



Communicator Express

cross cultural communication systems, inc.

November 2011

Adoption and Development

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Abstract:

Caregivers play a fundamental role in development, but biological parents are not always present or capable, often making adoption the best choice. However, the environmental transitions and stress that often accompany adoption may have implications for future developmental outcomes. There is extensive literature on the impacts of adoption on development, as well as the benefits of adoption compared with foster care. Longitudinal studies have linked adoption with an increased risk for behavioral and social problems (Brodzinsky, 1993). Adopted children are also overrepresented in the mental health field compared with their peers (Brodzinsky, 1993). Yet, in much of this research confounding variables make causation challenging to elicit. This paper will explore these variables in the framework of successful adoptee development.

Introduction:

When biological parents are unable to provide care, adoption is often the most stable and healthy option for the child. A longitudinal Swedish study looking at children placed in foster care, adopted families, and children whose mothers had originally registered them for adoption then changed their minds, showed that by age fifteen adopted children had higher mean grades and higher mean-adjustment scores compared with the other two groups (Brodzinsky, 1993). This research may indicate that children fare better in adoptive families than in foster care (Brodzinsky, 1993). However, while adopted children fared the best, they still had lower mean grades and adjustment scores than fellow classmates (Brodzinsky, 1993). In addition, there are more documented cases of mental illness in adoptees than in the general population. In the United States, 5% of adopted children are referred to outpatient mental health facilities compared with 2% of the non-adopted children (Brodzinsky, 1993). Between 10% and 15% of children in residential psychiatric facilities are adoptees (Brodzinsky, 1993).

This paper will investigate potential reasons for this overrepresentation through exploring several key areas surrounding adoption, including: (1) the age at which the child was

adopted, (2) if they were institutionalized and for how long (3) the prenatal environment encountered by the infant (4) the environment of the adoptive family and (5) social preconceptions about adoption (Howe, 2001; Castle et al. 1999; Miall, 1996). While, this paper will attempt to tease out the risks associated with adoption, there are many confounding variables that enter into human development and behavior. The methodology used to study adoptive child behavior is complicated and introduces many biases, causation is often difficult to determine and there has been much conflicting research comparing adoptees and non-adoptees (Brodzinsky, 1993).

Outcomes of Adoption:

The studies mentioned above indicate that adoption is often the best choice compared with institutionalization and foster care, however, adoption itself may come with a variety of developmental risks. This paper will primarily focus on socio-emotional developmental outcomes but will touch on cognitive development. A study compared adopted children with non-adopted siblings, measuring participating families with a series of assessments including the Youth Self-Report and Profile of Student-Life: Attitudes and Behaviors (Sharma, McGue, & Benson, 1998). The Youth Self-Report has subscales in behavior, including: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, aggressive behavior, and self-destructive/identity problems (Sharma et al. 1998). The YSR also has three summary scales in internalizing, externalizing, and total behavioral problems. The Profile of Student-Life: Attitudes and Behaviors supplemented the YSR with measurements of alcohol and drug use, and sexual activity (Sharma et al. 1998). The results of this study indicated that adopted children had higher levels of delinquent behavior, illicit drug use, and poorer school adjustment, socio-emotional problems and withdrawn behaviors compared with their non-adopted siblings (Sharma et al. 1998).

Some of these socio-emotional problems may be associated with attachment. Attachment theory originates from the work of John Bowlby and Mary Ainsworth and is centered

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around the idea that early in life there is an innate focused need for social interaction with one specific figure (Tomlinson, 1997). In an evolutionary context the proximity, communication and sensitivity between infant and caretaker provided by attachment is beneficial for survival (Tomlinson, 1997). The concept of secure attachment suggests a balance of the infant's need for caregiver's proximity and exploration of their environment (Tomlinson, 1997). In other words a secure attachment provides the child with the confidence to explore an environment (Tomlinson, 1997). Attachment phase during early infancy (the first year or so) preps the infant for the next face of instruction of behavioral rights and wrongs (Hughes, 1999).

Adoption can disrupt this security and make the child either unsure of adopted parent's want for them or encourage adoptive parents to use less disciplinary practices—both of which could create altered behavioral outcomes (Hughes, 1999). Lack of attachment may be an adaptive mechanism for some adopted children (Hughes, 1999). "Entering into a reciprocal parent-child relationship would require them to give up the control and self-reliance that had enabled them to survive years of neglect and emotional isolation," (Hughes, 1999, pp. 544). Secure attachment allows a child to proceed with the challenges of future developmental tasks (Hughes, 1999) Reactive Attachment Disorder (RAD) is defined as "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before five years of age," (Hughes, 1999, p. 550). These behavioral problems are observed in higher proportion of adopted children (Hughes, 1999). However, it also important to remember that attachment theory is for the most part based in a middle class American experimental context (Tomlinson, 1997). In varied cultural settings, where independence in infancy is more valued and several caregivers are present in an infant's life, attachment may manifest differently (Tomlinson, 1997). Examples of insecure attachment may not always be maladaptive (Tomlinson, 1997).

AGE AT ADOPTION:

The age at which a child is adopted is a likely influence on their later development. There appear to be fewer developmental risks associated with placement in early infancy compared with later adoptive placement (Howe, 2001). Children adopted in the first year appear at slight increased risk for socio-emotional problems, manifested in peer relationships or parental relationships (Howe, 2001). Children placed after 12 months have demonstrated a higher risk for more severe socio-behavioral problems (Howe, 2001).

A survey of adult adoptees who had recent contact with a biological relative asked adoptees how they felt about their relationships with their adoptive parents, specifically the statement, "I felt loved by my adoptive mother/I felt I belonged in my adoptive family [strongly agree/agree/uncertain/disagree/strongly disagree]," (Howe, 2001, pp. 222). The age at adoption was also classified into younger than 6 months, 7-23 months and older than 24 months (Howe, 2001). The results showed that age at placement was associated with adoptees' positive or negative descriptions of being adopted (Howe, 2001). Adoptees placed at older ages, especially those in the older than 24 months age group, were most likely to mark that felt they did not belong in their adoptive families

while growing up, that they did not feel loved by their adoptive mother, and had the least amount of contact with adoptive mother (Howe, 2001). It is important to note that these responses came from adult subjects who may have reinterpreted their experiences as children. In addition the study did place all children older than 24 months into one broad category, which could have skewed results.

Children adopted at a later age will not always have developmental problems or behavioral challenges. Biological predispositions, the adoptive environment, age and situation previous to adoption are all factors in development (Howe, 2001). The age of a child is hard to isolate in a non-experimental setting from the influences of institutionalization, foster care and/or other early care environments. In most cases, adoption at 6 month or a year means the child was institutionalized or placed in foster care previously. During this pre-adoptive period, the child may have experienced negative environmental exposure possibly including: deprivation, instability of environment, increased prenatal stress or abuse (Howe, 2001). All the factors are not inherent to institutional care and may be more reflective of the quality of care offered and the amount of time spent there. In other words, it may not necessarily be age of adoption but increased risk factors in early life that create the developmental gap in early versus late adoption (Howe, 2001).

Institutionalization

Institutionalization itself is often hard to separate from the type and quality of care and duration of time a child spent in the institution (Castle et al. 1999). A "natural experiment" arose when a dramatic increase in privatized orphanages occurred in responses to the severe economic deprivation under the repressive CeauSescu Romanian regime (Castle et al. 1999). These orphanages operated in appalling conditions (Castle et al. 1999). During this period, 100,000 to 300,00 children were "warehoused" in these institutions. The vast majority of children in these institutions suffered from severe malnutrition, sometimes leading to brain damage and impaired cognitive development (Castle et al. 1999). Children in these orphanages experienced extreme social deprivation with little to no handling, limited play opportunities, and often had little space to move, which restricted their motor development (Castle et al. 1999).

With the fall of the CeauSescu regime in Romania at the end of the 1980s, photos and stories emerged of the plight of these children. These powerful stories and horrible conditions motivated many Western families to become adoptive parents to the orphans (Castle et al. 1999). Many of these children were adopted into British and Canadian families and experienced the unique context of early institutional deprivation and later adoption into a stable environment. Due to the deprivation experienced by the children in these orphanages numerous research studies have been complete on their physical, social and cognitive development. Much research has been conducted on Romanian orphans to see the effects of early stress and deprivation on later on mental health, social and cognitive development (Rutter, 2004).

In a study comparing Romanian children adopted into Britain and British children adopted within Britain, the Romanian children adopted at 6 months or younger showed no significant deficient compared with British adopted children (Rutter, 2004). However, Romanian children adopted over 6 months

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showed significant cognitive impairments compared to British children adopted under 6 months (Rutter, 2004). The results indicate a strong association between length and age of the child during institutionalization and future cognitive development (Rutter, 2004). There were also attachment deficits found in the Romanian adoptees that did not present in British adoptees (Rutter, 2004). The observations of the adoptive-parents of Romanian children indicated that many of the children failed to develop any attachment (Rutter, 2004). Many of the children manifested symptoms of Reactive Attachment Disorder, which often has serious behavioral and social implications (Rutter, 2004). This research on Romanian adoptees indicates a sensitive (if not critical) period for cognitive and socio-emotional development (Castle et al. 1999). Several other studies on Romanian orphans have collaborated results that length of time spent in an institution is correlated with slower cognitive and socio-emotional development (Castle et al. 1999). However, it is unclear if it was the age of the child at adoption or the duration spent in such institutions that negatively influenced development. It may be that with the same length of time spent in an institution, children older than 6 months are more sensitive to deprivation and younger infants may have more ability to recover (Castle et al. 1999).



While much of the research on Romanian adoptees confirms the negative developmental impacts of institutions, this research is only based off the truly worst of institutional conditions. In the United States, orphanages have all but been eliminated in favor of foster care and adoption. Several studies have looked at long-term outcomes of children who spent time in orphanages in the United States. One study surveyed 800 adults who spent a portion of their childhood in orphanages in the Midwest and South before 1967 (Mckenzie, 2003). The orphanages were a combination of private and public institutions (Mckenzie, 2003). An extensive survey was given to the participants all of, which graduated from their orphanages before 1967. The responses drawn from the survey were favorable on the whole — in fact these individuals actually surpassed their peers on many economic and social measures (Mckenzie, 2003).

However, a second survey showed that there was an increased level of divorce among the orphans. What seems to be unclear is the positive outcomes of these cases (Mckenzie, 2003). First, the names of the participants were accessed through the alumni mailing lists of the institutions and orphans with more

positive experiences may have been more likely to maintain further contact with the institutions (Mckenzie, 2003). Secondly, more successful and content alumni may have been more likely to respond compared with less successful alumni (Mckenzie, 2003). Yet, the results of these surveys do indicate that the outcomes were significantly more positive than in the cases of Romanian orphans, meaning that the quality of institutional care is crucial in predicting future outcomes.

Open and Closed Adoptions:

The structure of an adoption may also have developmental implication for the child. There are several forms legal adoptions can take often they are referred by varying levels of "openness." Openness refers to the level of contact between the child and the biological parents (Korff, Grotevant & McRoy, 2006). In confidential adoptions there is no communication or identifying information exchanged between child, adoptive family and biological parent (Korff et al. 2006). In fully disclosed adoptions, frequency of communication with the biological parent may vary and may come in the form of letters, or visits (Korff et al. 2006). In legal adoption the level of contact with biological parents is agreed prior to the actual adoption and usually occurs with the mediation of a third party (Korff et al. 2006). There has been much debate surrounding the emotional ramifications of open versus closed adoptions (Korff et al. 2006).

A recent study looked at adolescent behavioral outcomes in the context of open adoptions (Korff et al. 2006). The participants in the study were all adopted before the age of one year, and were between four and twelve years old (Korff et al. 2006). The sampled families were either participating in fully disclosed adoptions or confidential adoptions (Korff et al. 2006). The results of the study were not conclusive, though adoptive parent reports indicated some correlation between adjustment differences and level of openness (Korff et al. 2006). The results also suggested externalizing behavior was more common in closed adoption settings (Korff et al. 2006) Children in open adoption presented with less externalizing behavior and had better adjustment scores (Korff et al. 2006). While, further research is needed in this area, this study implies that open adoptions may aid in better developmental outcomes for children. In open adoptions a more integrated view of biological and adoptive parents may minimize the child's stress.

Prenatal and Genetic Risk Factors

Another possible contributor to the overrepresentation of adoptees in the mental health field may be an increased rate of genetic and prenatal risk factors. Biological parents are often motivated to give up a child by factors that would interfere with their ability to care for the child (Miall, 1996). There are a wide variety of reasons why a pregnant woman might choose adoption; they may be situational, age related, or religiously based. Biological parents of adoptees may be at high risks for drug usage, being young mothers, not knowing they were pregnant, having limited prenatal care, living in poverty and suffering from other risk factors. In some cases, children may be given up for adoption due to maternal mental illness and inability to care for the child, abuse, or incarceration of mother (Botting et al. 1998). It is possible that exposure to one or more of these risks may lead to prenatal and/or early childhood stresses. In addition, there may be some higher risks for genetic predispositions to mental illnesses and some behavioral issues.

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This paper will specifically examine the risks associated with teen pregnancy. Less than five percent of teen pregnancies result in adoption. However, teenage mothers still contribute a large portion of the adopted children in the United States (Miller & Coyl, 2000). Adolescent mothers are more likely than older mothers to be poor, have limited education and job skills, to be welfare dependent, and be unmarried (Donnelly & Voydanoff, 1991). The social pressure and stigma on pregnant adolescents may increase prenatal stress levels, which could in turn have implications for the child and pregnancy (Donnelly & Voydanoff, 1991). According to the United Kingdom's Office of National Statistics, pregnant adolescents have increased risk of maternal mortality and babies have an increased risk of infant mortality as well as low birth weight (Botting et al., 1998). These complications may be related to insufficient and inadequate prenatal care (Botting et al. 1998).

A study of teenage mothers in 1992 indicated that a quarter of pregnant adolescents had first consulted their general practitioner when they were more than three months pregnant (Botting, Rosato & Wood, 1998). A fifth did not have their first prenatal visit until after the 20th week of pregnancy (Botting, Rosato & Wood, 1998). Half of these delayed visits were due to the fact that women did not know they were pregnant (Botting, Rosato & Wood, 1998). In such cases, pregnant women may not be receiving necessary supplements, or may be engaging in riskier behaviors than they would have, had they known they were pregnant. This could account for possible cognitive or behavioral deficits seen in slightly higher rates in adopted children.

The Adoptive Family and Environment

While, the genetic and prenatal background of the child is crucial, the environmental context that the child grows up in is equally if not more significant in development. Thus, it is important to address the demographic of adoptive parents. In the United States, individuals seeking legal adoptions tend to have a fairly homogeneous background (Stolley, 1993). In most cases adoptive mothers are between the ages of 25 and 34 (Stolley, 1993). In addition, almost all adoptive parents are married at the time of adoption (Stolley, 1993). However, there is a more recent trend of increased single-parent adoptions (Stolley, 1993). Adoption appears most common in a white demographic and least common in Hispanic groups (Stolley, 1993). Higher levels of education and income are also associated with legal adoption (Stolley, 1993). It is unclear exactly what homogeneity of adoptive parents means in terms of adoption outcomes. It may in particular have implications for transracial and international adoptive families. The process through which an adopted child is placed in a family is different from a "natural" birth. Adoption has social connotations that diverge from those surrounding production of biological offspring. Parents of adoptive children may slightly alter behavior due to these pressures and perceptions. Any behavioral differences that do exist in adoptive parents are likely exaggerated in the period after placement. This is not to say that adoptive parents "love" adopted children any less than biological children, but merely suggests that behavior could be slightly altered in such cases. It obviously difficult to study this phenomenon applied to human subjects (Darnaudery, Koehl, Barbazanges, Cabib, Moal & Maccari, 2004). However, several studies addressing parental rat behaviors on adopted pups have investigated a similar topic.



One study compared infant rats with adoptive rat mother and biological rat mother interactions after a 15-minute period of separation and stress (Darnaudery et al., 2004). The testing occurred from 1 day to 13 days postnatally. Adoptive rat mothers had increased levels of maternal behavior (licking and arched back) in response to the handling procedure. These maternal behaviors helped decrease infant stress levels. Stress levels were measured by ultrasound emissions of infant rats (Darnaudery et al., 2004). There were fewer ultrasound emissions from adopted rats indicating a less stressful experience. However, as postnatal days increased the maternal licking decreased in response to the separation period (Darnaudery et al., 2004). Right after the "adoption" rat mothers were more responsive to their offspring but by the 12th day there was little to no difference between maternal response in adopted and non-adopted cases (Darnaudery et al., 2004).

While the usefulness of such rat studies is limited, they do provide some evidence for possible altered maternal behavior in adoption. In humans, adoption could potentially increase maternal care. Some research has indicated that grateful adoptive parents are insecure, overprotective and indulgent (Miall, 1996). Other research on adoptive parents demonstrates perfectionist goals both socially and academically for adopted children (Miall, 1996). However, behavioral differences of this kind often show more about methodological bias of the researchers than actual behavioral differences in parents or children (Miall, 1998).

Another possible altered behavior of adoptive mothers may be related to evidence that links the neurotransmitter oxytocin to infant-mother attachment. Oxytocin is a uniquely mammalian neuropeptide (Insel & Young, 2001). Oxytocin appears to be one of the key facilitators of maternal love and attachment (Insel & Young, 2001). Childbirth, through vaginocervical stimulation, releases oxytocin and initiates maternal behavior (Insel & Young, 2001). Oxytocin also helps trigger lactation (Insel & Young, 2001). However, while oxytocin is clearly implicated in attachment, there is little evidence indicating that children born cesarean have less attached mothers. Release of oxytocin may occur with affective touch and proximity to the infant (Insel & Young, 2001). The only real impact that lack of a natural birth could have on attachment would likely last a short period. In other words, it may take several days for the neurochemical substrates of attachment to be up and running in adoptive parents.

Social Perceptions of Adoption:

The social context, which an adoption occurs in, has a profound influence on how the child and the family conceptualize their adoptee/adoptive statuses (Miall, 1996). There is an over representation of adoptees in the mental health field. However, this disparity does not necessarily stem from behavioral problems in adoptees but instead could relate to cultural preconception about adoption. In the United States adoption is a fairly accepted, practice but still may be subject to stereotypes and stigmas. The "norm" for most families in United States is the presence of biological offspring. In both the United States and Canada, establishment of kinship has historically been based off of blood ties (Miall, 1996).

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"These blood ties are conceptualized as indissoluble and as mystical in nature, transcending legal or other kinship arrangements" (Miall, 1996, pp. 310). Adoption separates the biological from the social and challenges the notion that parenting begins with process of child bearing (Miall, 1996). Socially and clinically, adoption may be seen as a last resort and thus inferior to natural reproduction (Miall, 1996). It has also been argued that adoptive parents lack a full sense of entitlement to their children, originating from the social perception that biological parents are the "real" parents (Miall, 1996). However, recent shifts in vernacular have begun to shy away from words such as "real" in favor of "birth" or "biological." In a survey of 71 adoptive mothers, the majority of women wrote they had personally positive experience with adoption (Miall, 1996). Nonetheless, there were still three main social stigmas that emerged, including: that biological relatedness is important for love, that with unknown genetic history adoptive children are second best, and adoptive parents are not real parents (Miall, 1996). Community attitudes surrounding adoption may shape both family and child experiences (Miall, 1996). Stress may be minimized by community support and lack of social acceptance may create anxiety for the family and child (Miall, 1996). Social alienation and stigma have powerful implications for the socio-emotional development of the child (Miall, 1996). Adoptive children are seen as at high risk for identity issues, behavioral issues, and socio-emotional problems, and this phenomenon may increase the number of referrals, directing them towards the mental health field (Miall, 1996). The parents, communities and educational institutions of adopted children may have preconceptions about adoption and thus be more likely to seek or recommend mental healthcare for these children (Brodzinsky, 1993). This discrepancy could also result from the fact that the adoptive parents are more comfortable utilizing social services (Brodzinsky, 1993).

Conclusions:

Not only are there more mental health referrals among adoptees compared with the general population, they also are at higher risk for behavioral problems compared with non-adopted siblings (Brodzinsky, 1993; Sharma et al. 1998). However, causation of increased risks for adoptive children is unclear due to the many factors and confounding variables that surround adoption. The age a child was adopted appears to be associated with developmental outcomes especially in the form of attachment disorders (Howe, 2001). If a child was institutionalized the quality of institutional care is associated with future development (Castle et al. 1999). There is some evidence indicating that open adoptions create less externalizing behaviors in children (Korff et al. 2006). In addition, adoptees may have increased genetic risk factors and limited prenatal care (Botting et al., 1998). Perhaps even more importantly, adoptive parents may have altered behaviors with adoptive children (Miall, 1996). The social context that the family and the child exist in may also prescribe certain ideas or risks associated with adoption (Miall, 1996).

It is a complex interaction of many of these factors that guides adoptive development in terms of both socio-emotional and cognitive development. However, there does not appear to be an inherent risk factor associated with adoption itself, and instead the child's environment will largely determine their future developmental outcome. Even the overrepresentation of adoptees in the mental health field may be more related to cultural associations than actual increased behavioral problems. The findings of this paper indicate that adoption seems the best choice for development. Most extreme developmental and behavioral risks are more associated with institutionalization and deprivation.

Other risk factors that may be related to genetic and prenatal risks are not a product of adoption in itself. Risk factors in adoption are most likely primarily related to social stigma and preconceptions related to adoption (Miall, 1996). Parents who plan to adopt should be aware of the power of social preconception. However, ultimately the resilience of children placed in a positive environment should be emphasized.

Works Cited

- Brodzinsky, D. M., (1993). Long-term outcomes in adoption. *The Future of Children*, 3(1) 153-166.
- Castle, J., Groothues, C., Bredenkamp, D., Beckett, C., O'Connor, T., & Rutter, M. (1999). Effects of quality of early institutional care on cognitive attainment. *American Journal of Orthopsychiatry*, 69(4) 424-437.
- Botting, B., Rosato, M., & Wood, R. (1998) Teenage mothers and the health of their children. *Population Trends*, 3, 2-27.
- B. C., & Coyl, D. D., (2000). Adolescent pregnancy and childbearing in relationship to infant adoption in the United States. *Adoption Quarterly*, 4(1), 2-25.
- Darnaudey, M., Koehl, M., Barbazanges, B. Cabib, S., Moal, M. L., & Maccari, S. (2004). Early and later adoptions differently modify mother-pup interactions. *Behavioral Neuroscience*, (3), 590-596.
- Donnelly, B. W. & Voydanoff P. (1991) Factors associated with releasing for adoption among adolescent mothers. *Family Relations*, 40(4),404-410
- Hughes, D. A., (1999). Adopting children with attachment problems. *Child Welfare League of America*, 5, 541-560.
- Howe, David. (2001). Age at placement, adoption experience and adult adopted people's contact with their adoptive and birth mothers: An attachment perspective. *Attachment & Human Development* ,3 (2) 222-237.
- Insel, T. R. & Young, L. J. (2001). The neurobiology of attachment. *Nature Reviews*, 2, 129-135.
- Korf, V. L., Grotevant, H. D., & McRoy, R. G. (2006). Openness arrangements and psychological adjustment in adolescent adoptees. *Journal of Family Psychology*, 20(3), 531-534. DOI: 10.1037/0893-3200.20.3.531.
- Mckenzie, R. B.(2003).The impact of orphanages on the alumni's lives and assessments of their childhoods. *Children and Youth Services Review*, 25(9), 703-753.
- Miall, C. E. (1996). The social construction of adoption: Clinical and community perspectives. *Family Relations*, 45(3), 309-317.
- Rutter, M. G., & O'Connor, T., (2004) Are there biological programming effects for psychological development? Findings from a study of Romanian adoptees. *Developmental Psychology*, 40(1) 81-94.
- Sharma, A. R., McGue, M. K., & Benson, L. P., (1998). The psychological adjustment of United States adopted adolescents and their nonadopted siblings. *Child Development*, 69 (3), 791-802.
- Stolley, S. K. (1993). Statistics on adoption in the United States. *The Future of Children*, 3(1), 26-42.
- Tomlinson, M. (1997). "Pathways to attachment": The strange situation and culture in the South African context. *Southern African Journal of Child and Adolescent Mental Health*, 9(2), 107-122.



President's Corner

Dear Interpreters and Colleagues:

On behalf of the entire CCCS team, we want to thank you for all of your hard work and for another great year! Your work is truly appreciated by our customers, the LEP population we proudly serve, and by each and everyone at CCCS.

Almost 16 years ago CCCS started from the basement of my house as I displaced my kids from their playroom. It started out of a vision and a dream to impact a larger number of people who did not speak English. I worked as a clinician for over 10 years and I loved it, but I often felt that my clinical work was constantly being interrupted due to the lack of qualified cultural-linguistic services outside my team.

CCCS was built with the understanding that all patients have the right to quality, effective, and safe healthcare. It took the dedication of many staff members, interpreters, and customers to be able to sell thousands and thousands of encounter hours in 47 different languages, at a reasonable price.

Your willingness to partner with CCCS in maintaining complete accuracy and by offering the best customer services available, has truly shaped CCCS into being a company of choice for most of the small and large customers in Massachusetts and New Hampshire.

It has been my family tradition for many years to count 12 + 1 raisins (12 for the past twelve months and the 1 for the New Year). We hold them dearly in our hands and at the stroke of midnight with my family and dear ones, we jump onto the couch and eat them all. We hug and kiss, celebrating the New Year.

This simple ritual takes teamwork, time to plan and a system to make sure that each one of us gets only 13 raisins, not one more and not one less, exactly 13. It sounds simple but not always easy, when we involve all ages in this process of building a ritual, symbolic of hope. Missing the correct count might not be a good sign for the next year! Therefore, our quality assurance process with small kids, since one may be tempted to eat one of the dearly counted raisins, is to place the 13 raisins in a small sandwich bag and assign them an overseer.

Imagine all of us interpreters and customers celebrating this New Year, building a new passage, the one who will assure that all interpreters will get the support they need to become certified.

Let's use the 13 raisins to get us off to a good start and together we will assist you to reach our new goals for the New Year!

Zarita

"CCCS WAS BUILT WITH
THE UNDERSTANDING
THAT ALL PATIENTS HAVE
THE RIGHT TO QUALITY,
EFFECTIVE, AND SAFE
HEALTHCARE."



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Poem on Adoption

by: Liana Araujo-Lane

At my school Kids were
Were yelling, jumping, laughing
I was sledding
Peacefully
Then Crash
Boom
Bang
I hit my head on a tree
Crying, weeping, whining.
Afraid of going to the hospital
with scary doctors
and yucky medicine.

Not able to know
my name
I wish
I could see my Mom and Dad`

They are at work
But suddenly my mom comes in and hugs me
I'm safe

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Going Green

Being Green on Christmas

Christmas is coming. This is the time of the year when families get together and gifts are exchanged, but how are you going to wrap those gifts?

In this edition, we would like to give you some tips on how to be Green on Christmas.

- Recycle, be creative. Use your imagination
- Re-use those gift bags that were given to you in the past. Also, re-use the left-over wrapping paper from last year
- Buy refurbished electronics. They are cheaper and greener
- Take advantage of the web and send e-cards to the ones you love

Have a Merry Green Christmas and a Happy New Green Year!

Daniel DeOliveira

English Idioms Explained

Idiom	Explanation	Example
To tend to	To be inclined	The candidates always tend to exaggerate during a political campaign.
By the seat on one's pants	By trial and error /Without instruments or tools.	The pilot had to fly the plane by the seat of his pants when all the instruments failed.
To knock it off	To stop/To cease	Please tell the kids to knock it off. It's time to go to sleep.
To pull a fast one	To be sneaky	When nobody was looking, he pulled a fast one and made an illegal U-turn.
A lot is riding on	Much depends on	We have to work hard because a lot is riding on this project.



Interpreter Services

To our valued interpreters:

The members of the Interpreter Resource Q. A. department here at CCCS would like to express their gratitude regarding everyone's cooperation over the past year. Providing updated information related to interpreters' immunization records, late service forms, quizzes, etc... Has been and shall remain to be a continuous process. We are very grateful for your cooperation in providing us with this information; this allows us to satisfy client requirements. As part of our contractual obligations with our clients, we are required to ensure that all Per Diem Interpreters hired by CCCS have updated immunization records. At this time we would also like to stress the importance of the service forms. In order to process client billing in a timely manner we ask that you send in all service forms within 48 hours of assignment. We cannot bill the client without the forms. The longer it takes for these forms to be submitted the longer it takes to receive payment for the services rendered.



We also ask that all CCCS Interpreters complete the mandatory quizzes when issued as soon as possible. The quiz program has been modified and implemented in a way that allows CCCS to satisfy HIPAA, Safety and Sexual Harassment regulations. Different companies deal with these regulations in different ways. The quiz program works best for our organization. It is important to note that we track when the quizzes are completed. Failure to complete the mandatory quizzes shall result in a failure to comply with these regulations. The failure of Per Diem Interpreters to comply with the regulations through our quiz program shall prevent us from assigning interpreting cases to those Per Diem Interpreters.

We have the quizzes available on line. When a new quiz is posted, an email shall be sent to let you know that the quiz is available. If you are not familiar with taking these quizzes on line please let us know. We will be more than happy to have you come into our office. We will help you take these quizzes if help is needed. We recognize that your time is valuable. As a thanks for taking the mandatory quizzes CCCS will send you a check for each of the quizzes taken for up to 4 quizzes a year. Mandatory quizzes must be done every two years. Please watch for these when they are issued.

Answers to the CCCS Crossword - November 2011

Across	
1. Fish	
3. Yogurt	
5. Nuts	
7. Pesto	
9. Predatory	
11. Toxin	
12. Omega	
13. Osteoporosis	
Down	
2. Saturated	
4. Gram	
6. Psychosis	
8. Adopt	
10. Alzheimers	
11. Thrombus	



Ask Dr. Lane

What is Fish Oil? Why is it Important and How can I get enough of it?

You have probably heard from a friend or seen on the net, that taking fish oil tablets is beneficial to your health. What is fish oil and how can it be helpful? First, you should know that the helpful elements of fish oil are called omega 3 fatty acids, specifically EPA and DHA. There are several health benefits but primarily preventing heart attack and strokes are the areas in which there is most convincing research.

Fish oil is a combination of fatty acids that are mono-unsaturated or poly-unsaturated fatty acids. These are chains of carbon atoms with a carboxyl section on one end which makes the molecule an acid. The majority of the carbon atoms are joined by a single bond. When there is a double bond between atoms, this is an unsaturated bond. Fatty acids with unsaturated bonds tend to be liquids at room temperature. They are also part of a diet which can lower cholesterol, low density lipoproteins and prevent or decrease the effect of coronary artery disease.

Fish produce poly-unsaturated fatty acids (PUFA) where the double bond is three carbons from the omega end of the chain. The omega end is opposite of the carboxyl end. When it is three carbons from the omega end, the PUFA is called omega 3. When it is six carbons from the omega end it is called an omega 6 fatty acid. And yes, when it is nine carbons from the omega end it is an omega 9 fatty acid. Note that omega 6 fatty acids are also felt to give cardiovascular health benefits. Omega 6 fatty acids come from plant oils such as corn, soybean and sunflower oil as well as from nuts and seeds.

Omega 3 fatty acids are the most beneficial to human health. The three major omega 3 fatty acids are EPA (eicosapentanoic acid), DHA (docosahexanoic acid) and ALA (alpha linoleic acid). EPA and DHA are found primarily in fish tissues of herring, halibut, salmon, coho, albacore tuna, bluefish, lake trout and pink and king salmons. ALA is actually found in vegetable oil such as canola, corn and soybean and even in some beef fat and lard. It can be converted to EPA and DHA in the body but this process is slow and inefficient. The health benefits of EPA and DHA include:

- Decreased risk of arrhythmias that can lead to sudden cardiac death
- Decreased risk of blood clots (thrombosis) that can lead to heart attacks or strokes
- Lower serum triglyceride levels
- Slowing the growth of atherosclerosis process (plaque formation)
- Improving the function of blood vessel walls
- Decreasing inflammation
- Decreasing high blood pressure

The US National Institute of Health lists three conditions for which fish oil and other omega-3 sources are most highly recommended: hypertriglyceridemia, secondary cardiovascular disease and high blood pressure. It then lists 27 other conditions for which there is less evidence. These include preventing cancer, treating depression, Alzheimer's disease, Lupus, Parkinson's disease, psoriasis and arthritis. There is also evidence for effectiveness in rheumatoid arthritis, menstrual pain, ADHD in children, Raynaud's syndrome, macular degeneration, osteoporosis, symptoms of bipolar disorder, and psychosis.

EPA and DHA can be found in highest concentrations in predatory fish such as shark, mackerel, albacore tuna, swordfish and tile fish. But as they are on top of the food

CONTINUED

"THE US NATIONAL INSTITUTE OF HEALTH LISTS THREE CONDITIONS FOR WHICH FISH OIL AND OTHER OMEGA-3 SOURCES ARE MOST HIGHLY RECOMMENDED: HYPERTRIGLYCERIDEMIA, SECONDARY CARDIOVASCULAR DISEASE AND HIGH BLOOD PRESSURE."

Ask Dr. Lane

(CONTINUED FROM PAGE 6)

chain they can accumulate toxic substances such as mercury and PCB's. The liver of these sea animals detoxes toxins from the body, so if the source of the EPA is liver and liver products (like cod liver oil), there may be excessive levels of PCB's which is a cancer-producing toxin. For this reason, some people are limiting their fish intake and relying on omega 3 containing supplements which reliably eliminate the toxins.

The FDA says it is safe to take 3000mg of omega 3 per day. However, note that this does not mean 3000 grams of fish oil. A 1000mg pill of fish oil typically has only 300mg of omega 3 so 10 pills would equal 3000 mg oral omega 3. The US National Institute of Health also lists possible safety concerns: "Intake of 3 grams per day or greater of omega 3 fatty acids may increase the risk of bleeding although there is little evidence for significant bleeding risk at lower doses. Very large intakes of fish oil/omega 3 fatty acids may increase the risk of hemorrhagic (bleeding) stroke."

How Much Should I take?

The most important advice is that for a fish oil supplement, you should discuss it with your doctor. Your specific conditions and particular goal will determine the amount of EPA and DHA you take. Here are some general suggestions, but check with your doctor before starting any regimen. (Remember that grams of fish oil are not the same as grams of omega 3 fatty acids.)

- For high triglycerides 1-4 grams of fish oil per day
- For high blood pressure either 4 grams of fish oil or fish oil providing 2.04 grams of EPA and 1.4 grams of DHA per day.
- For atherosclerosis six grams/day of fish oil for three months, then 3 grams /day thereafter.
- For weight loss 0.66 grams EPA and 0.60 grams from DHA.

Here are some other simple changes in your diet you can make to improve the amount of unsaturated fats including those from fish oil and vegetable oil in your diet:

- **Add Nuts to the Menu.** Nuts abound with omega 3 and omega 6 fatty acids. In 2010, a meta-analysis found a weekly serving of nuts lowered risk of dying of coronary disease by 8.3%. Suggestions: add cashews or almonds to stir-fried dishes, top salads with walnuts, put ground walnuts in pesto sauce and almonds on baked chicken or trout.
- **Put Fish in Your Diet.** As we've said, fish is rich in EPA and DHA both of which fight inflammation and protect against heart disease. If you do not have heart disease, eat 3.5 ounces of cooked fish (one serving) twice a week. If you have had coronary artery disease, the American Heart Association recommends at least one gram of EPA and one gram of DHA per day, preferably from fatty fish.
- **Switch from butter and cream to unsaturated oils.** Unsaturated fats from vegetable oils, nuts and fish can help lower cholesterol levels. Examples: sauté in vegetable oil instead of butter, drizzle olive oil over vegetables, dip bread in olive oil instead of spreading butter, use non hydrogenated margarine in place of butter, make cream sauces with low fat yogurt, eat oil based salad dressing over creamy dressings.

Bibliography

http://en.wikipedia.org/wiki/Fish_oil
<http://www.webmed.ocm/diet/healthy-kitchen-11/omega-fatty-acids>
<http://www.thenutritiondr.com/2011/12/omega-3-the-cardiovascular-super-hero/>

ABBREVIATIONS

Know your Acronyms and Abbrev.

TIA	Transient Ischemic Attac
Stat	(statim) at once, immediately
ER	Emergency Room
OR	Operating Room
PACU	Post Anesthesia Care Unit
ICU	Intensive Care Unit
P.A.	Physician's Assistant
q.l.	(quantum libet) as much as desired
q.i.d.	(quater in die) four times a day

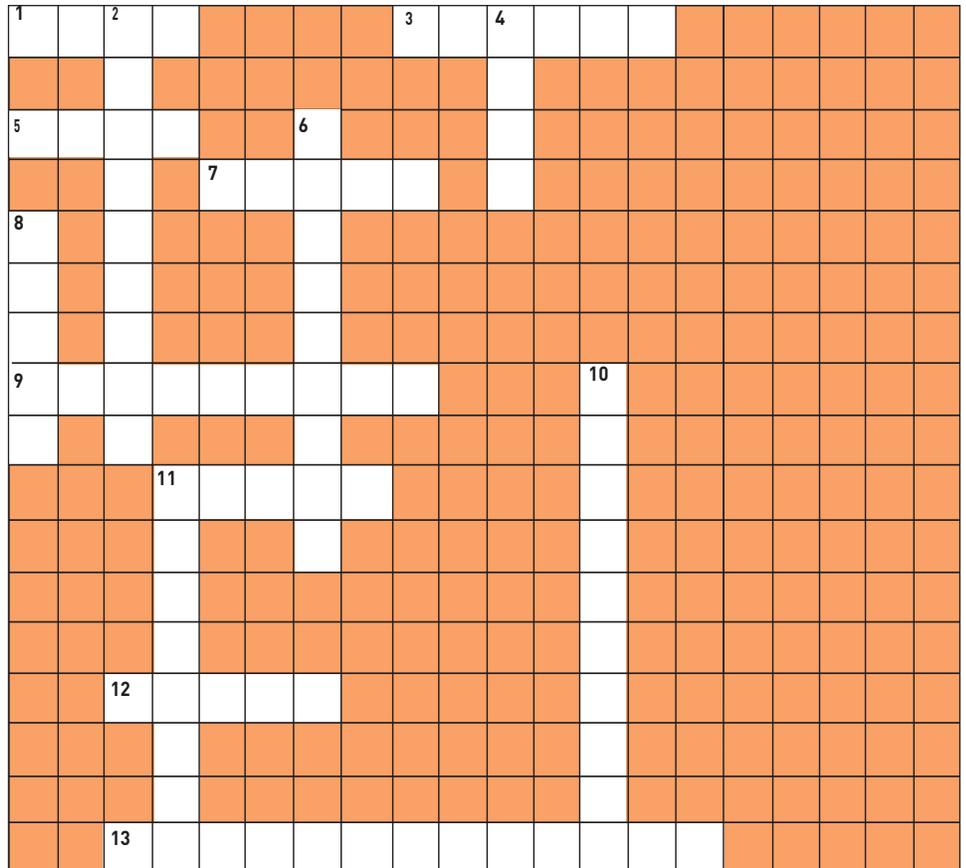
November Crossword

ACROSS

1. Any of numerous cold-blooded aquatic vertebrates characteristically having fins, gills, and a streamlined body.
3. A custard-like tart flavored food prepared from milk curdled by bacteria often sweetened or flavored.
5. Almond, walnuts, cashews, etc. are:
7. A sauce consisting of fresh basil, garlic, pine nuts, olive oil and grated cheese.
9. Shark, mackerel, albacore tuna, swordfish are this type of fish that contains the highest concentrations of EPA and DHA.
11. A poisonous substance. A protein, that is produced by living cells or organisms and is capable of causing disease.
12. The end - (the 24th letter of the Greek alphabet)
13. Disease in which bones become very porous, are subject to fractures and heal very slowly.

DOWN

2. Butter and cream are examples of these unhealthy fats
4. A metric unit of mass equal to one thousandth of a kilogram
6. A severe mental disorder, characterized by derangement of personality and loss of contact with reality
8. To take into one's family through legal means and raise as one's own child.
10. Disease marked by progressive loss of mental capacity.
11. A blood clot



Answers to the crossword can be found on page 9.

**CCCS Interpreters can go to
www.embracingcultureonline.com
 to take their continuing education quiz.**

Vocabulary

Arrhythmia – An irregularity in the force or rhythm of the heartbeat.

Arthritis – Joint inflammation causing pain and swelling.

Arthrosis – A degenerative disease of a joint.

Bipolar Disorder – A major affective disorder marked by episodes of mania and depression.

Cognitive – Characterized by involving or relating to cognition the mental process or faculty of knowing including aspects such as awareness, perception, reasoning and judgement.

Lupus – Any of several diseases especially systemic lupus erythematosus that principally affect the skin and joints.

Oxytocin – Hormone that causes myometrial contractions at term and promotes milk release during lactation used for the induction or stimulation of labor.

Plaque – A deposit of fatty material on the inner lining of an arterial wall, characteristic of atherosclerosis.

Psoriasis – A non-contagious inflammatory skin disease characterized by recurring scaly reddish patches.

Raynaud's Syndrome – A circulatory disorder that affects the hands and feet, causing cyanosis, numbness, pain and in extreme cases gangrene.

Thrombosis – The formation, presence or development of a thrombus.

Thrombus – A fibrinous clot formed in a blood vessel or in a chamber of the heart.