

Packet for Adoptive Parents of Waiting Children

Adopting a foster child requires parental commitment and a willingness to measure success in small steps. Families will need as much information as possible about a child's background and any applicable diagnosis. The following packet is suggested to read during the pre-adoptive process.

HELPING PARENTS PREPARE

Nesting: What to Do While Waiting To Adopt an Older Waiting Child
Becoming Your Own Advocate: Learning to be Assertive
Questions to Ask a Former Care-Giver
Understanding Your Child's Medical and Social History

COMMON DIAGNOSES OF WAITING CHILDREN

ADHD and Adoption
Sensory Integration Dysfunction and Adoption
Reactive Attachment Disorder: Mining Gold Using a Child's Map of Attachment
Fetal Alcohol Spectrum Disorder: Diagnosis and Adoption

PARENTING RESOURCES

A Glossary of Common Terms
Top Ten Lists for Parents Caring for Children with Multiple Diagnosis
Guidepost in Transracial Adoption

HELPFUL WEB SITES

www.mnasap.org	Minnesota Adoption Support and Preservation
www.nacac.org	North American Council on Adoptable Children
www.mofas.org	Minnesota Organization on Fetal Alcohol Spectrum Disorder
www.mkca.org	Minnesota Kinship Care Givers Association
www.pacer.org	PACER Center
www.dhs.state.mn.us	Minnesota Department of Human Services

HELPFUL BOOKS/ RESOURCES/PUBLISHERS

Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families, by Terry M. Levy, examines causes, interventions and parenting techniques.
Black Baby White Hands: A View from the Crib, by Jaiya John, is a guide to transracial adoption.
Fantastic Antone Series, by Judith Kleinfeld, Barbara Morse & Siobhan Wescott, is a handbook to parenting children diagnosed with fetal alcohol syndrome/effects.
Parenting the Hurt Child: Helping Adoptive Families Heal and Grow, by Gregory C. Keck, Ph.D. and Regina M. Kupecky, explains how to raise a child with loving wisdom, resolve and success.

- Readers' Guide to Adoption-Related Literature <http://members.aol.com/billgage/lit-list.htm>
- Guilford Publications 800-365-7006 or 212-431-9800 www.guilford.com
- Haworth Press 800-429-6784 www.haworthpressinc.com
- Insight Open Adoption Resources 248-543-0997 www.openadoptioninsight.org
- PACT Press 510- 243-9460 www.pactadopt.org
- Perspectives Press 317-872-3055 www.perspectivespress.com
- Tapestry Books 800-765-2367 www.tapestrybooks.com
- Readiness to Adopt Self Survey (on-line assessment tool) <http://data.che.umn.edu/rass/login.asp>

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Workers and parents are encouraged to contact MN ASAP for training, advocacy, support, referral and answers. In addition to factsheets contained in this packet, many others are available from
www.mnasap.org/information/factsheets.htm

To learn about statewide training for parents, see www.mnasap.org/calendar/detail_calendar05.htm

Nesting: What to Do While Waiting to Adopt an Older Waiting Child

by Cathy Bruer-Thompson, Hennepin County Special Needs Adoption Trainer and Melissa Sherlock, Social Service Program Consultant, Minnesota Adoption Support and Preservation and Minnesota Department of Human Services

While all prospective adoptive parents want to be thoroughly prepared for the adventure of adopting an older waiting child or sibling group, many are unaware on how to use the “expectant time” to prepare their families and themselves to parent an older waiting child.

Here are some suggestions:

- Volunteer in places with children/youth who are at risk, such as a homeless teen shelter
- Provide respite care or childcare for families who have adopted or who are parenting children with special needs.
- Hear adopted and foster youth speak about their experiences. Our Voices Matter, a youth advocacy group from Minnesota Adoption Resource Network (MARN), offers youth panels with insights and suggestions for adults. Contact Amy Snyder at 612-746-5128 or asnyder@mnadopt.org.
- If you are adopting transracially, attend a Harambee Village Evening sponsored by a community for African American and Pan-African children and their families. Contact Deb Reiser at 763-545-0293 or www.harambeevillage.org. For children adopted from other countries, find one of the many Minnesota support groups specific to the culture and home country of your child. See www.mnasap.org and click on Parents’ Programs to find groups in the Metro area and Greater Minnesota.
- See if your place of worship supports families who have children diagnosed with special needs... or start up your own support system in your faith community.
- Meet your regional MN ASAP parent liaison who will be a helpful resource and may facilitate a support group in your area. See www.mnasap.org/parents_programs/liaisons.htm
- Attend additional training on specific parenting strategies and topics such as the MN ASAP TIPS and LABS classes. Bookmark the MN ASAP Web site for updates on MN ASAP offerings as well as statewide adoption and foster care trainings.
- Sign up for *MN ASAP Family Voices* quarterly newsletter, available in print or online. Call toll free 877-966-2727 or 612-798-4033 or e-mail info@mnasap.org or visit www.mnasap.org.
- Attend an adoption support group meeting in either the Metro or Greater Minnesota area. For a list: www.mnasap.org/parents_programs/parent_support_groups.htm. At the support groups, you will meet people who are successfully parenting children with special needs. Listen to their stories. Memorize their techniques. Develop relationships with people who can provide respite, support and understanding and who may be just a phone call or e-mail away.
- Do research on the Internet and bookmark informative sites by topic for future reference.
- Increase your knowledge base on the impact of trauma, disrupted attachment and Fetal Alcohol Spectrum Disorder on child development in children. Learn additional parenting skills necessary in raising children with these issues.
- Read books from the annotated bibliographies handed out in trainings or listed on www.mnasap.org or www.tapestrybooks.com or www.hennepin.us
- Take time for yourself now...you won’t have much for quite a while once you adopt.
- Prepare children already in the home for the addition of other children in the home.
- Summer 2002 *MN ASAP Family Voices* issue, available online at www.mnasap.org/information/Newsletter/FamilyVoices_summer2002.pdf has many suggestions regarding ways to support “sibling” friendships.
- www.parentleaders.org has resources and ideas for promoting interaction and getting beyond jealousies common among children
- Get to know the school personnel in your area.
- Learn more about Individualized Educational Programs (IEPs) and 504 plans through PACER Center, an organization that assists families with children who have disabilities navigate through the school system. Call 952-838-9000 or toll-free 800-537-2237 or pacer@pacer.org, www.pacer.org

Becoming Your Own Advocate: Learning to be Assertive

Used by permission from While You Wait: Advocacy Tool For Prospective Foster and Adoptive Parents newsletter, February 2003, published by the North American Council on Adoptable Children (NACAC). For more information, contact NACAC at info@nacac.org or 651-644-3036 or visit www.nacac.org

As you start the process of becoming a foster, adoptive, or resource parent, you begin your journey of becoming an advocate for yourself and the children you will parent. Before you begin, it will be to your benefit to develop assertiveness skills. People who have learned to be assertive are often more successful in presenting themselves... their skills, abilities, and their needs...to their workers.

Workers are often burdened with heavy caseloads and you will be only one of many clients. To get noticed, make sure you do everything that is asked of you, such as attending and actively participating in training, completing assignments, turning in paperwork, and showing the initiative to learn more. This will help you establish and develop your partnership with your worker and the agency.

Know Yourself

Assertive people have an easier time getting their needs met because they are focused; they know who they are, what their values are, and how to ask and work for what they want. If you want to become more assertive, you will first need to know yourself better. List your 10 greatest strengths and 10 areas for improvement. If you are co-parenting, share lists with your partner, comparing strengths and areas for improvement. Part of advocating for yourself is looking for ways to strengthen your weaker areas or learning to accept help when you need it.

Address possible problems proactively. If you are co-parenting, maybe your partner's strengths complement your weaknesses. If you will be a single parent, think of the friends and family who will support you as you parent. If you are young, highlight your maturity and experience caring for other people's children. If you are single or a gay or lesbian couple, include references from members of the opposite gender who will serve as role models for your children. If you are older, emphasize your life experiences and the wisdom you have gained. Sometimes the best parents for a child with special needs have overcome a disability or a difficult time in their lives.

Know the System

You won't get very far as an advocate for yourself if you don't understand the system in which you are operating. You might want to compare different agencies before you choose one, so you pick one that is right for you. Find out how long training takes and what the average wait is for a referral or placement. Find out what the protocol is when a parent and a worker don't get along. Ask how the agency helps to resolve or address conflicts or disagreements. Ask big picture and detailed questions.

Keep in mind that each county or agency is a little different and that some might be better suited to your needs. Also note that all workers operate within a system of rules and regulations, and those rules might limit what you and your worker are allowed to do. Often workers within the same agency have their own personal style for doing things too. Some workers are comfortable working as partners with their families and others are not. If you plan to adopt, ask if you are allowed to actively look for children, or read your home study, updating it as you gain experience.

Ask your worker how often you can call. Some workers feel one call a month from you is the most productive, but also understand that parents often want more contact than this. Some workers are open to one call or e-mail a week if parents are contributing relevant information to their case.

Build a Relationship with Your Worker

Finding the right amount of assertiveness will be important when you develop your relationship with your worker. If you are too passive and appear uninvolved, you may be overlooked. If you are too aggressive, you can annoy a person who wants to help you become a foster or adoptive parent. When you contact your worker, think about how you present yourself. Do you only call to ask what your worker has done for you lately? Instead, think about letting your worker know what you have done to prepare to parent children with special needs. Maybe you read a book on attention deficit disorder (ADD) or you volunteered at a crisis nursery.

When you are assertive and take the initiative to learn more, you show your worker you are serious, committed, and hard working and have the time and energy to meet the needs of a child. When you commit to doing more than is required of you, you become more skilled and ready to parent children who have experienced significant loss and trauma.

Advocate in Partnership with Your Worker

When you have developed a good working relationship with your worker, your initiative and your worker's expertise can only enhance your chances of bringing a child into your home within a reasonable amount of time. Ask if your worker is open to letting you actively look for children. Some workers are happy to have parents look through Web sites or books that list waiting children as long as parents keep them informed and have their worker make the contacts. Other workers want more control as they match parents and children.

Social workers meet monthly to discuss waiting children and look for matches from their approved individuals. Ask your worker about statewide and regional meetings and other ways workers match children with families. If you are allowed to search for children, let your worker know when you have found children from your community that you are interested in. Remember your worker may see strengths you haven't yet recognized in yourself and be open to your worker's suggestions.

Find Peace

Waiting for a child can seem to take forever. There is a lot to do to become an adoptive parent and sometimes parents feel that pressure and focus too much on what they should do. An important aspect of waiting is allowing each moment to unfold and bring you closer to the union with your child. You may be ready, but remember you are a complex person with many aspects to your life beyond waiting for a child to join your family. Remember to live your life even as you wait.

Checklist for Tracking Your Progress

- As you wait, there are things you can track to make sure your part of the work is completed in a timely manner:
- Carefully document each step in the process—when you made your first inquiry call, attended orientation, signed up for training, etc.
- Make sure you attend all your training sessions.
- Be an active participant in the sessions and complete all training assignments.
- Keep a journal of your thoughts, new information, and questions. When you have questions, be sure to ask them.
- Complete and return all your paperwork right when you get it.
- Tell your references the agency has their name and contact information and to be prepared to receive a call or a form to fill out and to send it back immediately.
- Make follow-up calls:
- Make sure your county or agency received your home study after you mailed it.
- Check to see that your worker has the needed medical documents and information from references.
- After being fingerprinted, confirm that your fingerprints were sent to your worker and make sure your worker received them.
- Call periodically and ask if your worker has sent out your home study.

Questions to Ask Former Care Providers in Special Needs Adoption

In determining birth history, the best sources are birth family members. Foster care providers also have special insights that can be shared with a new adoptive family. Here is a list of potential questions for adopting parents to ask former care providers:

1. In the social/medical history of the birth family, what is significant? What might be missing from paperwork? Can we get more information?
2. Is there a history of drug/alcohol abuse? If so, might this indicate that the birthmother was drinking during pregnancy?
3. Is there a history of mental illness?
4. Is there any history of other genetically related illnesses?
5. What is known about the child's prenatal care and birth?
6. What is known about the child's developmental history—physically, emotionally, cognitively—including language development?
7. What is the child's current health? Are there any allergies or any diagnosis?
8. Why was the child removed from his/her birth family or why did the birth parents choose not to parent the child?
9. What does he/she understand or not understand about the reasons for removal or for not living with the birth family?
10. When was the last contact the child had with birth family?*
11. Are there siblings? If so, is there contact? Is it expected that these contacts will continue, and to what degree?
12. Is the child manifesting behaviors related to abuse, separation or other trauma? Are other children victimized by his behavior? If so, how?
13. How has this child functioned in foster care? How many moves has this child experienced in foster care and why is he/she being removed?
14. What methods of discipline does this child respond to best?
15. What comforts this child? What objects of comfort need to follow this child into adoption?
16. Would you, as a former care provider or birth family member, be willing to give permission to this child to join our family? (Such permissions have been found to be helpful for some children in attaching to new families.)
17. How does the child relate to peers in the neighborhood or school?
18. What level of openness, if any, is possible with birth family members?*
19. What special skills/abilities/talents/interests, do birth family members have?

**To investigate opening up an adoption, refer to MN ASAP factsheet, "Preparing for Opening Up An Adoption."*

Understanding Your Child's Social/Medical History

*by Cathy Bruer-Thompson, Hennepin County Special Needs Adoption Trainer and
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State law requires that specific health and social history be given to the adoptive parents or other permanent caretakers. Such information provides a healthy foundation for parents and children both for now and for the adult years.

The placing agency and the adopting family need to be in partnership regarding a child's social and medical history. While counties and private agencies are responsible for collecting and providing thorough and accurate health and social history information about the child to adoptive families, the adopting parents will need to comprehend the information. The following suggestions are made for parents to understand both verbal and written information about the child's social and medical history.

- Familiarize yourself with the Minnesota Department of Human Services' Commissioner's designated formats that describe a child's social/medical history:
(www.dhs.state.mn.us/main/groups/children/documents/pub/dhs_id_005777.hcsp)
 1. Background and Health History (DHS form 3235) includes the reason for the placement, describes the home from which the child was removed, education of the child, immunization record, peer and other relationships, and a behavior checklist.
 2. Birth Parent Social and Medical History (DHS form 3205) is designed to include non-identifying information about the birth parents that is vital to the child's medical, emotional and physical care. Information about the birth parents includes general background, education employment and armed services history, pregnancy and general health information, risk factors, drug usage, medical history, mental health history, other children born to either birth parent, extended birth family history.

While a county or agency is not required to provide these **exact** two forms prescribed by the Commissioner, make sure that you have an adequate social history about the child you are adopting. It should contain all the major categories outlined in the DHS form 3235 (see 1. above) and DHS form 3205 (See 2. above.)

- Be alert and ask for more thorough documentation if information seems to be missing or vague. The county or placing agency should be able to tell you why information is incomplete. Ask that relevant information found in the child protection file (parent file) be summarized in the child's social/medical history.
- In addition to the social history, the county should provide redacted copies (identifying information has been removed) of psychological evaluations, IEPs, birth records, medical records, immunization records, and all other supporting documentation. Generally speaking, the longer a child is in out-of-home placement or the more diagnoses a child has, the more supporting documentation the county is likely to have on the child. In such cases, if the file seems too small to reflect the child's out-of-home placement history, ask why.
- If you think there is more information/documentation in a child's file that you have not received from the county, ask your adoption home study social worker to review the file.
- Make sure you understand what everything means in the social history and supporting documentation that includes non-identifying information about birth family as well as any diagnosis the child may have. Do Internet or library research about any diagnosis with which you may be unfamiliar. Understand what is written and reported verbally. Ask many questions of your social worker, family physician, MN ASAP liaison or experienced adoptive parent.
- Start a separate notebook with forms and questions you intend to ask when you actually meet with professionals. Always take the notebook into any meeting or training with questions ready to ask at the meeting. Social workers, psychologists, doctors and teachers use acronyms and jargon. Don't be embarrassed to ask what the letters stand for in an acronym or about any term you don't understand. Then, do your homework by researching the terms through MN ASAP materials or on the Internet.

- Research any diagnosis of your child such as FASD or Fetal Alcohol Spectrum Disorder. Learn the implications for parenting a child with this diagnosis. What is the long-term prognosis? What are the effects at each developmental stage? What behaviors might your child exhibit? How might the diagnosis affect your immediate family including children and extended family members? What strategies might you need to use/develop to manage your child's behaviors? What extra support/services might you need? How will the diagnosis impact your child's education...ability to make friends...ability to recognize and understand likely consequences...likelihood of living independently as an adult?
- During your collateral meetings, be very inquisitive. When you meet with your child's current foster care provider, ask what kinds of behaviors the child demonstrates and the best methods the foster parent has developed to manage the behaviors. (See MN ASAP Factsheet: Questions to Ask a Former Caregiver)
- Be flexible to adjust your parenting style to meet the needs of the child. Those needs may differ widely from other children you have parented so that your parenting style tried and true with your other children may not fit the child you are adopting. MN ASAP trainings and resources can help you adapt your parenting, should you need to, to effectively parent your new children. Developing additional effective parenting techniques will be an ongoing need.
- Be willing to adapt your routines, household products, time schedules and activities to match what the child is used to, thereby making the child more comfortable in his/her new surroundings in your home.
- Be knowledgeable about child development stages so that you can decipher what is typical development from what may be delayed or out of the ordinary.
- Post adoption services may be made available to your family for 18 months following adoption finalization. Potential post adoption services are pro-active support, problem resolution and crisis intervention services. Know what post adoption services your agency or county is required to provide.

Attention-Deficit/Hyperactive Disorder and Adoption

Attention-deficit hyperactive disorder (ADHD) is probably the most controversial medical health issue of our time. While some suggest that no such disorder exists, new brain scan tests of adults diagnosed with ADHD have located a chemical imbalance in a part of the brain that uses the nerve messenger dopamine. Dopamine helps regulate attention and inhibits impulsive behavior. A perception exists that ADHD is over-diagnosed, although the Council on Scientific Affairs of the American Medical Association recently determined that this is not the case. Adoptive parents need to be vigilant since the incidence of learning disabilities such as ADHD appears to be higher among adopted children than among non-adopted children.

ADHD brings the nurture vs. nature debate to the adoption forefront. A genetic pattern of multigenerational transmission of ADHD has been documented, as well as a high incidence among children born in a crisis. The crisis may be generational and connected to addiction, depression and/or abuse. While genetic influences may offer cause-effect explanations to the diagnosis, environmental factors may also be at play. Some experts believe that the added childhood task of trying to make sense of altered life circumstances influences the learning styles of adopted children.

ADHD symptoms, manifested by the age of seven, include developmentally inappropriate impulsivity, inattention, and in some cases, hyperactivity. This neurobiological disorder affects three-to-five percent of school-age children. Symptoms typically continue into adulthood with a two to four percent occurrence among adults. The disorder results from parts of the brain being under-active, not hyperactive.

Three variations of ADHD exist:

- Combined (most common) – hyperactive, impulsive, inattentive
- Predominantly Inattentive – (most common in girls and adults)
- Predominantly Hyperactive/Impulsive

Determining if a child has ADHD is a multifaceted process that requires separating out biological and psychological problems that mirror those exhibited by children who may not have ADHD. A comprehensive evaluation by a specialist in the field should include a clinical assessment of the child's academic, social/emotional functioning and developmental abilities. A medical exam by a physician is also important.

By federal law, children suspected of having ADHD must be evaluated at the school's expense and, if found to be eligible, provided services under either The Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973. Some of the services that could be provided to eligible children include modified instructions, assignments, and testing; assistance from a classroom aide or a special education teacher; assistive technology; behavior management; and the development of a positive behavioral intervention plan.

In order to adapt education to the needs of youth with ADHD, educators need to:

- Send clear messages and teach for understanding
- Use multi-sensory teaching techniques and active learning strategies
- Provide clear, explicit structure for class time, space, materials and course of study
- Provide frequent assignments with meaningful feedback and evaluation
- Expose and teach the skills, information and expectations hidden in the curriculum
- Offer alternative assignments, when indicated
- Involve and respect students as central partners in learning
- Intervene early and effectively with individual students who have difficulty learning

Alternative schools with smaller classrooms or home schooling may suit youth whose educational needs are not being met in larger public school settings. Smaller classrooms offer less distraction compared to typical larger classes where attention strays to 30 voices, 30 faces, 30 bodies moving around.

ADHD presents some paradoxes, including:

- Psychostimulants prescribed for ADHD calm those with ADHD but can be potentially over-stimulating and even dangerous to those without the disorder
- Children with ADHD resist the structure they desperately need for symptom relief
- They love distractions, but function and feel best when hyper-focused
- They seek stimulation to stave off boredom and depression, but over-stimulation exacerbates their symptoms, causing distress
- They are capable of making connections between ideas/people at the speed of light, yet may act scattered and socially backward

Since children with ADHD often appear bright and capable, parents may find themselves arousing the suspicion of others who blame a child's behaviors on poor parenting. Child raising experts suggest that parents receive training specific to ADHD, get individual/family counseling, investigate a medical regimen, and create interventions based on these guidelines:

- Raise the bar; don't lower it
- Make life challenging in fun ways, not less
- Keep the stakes high with individual tasks

Untreated children with ADHD are "at-risk" for potentially serious problems: academic underachievement, school failure, difficulty getting along with peers, and problems dealing with authority. In the pre-teen and teen years, youth diagnosed with ADHD may be at greater risk for substance abuse if they turn to substances to mask the negative effects. Recent research investigating the calming effects of nicotine on ADHD may explain why many who have the disorder smoke. Studies show that children who receive adequate treatment for ADHD have fewer problems with school, peers and substance abuse, and show improved overall functioning, compared to those who do not receive treatment.

RESOURCES

Adoption and the Schools: Resources for Parents and Teachers, edited by Lansing Wood and Nancy Ng. Published by FAIR (Families Adopting in Response), www.fairfamilies.org

How To Reach and Teach Teenagers with ADHD by Grad L. Flick, Ph.D. Center for Applied Research in Education, New York, 2000.

Special Kids Need Special Parents: A Resource for Parents of Children with Special Needs by Judith Loseff Lavin, Berkley Books, New York, 2001.

Taking Charge of ADHD: The Complete Authoritative Guide for Parents by Russell A. Barkley, Ph.D. The Guilford Press, New York, 2000.

Children and Adults with ADD (CHADD), 800-233-4050, www.chadd.org

Sensory Integration Dysfunction and Adoption

In her book, *The Out-of-Sync Child*, Carol Stock Kranowitz defines Sensory Integration (SI) Dysfunction as the "inefficient neurological processing of information received through the senses, causing problems with learning, development, and behavior." In simple terms, children diagnosed with SI Dysfunction have brains that are wired differently than their peers, making it difficult for them to make sense of messages received through any of the five senses. They are often delayed and prone to explosive outbursts. Their reactions are often out of proportion, going into a frenzy when viewing a brightly painted wall or being so much an "escape artist" that parents have to put an alarm on the child's bedroom door.

For children of adoption, SI Dysfunction rates are higher than with non-adopted children, requiring their parents to gain an understanding of the many complex skills that are required to do what seems to be a simple act such as tying a shoe or playing a board game. With such children, the interventions that illustrate "good parenting" such as setting firm limits simply do not work, causing their parents to be blamed and shamed for the child's behavior. The child may also be treated unfairly with no regard to this invisible disability. As early as preschool, the child may be labeled as a bully.

Inefficient sensory intake translates into taking in too much or too little information. With too much information, the brain is on overload and causes an individual to avoid sensory messages. With too little information, the brain seeks more sensory stimuli.

Only an occupational therapist that has been carefully trained in sensory integrative theory and treatment can properly diagnose SI Dysfunction (for a list of Minnesota therapists who specialize in SI Dysfunction, go to www.mnasap.org/pages/resources/pediatric_clinics.htm). A teacher and/or parent can learn to recognize signs that a child may be having sensory processing difficulties. The teacher can initiate an evaluation so the child may eventually receive appropriate therapy.

A high correlation exists between SI Dysfunction and Learning Disabilities (LD), with 70 percent of children diagnosed with LD having SI Dysfunction. SI Dysfunction resembles ADHD with some overlapping symptoms. The optimum treatments for the two differ. While the symptoms of ADHD may be eased with medicine such as psychostimulants, targeted occupational therapy tailored to the individual needs of the child is more helpful in cases of SI Dysfunction. An overloaded child needs less stimulation such as dimmed lights, comforting with "deep pressure" bear hugs, or a "nest" of pillows and blankets under the dining room table. An under-responsive child requires more sensory stimulation with daily activities, gentle roughhousing, and perhaps a trampoline. Therapy that is appropriate to the child's type of SI Dysfunction can ease underlying difficulties.

Symptoms of Sensory Integration Dysfunction

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Occupational therapists suggest activities to help children increase their ability to regulate themselves and to be more in control of behavior and impulses. These include working on:

Sensory	Symptoms
Auditory	<ul style="list-style-type: none"> Responds negatively to unexpected or loud noises Holds hands over ears Cannot walk with background noise Seems oblivious within an active environment
Visual	<ul style="list-style-type: none"> Prefers to be in the dark Hesitates going up and down steps Avoids bright lights Stares intensely at people or objects Avoids eye contact
Taste/Smell	<ul style="list-style-type: none"> Avoids certain tastes/smells that are typically part of children's diets Routinely smells nonfood objects Seeks out certain tastes or smells Does not seem to smell strong odors
Body Position	<ul style="list-style-type: none"> Continually seeks out all kinds of movement activities Hangs on other people, furniture, objects, even in familiar situations Seems to have weak muscles, tires easily, has poor endurance Walks on toes
Movement	<ul style="list-style-type: none"> Becomes anxious or distressed when feet leave the ground Avoids climbing or jumping Avoids playground equipment Seeks all kinds of movement and this interferes with daily life Takes excessive risks while playing, has no safety awareness
Touch	<ul style="list-style-type: none"> Avoids getting messy in glue, sand, finger paint, tape Is sensitive to certain fabrics (clothing, bedding) Touches people and objects at an irritating level Avoids going barefoot, especially in grass or sand Has decreased awareness of pain or temperature
Attention, Behavior and Social	<ul style="list-style-type: none"> Jumps from one activity to another frequently Has difficulty paying attention Is overly affectionate with others Seems anxious Is accident prone Has difficulty making friends, does not express emotions

Books

For book ordering information, log onto www.mnasap.org

Answers to Questions Teachers Ask About Sensory Integration

by Carol Stock Kranowitz

Challenging Behavior in Young Children: Understanding, Preventing, and Responding Effectively

by Barbara Kaiser

The Out-of-Sync Child : Recognizing & Coping with SI Dysfunction

by Carol Stock Kranowitz

The Out-Of-Sync Child Has Fun: Activities for Kids with Sensory Integration Dysfunction

by Carol Stock Kranowitz

101 Activities for Kids in Tight Spaces: At the Doctor's Office, on Car, Train, and Plane Trips, Home Sick in Bed by Carol Stock Kranowitz

Websites

Sensory Integration International

A non-profit, tax-exempt corporation concerned with the impact of sensory integrative problems on people's lives.

310-787-8805

info@sensoryint.com

www.sensoryint.com

Learning Disabilities Association of America (LDA)

Dedicated to identifying causes and promoting prevention of learning disabilities and to enhancing the quality of life for all individuals with learning disabilities and their families by encouraging effective identification and intervention, fostering research, and protecting their rights under the law.

412-341-1515

info@ldaamerica.org

www.Idanatl.org

Developmental Delay Resources

Dedicated to meeting the needs of those working with children who have developmental delays, publicizing research and networking for parents and professionals after a diagnosis to support children who have special needs.

412-422-3373

devdelay@mindspring.com

www.devdelay.org

Apraxia-Kids

This online source provides comprehensive information about Childhood Apraxia of Speech* and is designed for families, professionals and all those who care about a child with apraxia.

**Childhood Apraxia of Speech is sometimes called Developmental Apraxia of Speech, Developmental Verbal Dyspraxia, Oral-motor Speech Disorder and other terms*

760-632-5020

helpdesk@apraxia.org

www.apraxia-kids.org

Reactive Attachment Disorder: Mining Gold Using A Child's Map of Attachment

Brain research reveals that attachment is a regulatory system that develops during infancy and early childhood. Positive parenting helps the developing child learn to soothe and calm himself or herself. Children who have suffered early trauma often lack the ability to self-regulate, a quality necessary for affection and attachment. No matter how loving and attentive adoptive parents are, the child returns to expectations based on past negative experiences.

Among therapist Dr. Anne Gearity's clients are adopted children who are in need of attachment repair. Dr. Gearity helps parents understand how unattached children navigate their way within their adoptive families. Unlike children whose earliest needs were met by care-takers, these children "have representational maps in their brain that say, 'When I'm distressed, nothing happens,' or 'No one helps me' or 'Someone helps in a way that frightens me.' Attachment repair is really about helping the parent read and decode their child's representational map and develop new maps that say, 'Maybe that happened with them, but with me, this is what we can do.'"

"When I had my kitchen rewired," says Dr. Gearity, "for months I would go to the wrong place to turn on the light. This is what these kids do, turning on the light as if it were in the old location." She describes attachment as a system "in which the parents provide essential functions for the child until the child can do them for themselves. A lot of attachment repair comes from helping children develop self-soothing capacities."

"Be patient in discovering your child's representational map."

Dr. Gearity acknowledges that parenting a child with attachment issues is not easy. "They love you one day, and then the next day they lose the reliability of your function. They don't lose you, but lose their trust that this relationship will keep functioning. Parents have to repeat and repeat the process, asking, 'When is she going to learn?'"

Dr. Gearity suggests that parents temper their expectations of the child. "It takes extraordinary patience to learn how to get in sync with my child so my child can get in sync with me. You can't make your role too personal. When I teach attachment I talk about it as a functional relationship. Love grows out of good functioning. Parents who adopt soon find that these children are not very gratifying in smiling, hugging, behaving or making you proud when you go to Target. They give double messages all the time, and you get very hurt." Dr. Gearity advises parents to understand that the child's rejection of them is not personal, but rather is based on falling back on old expectations of how things work.

"Determine the child's patterns that are based on their map."

Scientists have discovered that much of human behavior is based on two types of memory, implicit and explicit. Dr. Gearity explains, "Explicit memory is this-is-what-happened memory, of what my former care-taker did. Implicit memory is procedural, this-is-how-the-world-works

This-is-how-the-world-works memory or the why of memory. Most of these children operate out of pre-conscious implicit memories. It's like the body keeping score."

Parents who understand the function of implicit memories understand that they must alter their parenting style in order to create new patterns of learning. Their children can be aided in planning and anticipating what to do differently next time. In the process of creating new memories, parents need to forgo asking "Learning has to happen in the moment and must be focused on the future rather than in the past," says Dr. Gearity.

“Develop a language to express patterns aloud.”

Dr. Gearity says this is not different from raising children without attachment issues. “When my kids were young and we had a hard week, I used to say, ‘I can’t wait until Friday. What can we do to make it to Friday?’ so that it became a shared narrative. Attachment is all about inventing a mutually relating system that says, ‘I can get in sync with you and you can get in sync with me.’ Then you can celebrate, saying, ‘We did it!’”

Once parents determine a child’s pattern, they can bring attention to it, saying, “This is why you do this. Every time I say, ‘No more cookies, you get worried.’”

For a teenage boy who is still playing with GI Joes, parents might say, “I wonder why GI Joes are so important to you. Let’s get some and find out. I wonder if you didn’t have GI Joes when you were a baby.” Dr. Gearity says that such conversations hold the potential for enormous attachment repair.

“Create new patterns as a function of attachment repair.”

The process of attachment repair requires a lifetime of repair. Dr. Gearity describes it as “parenting a chronically ill child, but the illness is a psychological vulnerability.” At first, the repair process can be arduous, becoming more manageable as the child becomes conscious of their vulnerabilities. “There is an accumulation of confidence where the good memories start to be reliable enough so that the child can start to have the good memories as the default position. It takes a lot of work to get the default position to some thing more conscious,” says Dr. Gearity.

Therapy can introduce new patterns for children, particularly when parents cannot figure out their child or when they get pulled into the child’s past. Dr. Gearity says to expect developmental crisis in pre-adolescence, especially at the age of 13, caused by neural-psychological and biological effects. “Parents can think about such times as an attachment crisis and as an attachment opportunity. The intuitive response is to pull away because the child is acting obnoxious. You need a counter-intuitive response such as, ‘You are acting obnoxious and I want to help you figure it out.’ These are moments when children come back into therapy so you can help them ride it through.”

Other ages when parents can expect attachment issues to resurface for adopted children are five and seventeen, both transition stages in which children are practicing separating from parents. “When you’ve had the rope pulled out from under you, you don’t like it,” explains Gearity. “Transition signals that something is going to change, and on a pre-conscious level, that is scary.”

Anne Gearity, PhD, LICSW, MSW is a licensed therapist and clinical consultant to the Day Treatment Program at Washburn Child Guidance in Minneapolis.

Fetal Alcohol Spectrum Disorder: Diagnosis and Adoption

Minnesota has the tenth highest alcohol use rate in the nation. Consumption of alcohol during pregnancy is the number one cause of preventable mental disabilities. Alcohol consumption during pregnancy does far more damage to the unborn child than any other drug.

- Children diagnosed with **Fetal Alcohol Syndrome (FAS)** have abnormal facial features, slow growth both before and after birth, and brain injury.
- Children diagnosed with **Fetal Alcohol Effects (FAE)** may lack the outward physical appearance of alcohol damage and have some of the above characteristics. Or they may demonstrate all of the characteristics but still not have proof that the birth mother drank.

Together FAS and FAE are classified as Fetal Alcohol Spectrum Disorder (FASD), a lifetime disability that is not curable. Early diagnosis and intensive, appropriate intervention can make an enormous difference in the prognosis for the child, preventing secondary disabilities that result from primary disabilities related to FASD. Because of the brain injuries associated with FASD, individuals often have attention deficit and hyperactivity disorder (ADHD), learning disabilities, problems with daily living including poor impulse control, memory problems, sensory integration issues, relationship difficulties, an inability to understand cause/effect and thus to generalize. They also demonstrate a tendency towards high risk behaviors. **Considered “soft signs,” these symptoms are not behavioral problems but rather show the permanent, unchanging damage to the brain that is out of the child’s control.**

Adoptive parents need to be aware of FASD because alcohol consumption during pregnancy may not appear in adoption paperwork.

- Women who use drugs during pregnancy are very likely to be using alcohol as well.
- During pregnancy, a woman may not know that she is pregnant until several months into the pregnancy. Her pre-pregnancy pattern of drinking may continue into the early stages of pregnancy when the effects of consumption are most dangerous to the fetus.
- Medical history of siblings can help determine a diagnosis of an adopted child. A woman who has delivered a child with FASD is at 70 percent greater risk of delivering additional affected children. Often younger siblings have a higher incidence rate than older brothers and sisters.
- Children with FASD are over-represented in foster care and adoption. So prevalent is the diagnosis among older “special needs” children that some adoption workers tell potential parents to assume prenatal exposure to alcohol unless there is clear proof otherwise.
- Among the 2 million adults in the U.S. with suspected FAS disorders, the combination of the primary brain dysfunction (poor judgment, lack of impulse control) and the secondary disability of alcoholism results in another risk that is not always recognized. These individuals are very likely to have unprotected sex that results in pregnancy, and another generation of babies are at risk of damage from prenatal alcohol exposure.

The diagnosis process for FASD includes:

- A complete medical examination
- Psychological, occupational therapy and speech/language evaluations
- Evaluation of the prenatal, birth and previous medical history
- Measurement of head size and facial features
- Occupational therapy evaluation to determine motor functions and adaptive abilities.
- Speech and language evaluation to determine abilities to understand and communicate.

Adoptive parents can prepare for a diagnostic procedure by gathering all they know about their child’s health and family history. They can bring photos of the child, preferably at a young age. Photos should be straight on, not smiling and without glasses.

Diagnosis

Regional FASD clinics offer team evaluations for children with significant behavior, learning or physical problems that may be related to the disorder. A treatment plan will be developed based upon the recommendations of the team. Minnesota clinics that specialize in FASD diagnosis include:

**Minnesota Children with Special Health Needs
Division of Family Health
Minnesota Department of Health**
85 East Seventh Place, Suite 400
PO Box 64882
St. Paul, MN 55164
651-215-8956 or 800-728-5420
mn-cshn@health.state.mn.us

**University of Minnesota FAS/E
Diagnostic Clinic**
Pi-Nian Chang, Ph.D.
University Gateway Center
200 Oak Street SE (Oak and University Avenue SE)
Suite 160, KDWB Variety Center
Minneapolis, MN 55455
612-624-9134 or 800-688-5252

University of Minnesota Intl Adoption Clinic
Counsels international adopters (after viewing videos of children being considered), screens adopted children after arrival, providing follow-up and referral to specialists.
Dr. Dana Johnson
Box 211, 420 Delaware Street SE
Minneapolis, MN 55455
612-624-1164 or 612-626-2928

**Health Partners Ramsey Clinic
Child and Adolescent Psychiatry**
Elizabeth Reeve, MD
640 Jackson Street
St. Paul, MN 55101-2595
651-221-3061

Mayo Clinic - Department of Medical Genetics
Pamela Carnes, M.D.
200 First Street S W
Rochester, MN 55905
507-284-8208 Fax: 507-284-1067

Minnesota Indian Women's Resource Center
2300 5th Avenue S
Minneapolis, MN 55404
612-728-2018

Hennepin County Medical Center - Pediatrics
Works particularly with infants
Linda Thompson, M.D.
701 Park Avenue South
Minneapolis, MN 55415
612-347-2617

**Hennepin County Medical Center
Child Behavior Learning Clinic**
Rachel Trockman, M.D., Pediatric Neurologist
701 Park Avenue
Minneapolis, MN 55415
612-347-2675 Fax: 612-904-4227

Cass Lake Indian Hospital
Diane Pittman, M.D., Pediatrician
RR 3, Box 211
Cass Lake, MN 56633
218-335-2293 Fax: 218-335-2601

**Abbot Northwestern Hospital
Perinatal Center**
Shari Baldinger, M.S., Geneticist
800 E 28th Street
Minneapolis, MN 55407
612-863-3536 Fax: 612-863-5692

Glossary of Terms

Attention Deficit Disorder (ADD) - A child with ADD is not hyperactive but may have many of the following difficulties: concentration problems, difficulty following directions, difficulty completing tasks, easily distracted, loses things, and overly messy or overly neat.

Attention Deficit Hyperactivity Disorder (ADHD) - A disorder that involves problems with attention span, impulse control, and activity level. Typical behaviors include: fidgeting, difficulty remaining seated, distractibility, difficulty waiting for turns, difficulty staying on task, difficulty playing quietly, excessive talking, inattention, and engaging in physically dangerous activities without considering consequences.

Emotional Behavior Disorder (EBD) - Children who are diagnosed with emotional or behavioral disorders have an established pattern of behavior characterized by one or more of the following:

- Severely aggressive and impulsive behaviors.
- Severely withdrawn or anxious, depression, mood swings, pervasive unhappiness.
- Severely disordered thought processes manifested by unusual behavior patterns, atypical communication styles, and distorted interpersonal relationships.
- Inability to build or maintain satisfactory interpersonal relations necessary to the learning process with peers, teachers, and others.
- Failure to attain or to maintain a satisfactory rate of educational or developmental progress that can not be improved or explained by cognitive, sensory, health, cultural, or linguistic factors.

FASD - Fetal Alcohol Syndrome and Fetal Alcohol Effect - Conditions that result from alcohol use by the birth mother during pregnancy. Children born with FASD or FASD can have organic brain damage, low birth weight, birth defects, mental retardation, and learning impairments in varying degrees.

Individual Education Plan (IEP) - A plan drawn up by a child's special education teacher and other school personnel that outlines specific skills the child needs to develop as well as learning activities that build on the child's strengths.

Learning Disabilities (LD) - Some children find learning in regular classrooms difficult. Children with learning disabilities may be of average or above average intelligence, but have difficulty learning, sorting, and storing information. LD classes may be recommended to help them achieve their potential in school.

Oppositional Defiant Disorder (ODD) - A disorder characterized by behavior such as frequent loss of temper, a tendency to argue with adults, refusal to obey adult requests, deliberate behaviors to annoy others, spiteful and vindictive behavior, use of obscene language, and a tendency to blame others for mistakes. Symptoms sometimes indicate the early stage of conduct disorder.

Post Traumatic Stress Disorder (PTSD) - PTSD develops when a child experiences, witnesses, or is confronted with an extremely traumatic event or series of events. This could include actual or threatened death, serious injury or a threat to the physical integrity of self or others. For children, sexually traumatic events may include developmentally inappropriate sexual experiences or the threat of same to the child or others. These incidents cause the child to experience intense fear, helplessness, or horror. The child may also exhibit various physical symptoms related to this disorder.

Reactive Attachment Disorder (RAD) - A condition resulting from an early lack of consistent appropriate care, characterized by an inability to make appropriate social contact with others. Symptoms include developmental delays, lack of eye contact, feeding disturbances, hypersensitivity to touch and sound, failure to initiate or respond to social interaction, indiscriminate sociability, self stimulation, and susceptibility to infection. RAD may manifest as attaching to no one or attaching to everyone.

Top Ten List for Parents Caring for Children with Multiple Diagnoses

By Paul Buckley, Licensed Marriage and Family Therapist

Children with a mental health diagnosis typically display behaviors and responses to their life-space environment that create problems for them and difficulties for their caregivers as well. These problems cause significant distress in the form of discomfort and/or developmental delays. For example, a child might weep due to depression or be failing in school due to oppositional defiant behaviors. While all children cry and are oppositional, children with mental health diagnoses have more severe and persistent symptoms.

A dual diagnosis translates to a child meeting two or more diagnostic categories of a mental disorder. If your child has a dual diagnosis, don't panic. It's not uncommon. Statistics show that in 40 percent of cases, a child with ADHD will have a co-occurring diagnosis.

While families of children with multiple diagnoses can use similar parenting techniques that would work for any child, three general rules of thumb are:

- Increase structure in all settings
- Create nurturing moments
- Make sure as caregivers to get support and provide self care

The following top ten list is based on the experiences of many families and solid research findings. If one or two ideas resonate with you, focus on those.

1. Expect and accept setbacks, failures, embarrassment. Remember, difficult children often make very good parents look and feel bad. Keep in mind that over time the gradual shaping influence of your efforts is a tremendously important and convincing force.
2. Read to your children at times when they will accept your nurturing presence such as bedtime or mornings. Few activities have such a positive effect on the learning and emotional life of young people as reading.
3. Make use of empathy and natural consequences as often as possible. "Oh no, I'm sorry you spent all your allowance. I guess it'll be hard to go see that movie now."
4. Go to funny movies.
5. Use the child's diagnosis to your benefit. Use the treatment plan as a road map to assess services and as a guiding document to help you better understand your child's behaviors.
6. Make as few rules as possible, but increase the importance of those rules by posting them in writing. Regularly use and chart rewards and consequences.
7. Join your child's world now and then, using curiosity, empathy and lack of criticism. Too often a child's behaviors teach parents to be chronic critics, causing the child to not hear the criticism. Bake, play catch, listen to your child's favorite CD.
8. Blend your efforts with those of other adults such as coaches, educators, and clergy. The more adults who share a perspective about the child's problems, the greater the child's chances are for internalizing life lessons.
9. Develop consistent chores, routines and rituals. These elements of family structure should emerge from your core values and principles.
10. Bolster your support system, recreation and respite resources. One of the greatest risk factors for difficult children is that as they wear out parents and caregivers, problems cascade into even more difficulties.

RESOURCES

EP – Exceptional Parent magazine, Monthly periodical has information and support for the special needs community www.eparent.com

ADHD

Driven to Distraction by Edward M. Hallowell, MD and John J. Ratey
Eurkee the Jumpy, Jumpy Elephant by Cliff Corman, MD and Esther Trevino
Taking Charge of ADHD: The Complete, Authoritative Guide for Parents by Russell A. Barkley, PhD
How To Reach & Teach Teenagers with ADHD by Grad L. Flick, PhD

www.chadd.org	Children and Adults with ADD (CHADD)	800-233-4050
www.add.org	National ADD Association	847-432-2332

Attachment

Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families
by Terry M. Levy
*Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioral Change in Foster
and Adopted Children* by Daniel A. Hughes
Attaching in Adoption: Practical Tools for Today's Parents by Deborah D. Gray
When Love is Not Enough: A Guide To Parenting Children with RAD – Reactive Attachment Disorder
by Nancy L. Thomas

www.attachmentdisorder.net
attachmentdisordersite@hotmail.com

FAS/FAE

Fantastic Antone Series by Judith Kleinfeld, Barbara Morse & Siobhan Wescott
Our FAScinating Journey by Jodee Kulp
The Best I Can Be: Living with Fetal Alcohol Syndrome or Effects by Jodee Kulp and Liz Kulp

www.betterendings.org	Better Endings New Beginnings	763-531-9548
www.mofas.org	Minnesota Organization of Fetal Alcohol Syndrome	651-917-2370
www.nofas.org	National Organization on Fetal Alcohol Syndrome	202-785-4585

Sensory Integration Dysfunction

The Out-Of-Sync Child by Carol Stock Kranowitz, MA

www.sinetwork.org Sensory Integration Resource Center

Multiple Diagnoses

Adopting the Hurt Child: Hope for Families with Special-Needs Kids
by Regina M. Kupecky and Gregory C. Keck
Parenting the Hurt Child: Helping Adoptive Families Heal and Grow
by Regina M. Kupecky and Gregory C. Keck
Special Kids Need Special Parents by Judith Loseff Lavin

Oppositional Defiant Disorder

Your Defiant Child: A Parent's Guide to Oppositional Defiant Disorder by Douglas A. Riley
The Explosive Child by Ross W. Greene, PhD

www.aacap.org	American Academy of Child and Adolescent Psychiatry	202-966-7300
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A Guidepost in Transracial Adoption

*In 1968, just months following the assassination of Martin Luther King, Jr., Jaiya John became the first African American baby in New Mexico to be adopted by a White family. He describes growing up in a family who were blind to the racial tensions he encountered in a landmark book, **Black Baby White Hands: A View from the Crib**. The following is an excerpt of an interview in which he offers advice to families of transracial adoption.*

How important is it for adoptive parents and professionals to evoke and consider the child's voice in transracial adoption?

The more the child is distinct or unique from the family she is being adopted into, the more that child's voice becomes a critical source of authority on what her own needs are. This implicates not only racial differences, but those involving class, geographic region, community background, trauma experiences, special needs and general life experiences of the child relative to the parents/professionals.

The more adults' life experiences deviate from what the child has, is, or will experience, the more those adult insights need to be supplemented by honoring the child's voice; the child's voice being not only what she speaks orally but what she expresses nonverbally in her demeanor, actions, attitudes and reactions to life. Even the Black child adopted at birth will experience a life shaped by the world's reaction to her Blackness and so she will come to develop her own personal culture for existing in life. Attitudes such as, "The younger they are when we adopt them, the less we have to worry about things like race and culture," are misguided and can be counterproductive to the child's growth and the family's well being.

What is the impact of separating siblings in transracial adoptions?

Separating children from their siblings is just one aspect of separating them from their biological families as a whole. There are consequences. We cannot pretend that there are not. You are disrupting nature-borne ties. Biological connections inherently breed a sense of self; a sense of connectedness. No matter how damaging those biological family relationships may be or might have been, there is something of the human essence within them that we are severing. Whether that has to do with similarities in physical appearance, personality, health, learning styles, interests or values, these biological connections serve as a compass orienting children and adults within a vast and alienating world. That deeply rooted sense of, "I belong to this," that exists in ways that are unquestionable even if undesirable, serves to create a child's feeling of security, validity and value. Of course this impacts self-esteem and therefore every aspect of a child's movement through her stages of life. This is not an issue of affinity or affection. It is about undeniable evidence that you have come from something beyond yourself, that you are not simply an un-tethered life drifting without origin or purpose. Of course our child placement policies and practices must honor this truth, even within the limitations of the difficult circumstances involved.

What should White parents do and know about the hair of African American children?

White parents of African American children need only the humility and lack of ethnocentrism to realize that everything they've known and been taught about their own hair might not apply to the hair of their adoptive children. Hair care is much more than cosmetic. Hygiene impacts self-image and self-esteem, plays a role in social acceptance and rejection; in relationships and therefore ultimately, in success in life. In adoption, realizing as parents or workers that we might possibly not know everything there is to know about people/children who are distinct from us is the critical starting point in a healthy relationship and in delivering effective child welfare. The truth is that, culturally, this can be difficult for well-intending parents who are part of this society's racial mainstream. This country teaches that what is normal is White and what deviates from that is inherently inferior or at least not valid enough to warrant being valued or considered equally. This is a truth that all U.S. Americans are socialized into and grapple with, regardless of our heritage.

What must prospective parents understand before adopting a child of color?

Relax. Do not expect perfection on your part. Do not assume the mantle of cultural expert or demand of your child the role of cultural ambassador. Allow the child to tell her story in any way she is compelled. Listen.

Realize that a condescending attitude of charity toward your child is the most destructive energy you can carry. You haven't done anything wonderful by adopting a child, but you can do something wonderful by effectively raising that child. This is not a case of the "good" people lifting the poor, pitiable child out of a horrible fate. It is not our place to judge what might have been for the child. It is our place to receive the child as a blessing in our lives; a messenger come to us to teach us about life in ways we would not otherwise have been taught. It is a mutual relationship. The child is our equal in terms of life purpose. This is a dance not best performed by asserting and imposing our values but by bringing them respectfully to the table and clearing an equal space for the child to present hers.

Do you think that parents who have both biological children and transracially adopted children pay special attention to the children who are struggling with ethnic, racial issues?

Why wouldn't a parent pay special attention to any child struggling with her own special issues? We can't pretend children's issues away. We can't pretend Johnny isn't really Black, or that Ashia isn't really in a wheelchair, or that Tony doesn't really have a challenge with bonding and attachment. Pretending children into an illusory space of sameness may be tempting, but again, we confuse the parental objective of loving our children the same amount with loving them in the same way. Each child learns in a unique way; each child requires a unique manifestation of parental love.

Dr. Jaiya John is founder and executive director of **Soul Water Risking**, an educational organization devoted to improving human relations, combating prejudice, and fostering spiritual growth. *The Writer's Digest* award-winning author of *Black Baby White Hands: A View from the Crib* is a former professor of social psychology at Howard University in Washington DC and a former associate director of the National Center on Permanency for African American Children.

Contact Dr. John at 301-933-4967 or jaiya@soulwaterrising.com. See www.jaiyajohn.com or www.soulwaterrising.com

Black Baby White Hands is available through Amazon.com and local bookstores.

Salons that Specialize in African American Hair

*For a list of salons that specialize in African American hair, see the Spring 2004 issue of *MN ASAP Family Voices*.