Family Practice Grand Rounds

Adoption: The Family Physician's Role

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DR. DAVID LYMAN *(Resident in Family Practice)*: Many physicians find themselves involved in many phases of the complex relationships that exist among birth parents, adoptive parents, and the adoptee. With adoption providing an alternative to abortion for many women today, relinquishment is a growing part of the family physician's obstetrical practice. The relinquishing mother may need assistance in adjusting to relinquishment. Adoptive parents or agencies may seek advice about the health, development, and behavior of their adopted child. Families with adopted children often have questions regarding various aspects of rearing these children. Adoptees have an increased incidence of behavior, learning, and psychiatric problems.[1] Many adult adoptees are now seeking knowledge of their biologic heritage for many reasons, one being to make family planning decisions; and they seek their physicians out in consultation. Family physicians may become involved in any or all of these aspects.

At present, there are over 2.5 million adoptees younger than 21 years in the United States; this is 1 percent of all Americans and 2 percent of that age group.[1] There are an additional 350,000 children in foster families.[1] In the 1940s, there was an ample supply of newborn babies, producing what has been called "an adoptive parent's market." At that time there was a concerted effort to suppress the identity of the biologic mother. Records were sealed and new birth certificates were issued. The legal rights of adoptees were undefined. In the 1960s and 1970s there was a decrease in babies available for adoption due to many factors, including increased birth control and abortion and a decrease in relinquishment by young single mothers. It was no longer an adoptive parent's market. Black market adoptions increased, with fees anywhere from $10,000 to $100,000.

Adoption of foreign children increased. State and federal agencies got involved in funding to encourage the adoption of older and handicapped children. Today, legal adoptions are handled either through agencies or independently. Let's begin by describing the various adoptive arrangements.

SANDRA MARTIN *(Social Worker, Department of Social Services)*: The authorized vehicles for adoption in Colorado are county, state, and private adoption agencies. Adoptions can also be managed independently through a lawyer. Only licensed agencies, however, are empowered to act as an intermediary to pass the child from biologic to adoptive parents, and they are regulated by state law to provide specific services. Agencies usually offer several services that are not available through independent adoptions, such as counseling for the birth parents, screening and counseling of prospective adoptive parents, medical care for the newborn child, temporary foster care while the birth parents make their decision regarding termination of their parental rights, and ongoing assistance and counseling of biologic parents and adoptive parents. Agencies are also required to counsel the birth mother regarding all of her legal rights that might enable her to keep the child. For example, she would be entitled to such programs as

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AFDC (Aid to Families with Dependent Children) or food stamps. She could also sue the father of the baby for child support, whereas he in turn could sue her if he wanted to keep the child. Also, a court date for the termination of the birth mother's rights cannot be set until after the child is born and then only with her full participation. This precaution is designed to protect the birth parents from making a decision prematurely or under pressure or without reviewing all of their alternatives. After deciding to relinquish, the birth parents usually participate in choosing adoptive parents. Licensed adoption agencies may petition the court system for voluntary relinquishment in the first one to three weeks of the child's life, leading in a matter of days to a transfer of parental rights. The agency then has an ongoing responsibility to support and counsel biologic and adoptive parents.

Independent adoptions have certain drawbacks. Usually birth and adoptive parents are not offered the variety of services and opportunities for counseling. In an independent adoption, the lawyer must wait at least one year, have the birth parents sign a "power of attorney," then ask the court to terminate birth parents' rights based on the child's having an attachment to the adoptive couple. The adoptive parents take a significant legal risk in these cases because the birth parents can ask for the child back at any point during that year.

Because in Colorado, as well as across the nation, the birth father has legal rights and responsibilities to his child, his parental rights must also be terminated. Probably in about 60 to 70 percent of the cases in infant adoption, the birth father is not involved with the birth mother much beyond conception, or if involved, chooses not to be involved with the legal processes. The law allows the birth father to legally terminate his rights before the child is born simply by signing a notorized petition and waiver of rights. If the birth father is involved with the birth mother and wants to go to court, he can do so and his parental rights would be terminated with hers. Agencies encourage available birth fathers to be involved in the counseling process so that they too can make an informed decision.

DR. ARIS SOPHOCLES *(Family Physician)*: What sort of monetary exchange usually occurs?

MS. MARTIN: Agencies are restricted by the law from offering direct tangible assistance to birth mothers such as money for food, care, and clothing. Such assistance would be considered attempting to buy the baby and unduly influencing the mother's decision. What agencies can do is offer a limited amount of financial assistance paid directly to the hospital, physician, or clinic for the birth mother after the baby has been born. In our agency, this money comes from a fund created by potential adoptive parents. There is a maximum amount varying from agency to agency that agencies can pay per client. If more direct assistance is needed, the local Department of Social Services or United Way Agency can provide further resources.

In independent adoptions, the financial arrangements vary widely. Generally, the potential adoptive family pays medical expenses. They may also pay living expenses during pregnancy. The attorney receives a fee above the usual court costs, and sometimes the birth mother receives an additional sum of money, which is not considered legal. As a result, independent adoptions may prove more financially rewarding to mothers, though services and counseling are usually minimal.

DR. STEVEN POOLE *(Associate Professor, Family Practice and Pediatrics)*: Could you share with us the formal and informal criteria used in evaluating a couple regarding their potential as adoptive parents for infants?

MS. MARTIN: The women who come through our agency all seem to want a better life for their baby than they can provide. They also want as much control over planning an immediate future for their baby as possible. Therefore, many want to be involved in selecting a family for their baby. This in turn puts agency personnel in a position of wanting to select the most capable families available. We require that each family be able to financially support an addition to their family. We also require that the couple be married for at least two years and be in good physical health. The emotional and psychological status of an adoptive couple is assessed to make sure that there are no obvious instabilities and the couple has a good, solid marriage capable of sustaining itself for a long time. We also assess the couple's ability to parent a child. We look for open and flexible couples, since an adopted child needs open and understanding parents as he begins to deal with his biological heritage. Prospective parents who have chronic medical conditions are acceptable if their physician can assure us that they are managing the disease well. They must also be medically infertile

or have been unsuccessful in producing a child for at least five years.

DR. PAMELA McBOGG *(Pediatrician and Director, Developmental Evaluation Clinic, Children's Hospital, Denver)*: Would you comment on the motivating factors for adoption that would not be appropriate?

MS. MARTIN: We assess each couple individually and pay particular attention to their motivation for wanting a child. One couple we interviewed never had intercourse but wanted an infant. This is not a good motivation for wanting to adopt. In some crumbling marriages the couple wants to have a child "to save the marriage." During the assessment phase we will bring these issues to their attention, suggesting counseling to clarify their motivations for adoption, and offer an opportunity to strengthen the marital bond. After six months we will help them reassess their progress and readiness for adoption.

DR. LYMAN: What prenatal counseling does the relinquishing mother need? What interaction should she have with her baby? And what are the maternal complications of relinquishment?

MS. MARTIN: Adoption counseling begins with the counselor taking things as the client presents them. To assist the clients in making the best decision for themselves and their babies, it is important to explore thoroughly with them all the alternatives, from keeping their infants and all the responsibilities resulting from that decision to relinquishing and what that means. If the client leans toward relinquishment, it is important to review the birthing process and hospital stay with her. It is best for future psychological adjustment for the relinquishing mother to have as much involvement with her child as she feels comfortable having. For some, this means naming the child, caring for it in the hospital, and even rooming in with the child. For others, it means seeing the baby once and spending the rest of the time on a nonmaternity ward. Either way, contact with the baby is important for two reasons: (1) the birth mother continues to be emotionally responsible for her decisions, and (2) the birth mother is still legally responsible for the infant until she goes to court. If the birth mother is very much involved, this contact also tends to give her a strong sense of completion of her pregnancy, and when the baby is healthy, there is reaffirmation that her child will make someone a wonderful gift that is lovable and will begin in the world with a good start. These interactions seem to be important in terms of helping the client grieve the loss of parenting her child and then letting go to finish her own maturation. It is easier to let go of and grieve the loss of someone that you have memories of rather than something that is unknown.

There is considerable research to suggest that young unmarried women get pregnant for specific reasons of which they may or may not be aware. We, therefore, view many pregnancies as a possible symptom of another problem or problems in their lives they are unable to deal with in a way that has proven effective for themselves. For example, we find that a large percentage of the women get pregnant soon after the loss of a significant person in their lives, usually a parent or parental figure, through separation, divorce, or death. This person was very important to them, and his or her loss leaves the woman feeling unloved, unimportant, very alone, insignificant, and out of control of her life. The pregnancy becomes an attempt to get this person back, create a substitute loved one, or achieve a significance they feel they could not command on their own. The pregnancy may represent one of four things: a cry for help or attention, a way of getting control of their lives, an attempt at gaining recognition, or some combination of the three. Through the counseling process women are able to explore alternatives for dealing with the loss of a loved one (such as being able to grieve openly with the counselor), thereby gaining control of their lives by understanding themselves and their emotional needs, and gaining confidence in getting these needs met in a direct and satisfying way. Gaining recognition is for many young women a task tied to establishing themselves as adults that provides a feeling of accomplishment in their lives. Mastery of skills needed for school, athletics, or interpersonal relationships is required of every emerging adult. We assist our clients in finding ways to contribute to society other than through their sexuality.

DR. LORRAINE WOOD *(Family Practice Resident)*: How many women decide to keep their babies, and what is the outcome if they decide to keep them?

ANNE DECHANT *(Social Worker, Lutheran Family Services)*: I don't know of any national

Continued on page 449

Continued from page 445

data that indicate the proportion of women who relinquish vs those who keep their children. In our setting, 50 percent keep their babies and 50 percent relinquish them. The most common form of adoption occurs through relinquishment to a member of the extended family, accounting for two thirds of all adoptions.

DR. McBOGG: Of all unwed mothers up to the 1970s, the single criterion that determined outcome for mother and baby was socioeconomic status.[2] Another important criterion was age of the mother. A 12-year-old was considered a poorer risk as a parent than a 16-year-old girl.[2,3] After the maternal age of 16 to 18 years, age was not so important a factor.

DR. LYMAN: What do you do when a woman who originally decided to relinquish changes her mind after delivery?

MS. DECHANT: She keeps the baby. It's her decision.

DR. McBOGG: Prenatal counseling is especially important. If a therapeutic relationship is formed prior to delivery, then the therapist can say, "Remember all the things we talked about—what would happen if you kept the baby and what would happen if you didn't?" You can retrace your steps. If the mother still decides to keep the baby, then she keeps the baby. The relationship developed earlier with the mother continues to be beneficial. The therapist can proceed to be supportive and offer guidance to the new parent.

MARY ANN BARBEE *(Nurse Consultant, Children's Hospital)*: It may be difficult for the birth mother to combat the social pressures and the feelings of guilt and loss that develop as she faces relinquishment. Supportive counseling can help her deal with ambivalent feelings and begin the preparatory work of grieving as well as lay the foundation for making a good decision. If she decides to keep the baby, the resolution of ambivalent feelings is important to reduce the risk of future neglect or abuse.

DR. LYMAN: Are there data associating an extended family or social support network as either decreasing or increasing the incidence of child abuse?

MS. DECHANT: If a mother has support, she is less likely to be an abusive parent. Isolated parents are more likely to be abusive parents because they often have problems that have alienated those who are willing to help.

MS. BARBEE: There can be a paradoxical twist to extended family members serving as supports. Child abuse is often a multigenerational problem in terms of people learning to parent from their own parents; therefore, some extended family members may not be appropriate as support systems because of the similarities in family values about discipline, punishment, and violence. Supportive networks outside the extended family are crucial to stopping the abusive cycle.

DR. LYMAN: Is an apparently healthy adopted child at risk for more health problems or mental health problems than biologic children? What information do we need for an adequate initial assessment?

MS. DECHANT: When I went into adoptive services, I assumed that environment was the main determining factor in adaptation to life. My experience in adoption and foster care, however, has shown me that many aspects of personality and behavior are determined by genes. We usually know very little about the personalities and behavior of the adopted child's biologic parents, only what the mother tells us, and that is usually sketchy at best. Just as we need a good family history of medical diseases, we need good family history about temperament, personality, behavioral problems, mental illness, and learning problems to help us understand the adopted child's behavior and perhaps better counsel adoptive parents.

DR. McBOGG: I would urge physicians to take extensive family histories on adopted children. A way to improve the child's care is taking complete family histories, including mental health problems, learning problems, chronic medical diseases, and developmental delays. Each of these areas is likely to influence the adopted child's adaptation. We need to know much more about the biologic family history than simply a history of the biologic mother and father. Ask about the biologic parents' extended family, or interview members by telephone. It will pay off later for the child.

DR. RICHARD E. ANSTETT *(Assistant Professor, Department of Family Medicine)*: It is very important for adoptive parents to have realistic expectations for their adopted child. Knowing the birth family history can help adoptive parents understand and accept differences. It is one thing

Continued on page 452

Continued from page 449

to accept that an adopted child may not resemble the adoptive parents or adoptive siblings; it is another to have a deeper understanding of these differences, which can help new parents see why, for example, an adopted child is having to repeat kindergarten. When the adoptive parents have such information initially, the counselor can help them adapt their expectations: How smart does my son have to be? Will I still love him if such and such is the case?

DR. McBOGG: First, we could answer those questions better if we had a more extensive family history. Second, the interim foster parent or the counselor can get to know the child and provide the adoptive parents with a description of the infant's behavior and temperament. We can be much more aware at the beginning of an infant's disposition, and we can be much more specific in saying, "This is the kind of infant who needs such and such. Do you feel comfortable with that?" But I think there are specific problems we can get at much sooner. It is a lot easier for adoptive parents to accept an infant who is crying 24 hours a day if they know the father had colic and he somehow survived. Knowing that may be the only thing that keeps new parents going. So, the more information you have about biologic parents and the extended family, the better.

MS. DECHANT: State and county agencies often do not get this kind of information. We often have an antagonistic relationship with the birth parents once we go through termination, and then many birth parents disappear. It would be ideal if the physician who saw the child could get that information.

DR. McBOGG: Legally, I would like more access to their birth records and the ability to talk to family members just in terms of family history. We should make that effort.

MS. DECHANT: You'll have to change the law to do that.

DR. McBOGG: Yes, I think that's a legal issue.

MS. BARBEE: This whole area is begging for high-quality research. For many years the area of relinquishment and adoption was a societal taboo and was not discussed. There certainly wasn't money for studies to determine some of these children's issues or to identify some predictors about their adjustment and health problems.

DR. LYMAN: What should we know to help out with behavioral problems that arise in adopted children?

MS. BARBEE: It is difficult to generalize without considering the following factors: (1) the age of the child when relinquished and when adopted, (2) past experiences while with the birth parents, eg, abuse, neglect, parental death, abandonment, (3) number of previous separations or losses and coping patterns, (4) specific strengths and handicapping conditions, and (5) composition and dynamics of the adoptive family. Many older adopted children have experienced frequent moves from foster home to foster home. Some have specific learning disabilities. Others bring behavioral problems to their new family. Thus, issues of grieving losses, establishing trust, maintaining or increasing self-esteem, and testing limits and structures are paramount. Family physicians should assist adoptive parents in sorting out normal developmental issues from those that require specific interventions from health professionals.

DR. McBOGG: When considering a problem in the older adopted child, think of it in terms of separation and loss, and 99 percent of the problem will be solved. Separation and loss issues surface frequently around adoption. Adolescents who raise the question "Why was I adopted?" or "Why did someone want to get rid of me?" or "Why did they not want me?" are basically dealing with separation or loss. The child feels undervalued or abandoned and may be grieving, so explore the child's and parents' feelings about those issues.

It is also important to be aware of different temperaments. Many parents do not understand that a child's temperament highly influences how he or she behaves. They may have trouble with their adopted child because they just never had an experience with someone with that particular type of temperament. The child may be perfectly fine, just unfamiliar.

MS. BARBEE: The ongoing counseling and support that the family physician offers is crucial during the years after adoption. The social workers are usually available for counseling and support during that first year of the adoptive process, but not in subsequent years. Behavior problems may arise in children around anniversary dates

Continued on page 462

TRANDATE® Tablets (labetalol hydrochloride) BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS AND USAGE: TRANDATE® (labetalol hydrochloride) Tablets are indicated in the management of hypertension. TRANDATE Tablets may be used alone or in combination with other antihypertensive agents, especially thiazide and loop diuretics.

CONTRAINDICATIONS: TRANDATE® Tablets are contraindicated in bronchial asthma, overt cardiac failure, greater than first degree heart block, cardiogenic shock, and severe bradycardia (see WARNINGS).

WARNINGS: Cardiac Failure: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure. Beta blockade carries a potential hazard of further depressing myocardial contractility and precipitating more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, labetalol HCl can be used with caution in patients with a history of heart failure who are well-compensated. Congestive heart failure has been observed in patients receiving labetalol HCl. Labetalol HCl does not abolish the inotropic action of digitalis on heart muscle.

In Patients Without a History of Cardiac Failure: In patients with latent cardiac insufficiency, continued depression of the myocardium with beta-blocking agents over a period of time can in some cases lead to cardiac failure. At the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or be given a diuretic, and the response observed closely. If cardiac failure continues, despite adequate digitalization and diuretic, TRANDATE® therapy should be withdrawn (gradually, if possible).

Exacerbation of Ischemic Heart Disease Following Abrupt Withdrawal: Angina pectoris has not been reported upon labetalol HCl discontinuation. However, hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy; exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronically administered TRANDATE, particularly in patients with ischemic heart disease, the dosage should be gradually reduced over a period of 1 to 2 weeks and the patient should be carefully monitored. If angina markedly worsens or acute coronary insufficiency develops, TRANDATE administration should be reinstituted promptly, at least temporarily, and other measures appropriate for the management of unstable angina should be taken. Patients should be warned against interruption or discontinuation of therapy without the physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue TRANDATE therapy abruptly even in patients treated only for hypertension.

Nonallergic Bronchospasm (eg, chronic bronchitis and emphysema): Patients with bronchospastic disease should, in general, not receive beta-blockers. TRANDATE may be used with caution, however, in patients who do not respond to, or cannot tolerate, other antihypertensive agents. It is prudent, if TRANDATE is used, to use the smallest effective dose, so that inhibition of endogenous or exogenous beta-agonists is minimized.

Pheochromocytoma: Labetalol HCl has been shown to be effective in lowering the blood pressure and relieving symptoms in patients with pheochromocytoma. However, paradoxical hypertensive responses have been reported in a few patients with this tumor; therefore, use caution when administering labetalol HCl to patients with pheochromocytoma.

Diabetes Mellitus and Hypoglycemia: Beta-adrenergic blockade may prevent the appearance of premonitory signs and symptoms (eg, tachycardia) of acute hypoglycemia. This is especially important with labile diabetics. Betablockade also reduces the release of insulin in response to hypoglycemia; it may therefore be necessary to adjust the dose of antidiabetic drugs.

Major Surgery: The necessity or desirability of withdrawing beta-blocking therapy prior to major surgery is controversial. Protracted severe hypotension and difficulty in restarting or maintaining a heart beat have been reported with beta-blockers. The effect of labetalol HCl's alpha-adrenergic activity has not been evaluated in this setting.

A synergism between labetalol HCl and halothane anesthesia has been shown (see Drug Interactions under PRECAUTIONS).

PRECAUTIONS: General: ***Impaired Hepatic Function:*** TRANDATE® Tablets should be used with caution in patients with impaired hepatic function since metabolism of the drug may be diminished.

Jaundice or Hepatic Dysfunction: On rare occasions, labetalol HCl has been associated with jaundice (both hepatic and cholestatic). It is therefore recommended that treatment with labetalol HCl be stopped immediately should a patient develop jaundice or laboratory evidence of liver injury. Both have been shown to be reversible on stopping therapy.

Information for Patients: As with all drugs with beta-blocking activity, certain advice to patients being treated with labetalol HCl is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects. While no incidence of the abrupt withdrawal phenomenon (exacerbation of angina pectoris) has been reported with labetalol HCl, dosing with TRANDATE Tablets should not be interrupted or discontinued without a physician's advice. Patients being treated with TRANDATE Tablets should consult a physician at any sign of impending cardiac failure. Also, transient scalp tingling may occur, usually when treatment with TRANDATE Tablets is initiated (see ADVERSE REACTIONS).

Laboratory Tests: As with any new drug given over prolonged periods, laboratory parameters should be observed over regular intervals. In patients with concomitant illnesses, such as impaired renal function, appropriate tests should be done to monitor these conditions.

Drug Interactions: In one survey, 2.3% of patients taking labetalol HCl in combination with tricyclic antidepressants experienced tremor as compared to 0.7% reported to occur with labetalol HCl alone. The contribution of each of the treatments to this adverse reaction is unknown, but the possibility of a drug interaction cannot be excluded.

Drugs possessing beta-blocking properties can blunt the bronchodilator effect of beta-receptor agonist drugs in patients with bronchospasm; therefore, doses greater than the normal anti-asthmatic dose of beta-agonist bronchodilator drugs may be required.

Cimetidine has been shown to increase the bioavailability of labetalol HCl. Since this could be explained either by enhanced absorption or by an alteration of hepatic metabolism of labetalol HCl, special care should be used in establishing the dose required for blood pressure control in such patients.

Synergism has been shown between halothane anesthesia and intravenously administered labetalol HCl. During controlled hypotensive anesthesia using labetalol HCl in association with halothane, high concentrations (3% or above) of halothane should not be used because the degree of hypotension will be increased and because of the possibility of a large reduction in cardiac output and an increase in central venous pressure. The anesthesiologist should be informed when a patient is receiving labetalol HCl.

Labetalol HCl blunts the reflex tachycardia produced by nitroglycerin without preventing its hypotensive effect. If labetalol HCl is used with nitroglycerin in patients with angina pectoris, additional antihypertensive effects may occur.

Drug/Laboratory Test Interactions: The presence of a metabolite of labetalol in the urine may result in falsely increased levels of urinary catecholamines when measured by a nonspecific trihydroxyindole (THI) reaction. In screening patients suspected of having a pheochromocytoma and being treated with labetalol HCl, specific radioenzymatic or high performance liquid chromatography assay techniques should be used to determine levels of catecholamines or their metabolites.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term oral dosing studies with labetalol HCl for 18 months in mice and for 2 years in rats showed no evidence of carcinogenesis. Studies with labetalol HCl, using dominant lethal assays in rats and mice, and exposing microorganisms according to modified Ames tests, showed no evidence of mutagenesis.

Pregnancy Category C: Teratogenic studies have been performed with labetalol in rats and rabbits at oral doses up to approximately 6 and 4 times the MRHD, respectively. No reproducible evidence of fetal malformations was observed. Increased fetal resorptions were seen in both species at doses approximating the MRHD. There are no adequate and well-controlled studies in pregnant women. Labetalol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Infants of mothers who were treated with labetalol HCl during pregnancy did not appear to be adversely affected by the drug. Oral administration of labetalol to rats during late gestation through weaning at doses of 2 to 4 times the MRHD caused a decrease in neonatal survival.

Labor and Delivery: Labetalol HCl given to pregnant women with hypertension did not appear to affect the usual course of labor and delivery.

Nursing Mothers: Small amounts of labetalol (approximately 0.004% of the maternal dose) are excreted in human milk. Caution should be exercised when TRANDATE® (labetalol HCl) Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Most adverse effects are mild, transient and occur early in the course of treatment. In controlled clinical trials of 3 to 4 months' duration, discontinuation of TRANDATE® Tablets due to one or more adverse effects was required in 7% of all patients. In these same trials, beta-blocker control agents led to discontinuation in 8% to 10% of patients, and a centrally acting alpha-agonist in 30% of patients.

The incidence rates of adverse reactions listed in the following table were derived from multicenter controlled clinical trials, comparing labetalol HCl, placebo, metoprolol and propranolol, over treatment periods of 3 and 4 months. Where the frequency of adverse effects for labetalol HCl and placebo is similar, causal relationship is uncertain. The rates are based on adverse reactions considered probably drug-related by the investigator. If all reports are considered, the rates are somewhat higher (eg, dizziness 20%, nausea 14%, fatigue 11%), but the overall conclusions are unchanged.

The adverse effects were reported spontaneously and are representative of the incidence of adverse effects that may be observed in a properly selected hypertensive patient population, ie, a group excluding patients with bronchospastic disease, overt congestive heart failure, or other contraindications to beta-blocker therapy.

Clinical trials also included studies utilizing daily doses up to 2400 mg in more severely hypertensive patients. Certain of the side effects increased with increasing dose in the entire U.S. therapeutic trials data base for adverse reactions that are clearly or possibly dose-related.

In addition, a number of other less common adverse events have been reported in clinical trials or the literature.

Central and Peripheral Nervous Systems: Paresthesias, most frequently described as scalp tingling. In most cases, it was mild, transient and usually occurred at the beginning of treatment.

Collagen Disorders: Systemic lupus erythematosus; positive antinuclear factor (ANF).

Eyes: Dry eyes.

Immunological System: Antimitochondrial antibodies.

Liver and Biliary System: Cholestasis with or without jaundice.

Musculoskeletal System: Muscle cramps; toxic myopathy.

Respiratory System: Bronchospasm.

Skin and Appendages: Rashes of various types, such as generalized maculopapular; lichenoid; urticarial; bullous lichen planus; psoriaform; facial erythema; Peyronie's disease; reversible alopecia.

Urinary System: Difficulty in micturition, including acute urinary bladder retention.

Following approval for marketing in the United Kingdom, a monitored release survey involving approximately 6,800 patients was conducted for further safety and efficacy evaluation of this product. Results of this survey indicate that the type, severity, and incidence of adverse effects were comparable to those cited above.

Potential Adverse Effects: In addition, other adverse effects not listed above have been reported with other beta-adrenergic blocking agents.

Central Nervous System: Reversible mental depression progressing to catatonia; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance or neuropsychometrics.

Cardiovascular: Intensification of AV block (see CONTRAINDICATIONS)

Allergic: Fever combined with aching and sore throat; laryngospasm; respiratory distress.

Hematologic: Agranulocytosis; thrombocytopenic or nonthrombocytopenic purpura.

Gastrointestinal: Mesenteric artery thrombosis; ischemic colitis.

The oculomucocutaneous syndrome associated with the beta-blocker practolol has not been reported with labetalol HCl.

Clinical Laboratory Tests: There have been reversible increases of serum transaminases in 4% of patients treated with labetalol HCl and tested, and more rarely, reversible increases in blood urea.

OVERDOSAGE: Overdosage with TRANDATE® (labetalol HCl) Tablets causes excessive hypotension which is posture sensitive, and sometimes, excessive bradycardia. Patients should be laid supine and their legs raised if necessary to improve the blood supply to the brain. The following additional measures should be employed if necessary: **Excessive bradycardia**—administer atropine (3.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **Cardiac failure**—administer a digitalis glycoside and a diuretic. **Hypotension**—administer vasopressors, eg, norepinephrine. There is pharmacological evidence that norepinephrine may be the drug of choice. **Bronchospasm**—administer a $beta_2$-stimulating agent and/or a theophylline preparation.

Gastric lavage or pharmacologically induced emesis (using syrup of ipecac) is useful for removal of the drug shortly after ingestion. Labetalol HCl can be removed from the general circulation by hemodialysis.

The oral LD_{50} value of labetalol HCl in the mouse is approximately 600 mg/kg and in the rat is greater than 2 g/kg. The intravenous LD_{50} in these species is 50 to 60 mg/kg.

DOSAGE AND ADMINISTRATION: DOSAGE MUST BE INDIVIDUALIZED. The recommended *initial* dose is 100 mg *twice* daily whether used alone or added to a diuretic regimen. After 2 or 3 days, using standing blood pressure as an indicator, dosage may be titrated in increments of 100 mg b.i.d. every 2 or 3 days. The usual *maintenance* dosage of labetalol HCl is between 200 and 400 mg *twice* daily.

Since the full antihypertensive effect of labetalol HCl is usually seen within the first 1 to 3 hours of the initial dose or dose increment, the assurance of a lack of an exaggerated hypotensive response can be clinically established in the office setting. The antihypertensive effects of continued dosing can be measured at subsequent visits, approximately 12 hours after a dose, to determine whether further titration is necessary.

Patients with severe hypertension may require from 1200 mg to 2400 mg per day, with or without thiazide diuretics. Should side effects (principally nausea or dizziness) occur with these doses administered b.i.d., the same total daily dose administered t.i.d. may improve tolerability and facilitate further titration. Titration increments should not exceed 200 mg b.i.d.

When a diuretic is added, an additive antihypertensive effect can be expected. In some cases this may necessitate a labetalol HCl dosage adjustment. As with most antihypertensive drugs, optimal dosages of TRANDATE® Tablets are usually lower in patients also receiving a diuretic.

When transferring patients from other antihypertensive drugs, TRANDATE Tablets should be introduced as recommended and the dosage of the existing therapy progressively decreased.

HOW SUPPLIED: TRANDATE® Tablets, 200 mg, white, round, scored, film-coated tablets engraved on one side with "TRANDATE 200 GLAXO," bottles of 100 (NDC 0173-0347-43), bottles of 500 (NDC 0173-0347-44), and unit dose packs of 100 tablets (NDC 0173-0347-47).

TRANDATE Tablets, 300 mg, peach, round, film-coated tablets engraved on one side with "TRANDATE 300 GLAXO," bottles of 100 (NDC 0173-0348-43), bottles of 500 (NDC 0173-0348-44), and unit dose packs of 100 tablets (NDC 0173-0348-47).

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Issued: August 1984

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Continued from page 452

(birthdays, date of adoption, parental deaths), and during times when there are unique areas of adjustment involving issues the parents have not experienced in the same way with their own children. These issues are stressful to both parents and children. Both may be open to supportive crisis intervention at those times.

DR. POOLE: We try to be very sensitive to the role adoption may play in potential problems within the family. Adoptive parents, however, often see the family physician for such problems as tantrums, biting, lying, stealing, and adolescent adjustment problems, which are normal issues for children. Physicians and parents often make the erroneous assumption that the problem has to do with adoption when, in fact, it does not. We can help debunk some of the myths surrounding adoption and assist the parents in handling the problem.

DR. LYMAN: When do you tell the adopted child that he is adopted and how do you tell him?

DR. McBOGG: Didn't all of us at one time ask, "Am I adopted?" or say, "I wish I had another parent"? If the child is not adopted, parents can handle it. If the child is adopted, parents often panic, fear a terrible crisis is coming, and ask for help. The real issue is what it means to the parent to have an adopted child, because that's the message that will get conveyed no matter what words are used. These conversations ought to begin at the time interest in birth, pregnancy, and babies begins, around 3 to 5 years of age. We can help parents choose words they are comfortable with that convey how the child was born and came to be part of the family.

DR. ANSTETT: You could ask the child, too, what the word *adopted* means to him. For the longest time what it always meant to my adopted daughter was, "My other mommy couldn't take care of me." As she grows, her definition becomes more elaborate and we go with the way she can best conceptualize it.

DR. LYMAN: This child will eventually grow up and probably want to know more about his or her background. Do you have any thoughts on how we can help the adolescent who wants to know about his background?

DR. McBOGG: Children who successfully work through the stages of separation and individuation throughout childhood and handle losses well will usually adjust well to the fact of their adoption. Therefore, parents who wish to do some preventive work can pay attention to assisting their child in gaining independence and understanding the steps of growing up.

MS. BARBEE: I feel that children have an inalienable right to know who their biological parents are. There is value in knowing that life has continuity in terms of family history, ethnicity, and cultural identification. Teenagers in particular struggle with these issues of identity. We must be honest with them regarding their birth parents, but diplomatic—if there are sordid elements, we need not pass those along.

Adolescents may use the adoption issue as leverage once in a while as they struggle with emancipation and separation. "If I don't like it here, I've got somebody else out there in my life." They may threaten to leave to find their "real parents." It is helpful to adoptive parents to view such "threats" as a manifestation of normal separation, and the parents can treat the issues of searching for birth parents separately. Many adolescents, given a choice about finding out about birth parents, will choose not to. It is having the choice that is important to them. They are often not ready until young adulthood, when they may need help and support in understanding their need to find their birth parents.

DR. McBOGG: Somehow, adoptees need to be prepared for what they might find. For instance, one frequent fantasy about biological parents is that they were an airline stewardess or a pilot, which is a lot different from an alcoholic or a schizophrenic.

DR. MARTHA ILLIGE-SAUCIER *(Clinical Instructor and Family Physician)*: It doesn't take very much information to satisfy adolescents. My stepchildren were both adopted, and they both asked in midadolescence about their biological parents. Because my husband is a physician and had more information available, all he needed to say was, "Your mother was 16 and your dad was 17," and his son didn't want to know any more. The same sequence happened with my stepdaughter. We gave her some basic information about her mother being unable to take care of a baby, and that satisfied her at the time. Neither wanted to actually find the birth parents.

DR. McBOGG: The message must be that we are willing to share information and communicate

rather than withhold or have secrets, a maneuver that only facilitates the fantasies.

MS. DECHANT: In many states, as in Colorado, the law dictates that records are closed, and no person has the right to the identifying information in those records. You can go to court and try to get them opened up, but you have to have a medical reason for having them opened. The family physician should find out about the law in his state.

The records were very "diplomatic" with unwed mothers in the past and never mentioned fathers. You might find, "I was raped." This statement was very common, and it leaves nothing on the father's side and very little on the mother's. I have talked to many adoptees in search of their biologic parents. Personally, I would prefer the records be open to people aged over 18 years. Society continues to change, and laws may not reflect the changes in our understanding of adoptees' needs.

DR. McBOGG: There's another issue, that of the relinquishing mother, who, giving up her child 20 years earlier, started a new life denying that the child was a part of it. What about the mother's right to privacy?

DR. LYMAN: An English study suggests that everyone benefits when an adopted child meets the biological parents.[4] The relationship between adopted child and adoptive parents improves as they all realize there is no threat to the relationship. The adopted child remains very close to his adoptive parents. Most mothers who relinquish their babies have an undying concern for the welfare of that infant they relinquished. Knowledge reassures birth parents that their infant survived and is doing well. In addition, the adopted child deals with his or her origins and can move along to adulthood.

What about older children or handicapped children? Are their adoptions handled differently?

MS. DECHANT: It is more difficult to find adoptive parents for handicapped and older children. Older children are often neglected, abused,

handicapped, or multiracial, and, therefore, also difficult to place. Many continue in long-term foster care.

DR. LYMAN: Do adoptive parents of handicapped or problem children need any special counseling?

MS. DECHANT: Yes. I think people should know and understand the special needs of these children. Once all available information is gathered, we review it with prospective adoptive parents and discuss potential problems unique to the child; more general issues we handle in groups of adoptive parents. Parents need to understand chronic diseases or handicaps very well. If there have been behavioral problems, parents need advice on how to handle the problems. When there are developmental delays, the parents need a program to assist them in understanding and promoting development.

DR. McBOGG: I often am asked whether a child is "adoptable." My answer is always "Yes!" The real questions are, what are the child's special needs and who can meet those needs? One of our jobs as physicians is to describe the child accurately to prospective adoptive parents. I try to describe the range of expected development, the current medical, developmental, and psychological needs, and long-term needs. Prospective parents need time to think about what they want and what they can provide. I often invite adoptive parents for return visits to clarify problems and needs of the child and family.

DR. POOLE: Is there any final advice you have for family physicians?

MS. DECHANT: Many of us may have subconscious, subtle prejudices against people who relinquish their children or perhaps against the relinquished child. I would advise that each of us examine our feelings and attempt to deal with them.

DR. McBOGG: Be sure to take very complete family histories, including information on temperament and mental health.

MS. BARBEE: Just one other issue we have not discussed. Know the resources for adoptive families in your area. Many adoptive families (especially if the child has special needs) need some kind of supportive and informative community resources.

Continued on page 466

Table 1. The Family Physician's Role in Adoption

The family physician's role is to ensure that the following opportunities are available (though the family physician will not be likely to provide them himself)

Birth Parents
- Prenatal counseling and support
- Extensive family histories regarding physical and mental health, behavior, school function, temperament
- Help in handling separation from child and the grieving process

Adopted Child
- Assistance with childhood separation and individuation issues
- Assistance with losses in childhood
- Help in understanding need for finding birth parents and birth records

Adoptive Parents
- Assistance in understanding adopted child's family history, needs, and temperament
- Assistance with attachment and bonding
- Assistance in dealing with separation and individuation of adopted child
- Assistance with behavioral, school, and medical problems of adopted child
- Anticipatory guidance regarding how, when, what to tell the adopted child
- Assistance in finding community resources
- Assistance in locating reading material
- Assistance with the handicapped, abused, or neglected adopted child

DR. POOLE: Adoption-related issues can present in several different ways:

1. Obstetrical care of the relinquishing mother
2. Grieving and depression after delivery in birth parent
3. Behavioral problems in the adoptive child
4. Learning problems
5. Parent-child interaction problems
6. The vulnerable child syndrome
7. Medical care of adopted child
8. Depression, anxiety, and family dysfunction in adoptive parents
9. Assistance to adoptive parents in assessing a child's medical history and "adoptability"
10. Adoptive child seeking access to birth records

The family physician must be sensitive to adoption-related issues to identify the adoption component to such problems. The family physician has many potential roles with the birth parents, the adopted child, and the adoptive parents (Table 1). Further, we should prepare ourselves by doing some additional reading and making contact with local resources.[4-8] The family physician should also be prepared to recommend reading material to adoptive parents[9] and children.[10,11]

DR. LYMAN: Family physicians are in the unique position of potentially dealing with any or all members of the adoptive triangle at any stage of the process. Therefore, we need to be prepared to handle any of these roles.

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