be more tolerant of different sensations in and around the mouth. Additional oral activities, such as hand play in dry beans, rice, water, pudding, or whipped cream, maybe helpful in allowing the child to explore new textures. Learning to trust new parents to provide nourishment is a basic component of healthy psychology attachment of the child to their parents.

Feeding a child also provides a parent with a basic feeling of competency their role. When parents are extremely anxious about feeding their new child or when a child continues to be resistant to eating even after several weeks, referral for evaluation and ongoing consultation with a professional feeding therapist is recommended. This can prevent the development of a maladaptive "feeding war" in addition to the child's already selective eating.

## **BATHING AND TOILETING**

Many young children, even those less than 1 year of age, are said to be “toilet trained” when living in an orphanage. Like eating, toileting follows a routine in institutional settings. As a group, children are made to sit on small potties after meals and are not allowed to leave until they have voided or moved their bowels. The child is not yet really in control of their bowel or bladder function during this “training.”

Parents should expect to have children in diapers after adoption until the usual time that children are able to control and plan ahead for their toileting functions, generally around 2 to 3 years of age. Even children who truly have gained mastery of their bowel and bladder control often regress in these skills as a manifestation of stress associated with the many transitions related to their adoption. It is important for parents to realize that this “regression” is a common childhood response and that they should not punish the child for urine or stool “accidents.”

Older children may have been punished in the past for nocturnal enuresis and may try to hide wet clothes or bedding. In this situation, parents need to be supportive rather than punitive and help the child to realize that he or she simply needs to change the sheets. Occasionally, toileting struggles are the result of physical causes (i.e. constipation etc.), but most are related to stress and resolve with time.

Baths in orphanages are often unpleasant, involving a fast functional hosing off with hot or cold water rather than a fun playtime for the child. As a result, many newly adopted children vigorously protest bath time. Parents may need to clean the child with sponge baths at first and gradually desensitize the child to water with activities like playing in a bowl or sink full of luke warm water, playing together in a wading pool, or bathing with the child. For young children, hosting a “bath party ,” where the child can watch other young children have fun with bath toys and bubbles in the tub, is often quite successful in helping the child to learn to enjoy bath time.

## **SLEEP**

Newborns eventually learn to sleep for extended periods as a result of brains maturation; increased feeding intervals, and experiencing many cycles of having their needs met by consistent nurturing caregivers. Children adopted beyond infancy may not have developed good sleep habits or may lose previous good habits in response to transitioning to a new family, time zone, culture, and daily routine. Children may have never slept alone or in a quiet or dark room. Unfortunately, some children may have experienced abuse or other trauma during the nighttime, making bedtime particularly challenging. Many children with a history of trauma have difficulty initiating and maintaining sleep regardless of the timing of their negative experiences.

To sleep peacefully throughout the night, all children must feel safe and secure, be able to get themselves back to sleep if they wake at night, and trust that their parents to protect them. Just as for a newborn, this only occurs after the child experiences many cycles of having his or her needs met by nurturing, and consistent caregivers. Fatigue and anxiety can combine to leave a child emotionally vulnerable. Parents can help their child to make tremendous gains in attachment and sleeping by being there for them as a comforting presence.

“Cry it out” techniques are counterproductive for newly adopted children who do not yet trust that their parents are still going to be there. Such an approach may simply reinforce a child's impression, learned in an orphanage, that he or she is “in this life alone.” Instead, parents should be physically and emotionally present at the minimal level that the child needs to feel safe and secure, gradually weaning themselves out of the child's bedtime routine. Initially, it may be helpful for parents to sleep in the child's room, gradually removing themselves over the first several months that the child is home. Making sure that the child falls

asleep in his or her own bed during this process can ensure that the child can eventually fall asleep peacefully on his or her own in his or her own room and sleep through the night without difficulty.

## **POSTADOPTIVE BEHAVIORS**

### **SENSORY BEHAVIORS**

Sensory (touch, sound, taste) seeking or avoidance is frequently reported in children after international adoption. Children with sensory processing difficulties are described as having sensory over- or underresponsivity. They may be sensory seeking or have sensory discrimination problems or inability to correctly interpret sensory information. Occupational therapists with specific training in this area can assist with the diagnosis and management. Children who exhibit self-stimulating behaviors, such as rocking or head banging, do not necessarily have a sensory processing disorder. These behaviors typically abate with time, although they may never totally disappear.

### **AUTISTIC-LIKE BEHAVIORS**

Most infants in institutional care spend their days lying in a crib, devoid of toys, visual, sound and movement stimulation. More importantly, the children experience limited human interactions that stimulate infant growth and development. Toddlers and preschoolers often are allowed to play in beautifully equipped playrooms with adults watching but not interacting socially. As a result, institutionalized children have to come up with ways to amuse themselves. Many develop repetitive motion behaviors that provide some sensory input, are self-soothing, and are a distraction from boredom. These may take on many forms, but commonly include rocking, hand play (flapping, light and shadow play with fingers), head banging, and masturbation. These are adaptive behaviors in the orphanage environment but look quite alarming to new adoptive parents.

For most newly adopted children, the frequency and intensity of these autistic-like behaviors diminish over the first several months family life becomes more stimulating and nurturing. Many children revert to these self-soothing behaviors, when they are stressed, tired, or bored. Parents can learn to interpret these cues and respond appropriately. Many children continue to use these repetitive motions to put themselves to sleep, sometimes for months or even years after adoption. These are akin to the many other sleep association habits that adults and children alike use and should not alarm parents as long as the child is appropriately developing other social, emotional, and interpersonal skills.

Children who do not respond to nurturing and emotionally attuned parenting, who would rather continue to self-stimulate than to interact with the world, need a full developmental and behavioral evaluation. Such children may be “truly autistic,” or may have “institutional autism” (a reactive attachment disorder with autistic features) Regardless of the final diagnosis, all these children can benefit from early referral to intensive therapy programs designed to treat autism.

### **MEDICAL VISIT CONSIDERATIONS**

The child Doctor should conduct a thorough postadoption physical examination and ensure that routine postadoption screening laboratory tests and immunizations have been completed. Diagnoses raised before adoption, including possible rickets, hip dysplasia, congenital heart disease, or retinopathy of prematurity, may require confirmation or further assessment.

Before adoption, parents may be most concerned about potential medical concerns for their child; however, these are the issues most readily assessed and treated after adoption.

Evaluation at the US State Department (Immigration office) is mostly legal paper work and testing for a few transmittable infections or mental defects that would prevent a permanent residency visa. It is not a comprehensive assessment of the child’s health.

Children at the Immigration office are often screened for HIV, syphilis, and hepatitis B.

Since recently acquired infections are often missed on the initial Immigration office screen and because Immigration office screens are incomplete, all children require repeat screening of their initial tests and additional to screens for Hepatitis C, parasites and tuberculosis by their Primary care provider.

The primary care provider should also screen for anemia, abnormal hemoglobin disorders, leads and thyroid since they can affect health, growth and development.

Elevated lead levels have been reported after international adoption, and routine immediate postadoptive screening for lead exposure is extremely important to ensure that adequate dietary, and perhaps medical, interventions are offered if indicated.

All internationally adopted children should be screened and monitored for possible hearing, vision, growth, and developmental difficulties given their prenatal and preadoptive experiences. The following recommendations and rationale for screening for these concerns and referral for additional medical consultation in this population of children are described.

## **HEARING**

One study described 3.8% of international adoptees with hearing loss. The presence of permanent or recurrent transient hearing loss during the first years of life has the potential to compromise a child's speech and language acquisition. All internationally adopted children who are slow to acquire language skills should have a hearing assessment. Most adoption providers agree that evaluation and intervention should be provided sooner rather than later (within weeks rather than months).

Conductive hearing loss and nerve deafness occur at increased rates in internationally adopted children. Conditions that affect hearing include frequent upper respiratory tract infections; chronic ear infections; use of ear toxic medications; or birth bacterial, viral, parasitic infections. Specific infections include cytomegalovirus [CMV], herpes, parvovirus B-19, toxoplasmosis, syphilis.

Testing for these infections is usually not definitive but may offer some explanation for parents.

Brain CT or MRI may be indicated to delineate possible abnormal ear anatomy. In addition, a pediatric Ear, Nose & Throat Physician can be helpful in further elucidating an underlying cause of hearing loss.

Hearing can be assessed using a variety of methodologies, depending on the age of the child and his or her willingness to cooperate. Children less than 3 years (possibly 4 years) of age should be referred to a reliable hearing center, where a variety of hearing test can be performed despite the child's young age. Most experienced examiners use behavioral measures to assess the hearing of children as young as 6 months. Children 3 years (to 4 years) of age or older can be screened in the primary care provider's office, depending on the child's ability to cooperate. Occasionally, language barriers mandate testing typically used for younger children. Any questionable test results should mandate referral to a hearing center.

## **VISION**

Many visual problems are noticed by the parents long before they are apparent in the medical office setting. Common concerns include crossed eyes and light sensitivity. Many children of Asian descent as well as some children from Eastern Europe have widely spaced eyes with flat nasal bridges. One eye may give the false appearance of turning inward. ("pseudostrabismus"). Because previously institutionalized children are more likely to have true strabismus (occurring in 10%–25% of internationally adopted children), all previously institutionalized international adoptees should be examined by a pediatric ophthalmologist within the first few months after arrival.

## **PRENATAL SUBSTANCE EXPOSURE**

Ongoing evaluation for fetal alcohol syndrome (FAS) and alcohol-related neurodevelopmental disorder (ARNDD) should be conducted for any internationally adopted child, particularly for those whose birth mothers were reported to have used alcohol during pregnancy. Doctors must remember that as children grow, the typical facial features of Fetal Alcohol Syndrome can develop. Learning and behavioral problems attributable to maternal alcohol use may become more apparent as children grow older. One early suggestion of alcohol exposure is poor catch-up growth in the infant or child with a small head circumference. These children may also demonstrate weak verbal development and increased impulsivity. If suspicions of FAS or ARNDD arise, referral to a specialty center is indicated. Confirmation of a diagnosis of prenatal alcohol exposure may be quite difficult given a child's lack of history, but providers should be vigilant about this possibility over time, because additional information or new physical examination findings may become evident.

## **GROWTH MONITORING**

Most children grow rapidly during the first months in their new home, crossing percentiles on the height, weight, and head circumference curves until they have reached their genetic potential. Most children begin to follow closely to their Genetic potential for height and weight within 9 to 12 months after arrival. Some children, however, particularly older children who endured malnutrition and deprivation for longer, may continue to show catch-up growth for years after adoption. When a poorly nourished child is not exhibiting catch-up growth after international adoption, they should be evaluated for other conditions that might cause growth failure, such as tuberculosis or Fetal Alcohol Syndrome.

## **ROUTINE DEVELOPMENTAL SCREENING**

Data over the last 15 years have consistently suggested that between 50% and 90% of internationally adopted children have a developmental delay on meeting their new family. Delays in gross motor, fine motor, cognition, and language are all common. The degree of recovery seems to be more dependent on the duration of time spent in an institution than on the age at adoption. The likelihood of long-term developmental, behavioral, or academic problems increases with the age at adoption. Delays in specific areas of development may be partially or completely reversible after adoption.

The primary care provider should remember that developmental and behavioral issues may have multiple causes, including genetic predisposition, prenatal exposures, and individual experiences with early neglect or abuse. Because each child's experience is unique, it is impossible to predict a child's long-term outcome at the initial meeting.

After a child's adoption, primary care providers should perform a baseline screening of development at the first visit and repeat screenings at follow-up visits and well child checks. More frequent visits may be required depending on the severity of the delay.

## **DEVELOPMENTAL DELAY: WHEN TO REFER TO EARLY INTERVENTION**

The decision to refer to an early intervention (EI) program or to the school district because of developmental delays should not be a difficult one, because most children qualify for services and parents are typically quite motivated to support their child's ongoing development. Almost 90% of children who have spent more than 1 year in an institution are delayed in at least one area of development at the time of arrival. Prior studies of growth and cognitive development have determined that after adoption, many institutionalized children make developmental gains, but it is **impossible to predict** which children are going to catch up and which children are going to have ongoing needs, however. For this reason, it is recommended that providers refer children for evaluation and treatment of developmental delays sooner rather than later. Occasionally, parents or an EI program or school district wants to take a "wait and see"

approach. Unfortunately the “wait and see” approach may miss an important window of opportunity in the child’s developmental maturation. Providers may need to intervene on the child's behalf should a local development program or school district elect not to provide services. (Though responsible)

Communication difficulties are significantly related to behavioral concerns. Not all infants and toddlers develop English according to the same language acquisition trends that are seen in their English-speaking peers.

Glennen and Masters have created criteria for referral for speech and languages services based primarily on language production, age at adoption, and time elapsed since adoption.

**Table 1 . Criteria for referral for speech and language services**

<u>Age at adoption</u>	<u>Suggested referral criteria</u>
0–12 months	Use the same criteria for referral as native English speaker
13–18 months	Refer if not producing 50 words or 2 word phrases by 24 months
19–24 months	Refer if not using any English by 24 months, 50 words at 28 months, or 2 word phrases by 28–30 months
25–30 months	Refer if not using English within several weeks at home or if not speaking 50 English words or 2 word phrases by 31 months

Data from Glennen S, Masters MG. Typical and atypical language development in infants and toddlers adopted from Eastern Europe. *Am J Speech Lang Pathol* 2002;11:417–33.

### **AGE UNCERTAINTY AND DETERMINATION**

Although many internationally adopted children are born in hospitals or have a reliable birth history, there are children for whom a true birth date is unknown. Sometimes, children were born at home with no official recording of the birth. More commonly, children come into care after having been abandoned, usually on the streets or at the door of an orphanage, police station, or hospital. In China, virtually all the children who are available for international adoption have been abandoned as infants because of the country's “one child” law (and most of these children are girls because of the centuries old cultural preference for a male child). An infant is sometimes found with a note specifying his or her birthday; however, more often, an estimated date is assigned. Older children may know their age or birthday. The growth and developmental delays associated with malnutrition and neglect often make children appear younger than their true age; thus, age estimates shortly after arrival into the institution are often an underestimate of the child's true age. Younger ages are sometimes intentionally assigned because of the belief that is more difficult to find adoptive homes for older children.

Most children have growth and developmental delays at the time of adoption. The degree of delay can be quite alarming to parents. and when there is an assigned birth date, parents frequently assume that the child must truly be significantly younger. Most children, however, begin to make rapid gains in growth and development within days or weeks of joining a family and continue to catch up for months (or even years for older children) after their arrival.

It is therefore rarely, if ever, advisable to make decisions about changing a child's birthday until at least a year after the adoption, when catch-up growth and development can be taken into account. Estimation of the child’s age by Bone age testing is not helpful any earlier than one year, because malnutrition and deprivation delay bone age. It is only after malnutrition and other stressors have resolved that a bone age film may be helpful. In addition, the standard deviation for a bone age assessment is typically at least several months in either direction, making it a useful test only for children for whom the birthday might be off by many months or years.

Most often, concerns about age discrepancies resolve as children catch up in growth and development. When significant concerns persist a year or more after adoption, it may be reasonable to consider legally changing a child's birth date. Before making such a change, parents and pediatricians should carefully consider what might be gained or lost for the child involved. For children with significant developmental disabilities, a later birthday (i.e., making the child younger) may provide the child with more time to receive educational support but may inadvertently deny the child services, because his or her performance is then closer to his or her stated age. A child who is quite small and socially immature might fit in better with school classmates of a younger age. Children who may appear emotionally and physically younger than their reported age may enter puberty well before their classmates. Perhaps most importantly, a child whose birthday was changed after adoption may later feel a profound sense of loss for that piece of his or her original identity. Documents at the time of adoption require a date of birth, and that has become a part of his or her identity, even if not factually correct.

For children for whom there is not likely to be identifying information to allow them to reconnect with birth families, that original birthday, although assigned, may be the only remnant of the child's original identity. Because there is no way to know which young children may find this to be profoundly important later in their lives, parents should think carefully before changing this piece of their child's history. Many professionals involved with this population of children suggest that changing a birth date is indicated only if the date is going to be changed by 1 year at least, preferably retaining the originally stated month and date of birth. If the decision is made to change a child's birth date, this may involve significant costs as well as requiring documentation for court proceedings from a range of professionals (e.g., medical, psychological, dental) supporting this decision.

### **REFERRALS TO MEDICAL CONSULTANTS**

It is not uncommon to see many diagnoses and unusual terminology on some adoptive referrals. For example, physicians in other countries often use ultrasound imaging to examine numerous organs, leading to diagnostic interpretations that may not be based on US pediatric standards. If there is a question of pathologic findings on examination or by history, referral to a subspecialist is warranted. Common situations include the child suspected to have congenital heart disease or neurologic abnormalities or the child with an infectious disease that poses risks to family members. Timing of these referrals should balance the urgency of a child's medical needs with the transition needs of the child. Obviously, a child is better able to handle the stress of medical care after developing some trust that the new parents are going to provide comfort and protection. Even with repeated physical examinations without pathologic findings and normal laboratory results, the provider may still wish to refer the child to the subspecialist if only to relieve parental anxiety.

### **TIMING OF ELECTIVE SURGERY**

Timing of elective surgery is ultimately at the discretion of the surgeon. As with any type of surgery, the risks and benefits of the procedure as well as those of anesthesia need to be explained to the parent. Many surgeons prefer that a child be at least 6 months of age or weigh 20 lb before performing any type of elective surgery. The most common type of elective surgery that an internationally adopted child may face is circumcision. For the older adopted child, it is recommended that the procedure be explained to the child in the language he or she is most comfortable with. Truly elective procedures should be deferred until at least several months after arrival (the longer the better) to allow the child to be comforted as much as possible by his parents during the perioperative period.

## **Review of Medical Evaluation of Internationally Adopted Children**

Screening at the US State Department is mostly legal paper work and a few screens for serious communicable diseases or mental defects that would prevent a permanent residency visa.

It is NOT a comprehensive assessment of the child's health.

Internationally adopted children should be examined within 3 weeks of arrival (earlier if there are problems)

**Hearing test:** if slow to acquire language skills (see notes above)

**Vision:** all institutionalized international adoptee should be examined by a pediatric ophthalmologist

### **Labs Evaluation by primary care provider**

CBC, Lead, T4, TSH

PPD

Hepatitis B surface antigen antibody and core antigen antibody

Hepatitis C (if from Russia or China, Eastern Europe and Southeastern Asia or history of maternal drug use or blood products)

RPR and FTA

HIV1&2 serologic testing

Stool for O&P (3 specimens)

Stool Exam for Giardia Lamblia & Cryptosporidium antigen 1 (1 specimen)

### **Immunizations**

Children < 10 years are exempt immunizations upon arrival to the US, however must sign a waiver of their intention to comply with the US recommended immunization after arrival.

Center for Disease Control Yellow Book recommendations:

For any child, if there is any question as to whether the immunizations were administered or were of poor quality, the best course is to repeat them. Vaccination is generally safe and avoids the need to obtain and interpret multiple vaccine antibody blood tests.

This is particularly important with adoptions from Russia, China and Eastern Europe where many vaccines may have been diluted or fail to meet production standards

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#### **Evaluating Acceptability and Completeness of Overseas Immunization Records of Internationally Adopted Children**

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