

CARING FOR 'OUR KIDS': INTERNATIONAL ADOPTION MEDICINE
AND THE FAMILIES IT HELPS CREATE

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ABSTRACT

Emily J. Noonan: Caring for ‘Our Kids’: International Adoption Medicine
and the Families it Helps Create
(Under the direction of Michele Rivkin-Fish)

This dissertation is an ethnography of international adoption medicine, a U.S. pediatric subfield concerned with the healthcare of internationally adopted children. Two central research questions inform this study: (1) how do the knowledge and practices of international adoption medicine along with its practitioners promote or challenge the kinship identities among members of adoptive families? (2) how do members of adoptive families use the knowledge and practices of international adoption medicine to create kinship? As a specialty focused on one particular family form, international adoption medicine provides a unique site through which the entanglement of contemporary biomedical expertise in the production of families becomes visible.

Through interviews with clinicians and adoptive parents and through participant observation in an international adoption medicine clinic and conferences about adoption, I show how the specialty is a practice that aids in the formation of 21st century U.S. families. Inside and outside of the clinic, international adoption medicine and the knowledge it produces are used by adoptive families as they form themselves, negotiate what it means to be an internationally adoptive family, and produce health. International adoption medicine, in turn, builds its expertise on the experiences and needs of adoptive families.

Building on a history of the development of international adoption medicine practice, I focus on three processes key to family life: the nurturing of family feeling and cohesion, through discourse and practices of attachment, and through the caretaking and body work related to feces and toileting in which parents engage.

Bringing together anthropological literatures on kinship and biomedicine with ethnographic methods, this study highlights the varied and uneven uses of biomedical knowledge, the management of risk at the level of the family, and the social processes that help constitute families.

To my family.
I'm sorry this took me so long.

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LIST OF ABBREVIATIONS

AAP	American Academy of Pediatrics
CDC	Centers for Disease Control and Prevention
ChIFF	Children in Families First Act
FAS	Fetal Alcohol Syndrome
IAM	International Adoption Medicine
JCICS	Joint Council on International Children's Services
OCA	Orphan Care Alliance

CHAPTER 1: CONCEPTUAL FRAMEWORK

Introduction

My work provides an ethnographic “thick description” (Geertz 1973) of the pediatric subfield of international adoption medicine (IAM) in order to understand the role of this field in the production of kinship identities that emerge from the process of international adoption. Through ethnographic participant observation in a clinic serving internationally adopted children, interviews with clinicians and adoptive parents, and conferences about international adoption, I show how IAM operates as one space where kinship and biomedicine intersect.

While the anthropological literatures on kinship and biomedicine are vast and of central importance, little work has been done on the intersection of these literatures. International adoption medicine, as a pediatric specialty, has been largely unexplored by medical anthropologists and other social scientists who study health (but see Van Wichelen 2014).

International adoption medicine provides a unique site through which the entanglement of contemporary medical expertise in the production of families becomes visible. Also key are practices of health and wellness that occur outside the clinic and outside the purview of clinicians. A central goal of this project is to understand how medical facts and action, in this case those articulated and performed by adoption medicine and adoptive parents, transform categories of people and promote the creation of new identities (Clarke et al. 2003; Dumit 1997, 89).

To that end, I focus on the following two aims:

1.) To identify how the knowledge and practices of international adoption medicine and its practitioners promote or challenge the kinship identities claimed by members of adoptive families

2.) To discover how members of adoptive families use the knowledge and practices of international adoption medicine to create kinship. That is, how they come to use IAM and health practices to understand, identify, and define their families.

Overview of Conceptual Framework

The purpose of this section is to provide the theoretical backdrop to my project. Situating my work in medical anthropology, kinship, theories of how family is made, I show how a particular medical subspecialty—international adoption medicine—plays an important role in the building of adoptive families. I start by positioning this project in relation to Pierre Bourdieu’s (1996) conceptualization of the family as “a realized category.” Family, for Bourdieu, is a field of “physical, economic,... and symbolic power relations” (22) (also see Atkinson 2014; Haimes 2003). Within this field, family comes about through talk of family and through practices that reinforce “family feeling.” I then review the anthropology of kinship in order to show how international adoption makes families and to situate my work in the context of this field. Finally, I review medical anthropology and anthropology of the clinic. This ethnography of international adoption medicine contributes to the growing literature on how individuals and families negotiate clinical settings (Buchbinder 2015a; Buchbinder and Timmermans 2011; Landsman 2009; Latimer 2007; Mattingly 2009; Rapp 2000; Stryker 2010).

Identity and the Making of Family

In a 1996 essay “On the Family as a Realized Category,” Bourdieu revisits family and

kinship that he initially explored in *Outline of a Theory of Practice* (1977), arguing that talk and action (both structural and individual) make family a social unit that transcends individual members.

Bourdieu resists the understanding of family as a static, essentialized unit: “[N]othing seems more natural than the family; this arbitrary social construct seems to belong on the side of nature, the natural and the universal” (21). Though recognizing the social in the construction of family, he also resists the understanding of family as a mere social artifact. Rachael Stryker (2010), writing about attachment therapy in families, argues that Bourdieu’s argument is a response to social scientists who were dismissing family as purely an oppressive construction or “discursive fiction” (9). Instead, Bourdieu recognizes, and calls for, a more complete and complex approach to the sociology of the family. Family is “an objective social category (a structuring structure)” that supports the “family as a subjective social category (a structured structure)” (21). This is cyclical; the actions and representations of the subjective social category reproduce the objective social category: “Every time we use a classificatory concept like ‘family’, we are making both a description and a prescription, which is not perceived as such because it is (more or less) universally accepted and goes without saying” (20). For example, the act of marriage and images of weddings reproduce marriages. This back and forth between “the subjective and objective categories provides the foundation for an experience of the world as self-evident, taken for granted” (21; also see Atkinson 2014).

Talk also matters. Pierre Bourdieu (1996) describes family discourse as “[t]he language that the family uses about the family” (20) that constructs and makes real family: “The family discourse...is a powerful, performative discourse, which has the means of

creating the conditions of its own verification and therefore its own reinforcement, an institutional discourse which durably institutes itself in reality” (25). Familial and individual identities, as well as families themselves, are produced through talk (Kendall 2007, 4).

In addition to talk and discourse, Bourdieu (1996) describes how both structure and practice create family. Certain types of families are produced and reproduced by the state. The state does this by recognizing some kinds of families while ignoring others, bestowing benefits on some family forms (the child tax credit and the adoption tax credit come to mind), and simply by counting them, as in a census. Bourdieu says, “the family exists, we have met it under our statistical scalpel” (25). In turn, the practices that individuals engage in to obtain recognition by the state (e.g. submitting a marriage license to the state, filing birth certificates) reinforce the family as conceptualized and recognized by the state.

Bourdieu discusses how individual family members reinforce “family feeling” through action (22). He lists “the exchange of gifts, service, assistance, visits, attention, and kindnesses”—often women’s work—as ways the family is made real through action (22). In other words, the family is real because we engage in gift-giving, is real because we go through rituals like funerals and weddings together, and is real because there are carefully curated photos documenting our existence as a family. (In chapter 7, “Parenting and Bodywork,” I extend this to practices around caregiving.)

I take these things from Bourdieu: Family is made through talk. Family is made through practice. Family is made through social structure. The making of family is a process. It happens again and again over days, months, and years. Looking at family through the lens of IAM, we see that IAM contributes to the making of the adoptive family through the talking about, seeking, and providing health care over time.

In this dissertation, I will show how the adoptive family becomes real through both the practice and discourse of biomedicine and health care. I want to be clear that I am not arguing that IAM is necessary for an adoptive family to be “real” or successful. For all families, multiple sites, institutions, and processes aid in the construction of the family. Instead, I mean that international adoption medicine is one of many practices and discourses (like those that Bourdieu lists) that aid in the construction of the adoptive family.

Family Identities That Depend on Discourse and Action

It is key to understand that all of these family-constituting matters—discourse, action, institutions—are sites of struggle. Definitions and understandings of family are not shared, either within U.S. culture or within a given family. Forming family is not only about inclusion; it is also about maintaining boundaries. Reflecting on Naples (2001), Margaret Nelson (2006) argues “in contrast to the casual assumption that doing family only involves forging and enhancing links among individuals...the interactional work of doing family can involve excluding some individuals from a set of valued relationships” (782).

International adoption is built on both inclusion and exclusion. Specific children come to join specific families based on the criteria set forth by the adopting parents and birth country regulations. In other words, particular types of children are desired by a given family; therefore children not fitting this type are excluded. If adoptive parents select China as the birth country and indicate that they will accept referrals for healthy girls under the age of 18 months, it is unlikely that a 7-year-old boy with spina bifida will join the family. Non-acceptance occurs at the level of the individual child in those cases where adoptive parents do not accept the referral of a child. In chapter 5, “Realizing the Category of Family,” I explore the role of international adoption medicine in referral review and drawing family

boundaries. While individual children join U.S. families through international adoption, the child's birth parents and extended biological kin are explicitly excluded through the legal process of adoption.

Contemporary sociologists have argued that it makes more sense to think of how people “do family” rather than how people “be” in families (Naples 2001; M. Nelson 2006; Silva and Smart 1999, 8; Suter, Reyes, and Ballard 2011). I want to focus here on family as an entity that comes into existence through practice. As I discussed in the previous section, Bourdieu (1996) argues that family is made through action, or practice. Contemporary sociologists (though not referencing Bourdieu, usually) have argued that some families are more dependent upon discourse and action than others. When a family is not seen as a family by those around them, they engage in purposeful action and talk to highlight their status as family.

Barbara Katz Rothman (2006), a sociologist and adoptive mother of an African American girl, writes about how her family has to “do family” in order to be recognized by others as family: “We don’t look like a family. I’m white and Victoria is black. So we’ve learned, over the years, the little tricks we need, to make you see us as a family” (4). For instance, when meeting new people, Rothman is quick to introduce Victoria as her daughter, making their family tie is clear to strangers.

In addition to transracial and some visibly adoptive families, other families that are not immediately read as families—families with same sex parents and families in which grandparents are parenting grandchildren, for example—are discourse and action dependent (Suter, Reyes, and Ballard 2011, 243).

Anthropologist Signe Howell (2003), studying families in Norway that adopted

internationally, uses the term “kinning” to describe the process through which a child “is brought into a significant and permanent relationship with a group of people that is expressed as a kin idiom” (465). Children are incorporated into the family through a variety of practices, but Howell highlights how families photograph the children in Norwegian dress and doing typically Norwegian activities (being outside in the snow), and showing how the children have been loved and accepted by grandparents and extended family. Roots trips, where internationally adopted children and their adoptive parents travel to the child’s birth country, are a type of family adventures that acknowledge the child’s “dual identity” (477). In the end, Howell argues, these trips reinforce familial identity, as the adoptees are Norwegian citizens traveling with their Norwegian parents, none of whom speak Korean or are familiar with Korean customs. Through this process of practice and discourse, adoptive parents make it so that the child and parents share a kinned future together; they must make it so that they can have a “familial future” (468).

Discourse

Adoptive parents do not produce narratives about adoption in a vacuum. Instead, they interact with one another through previous experiences, as well as communities of similar parents, and through the expert advice they receive: “The subject authors herself by answering, producing herself through utterances that can exist only as responses to other utterances of other speakers, prior or anticipated. In order to engage in this interactive self-creation, one necessarily employs (and modifies) available models and resources” (Sawin 2004, 4). In other words, individual and relational identities come out of adoptive parent-produced discourses, and prior understandings of identity and family are crucial in developing narratives. In their discussion of how individual selves are produced through

discourse, Bronwyn Davies and Rom Harré (1990) argue:

An individual emerges through the processes of social interaction, not as a relatively fixed end product but as one who is constituted and reconstituted through the various discursive practices in which they participate. Accordingly, who one is is always an open question with a shifting answer depending upon the positions made available within one's own and others' discursive practices and within those practices, the stories through which we make sense of our own and others' lives (46).

Adoptive parents structure 'who they are' through their interactions with one another, as well as through their interactions with those not involved in the adoption process.

Ontological Choreography and the Making of Families

Also helpful is Charis Thompson's (2005) concept of ontological choreography. In her work with patients in infertility clinics, Thompson argues that individuals engage in ontological choreography in order to become parents through pregnancy:

The term *ontological choreography*¹ refers to the dynamic coordination of the technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of [assisted reproductive technology (ART)] clinics. What might appear to be a hybrid mess is actually a deftly balanced coming together of things that are considered parts of different ontological orders... These elements have to be coordinated in highly staged ways so as to get on with the task at hand: producing parents, children, and everything that is needed for their recognition of such (8).

It is through a dance of technology, expertise, law, and kinship that people become parents through ART.

Using ontological choreography as a lens, we can see how international adoption medicine works to help create a family and familial identities. Children, parents, medical practitioners, social workers, medical records, and adoption referral paperwork interact in the service of creating family. All of the people and actions that have to come together in adoption is a kind of choreography to make the adoptive family. People—children, birth

¹ Emphasis in original.

parents, adoptive parents, foster parents, social workers, orphanage staff, bureaucrats, lawyers, diplomats, judges, and clinicians—come together in various configurations to make international adoption happen.

Thompson's analysis is also useful because fertility clinics, like adoption, unsettle the primacy of birth and blood in kinship. She argues, "the clinic is a site where certain bases of kin differentiation are foregrounded and recrafted while others are minimized to make the couples who seek and pay for infertility treatment—the intended parents—come out through legitimate and intact chains of descent as the real parents" (145). Throughout this text, but especially in chapter 5 ("Realizing the Category of Family"), I show how IAM and practices of health and wellness operate to reinforce the adoptive family as a cohesive unit, while gently uncentering birth families. The adoption medicine clinicians I observed were careful to never demonize or negate the birth family. Noting that children have strong feelings of love and attachment even to abusive caregivers, it is "bad for kids" to talk negatively about birth parents. One doctor told me, "we have to assume they were doing the best they could." Once in the IAM clinic, adoptive parents are the legal parents and caretakers who have committed to the child, usually for life. Clinicians foreground this relationship and work to reinforce "family feeling" between all members of the adoptive family.

The Anthropology of Kinship

Kinship has long been a central focus of anthropologists, but the field has changed significantly in recent decades. Rejecting the premise that societies progress through a series of increasingly complex and modern modes of living (e.g. Morgan [1887] 1996), that kinship is best conceptualized in terms of social structure and terminology (Levine 2008; e.g. Lévi-Strauss 1963), or that kinship makes a clear distinction between relatedness based on biology

(sex and reproduction by birth) and social ties that comprise other forms of relatedness (critiqued by Schneider 1984), the “new kinship studies” (e.g. Carsten 2000, 2004a; Franklin and McKinnon 2001; Franklin and Ragoné 1998; Ginsburg and Rapp 1995; Strathern 2005) emerged. In the 1980s and 1990s, biomedical reproductive technologies raised questions about how people understand their relatedness to others. Anthropologists, most thoroughly and significantly David Schneider (1980, 1984), questioned the divide between “natural” and “fictive”² or social kinship, and began developing theoretical frameworks for understanding relatedness, and symbols of kinship (Faubion 2001, 6; Sahlins 2013). Anthropologists and other social scientists demonstrated the multiple ways kinship ties are understood to be formed—by blood and law (Schneider 1980), choice (Weston 1991), affinity (Mamo 2007), shared substance (Weismantel 1995), reciprocity and gift (Stryker 2010) and genetics (Finkler 2000, 2001). To be sure, biogenic relatedness—especially through genetics—is stressed in American conceptions of kinship (Finkler 2001; Howell 2009, 150; Lebner 2000), but anthropologists consistently question the universality of this assumption. Drawing on Schneider’s work, as well as their experiences as activists in the second wave of the U.S. women’s movement, feminist scholars from a range of disciplines examined how power and control are exercised through dominant expressions of kinship and reproductive practices (Rapp 2001, 468).

In post-Schneiderian kinship studies (Fabion 2001, 5) adoption emerged as a key site of analysis (Bowie 2004; Howell 2009; Leinaweaver 2008; Modell 1994; Yngvesson 2007). Adoption—the care and nurturing of children by adults other than their genitors—was considered a type of “fictive kin” by earlier scholars of kinship, but adoption practices have

² The term “fictive kin” expresses that idea that familial relationships not formed through blood, biology, or some other “real” substance were less real than those that are biogenetic (Modell 1994, 226; Schneider 1984, 172).

always highlighted the tension between nature and culture in kinship studies: “it is precisely because adoption challenges the very referential principle of flesh and blood in Euro-American thinking that its significance cries out for analysis” (Howell 2009, 153). Most societies have adoption of some form, but the meaning and cultural understandings of adoption vary (Bowie 2004; Howell 2009; Terrell and Modell 1994). Jack Goody (1969) describes historical and contemporary (at the time of his writing) adoption practices in Rome, Greece, India, and China, arguing against imposing Eurasian understandings of adoption onto African fostering practices. Even in the last 200 years, North American and European adoption practices have changed significantly. Children were once economically valuable as laborers (Zelizer 1985, 172). In the second half of the 19th century, orphan trains moved children “chosen for their promise, their hardiness” (Gordon 1999, 5) from New York and other centers of urban poverty to the American West where the “demand for [their] labor is practically unlimited” (7). Infants, however, were not an asset, and baby homes or nurses charged birth mothers for taking in their babies (Wedd 2009, 7; Zelizer 1985, 174–75).³

By the late 1800s and early 1900s this perspective had changed. The burgeoning social work movement pushed for the passage of child labor laws, and children became economically worthless. Instead, they were emotionally priceless. Adoption became a way to help needy children and provide parents with children; adoption became a way to form families. It was not until the 19th and 20th centuries that the legal system became involved in these exchanges (Herman 2002, 2009; Zelizer 1985, 190).

Distinct from other forms of adoption in the ethnographic record (informal fostering

³ In 18th century London, for example, the Foundling Hospital was so overcrowded and mothers so desperate to place their children somewhere they would be fed and cared for, that children were admitted to the Hospital by lottery. If you pulled a white ball, your child would be taken in if healthy; a red ball, your child waitlisted; a black ball, refused (Wedd 2009, 26).

or the circulation of children within kin networks), modern, state-coordinated adoption, both international and domestic, is marked by an infrastructure of legal and social service experts. In the contemporary U.S. and Western Europe, adoption is understood as the legal process of permanently transferring a child from a (usually) biological parent to non-biological adoptive parents and occurs within and between national borders. This process is marked by the participation of a cadre experts, professionals, or “rationalizers”: lawyers, social workers, state department bureaucrats or embassy officials, orphanage staff, and now, physicians (Herman 2002, 341; 2009).⁴ The transfer of a child from the care of one adult to another is not thought of as “real” or official unless the legal and immigration authorities of the birth country, the adoptive country, and international law consent to and facilitate the transfer. This bureaucratic and rationalized process (Herman 2002) is distinct from other forms of adoption in the ethnographic record.

This project is part of the broader anthropology of kinship and family. Looking at health care of children adopted throughout this legalized, rationalized, and international process, I explore how families are produced and supported.

Medical Anthropology and the Family

The practice of international adoption medicine and the primary field site for this project is centered on the clinic, a space in which patients seek medical care from experts. Understanding medicine and health care as a complex cultural system, as “a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal relations” (Kleinman, cited in Buchbinder 2015a, 7; also see Fortin 2008), I examine a pediatric clinic as a key site within that cultural system.

⁴ Exceptions to rationalized adoption do exist in the U.S. Judith Modell (1998, 159) describes the tension between legal adoption and *hanai*, or customary adoption in contemporary Hawaii.

In the decades since Foucault described the clinic as a site for the making of identity (1994), medical anthropologists have extended his arguments through their research, showing that clinics are sites where social relations are enacted, where race, class, and gender intersect (Buchbinder 2015a; Good 1994; Latimer 2007; Mattingly 2009; Raspberry and Skinner 2007); how the medical gaze, rooted in the clinic, also extends beyond the physical space of the doctor's office to public policy, the law, and public discourse (C. Patton 2010); and how children's identities as "normal" or "abnormal" are made in the space of the clinic (Davis 1982). Developmental or well-child checkups are key to determining whether an individual child's body is "normal" or "not normal" (Kelle 2010, 10).

Biomedicine, though based in Enlightenment ideas about positivist science and mind/body dualism, is not monolithic (Lock and Gordon 1988; Mol and Berg 1998, 4). In the diversity of biomedicines found throughout the world (Van der Geest and Finkler 2004; e.g. Finkler 2004; Livingston 2012; Rivkin-Fish 2005; Wendland 2010), hospitals and clinics are key sites where dominant cultural values are enacted and can be observed (Buchbinder 2015a; Davis 1982; Long, Hunter, and Van der Geest 2008; Strong 1979; Van der Geest and Finkler 2004). Hospitals and clinics can be understood as separate spaces or "islands" set off from the public by distinct dress, norms, and rules (Van der Geest and Finkler 2004); they are also social institutions inextricably linked to economy, politics, and kinship (Long, Hunter, and Van der Geest 2008, 73). Writing about the pediatric clinic, Fortin argues that this encounter, with clinicians, parents, and children usually present, should be "conceived as the meeting of different perspectives, as a space of negotiation" (Fortin 2008, 176). Fortin goes on to highlight the clinic as a space of intersecting "norms and values" of those who meet in the space, including insiders and outsiders, locals and foreigners, experts and non-experts

(176). Following Kleinman (1981, 1995), Good (1994), Fortin (2008), and others, I see culture imbricated in the health care system. It is not just patients who “have culture”; clinicians and the system in which they work “have culture” as well (J. Taylor 2003).

Children, Their Bodies, and Medical Anthropology

Childhood, like biomedicine and its articulations of disease and the body, is biocultural. Though all children go through biologically-driven physical and developmental stages, these experiences are only understood and given meaning through cultural beliefs and practices (Lancy 2008; LeVine 2008; Scheper-Hughes and Sargent 1998, 1). What it means to be a child or what constitutes an appropriate childhood is not static. Rather, understandings of childhood and children are culturally and historically contingent (Ariès 1962; Bluebond-Langner and Korbin 2007; Lancy 2008, 2017; LeVine 2007, 247; Nieuwenhuys 1998; Zelizer 1985).

Anthropologists often study children as indicators of community or public health (e.g. (e.g. Kamat 2009); nutrition (e.g. Crooks 1996; Dettwyler 1998), in terms of their development (LeVine 2008); in discussions of rites of passage and initiations such as circumcision, genital cutting (Scheper-Hughes and Sargent 1998, 14; e.g. Gruenbaum 2009); and violence (Korbin 2003). There are few projects focusing on children’s experiences from their own perspectives or on children’s bodies as a site through which power and meaning are negotiated (Van der Geest 1996; but see Bluebond-Langner 1978; Buchbinder 2008, 2015a; Clark 2003; Spray 2018; Stryker 2010).

Speaking of bodies in general, Farquhar and Lock (2007) argue that bodies “have begun to be comprehended as assemblages of practices, discourses, images, institutional arrangements, and specific places and projects” (1). The bodies of children, too, can be

understood as gaining meaning from practices and institutions: “Children’s bodies then appear in a variety of roles: in the construction of social relations, meanings and experiences between children themselves and with adults; as products of and resources for agency, action, and interaction, as sites for socialization through embodiment” (Prout 2000, 11; also see Castañeda 2002; Hörschelmann and Colls 2009; J. McLaughlin, Coleman-Fountain, and Clavering 2016).

Discourse analysis helps us see how children’s bodies are a key site for expressing meaning. A particularly interesting example of discourse in relation to the child’s body is Brada’s (2013) work in Botswana on adults’ use of ritualized speech to communicate with children about HIV. Drawing on John Austin’s ([1962] 2006) “How to Do Things with Words,” Brada shows how clinicians “do things to children with words.” Brada found that clinicians believed that the word “AIDS” would lead children to believe that their death certain and that this understanding of the disease would make them less likely to comply with anti-retroviral medication regimen. In place of “AIDS” clinicians used words like “soldier” and “bad guy” to “cultivate children’s positive affective orientation toward treatment” (438). It was important for the pediatricians—mostly from the U.S.—that the children be told of the diagnosis, but it was equally important that they understand the diagnosis as manageable, thus ensuring the child took her or his medicine and were a “stable object of biomedical intervention” (448).

Medicalization and Risk

The process of medicalization is key to understanding IAM and the health care of international adoptees. Medicalization as the process through which human problems are understood as health problems, and therefore under the “jurisdiction of medicine” (Clarke et al 2003, 161). Medical anthropologists and sociologists have shown how bodily processes and behaviors related to reproduction (e.g. Davis-Floyd 2004; Malacrida 2015; B. Rothman 2000; Torres 2015), menopause (Bell 1987), erectile dysfunction (Carpiano 2001; Conrad and Leiter 2004), alcohol and drug use (Conrad and Schneider 2010, chs. 4-5; Tournier 1985), hyperactivity (Conrad and Potter 2000; Malacrida 2004; Rafalovich 2005), and challenging behaviors in school (Bosk 2013)—once understood as human problems or as slight deviations from typical behavior—are now described, defined, and treated by medical professionals (also see Conrad 2007).

The process of medicalization is apparent in pediatric practice: rather than being concerned only with illness and disease, contemporary pediatricians are concerned with “social” problems such as potty training, tantrums, and hyperactivity (Pawluch 2009, 131). In her text on the history of pediatrics, Pawluch (2009) describes the transition from the “old pediatrics”—concerned primarily with infectious and congenital disease—to the “new pediatrics,” also concerned with the social and behavioral issues of childhood. IAM is squarely part of this “new pediatrics,” as the scope of clinical practice includes control of infectious disease, treatment of acute illness, *and* management of “social” problems related to bonding, family dynamics, and education.

Features of the adoptive family that were once considered legal, cultural, kinship, or interpersonal problems are now defined as medical problems. Medical professionals are

increasingly considered necessary for the correct forming of family. Leinaweaver (2009) shows how the phenomenon of adoption is medicalized at multiple levels: the birth family, the adoptive family, and the global flows of adoption.

In both political and medical discourse, risk has emerged as a key concept. Mary Douglas (1990) argues that risk no longer refers to the probability of a negative outcome, but to danger itself. In this construction, risk is the same as danger, but with an “aura of science,” or supposed verification through statistical tools (3-4; also see Skolbekken 1995). Harm is seen as coming from individual actions or failure to act, (as opposed to fate or outside forces) and individuals are charged with responsibility of acting to prevent or avoid harm.

For adoptive parents, the “unknown” of their child’s medical and genetic history is problematic, because the parents feel limited in their “medical preparation” (Lebner 2000, 376). Strathern (2005) describes how the child can be understood to have two bodies for which the biological parents (usually the mother) are responsible: the genetically given body and the one constructed through nurturing and careful attention to development (5). Parents have the responsibility to act on what they know about diet, exercise, nutrition, and education to insure their child’s proper development. Adoptive parents are in a different position. They have no control over the child’s genetically given body; they have passed on no vulnerabilities or resistances to specific illnesses. Adoptive parents also have no control over the social determinants of health that impact their child’s earliest days. A central question that Lebner (2000) asks (and one that runs through adoption medicine) is: “how do [adoptive parents] experience this absence of knowledge” (375) or uncertainty about child’s genetic history? They now have control of the child’s current environment, diet, exercise, nutrition, and education, but not the child’s pre-adoption experiences or biological makeup.

Davis (1982), writing about pediatric health care, posits that parents experience enormous responsibility for child health, even more than pediatricians: “The weighty responsibility of a doctor for ‘his’ patients is mirrored by the responsibility which adults have for their children’s health and illness, a responsibility not backed by years of training, but with recipe knowledge and practical everyday judgment.” “Parents,” Davis argues, “are guardians of a hazardous and unpredictable new product...” (24). One of the mothers in my study echoed this sentiment: “I was in shock because here we were, in a hotel room in a strange country where we don’t speak the language. The kid is screaming and we don’t know why. Is he scared? Does he have an ear infection? Is he hungry? Does he just want a cookie? You don’t know.” Not only did the mother not know what why her child was crying, she also knew she was charged with managing the uncertainty of the situation. Regardless of the language barrier or what could be the child’s grieving, parents must resolve the situation.

Parents understand their roles within the “risk society” (Beck 1992; Douglas 1990; Giddens 1999) and perceive their roles to do all they can to position their child for future success. Scholars of parenting and childhood describe contemporary middle and upper middle class parenting in the U.S. and Western Europe as “anxious” and “intensive” (Francis 2012; Hoffman 2010; M. Nelson 2012; Stearns 2004). Parents are motivated to protect their children from immediate harm (abduction by strangers, violence, random accidents) but also future harm that occurs because they were not prepared or protected. I argue that IAM is one location and arena of interaction in which the risk of “not knowing” about adoptive children is managed through the use of clinical services and medical expertise.

The Family in the Clinical Encounter

Medical encounters are important sites for the making of family (Buchbinder 2015a;

Buchbinder and Timmermans 2011; Dimond 2014; Good 1994; Landsman 2009; Latimer 2007; Mattingly 2009; Rapp 2000; Rapp and Ginsburg 2001; Raspberry and Skinner 2007; S. White 2002). Medical anthropologists and other social scientists writing about health have shown that health is often linked to family dynamics. Linda Garro (2010, 2011) has argued that for middle-class California families, health is about family wellbeing and not simply the health of individual family members.

Pediatrics is unique in that the clinician's gaze extends beyond the individual child to the family as a whole. Pediatricians are often seen as responsible for the family unit, as Buchbinder's (2015a) ethnography of families of children being treated by a multidisciplinary pediatric pain clinic shows how parents and children often share a "patient role" (also see Buchbinder 2012, 113; S. White 2002).

Jocelyn Chua (2011) shows how anxieties about youth suicide in Kerala, India have led to the promotion of parenting practices designed to "inoculate" children against suicide. Concerned that children who are "spoiled" and unable to cope with disappointment or delayed gratification will kill themselves, parents are instructed by experts to teach their children how to wait: for gifts, treats, attention. The problem of youth suicide is associated with parents and the solution is also located with the parents. In a dance among parents, experts, and children (126), making children wait has become a key to child mental health in Kerala.

Role of Parents

In most pediatric clinical encounters, one or both parents are "key actors" (Dimond 2014). In most clinical pediatric encounters, at least one parent is present and, depending on the age of the child, is responsible for reporting to the clinician on the child's health and

wellbeing. In his analysis of English-language textbooks and articles from [dates] on taking a medical history in pediatrics, physician and medical historian Jonathan Gillis (2005) highlights, “Children have always had parents, and therefore, in any medical text dealing with children, parents are inevitably ‘present’” (394).

Examining this assumption—that parents are nearly always present at the pediatric appointment—is of particular importance to this project. While Gillis and others are correct in observing the importance of parents in pediatric care, this reality becomes more complicated when talking about children who are orphaned (social or otherwise) or newly adopted into a family. Until adoption, most internationally adopted children are indeed without parents. Upon adoption, the child is with parents who simply do not know all that the child has experienced. For biological and social orphans, the absence of parents or adults who are familiar with their life stories makes the clinical history a distinct challenge. In international adoption medicine, the absent birth parents are a “phantom” presence, to borrow from Raspberry and Skinner (2007) on ancestors in pediatric genetics. Here, I want to note my agreement that the role of parents is key to understanding clinical pediatrics, but I also want to complicate this. In international adoption medicine, the position of the parents as parents to this specific child, responsible for their health and welling, is new and tenuous. The background of the child’s birth family and experiences with institutional care are almost always unknown to the adoptive parents.

Despite the near constant presence of parents in pediatric clinical settings, the role of parents in the pediatric clinical encounter is “poorly understood” (Dimond 2014, 2). Dimond highlights how parents serve as “gatekeepers” to the child’s body. Parents are charged with undressing and dressing the child—through this they either consent or don’t consent to what

is done to the child's body. Parents also serve as narrators on behalf of most children, especially those who are very young, pre-verbal, or do not share a language with the clinicians. Pediatrics can be more about the parent's perception of the child's health than the child's perception of health. Furthermore, diagnoses and treatments are often a negotiation between clinicians and parents (Kelle 2010, 10)

Social scientists writing about the pediatric encounter have argued that “normative judgments about parents are a routine feature of the work” (S. White 2002, 428; also see Buchbinder 2015a, 113; Strong 1979). Family dynamics and behavior may contribute to a child being sick (Buchbinder 2012; 2015a, 100), parents may be inadequately following the doctor's instructions regarding treatment, or the parents may not have the cognitive abilities necessary to follow treatment instructions (S. White 2002). Parents are regularly classified as “good parents” or “bad parents” in the pediatric encounter (Fortin 2008).

While conversations in the IAM clinic certainly communicated the norms and values of clinicians and parents, the context of the IAM clinic is different from other pediatric visits. The clinicians perceive that, were it not for the adoptive parents, this child would be parentless and not receiving medical care in the U.S. Knowing that children in orphanages and foster care outside of the U.S. are in poorer health than children residing with families in the U.S., clinicians often enter the room assuming they will meet “good” parents because any parents are better than no parents, and that adoptive parents are especially dedicated. In an early IAM publication, Hostetter and Johnson (1989) explain, “we have found that caring for adopted children from abroad can be one of the highlights of pediatric practice. Not only are the children delightful, but one could scarcely find more devoted or motivated parents” (332). IAM clinician Jennifer Chambers (2005) argues that the neediness of the children

combined with the dedication of the parents set IAM apart from other pediatric practices: “International adoption pairs the most vulnerable and high risk pediatric population with the lowest risk parent group” as she perceives that adoptive parents are typically highly educated, financially secure, and have a low divorce rate (1263).

Clinic appointments were an opportunity for clinicians to help families explore their specialized identity as an “Adoptive Family.” Even the fact of the medical appointment positions parents as “good” parents who are seeking specialized care for their child. Knowing that the American Academy of Pediatrics (AAP) and most adoption agencies now recommend that internationally adopted children see a clinician who specializes in adoption medicine, many parents understand the visit to the IAM clinic as “the right thing to do.” In chapter 5 (“Realizing the Category of Family”), I explore how the IAM clinic reinforces and structures familial identity.

Parental involvement in pediatrics is also marked by gender norms, with mothers nearly always present (Davis 1982, 21). In the 1970s and 1980s, Davis observed that when fathers are present and participate in the clinical encounter, they are often doubted and considered unreliable (34). Other scholars have observed that gendered expectations of parenthood are complex and often subtly communicated in the clinic (Buchbinder 2015a; Mattingly 2009; Tiitinen and Ruusuvoori 2015).

In her study of children and families being treated at a pediatric pain clinic, Mara Buchbinder (2015a) relates how clinicians expressed concern that one stay-at-home father was over-involved, especially in the physical caretaking of his teenage daughter. The family was advised that the mother should spend more time with the daughter, as the clinic team thought it strange that a father would be spending more time with a teenage girl than the

mother did (126-132).

In their study of gendered parenthood in pediatric health care, Tiitinen and Ruusuvuori (2015) find that clinic staff assume mothers to be the primary caregivers with fathers relegated to a secondary role. I witnessed the privileging of mothers' knowledge in a slightly different way in my own clinical observations. While clinicians rarely explicitly doubted father's narratives, mothers sometimes did. In one memorable instance of a married heterosexual couple and their China-born child, when the father answered a question asked by the occupational therapist, the mother sighed, glared at him, said, "oh, you wouldn't know about that!" and proceeded to give a slightly different answer. When fathers and mothers were both present at the appointment, the mother usually answered most questions. Fathers would frequently defer to mothers, saying that they (the mother) handled more of the bedtime/meal time/bathroom stuff. In the case of my participants, it wasn't clinicians who expressed concern about gender dynamics in the household. Mothers usually occupied the role of expert on the child through their own assertion of knowledge and through the father's assertion that they would know better. It may also be true that mothers are trying to assert their status as "good mothers" by claiming authority over the child's health.

Cultural Health Capital

As Buchbinder (2015a, 38) points out, the concept of cultural health capital is key to understanding how parents or families as a whole understand and consume medical treatment. "Cultural health capital" refers to the "socially-transmitted and differentially distributed skills and resources [that] are critical to the ability to effectively engage and communicate with clinical providers" (Shim 2010, 1-2). Shim continues: "At present, specific elements of [cultural health capital] may include linguistic facility, a proactive

attitude toward accumulating knowledge, the ability to understand and use biomedical information, and an instrumental approach to disease management” (2). In the context of pediatric health care for young children, cultural health capital is the ability of parents to productively communicate with clinicians with the goal of achieving health for their child. To do this, parents must be able to understand the language of biomedicine and the goals and norms of pediatrics, to learn more about what they do not know, and to be willing to act on the clinician’s advice. Clinicians noted when parents had a medical background, inferring that the parent was knowledgeable about biomedicine.

Not all parents can do this. While the IAM clinic usually saw only children adopted internationally, they occasionally saw children from the U.S. foster care system or children who had immigrated from abroad with their families. In one case, a mother and her four children went to the emergency room (ER) at the local children’s hospital. This refugee family was from Central Africa and spoke no English. The ER was able to address the immediate problem, but could not provide the screening and primary health care all of the children needed; it was clear that the children were in need of prompt and comprehensive care. Knowing that the adoption clinic was seeing patients the next day and that the clinic staff would be able to thoroughly evaluate all of the children, an ER staff member referred the family to the adoption clinic.

This referral and others like it border on accidental. If it had not been for an employee who knew that the adoption clinic staff would have the expertise to treat these children, they may not have received the primary and specialized care they need. Pediatric care in the U.S. lacks the infrastructure to fully address the needs of all immigrant children.

These children were strikingly similar to international adoptees, especially those from

Central Africa. The kids showed signs of long-term malnutrition and the clinicians considered them at risk for tuberculosis, other infectious diseases, and parasites. Like adoptees, they needed to be re-screened six months later, as many diseases don't appear until some months after infection.

Why is it that there's a safety net—in the form of a subspecialty and a widely articulated rationale for this subspecialty—for internationally adopted children but no such safety net for similar groups of children? I see several reasons for this peculiarity: health insurance, documentation, and parental status. U.S. citizens adopting children must meet prescribed standards, including the ability to provide health care for the child, so nearly all internationally adopted children have private health insurance provided by adoptive parents.

Unlike children in some similar pediatric populations, in almost all cases internationally adopted children enter the U.S. health care system with U.S. citizenship established. While health care—especially health care for children—should not depend on citizenship, in practice it often does. Immigrant families that are undocumented may be reluctant to engage with the public health system, especially in regions with strong anti-immigrant sentiment.

Parental status is critical here. By status, I mean the parent's education, relative wealth, occupation, language, and comfort with the health care system. Parents of internationally adopted children are overwhelmingly white and wealthy by global standards. Most of the families I have encountered in the clinic include at least one parent who holds a white-collar or professional job. Adoptive parents have also successfully navigated the “paper chase” of the adoption process. To many, the bureaucracy of U.S. health care pales in comparison to the overlapping bureaucracies of state adoption agencies, the U.S. State

Department, international treaties, governments of birth countries, orphanages, and foster homes.

When the refugee family I discussed above visited the adoption clinic, one of the practitioners remarked that she was concerned about the children's future because, in addition to their already poor health, they did not have a parent who could advocate for them: "I worry about them. Our other kids, our adopted kids, I don't worry about them as much. They have parents who can make sure they are okay". The immigrant mother speaks no English⁵ and must depend on others for the transportation, money, and knowledge needed to access the pediatric health care system. In other words, most parents of internationally adopted kids have the cultural health capital that makes it easier to engage with and navigate health care institutions.⁶ It is important for the reader to grasp the importance of the cultural health capital held by middle- to upper-class white adoptive parents. In the chapters that follow, I will highlight events or scenes where this capital is visible.

Pediatric Genetics

I want to briefly take on the social science literature on pediatric genetics because the care of children based on genetics has an interesting, if indirect, relationship with international adoption medicine. Howell's (2009) point that adoption is key to kinship studies *because* adoption challenges "the very referential principle of flesh and blood in Euro-American thinking" (153) is important here. Pediatric genetics is about the centrality of and implications of this flesh and blood principle. IAM is, at least in part, about families formed

⁵ After much difficulty and confusion around which language the family spoke, the hospital was able to provide a translator via teleconference.

⁶ Note that cultural health capital is not limited to wealthy white people. Impoverished people and those experiencing ill health often develop the knowledge needed to navigate health care systems (Mattingly 2009).

without the blood and gene connection, and the implications orphan-hood and adoption have on health.

As in IAM, parents occupy a unique position in pediatric genetics. As in the IAM clinic, parents act as facilitators, mediate access to the child's body, and represent the child (Dimond 2014). But in the genetics clinic the parent occupies a more central role as a quasi-patient, as genetic screening and diagnosis are concerned with medical problems transmitted from parents to their biological children. Dimond argues that in pediatric genetics, the "boundaries around the 'patient' are fuzzy, as the clinician's gaze extends beyond the child to include family members. In the intersection of paediatric and genetic medicine, the role of the parent takes on new meaning" (2), as parents are quasi-patients. McLaughlin and Clavering (2011) posit that genetic medicine does two things for families. First, assuming that moral worth is linked to one's family line, disease explanations based on genetics challenges this kin connection and their moral worth. Second, disease explanations based on genetics can protect an individual's moral worth, as mutations are "random bad luck" (400) and not the results of a parent's negligence. In IAM as well, the role of parent has unique meaning, and the clinician is concerned with the health of the family as a whole.

Other corollaries exist. For example, the practice of dysmorphology and genetics screening is about the interaction of family and information (Latimer 2007, 108; Raspberry and Skinner 2007), as parents visiting these clinics are often doing so to learn about risks of problems in future pregnancies as well as seek treatment for their living children. Raspberry and Skinner (2007) show how "phantom ancestors" are present in the genetics clinical encounter. Long dead ancestors live on in genetic material and determine risks to the future family (374).

Ashley Lebner (2000) highlights the ways in which the medicalization and geneticization of American culture have affected adoptive parent discourse.⁷ Interviewing 28 parents and exploring internet bulletin boards, Lebner explores American kinship's dominant metaphor of blood ties and now, genes.⁸ Adoption has historically been stigmatized partially because the practice lacks such biogenetic kinship ties (Miall 1987, discussed in Lebner 2000, 373). Lebner found that all adoptive parents she interviewed articulated some anxiety or concern over their lack of blood or genetic tie to their child(ren). Adoptive parents were especially concerned about their children's health and not knowing about the child's birth family health history. This anxiety demonstrates how risk is managed by American parents. Now that many Americans believe that disease risk can be determined by genetics, screening and testing is seen as way to protect oneself and one's children (373). To what extent is genetic management on behalf of one's children part of being a good parent? For adoptive parents, the "unknown" of their child's medical and genetic history is problematic, because the parents feel limited in their "medical preparation" (376). A central question that Lebner asks (and one that runs through adoption medicine) is: "how do [adoptive parents] experience this absence of knowledge?" Extending this, how do adoptive parents conceptualize genetics in relation to their families? Finally, Lebner calls on family doctors to recognize the increasing medicalization and geneticization of American culture and to keep in mind the anxieties this often causes for adoptive families.

Although not writing specifically about international adoption, Kaja Finkler's (2001)

⁷ Lebner defines medicalization as the process through which biomedicine is centered as the authority, and mass media and the public internalize biomedical discourse. The term "geneticization" is used to "identify both the biomedical and political implications of the current drive to determine the genetic antecedents to illness, disease, and behaviours" (Lippman in Lebner 2000, 372).

⁸ Judith Modell's (1986) work with U.S. birthparents also highlights how adoption discourse challenges dominant metaphors of kinship. The end result of this domestic birthparent narrative is to "assert the biological basis of parenthood without excluding the social basis" (649).

ethnographic work with domestic adoptees illustrates that for many adoptees, the search for one's birthparents is in part motivated by their desire to meet people with whom they share genes. Like Lebner, Finkler notes the problems medicalization causes for adoptive families: "For the adoptees...the medicalization of family and kin produced fragmentation, internal conflict, and turmoil, creating special dilemmas that do not affect individuals who have been raised by blood kin" (246).

Genetic testing is also used by adoptive families in searches for birth parents (Lebner 2000). More recently, DNA testing has been used in searches for twins or siblings of internationally adopted children, as well as to gather information on potential ancestry and health risks (Bahrapour 2016; Baptista et al. 2016; Crouch et al. 2015; May and Grotevant 2017; Swarns 2012). The results of these sibling searches have caused families to extend their kin networks and to consider both adoptive and biogenetic relatives kin to their adopted children (Volkman 2009).

There has been some discussion among bioethicists about the genetic screening of children available for adoption, but this does not appear to be a widespread practice in the United States. Rather, requests for testing by parents in the United Kingdom have spurred discussion on the ethics of genetic testing of adoptable children. The American Society of Human Genetics Social Issues Committee and the American College of Medical Genetics Social, Ethical, and Legal Issues Committee (2000) oppose most pre-adoption genetic testing on the grounds that it exposes children to "stigmatization and discrimination" while providing little to no medical benefit. Such genetic testing is ethical only if it is "(1) consistent with preventative and diagnostic tests performed on all children of a similar age, (2) generally limited to testing for medical conditions that manifest themselves during

childhood or for which preventative measures or therapies may be undertaken during childhood, and (3) not used to detect genetic variations within the normal range” (766; also see Freundlich 1998; c.f. P. Taylor 2008). In my review of literature about international adoption medicine, I have not found genetic testing listed as a service commonly provided by international adoption clinics. In my interviews with clinicians, I asked whether they parents had asked about pre-adoption genetic testing. No clinicians had had such requests, and one seemed taken aback that I would even ask the question.

While the adoptive parents I interviewed are concerned about their lack of knowledge about their child’s genetic health history, none worked with a medical provider to get genetic tests done. Some families used popular DNA testing services (23andMe, Ancestry.com, etc.) to learn what the test revealed about the child’s ancestry, but for this was for “identity” more than “health.”

The relationship between adoption and genetics discourse is also played out in national and international politics. Most fretting about genetics is on behalf of an individual or a family. But international adoption causes anxiety about the genetic health of the nation-state. Khabibulloina’s (2009) analysis of Russian perceptions of international adoption reveal how the government has expressed concern that if large numbers of Russia-born children are adopted by U.S. parents, Russia’s “genofund” or gene pool will be depleted. Khabibulloina argues that Russians express concern that Russia will lose potential geniuses to a rival, the United States. On the flip side, many Russian citizens are wary about domestic adoption because they fear they might adopt a child with “bad genes.” In this understanding of genetics, “bad genes” are indicated by criminality, sexual promiscuity, and poor intellect.

Conclusion to Chapter 1

Using ethnographic data, histories of adoption and IAM, and the tools of practice, structure, and discourse, I explore how “human beings make meaningful the world which makes them” (Bourdieu and Wacquant 1992, 7), specifically how parents and clinicians use IAM and health care in the establishment of adoptive families.

Chapter 2, “Methods,” is a description of the research tools and approaches I used to understand IAM and the health care of internationally adopted families. Chapter 3 is an overview of international adoption in the U.S., with particular attention to the factors shaping adoption during the period of my research. In chapter 4, I describe the pediatric subfield of IAM: the pediatric context in which it developed, its beginnings, the epidemiology of adoptee health, and provide an ethnographically grounded description of an IAM clinic.

In chapter 5, “Realizing the Category of Family,” I explore how adoption medicine as a whole, and the clinic visit in particular, reinforce Bourdieu’s (1996) “family feeling.” Detailing how IAM “makes family” before adoption, during the transition period when a child joins a family, and in long-term care, I show that IAM is an important site for reinforcing family feeling and negotiating what it means to be family. I will examine how IAM plays into broader issues such as the negotiation of race and ethnicity and feelings of kinship among adoptive families.

In chapter 6, “Balancing Connection and Science,” I look specifically at a central concern of medical professionals and parents alike: the process of parent-child bonding and the importance of those bonds. I explore how parents and clinicians understand the concept of attachment and mutually shape such bonds. I will show how parents use IAM-generated literature on attachment and brain development in their articulation over expertise about their children and in parenting decisions.

In chapter 7, “Parenting and Bodywork,” I examine how physical caretaking of children by parents is key to the making of the adoptive family. While Bourdieu shows how family is made through “clean” activities—gathering as a family, the gift-giving—I will show how the “dirty” practices of parenting—changing diapers, cleaning up vomit, collecting stool samples, feeding, and cleaning—contribute to “family feeling” and the making of family as much as, if not more than, “clean” practices.

Finally, in chapter 8, “Conclusion,” I reflect on IAM through the story of one family. Bringing together “family feeling,” attachment, and physical caretaking, I discuss how this ethnography adds to our understanding of kinship, medical anthropology, and the making of family.

CHAPTER 2: METHODOLOGY

In order to address my research aims of examining the intersection of kinship and medicine, I conducted a multi-sited ethnography (Marcus 1995), doing fieldwork in diffuse physical and virtual locations between 2011-2015: participant-observation at an International Adoption Medicine (IAM) clinic and conferences of adoption doctors, adoptive families, and adoption agency staff; in-depth interviews with adoption doctors and adoptive parents; analysis of documents produced by participant groups; and online surveys of adoption doctors and adoptive parents. I selected these methods based on their utility in uncovering implied, explicit, and official aspects of culture.

My primary method, participant observation, is best described by James Clifford (1998) as the “dialectic of experience and interpretation” (38). Ethnography and the representations it projects are always partial, as the perception of an individual cannot account for the multiple experiences and perspectives of the people involved in a given phenomenon. My project should be understood as a selection of the texts of IAM, an interpretation based on my experiences and my understanding of what I heard and saw. The participants themselves may not view kin relations and health care as connected, as I do. This text is my effort to understand the experience of IAM and family building and interpret them through the lenses of kinship and medical anthropology literatures.

Field Sites

Clinic as Site

The primary field site for my project is an International Adoption clinic (The Clinic) located in the outer suburbs of a large Midwestern city, on a satellite campus of a nationally recognized pediatric hospital system and teaching hospital. The building is relatively new, fewer than 10 years old. The interior is that bizarre combination of sterile and circus-like atmosphere unique to pediatric hospitals. The floors are tile and there seems to be a hand sanitizer dispenser every 25 feet, but there are splashes of bright colors on the wall, the TVs play Mickey Mouse Clubhouse, and there are video game consoles in waiting areas.

Once a week, The Clinic convenes to meet the needs of internationally adopted kids and their families. The clinic space is designed to be flexible, with different rotating specialists moving in and out throughout the week; The Clinic uses space occupied by the ear, nose, and throat specialists on other days.

Director Barbara Smith, a pediatric infectious disease doctor, heads The Clinic. Other staff include a nurse practitioner (Carol Hite), an occupational therapist (Molly Sanders), and two licensed clinical social workers (Patty White and Caitlyn Schmidt). All staff members are female, white, and range in age from late 20s and early-50s. Occasionally, temporary nurses, therapists, and trainees are present.

Nearly every Monday for 15 months (October 2012-December 2013) I visited The Clinic to observe. In the course of this fieldwork, I observed some component of 75 children's visits to the clinic.⁹ Fifty-seven percent of the patients I saw were identified as

⁹ This number excludes two families, as I was not able to account for individual members of these families. One was a large family (20+ people). Their visit was hectic and it was difficult for me to figure out which children were biological children of the couple, which had been adopted from foster care, and which were internationally

female and 43% were identified as male. Of the children and families I saw, children adopted from China were by far the largest number (n=35). The number of Ethiopian and Russian adoptees followed, with seven children from each of these countries (See table 1).¹⁰

China	35
Ethiopia	7
Russia	7
Guatemala	4
Haiti	4
Ukraine	4
Philippines	3
Bulgaria	2
Columbia	2
India	2
Congo	1
Dominican Republic	1
Hungary	1
Marshall Islands	1
Uganda	1

I did not specifically ask adoptive parents about their own race or ethnicity. Based on my own perception, all were white, with the exception of two Asian parents (one Asian woman married to a white man and one Asian man married to a white woman).

Conferences

Conferences and meetings on adoption and adoption medicine are key sites of interaction among adoptive families, adoption doctors, and other adoption professionals. Schwartzman (1993) highlights the importance of participant-observation at meetings. The hierarchical structure of the organization and key values of the organization are on display.

adopted. The second family was a family of refugees, not international adoptees.

¹⁰ Chapter 4, "History and Practice of International Adoption Medicine," includes additional details about The Clinic and the patients I met there.

Meetings say, this is who we are, this is what we think is important.

In the sections that follow, I describe two key conferences I attended multiples times: the national JCICS Symposium and the local Orphan Care Alliance. I also attended one conference hosted by a national adoption agency in Austin, Texas. Some of these conferences are not directly related to child health or focused on adoption medicine, but are an indirect lens into IAM, as child health is a frequent topic. These conferences are also key sites for understanding the structure of adoptive family networks at the national and local levels.

The Symposium

Early in my research, I identified the Joint Council on International Children's Services (JCICS) Annual Symposium on Child Welfare as a field site. The Joint Council is a non-profit trade and advocacy organization working with adoption service to support pro-adoption legislation, improve adoption services, and advocate for orphans worldwide.¹¹ For over three decades, the Joint Council has held an annual meeting (later called the Symposium) that includes a full day of sessions focused on adoptee health, nutrition, and development. The Symposium is not necessarily the most important professional conference for IAM clinicians, but it is the conference at which IAM doctors communicate best practices of IAM to adoption professionals (social workers, adoption agency staff, and a handful of adoptive parents).¹² I attended the 2012, 2013, and 2014 JCICS Symposiums. As such, it is a

¹¹ JCICS is now closed; see chapter 3 for a brief discussion of the organization and its closure. An archived copy of the JCICS website details the organization's history (Joint Council on International Children's Services 2013).

¹² While adoption agencies were not the focus of my research, agency staff participation in conferences allowed me to see how IAM relates to the broader adoption world. Like IAM medicine as a discipline, adoption agencies and the processes they facilitate are also sites where family is made and negotiated.

key location for participant-observation of IAM clinicians and adoption professionals. Attendance of and participation in the symposiums provided me a lens through which to see the translation of IAM to the adoption professionals; I saw how IAM knowledge was communicated to and interpreted by the broader world of adoption professionals. The symposiums were attended consistently by some of most well-known IAM clinicians and included multiple presentations on IAM (see table 2).

Table 2: IAM-related presentations at JCICS Symposiums, 2012-2014	
Year	Title
2012	“Best Practices in Post-Adoption Nutrition”
	“Helping Adoption Agencies Understand the Medical Conditions of the Special Needs Child”
	“International Adoption Basics for Adoption Agencies: Useful Medical and Developmental Information through the First Year After Adoption”
	“Intervention for Children with Fetal Alcohol Spectrum Disorder: A Research AND Family Perspective”
	“Is this ADHD? When and How to Access Early Intervention and Special Education Services”
	“More Than Peas and Carrots: Nutrition’s Critical Role in Early Brain Development” (Keynote)
2013	“Adverse Outcomes in Children without Families: A ‘Perfect Storm’ of Malnutrition, Inflammation, and Social Isolation”
	“HIV Adoption and a New Clinical Model”
	“The Impact of Global Health Issues on Children and their Caregivers”
	“Nutrition and Feeding of Orphaned Children Living in Institutions: Recent Findings from Kazakhstan, Haiti, and India”
	“Preventing Malnutrition in Orphanages: Where to Begin?”
	“Understanding the Medical, Nutritional, and Feeding Needs of Children with Special Needs”
2014	“Cutting Edge Research: FAS, Foster Care, International Adoption Registry”
	“International Adoption of the Older Child: Approaches to Challenging Medical, Developmental, and Behavioral Conditions During the First Year Home”
	“The Pre-Adoption Proposal in International Adoption: An Intriguing and Complex Dialogue”
	“Raising Children with Fetal Alcohol Spectrum Disorders”
	“Strategies for Post-Adoptive Success: Parents Collaborating with Schools after Intercountry Adoption”

Source: JCICS Symposium programs, 2012-2014

Attending the symposium helped me make contact with potential interviewees and see how IAM knowledge was disseminated to non-clinicians involved in adoption. The sessions were also valuable as they provided me an understanding of the epidemiology, pathologies, and diseases processes of IAM medicine. In the clinic, I was able to make sense

of the individual children I was seeing, the doctor's concerns, and treatment plan because I had a baseline knowledge of the diseases of IAM.

Orphan Care Alliance

When I began this project in 2010, I did not anticipate that religious or emerging Christian ministries would play a significant role. In my initial prospectus, I named “organized groups of adoptive families” such as Families with Children from China and Latin Family Connection as probable sites for participant observation among adoptive families. Once I officially began my research, I found that these groups were largely inactive, or met annually for reunions; they did not meet regularly for family support and peer interaction. I quickly learned that the local active groups for adoptive families were centered around a non-profit, Orphan Care Alliance (OCA) (Orphan Care Alliance, n.d., “About”), with roots in local evangelical churches (at least one is commonly described as a mega-church). OCA offered quarterly half-day “Seminars” on adoption, foster care, and “ministering to orphans,” and annual daylong local conferences or simulcasts of national conferences on parenting children who have experienced trauma. This local effort, along with similar ministries at evangelical churches throughout the U.S., is part of the orphan care ministry movement in which evangelical Christian churches devote time, money, and effort to ministering to abandoned children, usually through adoption (see Joyce 2013 on the national evangelical orphan ministry movement). I detail the orphan ministry movement in chapter 3, “Overview of International Adoption in the U.S.,” but will briefly discuss my interaction with the local movement here.

This shift from non-sectarian support groups to orphan ministry organizations was unexpected, and I was nervous about attending. As a lesbian married to a woman, my

perception was that I was not welcome at these evangelical churches. As a local, I knew that these churches had organized around anti-gay legislation, at times supported conversion therapy, and still offered prayer groups for those “struggling with same-sex attraction.” I had experienced this at a personal level as well. A close family friend had left our shared Catholic parish and joined the mega-church. When I invited him to my wedding, he rejected the invitation, and me, though he did offer to pray for me.

Indeed, the rhetoric of those speaking at the conferences focused on the need for two-parent, heterosexual, father-headed, evangelical Christian families to care for children through adoption and foster care; more than once, a speaker declared that families that did not fit this description could not meet the needs of these child. In this evangelical discourse, I was excluded, but in person, fellow attendees welcomed me. Of course, sexuality did not come up in the relatively brief interactions I had with attendees and organizers. Their reactions may have been different had I disclosed that I was a lesbian.

I also began my observations at OCA conferences with the perception that the evangelical orphan movement was a more fanatical extension of problematic rescue narrative of adoption. I thought that rather than just saving children, the broader movement seeks to save children for Jesus. This is true, to an extent—the movement does want to “save children for Jesus” or “in Jesus’ name”—but the actual work of OCA is broader and far more nuanced. OCA’s work extends beyond international adoption to foster care, respite care, material support for impoverished families, volunteering with local children living in residential homes, and sponsoring conferences for parents to help them learn the skills needed to parent “children from hard places”—children who have experienced trauma and neglect.

In describing my fieldwork to friends and relatives, I soon came to describe OCA as an organization that “practices what it preaches” and “talks the talk and walks the walk”—its members care for children in the multiple ways I listed, not just through adoption. This was an unexpected personal gain from this research. Instead of understanding evangelical orphan ministries as a monolithic movement, I came to see the local nuances and positive effects of OCA and its members.

Attending the OCA seminars and conferences helped me understand the motivations of Christian parents who are adopting children with significant health problems or children who have been traumatized by institutionalization.

Interviews

In order to gain perspective on the use of IAM and how health care and kinship come together in adoptive families, I conducted semi-structured interviews with 10 IAM clinicians and 23 adoptive families in 2014 and 2015. Interviews were conducted in-person or over the phone. I transcribed the majority of the interviewees; a professional transcription company transcribed a small number. I recruited IAM clinicians from the IAM clinic that is my primary field site, attendees at the JCICS conference, and individuals recruited from a listserv of IAM doctors. Adoptive parents and adopted children were recruited from the IAM clinic, online networks of adoptive families, and among local adoptive families I know personally. These are non-probability purposive samples, meaning they are not designed to be either generalizable to an extensive population or suitable for statistical analysis. Instead, this sampling is designed for studies that are in-depth, intensive studies of a specific culture or group and to include informants who are knowledgeable about the topic (Bernard 2011, 143). Sample size was determined based on Morse’s findings that 10-20 people in each

group, and 30-50 people total, is sufficient for ethnographic investigations of a specific group (discussed in Bernard 2011, 154).

All of my parent interviewees identified themselves as white. Of the 23 adoptive families I interviewed, one interview was with a father, two were joint interviews with mother and father, and the remaining interviews were with mothers only. I asked parent interviewees to describe their family. Two identified as single mothers, two mothers adopted as part of an opposite-sex married couple but have since divorced, one identified as a queer couple,¹³ and the remaining were part of opposite-sex married couples (see table 3). Like the children seen in *The Clinic*, the majority of interviewees adopted from China (see table 4).

Table 3: Family descriptors from parent interviews	
Married, opposite-sex couple	18
Adopted as single mother	2
Adopted as married, opposite-sex couple, now divorced	2
Queer couple	1

Table 4: Birth countries represented in parent interviews	
China	14
Russia	7
Kazakhstan	4
Guatemala	3
Ukraine	2
India	1
Latvia	1
Congo	1

¹³ The Hagan-Rosch family includes Alex, who identifies as queer and gender nonconforming, Katherine, who identifies as queer and bisexual, and their sons, Lucas and David, both born in Guatemala.

While I did not specifically ask providers to identify their racial/ethnic group, having met most of them at conferences, my perception is that only one was not white; she was Asian, adopted from Korea as a child.

I obtained written consent from all interviewees. Interviews were recorded on a digital audio recorder or password-protected iPhone, uploaded to a secure location (per IRB data security protocol), and transcribed. Transcriptions were uploaded to MAXQDA, a qualitative data analysis software (VERBI Software 2015).

In-depth interviews are necessary because they help elicit explicit expressions of culture. Following Charles Briggs (1986), I recognized that for each of my participant groups (medical practitioners and adoptive parents), the communication norms and contexts differed. Interviews with clinicians had a more formal feel, with participants answering questions as content experts. Parent interviews were more informal, focusing on the “adoption story” in their conversation with me. The “adoption story” is a type “origin story” in which parents recount how their family came to exist through adoption (Sawin 2017).

Documents

Documents are keys to understanding bureaucratic and rationalized systems like international adoption and biomedicine as they reveal the implied and expressed culture of a process. As “contemporary cultural artifacts” (Murchison 2010, 164), texts are powerful in that they define and direct individuals’ roles and identities within these systems and serve as guides to those outside of these systems (DeVault 2006, 294–95; Peräkylä 2008). The legal realm of international adoption and the medical world of IAM are governed by texts: medical records, medical journals, visas, adoption application, and policy documents. Less official texts such as web pages and conference programs are also important. Analysis of texts

provides insight into what can be understood as the official, written culture of IAM.

An ethnographic analysis of texts also includes asking questions about the text itself. Going beyond content analysis, I investigate each text for authorship, context, and purpose (Murchison 2010, 166). As Hammersley and Atkinson suggest, I approach texts with questions such as, “How are the texts written?”, “Who writes them?”, “Who reads them?”, “What is taken for granted?”, and “What do readers need to know in order to make sense of them?” (cited in (Silverman 2001, 129). Such questions—and the contextual understanding they allow—contribute to my analysis of the texts.

In addition to the dozens of journal articles on IAM that I reviewed, I came to consider Laurie Miller’s (Miller 2005) *The Handbook of International Adoption Medicine: A Guide for Physicians, Parents, and Providers* to be a central text of IAM.¹⁴ As the title suggests, *The Handbook* is written so that it is understandable and accessible to the lay reader (parents). The text is meticulously researched and claims are supported by the hundreds of references, thus providing the “evidence” of evidence-based medicine that IAM clinicians desire to practice. Other book-length texts that contribute to the IAM literature include a special issue journal of *Pediatric Clinics of North America* (Albers et al. 2005), a brief clinically-focused manual (Schwarzwald et al. 2015), and an edited volume published by the American Academy of Pediatrics (American Academy of Pediatrics et al. 2014).

Surveys

I conducted two online surveys—one of adoptive parents and one of IAM clinicians—using SurveyMonkey (SurveyMonkey, Inc. 2018) from 2013-2014. Low response rate (n=20 adoptive parents and n=16 IAM clinicians) limits the utility of these

¹⁴ See Van Wichelen (2014) for another medical anthropologist’s analysis of this text.

results. Generally, they confirmed what I already knew about why parents adopt; the range of experiences concerning the health of their child that IAM doctors were seeing fewer adopted children; that many IAM clinicians were adoptive parents themselves; and that IAM clinicians came from a mix of infectious disease, developmental pediatrics, and general pediatrics.

Analysis

At the close of my data collection (May 2015) I had data in the form of field notes, recorded interviews and accompanying transcripts, and text or documents. All transcripts and field notes were uploaded to MAXQDA, a qualitative data analysis software (VERBI Software 2015). Using MAXQDA, I organized and coded my research material.

My first step in analysis was to assign preliminary codes derived first from the theory underpinning the project, my stated aims, and my experience researching IAM. These initial themes included the stages of IAM involvement in the adoption process I detail in chapter 4 (pre-adoption, referral, pick-up visit), processes that IAM clinicians ask about (feeding, pooping, sleeping, and bonding), portions of most IAM visits (seeing the nurse, evaluation by the occupational therapist and social worker, meeting with the doctor), and specific references to family formation in relation to health care.

As I continued my review, I added codes that emerged, but that I had not previously identified (Bernard 2011; Boyatzis 1998). These included codes that usually developed into chapters or sections: moments where “family feeling” is apparent at individual and community levels; references to attachment theory and science related to attachment; all physical caregiving, and cultural difference; and difference understood as related to race, ethnicity, disability, and culture. These second round codes did not replace my initial codes,

but they allowed for nuance. I continually reviewed the themes I identified and adjusted them as dictated by new data. I increased the reliability of my analysis by including constant comparison and deviant case analysis (Silverman 2001, 238-240). For example, instances in which parents opt not to have referral files reviewed by IAM clinicians reveal the uneven use of the discipline by parents.

In my review of the data, I was attuned to particular phenomena that are key in ethnographic analysis: recurring ideas or expressions; terms that are specific to IAM doctors and adoptive families; the use of metaphors; what people do not say or do, as this missing information may indicate what is assumed by the group; and data that disputes the theory informing this (G. Ryan and Bernard 2003). I made connections between various sites and texts. Over time, I identified broad themes within the data that were relevant to the theories I wanted to explore (Boyatzis 1998; G. Ryan and Bernard 2003).

My Position

Cultural anthropology is built on the concept of participant observation, which can be difficult in health care settings because they are spaces of strict hierarchy. Ethnographers are always limited by their social position and characteristics and by the social structure of community they are working in, but Wind (2008) argues that roles are especially limited in hospitals and clinics, as individuals occupy highly specialized roles. Specialization extends beyond the skills or competencies that an individual possesses. Roles are carefully regulated and status carefully marked, down to the color of badge, scrubs, or coat the individual wears (Blumhagen 1979; but see Salhi 2016 for discussion of specialization-specific nuances). The typical roles available to the ethnographers are health care worker, patient, visitor, researcher, student, and volunteer (Wind 2008).

Initially it was difficult for me to articulate my role, because my role did not really exist in the clinic. I was not, after all, a health care worker or patient. When I began my fieldwork, and for months after, members of the clinic staff would ask, “so what are you doing? What is your project?” Several people asked this more than once. Perhaps I was just bad at explaining myself or describing my project, but I think staff members’ confusion was at least partially about lack of familiarity with ethnographic research methods and how I fit into the hospital framework. I was not an intern, a medical student, or a student occupational therapist. I was a woman standing there, taking notes and talking to people. As Van Mannen (1988) observed, participant observation can be socially uncomfortable. Early in my fieldwork I scrawled in my notebook, “90% of fieldwork is standing around looking and feeling awkward.”

It was not until May and June that I figured out what clinical role I fit. About six months into my fieldwork in the clinic came the summer of the students. Within a two-week period that summer, two students began shadowing at the clinic. One was in medical school, and one was a pre-med undergraduate. The clinic staff understood the category of “student.” Seeing me with other students seemed to help the clinic staff see me as a student. The presence of so many observers made space a problem. Our desire was to be as inconspicuous as possible. Sometimes we stood huddled together in a corner of the exam room; sometimes we each stood alone in a different corner. If there were multiple appointments in a given day, we would split up, each going to a different room. Despite the space problem, having the other students present helped cast me as a student. We were all doing the same thing: observing, watching, and sometimes asking questions.

At times, my role shifted to volunteer assistant. I was frequently asked to help hold

the arm of a child receiving vaccinations or while the TB skin test was being placed.¹⁵ In one way, I liked being asked to do this, as it indicated that the head nurse, Carol, saw me as useful and as part of the team. But holding down the arm of a child is a hard thing to do. By the end of the visit, when it was time to do shots and the TB test, the child was often exhausted. Nearly all of the children screamed, fought, or sobbed. Carol always instructed the mother of stand at the head of the exam table so her child could see her and hear her comforting words. A translator was usually present to explain to the child what the nurse was doing and that vaccinations and TB tests were important. I usually felt as though the level of stress in the room was highest during the vaccine/TB test portion of the visit.

Occasionally, I distracted a child or set of children while their parent(s) had a conversation with the doctor. This was especially true when a family had multiple children. I would sit with kid in the waiting room while they played on their parents' smartphone or the video game screen on the wall of the waiting room.

I sat in on the short meetings the clinicians had in which the nurse, occupational therapist, and social worker would fill the doctor and clinic director in on their findings before she conducted her exam and talked with the family. While I mostly listened during these meetings, I occasionally chimed in with my impression. Because I was the only person who had observed each of the clinicians' session with the family, I was sometimes able to point out connections. Parents sometimes described the child's behavior differently to each clinician. For example, parents would tell the nurse practitioner taking the initial history that they had no concerns about the child's eating habits. When the occupational therapist asked about sensory issues, the parents would report that they had no concerns. But in a

¹⁵ This is done by using a needle to insert a small amount of tuberculin fluid just under the skin of the forearm. The injection site is later "read" for signs of past or current infection (Centers for Disease Control and Prevention 2016).

conversation with the social worker, the parents made an offhand comment about how the child eats mostly yogurt, oatmeal, and applesauce. The parents' observations are correct—the child eats well—but they do not recognize that the fact that the child eats only soft, liquid foods is indicative of a developmental delay (Miller 2005, 404).¹⁶ The nurse practitioner would report “no problems with food” and the occupational therapist would report “no significant delay” to the doctor. The social worker, screening for problems with attachment and mental health, did not note the family's comment about the child's preference for soft foods. In this case, I informed the team of the parents' comment about food, and the occupational therapist was able to go back to the family, gather more information, and recommend ways to strengthen the child's oral capabilities such as using a straw and continuing to introduce crunchy foods.

My role shifted again on the few occasions I encountered a child with medical problems similar to my own. I was born with multiple heart and limb problems and spent my share of childhood visiting pediatric specialists and undergoing surgeries in order to manage these problems. Most significantly, I have had three heart surgeries to correct congenital defects and a foot amputated due to limb defects. My interest in pediatric health care is rooted in my own experiences as a pediatric patient.

On several occasions during my fieldwork, I met children diagnosed with similar problems. Rachana, age 9, was adopted from India by the Mueller family. She was coming to the clinic for a 6-month recheck. She had previously been diagnosed with limb differences and treated for TB. Reviewing the day's visits, I realized Rachana had a similar limb defect to my own, but had not yet had her foot amputated. Dr. Smith related that Rachana's mother

¹⁶ Children in institutions are often fed with a bottle into toddler-hood. Meals for older children are often soups, gruels, and stews—it's easier to cook a pot of soup for a large crowd than it is to prepare separate dishes. Institutionalized children don't have exposure to crunchy foods so their oral strength is compromised.

was having difficulty with the idea of amputation, as she viewed amputation as an extreme solution. Before meeting Rachana, I talked with Dr. Smith, asking whether it was appropriate for me to share my experience with limb differences and amputation with Mrs. Muller. She responded that sharing my experience would likely be helpful. Mrs. Mueller and I had a positive conversation; she seemed relieved to meet an adult with a similar problem.

According to Mrs. Mueller, Rachana had been excited about coming to the U.S. to get a new leg, but it had been hard because she had imagined that she would get a “real” leg—flesh and blood—as opposed to a prosthetic made of plastics and metal. Though Rachana’s English was limited (and I have no ability to speak Tamil), I was able to show her my leg and communicate that it made walking easier for me. I do not know the outcome—whether the Muellers decided to proceed with the amputation and if so, how Rachana adjusted to life with a prosthetic. Mrs. Mueller and I connected over the experiences I seemingly shared with her daughter. In this moment, I went from observer to participant.

IRB

I sought and received approval by expedited review from UNC’s IRB in August 2011 and renewed my application through May 2015 (study number: 11-1431). The IRB of The Clinic’s hospital system determined that they did not need to review the project, as I was not a formal member of the system as staff, faculty, or student.

Limitations

The primary limitation of this project is that I vacillated between trying to find out as much as possible about the field of IAM and the detailed, individual understandings of adoption and health care. I now have, of course, perfect hindsight. At the outset of this project, my goal was to understand the field of IAM, so I was intentional in trying to see as

many cases as possible in the clinic. While the results of my research are meaningful, I find myself wishing I had done fewer, but more detailed interviews. I will take this as a direction for future research. With a broad understanding of IAM, I will be able to delve more deeply into the stories and experiences of a few children and families.

Other limitations:

In recruiting adoptive parent interviewees, I was intentional in my choice to recruit parents who I had not met through the clinic. My goal was to gauge the health care experiences of a broader range of adoptive parents than those I saw in the clinic. I also found that adoptive parents I met in the clinic felt overwhelmed (as they had just adopted child!) and often declined interviews. Despite my rationale for this decision, I now see this as a limitation. Focusing more of my effort on contacting and following-up with parents I met in the clinic for in-depth interviews would have been beneficial for this overall project.

I was unable to obtain access to individual electronic medical records during my time in the clinic, though I did have access to the brief, paper charts (with registration form and whatever referral information was available) that were printed for each patient visit. It became clear that the bureaucratic hurdles necessary to access electronic medical records were insurmountable, so I decided to focus my efforts on interactions in clinic visits instead.

Interviewing Alex highlighted a limitation of my interview questions. While I initially perceived Alex and Katherine as a “lesbian couple,” they do not use those terms. Alex was the only participant I directly asked to describe the language Alex uses when describing their family. My descriptions of all other participants’ families are based on my own perceptions. The same is true of the race/ethnic categories of practitioners I interviewed and parents I met in the clinic. I did not ask them how they identify in relation to race and ethnicity.

About Language

A few notes on my use of names: I publicly identify the conferences I attended, but not the names of the key IAM clinic and the other clinic I visited. My rationale for doing this is because conferences were open to the paying public. Attendees largely understand these as public events and spaces. Clinics, on the other hand, are private spaces. I have assigned pseudonyms to all individuals, or speak of individuals in generic terms: “a parent” or “an IAM clinician presenting at” a given conference. While there would be some advantage to identifying the IAM clinicians who spoke at conferences, as they are public figures, I do not have the explicit permission to use their names.

Throughout the text, I refer to clinic staff as their coworkers and patients do. Doctors are nearly always called, “Doctor,” as in “Dr. Smith.” Non-physician staff are referred to by first name and role: “the occupational therapist, Molly” or “Caitlyn, the social worker.” The difference in social status between doctor and all other staff is clear. My use of these terms is intended to reflect the language of the clinic.

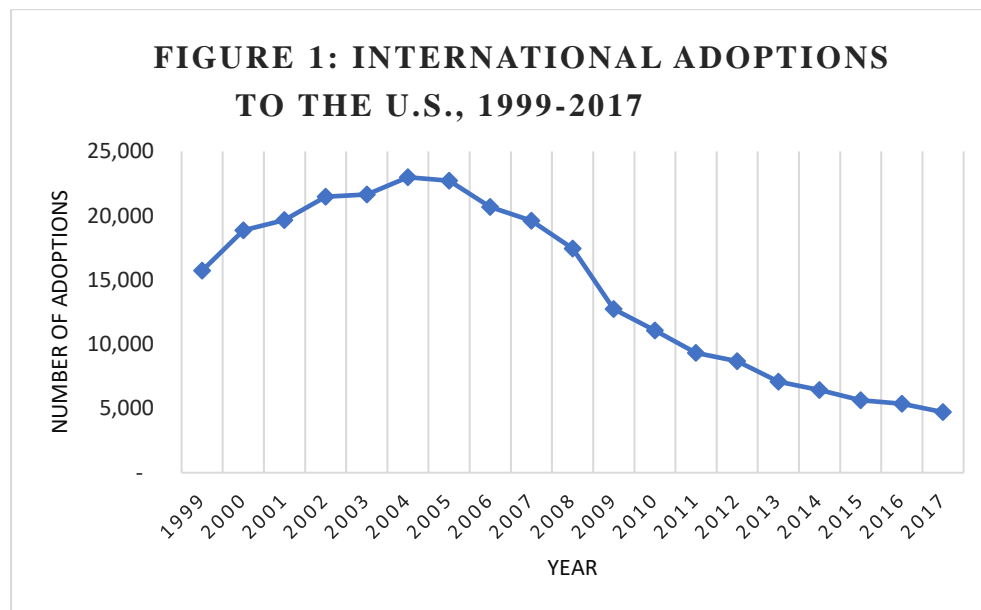
Some additional notes about language. Terms such as “deformity,” “malformation,” and “defect” are rightly criticized as coming from the medical model of disability that casts physical difference as pathological (Zola 1993). Throughout this text, I have tried to balance the language used by clinicians (“defect,” “malformation,” “disability”) with language that resists pathologizing labels, and instead centers the person rather than the diagnosis. That said, it is important to use the terms that my participants use, so to the extent possible, I mirror the language of clinician, parent, or text. One goal I have for future work is to analyze my data from the perspective of disability studies.

CHAPTER 3: OVERVIEW OF INTERNATIONAL ADOPTION IN THE U.S.

International adoption is the process of the legal adoption of children born outside of the U.S. by American citizens and is a common way for American adults to build families.¹⁷ (I discuss adoption from the perspective of the anthropology of kinship in chapter 1. My goal here is to describe the phenomenon of international adoption to the U.S. in the contemporary period.) Adoption is not a new process, but contemporary international adoption is marked by bureaucracy, rationalization, the involvement of experts, and international and domestic legal processes (Herman 2002). The scale of such adoptions since the mid-1990s is notable. To adapt a phrase from Ehrenreich and Hoschchild (2004)—“women are on the move as never before in history” (2) —children are on the move as never before in history. Through this “diaper diaspora” (Selman 2007), never before have so many children traveled so far to join a family. In the mid- to late 1990s, the number of children adopted internationally by U.S. citizens rose rapidly and peaked in 2004, with nearly 23,000 such adoptions. For most of the 2000s, most internationally adopted children came from Russia, China, Guatemala, Korea, and Ethiopia (Selman 2007, 2016). International adoption rates have declined steadily since 2004, with 4,714 international adoptions in fiscal year 2017 (figure 1). In 2016, the most recent year for which data are available, the top birth country was China, which accounted for over 40% of all international adoptions by U.S. families. Other countries

¹⁷ Internationally adopted children receive U.S. citizenship under the category of “Immigrant Orphans.” The term orphan is problematic, as most internationally adopted children are not true orphans. That is, their parents are not deceased. Instead, adoptable children have been abandoned or relinquished by their parents. For example, in Romania: 98% of children in institutions had been abandoned at birth, not true orphans (Hord et al. 1991). The same is true of Chinese children in orphanages (Andrew 2007). Lisa Cartwright (2005) uses the term “social orphans” to describe such children (207n1).

sending more than 200 children each include Democratic Republic of the Congo, Ukraine, Korea, and Bulgaria (U.S. Department of Homeland Security 2017, table 12).



Source: U.S. Department of State, Bureau of Consular Affairs (n.d., “Adoption Statistics”)

Demographer Peter Selman (2009a) traces the steep rise of international adoption until the mid-2000s to factors in receiving countries; there was demand for healthy infants in the U.S. and Europe. In the 1970s, changes in access to birth control and abortion and increased access to wage labor for women led to fewer American birth parents placing their children for adoption (L. Briggs and Marre 2009). As single and unmarried parenthood has become more acceptable, more women have kept their children (Melosh 2002; Pertman 2000).¹⁸

¹⁸ Other factors influence American’s use of international rather than domestic adoption. Most children now available for adoption through state and local systems were removed from their birth families, so they are generally older and may have been abused and neglected, or have physical or cognitive disabilities. Prospective adoptive parents may be able to adopt a healthy infant through a private adoption, but this is costly, and usually involves a long wait. Adoptive parents who were discouraged by incidents in which American birthparents attempted to reclaim their children saw transnational adoption as a solution, as distance prevented birthparents from seeking their children (Melosh 2002, 192-193). Open adoptions—where the adoptive family and adopted child have regular contact with the birth parent(s)—have also increased. Some adoptive parents are not interested in an open arrangement or are concerned about the effects of the arrangement (Pertman 2000, 179). (For comprehensive histories of adoption in the U.S., see Conn 2013; Herman 2009; Winslow 2017.)

Conversely, Selman (2016) traces the more recent decline in numbers of children adopted internationally to changes in birth or sending countries, which I will discuss at length in the following sections. Despite this recent decrease in the number of international adoptees who enter the U.S. each year, the population of adoptees in the U.S. is significant. Since 1999, over 270,000 children have entered the U.S. through this process (U.S. Department of State, Bureau of Consular Affairs n.d., “Adoption Statistics”).

In order to understand the landscape of contemporary international adoption by U.S. citizens, I will explore the factors that contributed to peak adoptions in 2004, and then the factors that influenced the decline in adoptions since 2004.

International Adoption at its Peak

A central feature of international adoption at its peak is that the flow of adopted children generally runs from South to North and East to West: children from Russia, China, South Korea, Vietnam, Ethiopia, and Guatemala are adopted by citizens of the U.S. and Europe. International adoption flows are associated with stratification, civil or international conflict, state regulation of reproduction, and humanitarian or “rescue” efforts (Altstein and Simon 1991, 2).¹⁹ In the following sections, I will outline each of these features as they relate to contemporary international adoption to the U.S.

Stratification

Birth or “sending” countries generally have less social and economic power and resources than “receiving” countries. The flows of transnational adoption follow similar

¹⁹ Altstein and Simon (1991) note another feature of sending and receiving countries: there are networks and links between social service agencies of all countries involved. These relationships are less explored in the international adoption literature. Exceptions include histories of adoptions of Korean children (Bergquist et al. 2007; Choy 2013; Oh 2015).

patterns as those of female labor migrants; both are part of the system of “stratified reproduction,” where “some categories of people are empowered to nurture and reproduce, while others are disempowered” (Colen quoted in Ginsburg and Rapp 1995, 3). Nearly all adoptive parents in such non-relative adoptions are white (Fisher 2003, 338; Pertman 2000, 22) and able to afford (through either cash or credit) the \$30,000-\$50,000 cost of an international adoption. Birthparents and other citizens of sending countries, however, are often non-white and relatively poor. Given this pattern, transnational adoption has frequently been criticized as a neo-colonial, imperialist practice (Altstein and Simon 1991, 2; L. Briggs 2006, 2012; Hoelgaard 1998, 203; Howell 2009, 162; Masson 2001, 148; Pilotti 1985, 32) or described as a “manifestation of exploitation of poorer nations by more affluent ones” (Freundlich 1999, 88). Laura Briggs (2006, 2012) argues that the practice of adoption from Guatemala cannot be separated from the history of unequal power relations between the U.S. and Latin America. Many Third World citizens view transnational adoption as yet another example of First World exploitation: “The West...took their sugar, their coal, their bauxite, their gold, and their silver, and now it is taking their babies” (Jupp quoted in Barrett and Aubin 1990, 130).²⁰

This is not to say that the system of international adoption is necessarily or explicitly a colonial or neocolonial project. International adoption is frequently characterized as such, but the relationships the U.S. has with multiple sending countries cannot be universalized in this way. The dynamics between sending and receiving countries may have historical and contemporary relations best described in terms of colonial domination, but these categories

²⁰ Similar critiques are now coming from adults who were adopted as children. Adoptees from South Korea form the first large cohort of adult adoptees now describing their personal experiences (E. Lee, Lammert, and Hess 2008; Trenka 2005) and engaging in scholarship on international adoption (Bergquist et al. 2007; Hübinette 2006a; Hübinette and Tigervall 2009; Trenka, Oparah, and Shin 2006).

do not help us fully understand the practice of international adoption. The countries that sent the highest number of children to the U.S. in peak years are not the most impoverished or those with the highest birth rates (Selman 2007). Rather, power relationships are central. The U.S. has or once had significant economic or political/military interests in some sending countries: Guatemala, Vietnam, South Korea, and Haiti. This dynamic is absent from or is transformed in relationships with other countries, including Russia, former Soviet republics, and Ethiopia. Large-scale economic, political, and social changes, as well as state restrictions on reproduction, often spur the growth of international adoption from a given country. Adoption from Russia and other eastern European countries was preceded by the collapse of the Soviet Union and its transition to a capitalist economy; orphaned children were stigmatized as reminders of “a failing government” (Stryker 2000, 81). Drug and alcohol abuse and instability within the family were all amplified in the years after this transition (McKinney 2009, 23). Adoption from Russia and former Soviet republics has been critically understood as “confirm[ing] the U.S. victory” against the Soviet Union in the aftermath of the Cold War (Ortiz and Briggs 2003, 42). (In a following section of this chapter, I discuss U.S.-Russia relations as they link to adoption.) Humanitarian and “rescue” efforts in the wake of disaster and failed social policy are associated with adoptions from China, Romania, and Haiti. Adoption flows are characterized by complex and multiple forms of power relations, including stratification, but also the politics of aid, reproduction, and war.

It is also the case that the U.S. is a birth country, sending 315 children in 2009 (Selman 2012a, 14). Most U.S.-born children were adopted by parents in Canada and the Netherlands; Selman (2012a, 14; 2016) reports that most are private adoptions of mixed race or African American infants (also see Groza and Bunkers 2014; Naughton 2012). In such

private adoptions, birth mothers select the family their child is placed with. Susan, a birth mother interviewed as part of a CNN article, chose to place her mixed-race child with a Dutch couple, as she felt that her child might be able to avoid racism and discrimination pervasive throughout the U.S. (Brown 2013). The phenomenon of black and brown U.S.-born children being adopted outside of the U.S. points to the need to examine racial stratification in the U.S. as a key factor. (See Naughton 2016 for discussion of this phenomenon.)

All of that said, stratification and colonialism are still central to understanding international adoption. Stoler's (2016) articulation of colonial durabilities is helpful here. Stoler argues that colonial and postcolonial artifacts and practices are usually not readily apparent. Instead, we confront power relations that go by other names and are seemingly unconnected to colonial histories. While relations between the U.S. and birth countries may not be rooted in obvious colonizer/colonized relationships, the conditions that make adoption possible—poverty, primarily—are vestiges of colonialism and white savior-ism. The idea of “saving children” through adoption is part of the colonial paradigm.

The adoption of U.S.-born children by Canadian and European parents is a case in point. While the status of the U.S. as a birth country seems to undermine the idea that the U.S. is an imperial power, the race of the children being adopted belies this interpretation. Within the U.S., specific classes of children—black and brown children—are marginalized. The racist logic of colonialism continues.

Civil and International War

International adoption programs often begin during or after civil or international violent conflict (Altstein and Simon 1991; L. Briggs 2006; L. Briggs and Marre 2009;

Leinaweaver 2008, 157). Initially concerned with the fate of the children of Korean women and American soldiers, adoption from Korea is the oldest large-scale international adoption effort (Bergquist et al. 2007; Choy 2013; Oh 2015; Ressler, Boothby, and Steinbock 1988, 42). This continued during the Vietnam War with Operation Baby Lift, which rapidly evacuated over 2500 children from Vietnamese orphanages to the U.S. and other countries. Most of these children were adopted by U.S. citizens, though it later became clear that some children were not true orphans and had living family members (Ressler, Boothby, and Steinbock 1988, 71–75). The “small” wars of the Cold War also spurred the adoption of children by U.S. and European citizens. Guatemala serves as a key example.²¹ Children were abducted during the civil war for both domestic and international adoption. Some children were adopted into the families of soldiers and military officials (Human Rights Office of the Archdiocese of Guatemala 1999, 38). Between 1979 and 1983, the period when most children were kidnapped, approximately 438 Guatemalan children were adopted by U.S. families (McConahay 2000). More recently discovered documents have revealed that at least 333 children were stolen by military forces and sold to parents in Europe and the United States (L. Briggs and Marre 2009, 11; Grainger 2009). Unlike adoptions stemming from other wars of Central and South America, where transnational adoptions slowed or ended with the war, adoptions from Guatemala continued at low levels through the 1990s, and increased significantly in the 2000s, until 2007, when the movement of children from Guatemala to the U.S. was halted by the Hague Treaty, which I discuss in a later section in

²¹ Children were similarly used as pawns during Argentina’s and El Salvador’s civil wars. Over 6,000 Salvadoran children are thought to have been kidnapped and then sold into adoption to U.S. and European parents who eager to aid a “war orphan” and were not aware that the children had been stolen by Salvadoran military forces (L. Jones 2000). During the “Dirty” internal war of Argentina of 1970s and 1980s, children were also subjected to abuse, older children were kidnapped, tortured, and then returned to their families, while some were harmed in the presence of their parents. Many disappeared Argentinean children were adopted into the families of military officials (Scheper-Hughes 1996; Rotabi 2012).

this chapter.

State Regulation of Reproduction

China's one-child policy and Romania's 1980s ban on contraception and abortion both resulted in large numbers of children being abandoned by their birth parents.

Romania

Pronatalist policies by Romania's Nicolae Ceaușescu set the stage for demographic disaster (Kligman 1995, 1998). Between 1966 and 1989, birth control, most abortions, and other family planning measures were banned in Romania by Nicolae Ceaușescu. Birthing at least five children was nearly compulsory; failure to do so resulted in heavy fines.

Ceaușescu's goal in implementing these policies was to increase the birth rate in order to increase the number of workers available to the national economy (Hord et al. 1991; Moskoff 1980; Zeanah et al. 2006). The high numbers of unwanted children and the lack of resources to care for them led many women to relinquish their children to state-run orphanages.²² By 1989, when Ceaușescu and his government were overthrown, more than 170,000 children were in these institutions (C. Nelson, Fox, and Zeanah 2013). In the wake of international media coverage of conditions in Romanian institutions, international adoptions increased. Adoptions from Romania were short-lived but intense; 1991 was the focal year (Ortiz and Briggs 2003; also see L. Briggs and Marre, 2009; Cartwright 2005).

China

China is well-known for its "One Child Policy" which dictates that most families in

²² The impact of these policies on maternal mortality were similarly dire. Unsafe abortion resulted in the deaths or permanent infertility of scores of women (Hord et al 1991).

China are limited to having one child (exceptions are made for particular ethnic minorities, parents whose first child is disabled, and in some rural areas). While this policy was relaxed in 2013 and ended 2015 (Buckley 2015), the policy was key in international adoption processes. The policy was implemented in 1979-1980 as a way to manage population growth in order to improve the country's economic future (Croll, Kane, and Davin 1985; T. White 2006).²³ Popular understandings of the one child policy and Chinese culture posit that in the patrilineal system of Chinese kinship in which males are preferred because they will continue the lineage, limiting families to one child led to the abandonment of large numbers of girls to state-run institutions, but scholars complicate this understanding (K. Johnson 2004, 2016b; Short et al. 2001). Shang (2008) and K. Johnson (2004, 2016a, 2016b) demonstrate that local care of abandoned infants by both related and unrelated families continued throughout the one-child policy implementation, but these efforts were stymied by one-child regulations. Disability has also proved a key variable. In China, children who are disabled are more likely to be abandoned, as families do not have the resources to care for them (K. Johnson 2004).

Kay Ann Johnson has researched infant abandonment, orphanages, and social policy in China for decades and argues that the trope of Americans adopting “unwanted abandoned girl[s]” (2016b, 9) is inaccurate. Many Chinese families wanted to parent or adopt girls as had been customary before the implementation of the one-child policy. Girls were, indeed, wanted and desired, but state policy and local enforcement efforts forced families to abandon the children. While U.S. families imagined themselves as “rescuing” girls from patriarchal tradition, this representation fails in ignoring the desires of Chinese families to parent girls in the face of governmental regulation (K. Johnson 2004, 2016a, 2016b). The number of

²³ Here, my goal is to note the policy's impact on international adoption, but for detailed, anthropologically-oriented explorations of the one-child policy, see (Dorow 2006; Greenhalgh 2003, 2008; K. Johnson 2004, 2016a, 2016b; Wang 2016).

abandoned girls in a given area is also impacted by local conditions; economic conditions and local government efforts to enforce the One Child policy are also key (K. Johnson 2004).

Demographer Selman (Selman 2015) estimates that over 130,000 children had been adopted from China (not limited to U.S. adoptions).

Adoption and the Rescue Narrative

In the context of neo-colonial power relations and humanitarian crises in birth countries, popular discourse about adoption is frequently couched in terms of rescue (L. Briggs 2003; also see Cartwright 2005). Rachel Stryker (2010) shows how adoptive parents' idea that they are providing children with a "good home" and rescuing them to this home, influence what adoptive parents expect from their children (41). The rescue narrative is not confined to adoption-related discourse. The American and Western European ideology that children are vulnerable and children should be innocent, happy, carefree (Burman 1994, 239) dominates not only popular media representations, but also human rights discourse about children (Nieuwenhuys 1998). Images of children are often used to depoliticize a given situation (Bornstein 2001; L. Briggs 2003; Burman 1994): "The widespread anxieties and consternation over government inactivity throughout the crisis could be deflected and resolved by rescuing a handful of children" (Burman 1994, 245). Rachel Stryker (2010) argues that images provided by adoption agencies and facilitators lead adoptive parents to believe that adoption is an altruistic act, if not actual rescue (41).

The "rescue trope" is especially apparent in adoption movements related to disaster and those motivated by evangelical Christian orphan ministries. I discuss both in the following sections.

Individual Motivation to Adopt

In the preceding sections, I reviewed the systemic political and economic forces that shape international adoption. This broad overview neglects the personal, micro forces shaping adoption. As Sawin (2017) demonstrates, discourses about international adoption as a whole often overshadow or supplant the stories that adoptive parents and adopted children might tell about their lives. Instead of understanding their adoption processes through the lens of stratification, rescue, or in relation to political turmoil, potential adoptive parents articulate different, very specific reasons for adopting. This is clear from the literature as well as from my interviewees (for discussions of adoptive parent motivations to adopt, see Denby, Alford, and Ayala 2011; Hoksbergen 1998; Hollingsworth 2000; Jennings et al. 2014; Malm and Welti 2010; Zhang 2006).

Prospective adoptive parents desire to care for a child. Many adoptive parents are impacted by medical infertility and cannot conceive, gestate, and birth a child because of physiological factors. Others are impacted by social infertility, meaning they are unable to conceive, gestate, and birth a child because of their social status—single women or men, and LGBTQ people (single and in relationships). International adoption was often the only way for people who are socially infertile to become parents. This is particularly true of LGBTQ people, who were disproportionately impacted by discriminatory laws.

Recent Developments in International Adoption

Adoption flows are constantly changing, as they are contingent on local and global processes, including wars and other violent conflict, media stories about adoption-related scandals, public discourse in sending and receiving countries about adoption, international treaties and incidents, new social movements, and disasters. Changing political, social, and

economic forces have led to the steep decline in international adoptions between 2004 and 2016. The characteristics of children available for adoption has also changed. At the height of international adoption, most children were relatively healthy, or at least they usually didn't have a diagnosed congenital disease. Now, the majority of children available for adoption to the U.S. are classified as special needs. In the following sections I detail the most significant changes.

Suspensions, Slow-downs, and Closures

Social Welfare Systems in Birth Countries

International adoptions also decreased after 2004 because of improved internal social welfare systems in Korea and China. Criticism by Korean citizens and Korean adoptees (Haruch 2014; Hübinette 2004, 2006b, 2016; Hübinette and Arvanitakis 2012; McGinnis 2016; Sang-Hun 2013; Trenka 2005; Trenka, Oparah, and Shin 2006) led to the establishment of a truth-and-reconciliation-style commission to study the decades of international adoption from Korea (Selman 2015); both groups advocate for culture change in Korea to destigmatize single motherhood (Haruch 2014). Korea has committed to gradually reducing the number of Korea-born children adopted through international adoption by supporting domestic adoption (United States Department of State, Bureau of Consular Affairs n.d., "South Korea"; Selman 2015).

Internal changes encouraging domestic adoption and foster care (Budiman and Lopez 2017) and ending the country's one-child policy (Buckley 2015) mark the decline in adoption from China. In her long-term research in China, Kay Ann Johnson (2004) notes nascent efforts to improve foster care in China (149-151).

China also developed tighter regulations on eligibility requirements for adoptive parents, mandating that adopters be heterosexual and married, ending adoptions of Chinese children by lesbian women (Selman 2009b, 590) and restricting adoptions by unmarried women (Selman 2015).

The Hague Treaty

Most significantly, the implementation of the Hague Convention on the Protection of Children and Co-operation in Respect of Inter-Country Adoption (known as the Hague Convention or Hague Treaty) has reshaped adoption patterns (Hague Conference on Private International Law 1993; Hamilton 2006; Hollingsworth 2008; Maskew 2008; Rotabi and Gibbons 2012; E. Ryan 2006; U.S. Department of State, Bureau of Consular Affairs n.d., “Understanding the Hague”; Worthington 2008;). The goal of this international treaty is to prevent the trafficking of children, to ensure that children in the adoption pipeline are truly eligible for adoption and that effort has been made to find a home in the birth country, and to prioritize the “best interests” of the child in the adoption process. Unsurprisingly, “best interests” is an ambiguous term. In the text of the Hague Convention, this standard is apparently a child’s “fundamental rights as recognized by international law,” particularly the UN Convention on the Rights of the Child and the UN Declaration on Social and Legal Principles related to the Protection and Welfare of Children (Hague Conference on Private International Law 1993, preamble).²⁴

Countries that are signatories to the Hague treaty must establish a Central Authority to regulate international adoptions. In addition to accrediting adoption agencies and

²⁴ Nieuwenhuys (1998) argues that the UN Convention on the Rights of the Child adopts Western European and U.S. ideals of childhood. Drawing on Zelizer (1985), Nieuwenhuys argues that children and childhood have been made sacred; children are inherently innocent and should thus be shielded from the dangers of wage labor, public spaces, and the adult world.

protecting the child's "best interests," the Central Authority provides protection for adoptive parents: adoptive parents are to be provided with agency fees in the initial contract and are to have at least two weeks to review the child's medical records. Adoptive parents must undergo ten hours of "parent education" on topics related to international adoption: attachment, post-institutionalized children, adoption travel, health and development, and multicultural families (Adoption Learning Partners n.d.; National Council for Adoption n.d.). Adoptions that occur between Hague signatory countries must abide by the regulations established by the Convention. The United States signed the Convention in 1995 and fully implemented it in 2008 (U.S. Department of State, Office of the Legal Adviser 2018, 505). As a result of this implementation, the U.S. no longer processes adoptions from Guatemala (U.S. Department of State, Bureau of Consular Affairs n.d., "Guatemala") and Cambodia (U.S. Department of State, Bureau of Consular Affairs n.d., "Cambodia"); both are signatory nations not in compliance with the treaty. China is a signatory nation, but adoptions continue, as they are in compliance (U.S. Department of State, Bureau of Consular Affairs n.d., "China"). Korea is not party to the Hague Treaty (U.S. Department of State, Bureau of Consular Affairs n.d., "South Korea"), but adoptions continue through non-Hague procedures.

Russia

A significant reason for the decline in international adoptions to the U.S. since 2004 is the Russian ban on such adoptions. Beginning in late 2000s, Russia has also decreased the number of children available for international adoption as Russian citizens expressed concern that the adoption of children by U.S. citizens would deplete Russia's "natural wealth" of children or that adoptive parents would abuse and neglect Russian children—cases of such

abuse have received media attention in both the U.S. and Russia (Khabibulloina 2009; McKinney 2009, 33). The Russian government suspended adoptions in response to public outcry over a disrupted adoption in which an American adoptive mother put her 9-year-old son on a plane back to Russia, citing severe, intractable psychological problems (Levy 2010a; Rotabi and Heine 2010; Selman 2012b). While American citizens largely understood this and other incidences as examples of individual “bad” mothers, ill-prepared mothers, or as calls for greater adoption support services, the Russian public saw this incident as an international problem, suspending adoptions until diplomatic negotiations eased tensions (Levy 2010a, 2010b).²⁵

Finally, in 2012, Russian president Vladimir Putin signed a law banning adoptions of Russian children by U.S. citizens. The law was named after a Russia-born child who died in the care of his U.S. adoptive parents, but U.S. politicians and adoption policy makers saw it as a reaction to an event unrelated to adoption: a protest of U.S. sanctions against Russia for human rights violations related to the death of a Russian lawyer (L. Rothman 2017). Legal scholar High (2013) criticizes Russia’s ban: “The subordination of the best interests of the child to state-centric political considerations is problematic, in terms of the short-term interests of Russian children currently without parental care.”

The “politicization” of Russian adoption continues, as election and administration of Donald Trump is investigated for questionable or illegal interactions with the Russian officials and operatives. Defending a meeting between his son, Donald Trump, Jr., and Russian officials, President Trump described the meeting as concerning “the adoption of Russian children.” Journalists and others observing the Trump-Russia investigation, highlight

²⁵ Russians understand this incident as the latest in a series of cases of maltreatment of Russia-born children by U.S. adoptive parents. According to Russian officials, since 1996, 14 Russian children have died of abuse at the hands of their American adoptive parents (Levy 2010a; also see Hegar, Verbovaya, and Watson 2015).

the connection between Russian adoptions and sanctions (Taub 2017).

Disaster

Like war, disasters also precede many adoption surges (Agrell 2010). In the wake of the January 2010 earthquake that struck Haiti that killed between 220,000 and 300,000 people (CNN 2017), adoption agencies were flooded with calls from Americans seeking to adopt Haitian children.²⁶ Christianity Today cast the disaster as a reminder that there are “210 million reasons to adopt”—210 million being the estimated number of orphans globally (Christianity Today 2010).²⁷ Media reports on the earthquake often focused on Haitian children, particularly those residing in orphanages. Before the quake, Haiti had a significant number of children living in orphanages or group homes, usually because their parents did not have the resources to care for them. Haiti also had a small but growing international adoption program. Almost immediately, prospective American adoptive parents began pressuring government officials to evacuate children they were in the process of adopting. Pennsylvania Governor Ed Rendell organized and accompanied an airlift to Haiti, bringing 54 children to the U.S. (most already in the process of being adopted, 12 were not) (G. Thompson 2010a). In the weeks and months following the quake, over 1,150 children at varying stages of the adoption process already residing in orphanages were evacuated to the U.S., their adoptions expedited by the U.S. and Haitian governments (G. Thompson 2010a, 2010b). Some children were already matched with U.S. families; others were not. The 12 evacuated children by Rendell who were not in the adoption pipeline were later cared for in

²⁶ There were similar calls for adoption as a form of rescue by adoption in the wake of the 2004 tsunami (Evan B. Donaldson Adoption Institute 2005) and the 2008 China earthquake (Koch and MacLeod 2009).

²⁷ Joyce (2011, 2013) casts the Haiti earthquake as a key moment for the evangelical orphan ministry movement.

an institution in Pennsylvania (G. Thompson 2010a). Many evacuees arrived with little or no documentation of their identities or history (Rotabi and Bergquist 2010; G. Thompson 2010b).

More children were evacuated to the U.S. than had been adopted by U.S. citizens in the preceding three years (G. Thompson 2010b). The evacuation efforts have been compared to the Vietnam Baby Lift. The Miami archdiocese briefly discussed launching Operation Pierre Pan (Olmeda and Campbell 2010), modeled after Operation Pedro Pan, a 1960-1961 effort that evacuated 14,000 children from Cuba to Miami after the revolution (Agrell 2010; L. Briggs and Marre 2009, 10; Ressler, Boothby, and Steinbock 1988, 51). Officials quickly backed away from Operation Pierre Pan (Olmeda and Campbell 2010), as adoption experts and international aid groups argued that removing the children from the disaster area would only make it more difficult to determine whether or not the children could be reunited with parents or other relatives (Evan B. Donaldson Adoption Institute 2005; Rotabi and Bergquist 2010). Adoption scholars Rotabi and Bergquist (210) call on the social work profession to act with “global will and impulse control...in the context of emergency” so that children are not trafficked, family reunification can occur, and individual counties can determine how children should be cared for (n.p.; also see Bergquist 2009; Fronek and Cuthbert 2012). While the number of adoptions from Haiti did increase in 2010, these high numbers have not continued (Selman 2011, 2012b, 390).

Evangelical Orphan Ministry Movement

As I described in the chapter 2, I was surprised to find that evangelical orphan movement was a central organizing feature of contemporary international adoption. I centered much of my local participant-observation to Orphan Care Alliance (OCA)-

sponsored events. Meetings of this Louisville group are part of the national orphan care ministry movement.

Contemporary orphan ministries refer to James 1:27 as the Biblical anchor for their mission: “Pure religion and undefiled before God and the Father is this, To visit the fatherless and widows in their affliction, and to keep himself unspotted from the world” (James 1:27 KJV). Under the heading, “Who We Are,” OCA’s website describes their mission: “Simply put, James 1:27 describes pure and faultless religion as caring for orphans and widows. Acting on this Biblical invitation, OCA equips Christians and connects them with opportunities to care for fatherless children and family preservation. We desire to see every child have a home and know the love of a family with the body of Christ leading the efforts....” OCA’s vision is “for the Body of Christ to lead the efforts of caring for the fatherless in Kentucky and southern Indiana” (Orphan Care Alliance n.d., “Who We Are”). Orphan care as a Christian ministry is not new—scholars have noted how the international adoption of children from Korea was linked to Christian missions (Joyce 2013, 47–50; Oh 2005), but the scale, nationwide networks, and organization set this contemporary movement apart. The goal of the orphan ministry movement is to encourage church members to care for children, usually through adoption, because they are called to do so as Christians. This is done “in Jesus’ name.”²⁸

I want to note that there is variation in orphan care ministries. Some prioritize adoption as the best means to minister to orphans. Journalist Katherine Joyce (2013) describes Pastor Rick Warren’s exhortation at a 2012 orphan ministry event his California mega-church, Saddleback Church: “When I say ‘orphan care’ ...it’s adoption first, second,

²⁸ Journalist Kathryn Joyce has written extensively on the national orphan care ministry movement (Joyce 2011, 2013, 2016).

and last” (41). Criticisms of the orphan care movement center around the casting of (mostly) white adopters as rescuers or saviors of (mostly non-white) children, encouraging “child finders” in birth countries to locate more children for adoption (coercion, corruption), prioritizing evangelization and conversion over the best interests of a child (Crary 2013a; Joyce 2013; Smolin 2012a; Smolin 2012b). In the wake of criticism some evangelical leaders have tried to address these concerns by distancing themselves from rescue rhetoric, highlighting the work they do in addition to adoption such as foster care and mentoring, fighting child trafficking, and advocating for ethical adoption practices (Crary 2013a; Joyce 2016).

Louisville’s OCA tries not to prioritize adoption over other efforts to care for “fatherless” children. In addition to support of domestic and international adoption, their goals include family preservation through respite care, material support, and prayer; volunteering as life coaches to aid children transitioning from foster care to independent living; as well as offering educational programming on parenting “children from hard places”—children who have experienced trauma and neglect.

Just as I was surprised to find that evangelical Christianity had become a key part of my research, some IAM clinicians were similarly surprised. Melinda Stein, an IAM doctor I interviewed, noted that the evangelical families that are adopting are “a different kind of family” with unique motivations. For Dr. Stein, practicing in New York City and historically having a large population of Jewish families in her practice, the evangelical parents, motivated by Christian faith or theology are a distinctive group.

Throughout my ethnography, I refer to the evangelical orphan care movement, as it has been a catalyst for the families I met in the clinic to adopt and shapes public

conversations about adoption. It is, I believe, currently the most significant force in international adoption in the U.S. and deserves focused research attention in-and-of-itself.²⁹ In this study, I focus on IAM as a field of expertise more generally. An ethnography of the orphan care movement and a comprehensive analysis of IAM's role in it is beyond the scope of my project.

ChIFF and the Decline of Adoption Organizations in the U.S.

As international adoptions declined after 2004, adoption advocacy organizations and legislators made several efforts to reverse the decline. The introduction of Children in Families First (ChIFF) to both houses of Congress in 2013 was the culmination of this effort. U.S. legislators and other proponents of ChIFF, developed the legislation as an effort to create an international system for child welfare, with adoption as a central solution.³⁰ With the argument that children need families to reach their full potential. ChIFF, a legislative effort to increase the number of international adoptions by U.S. families, was sponsored by then-Louisiana Senator Mary Landrieu and aimed to tackle the decline through U.S. regulation and policy. ChIFF would have required the state department to prioritize adoption in child welfare aid (Crary 2013b; Landrieu and Reitz 2013). ChIFF effectively died with the end of the 113th congressional session in December 2014 (Evans 2015a; Wetzstein 2014). Maureen Evans, the first executive director of JCICS, and now a writer, posits that ChIFF was unsuccessful because its backers dismissed opposition from adult adoptee organizations,

²⁹ One specific area to investigate involves orphan care movement's language about the physical body and Body of Christ, "saving" children with disabilities, and orphan care as a mission to save the body AND soul, etc.

³⁰ Other organizations advocating for ChIFF included advocacy groups such as Both Ends Believing (previously called Both Ends Burning) (Both Ends Believing n.d.), evangelical orphan ministries, and the Joint Commission on International Children's Services (JCICS).

failed to include input from adoptees and birth parents, and therefore were not credible in claiming that CHIFF would help preserve and reunite birth families. CHIFF also failed, Evans argues, because it did not address some of the most pressing issues in adoption policy: legislation concerning adoptees who do not technically have citizenship, legislation regarding the “re-homing” of adopted children among multiple families, and support for birth or “first” families (Evans 2015a).

With the death of ChIFF, no reverse in the decline of international adoptions, and the continuing closure of adoption agencies, JCICS closed in 2015 (Evans 2015b; Mellon 2015).

Conclusion to Chapter 3

My review of the context and history of international adoption by U.S. citizens describes the conditions of the pre-2004 rise and the post-2004 decline in international adoptions. Through discussion of stratification, war, state regulation of reproduction, and the trope of adoption-as-rescue, I highlight the factors that were catalysts for the height of international adoptions by U.S. citizens. The decline in international adoption is understood through my exploration of changing conditions in birth countries, the implementation of the Hague Treaty, and tensions in diplomatic relations between the U.S. and Russia. While not responsible for the decline in the number of adoptions, the evangelical orphan movement, post-disaster adoption efforts, and the radical changes in the number of adoption-related organizations in the U.S. are central to understanding the current landscape of international adoption. In the next chapter, I describe the practice of international adoption medicine: its development and roots, growth, and recent changes that mirror those seen in the practice of international adoption.

CHAPTER 4: HISTORY AND PRACTICE OF INTERNATIONAL ADOPTION MEDICINE

What is International Adoption Medicine?

International adoption medicine (IAM) is the U.S.-based pediatric subfield concerned with the health care of internationally adopted children. IAM is multi-disciplinary in nature, as the health needs of internationally adopted children span multiple disciplines. IAM physicians come from a variety of pediatric specialties, most commonly infectious disease, development and behavior, psychiatry, and tropical/global medicine. Other IAM providers include occupational therapists, physical therapists, speech/language therapists and pathologists, nurses, nurse practitioners, social workers, and mental health counselors.

The first practice describing itself as IAM opened in 1986 (University of Minnesota n.d.) and the American Academy of Pediatrics (AAP) established a special section devoted to adoption medicine in 2000 (American Academy of Pediatrics n.d.). The field's development and growth mirrors that of international adoption itself: slow growth in the 1980s and early 1990s; fast growth and legitimacy in the mid-1990s and 2000s; and finally contraction, slowed growth, and shifts in focus in the late 2000s and 2010s. My 2018 census³¹ of IAM clinics indicates that there are between 30 and 35 IAM clinics in the U.S., not including individual physicians in private practice who list adoption medicine as a specialty.³² (For the

³¹ I conducted this census through a systematic web search. I attempted to find sites for clinics listed by adoption support groups and popular adoption and parenting publications. I then searched for clinics using the Google search engine by U.S. state. The search terms I used were [state name] "international adoption medicine," "adoption health," "adoption clinic," and "adoption doctor."

³² I distinguish clinics from individual practices, though some clinicians are involved in both. For my purposes,

most recent publications from the AAP section, see V. Jones and Committee on Early Childhood, Adoption, and Dependent Care 2012; V. Jones et al. 2012.)

In this chapter, I will draw on multiple sources to describe the field that is IAM. These sources include peer-reviewed publications, popular press publications, a census of existing IAM clinics and practices, ethnographic observation at an IAM clinic and at IAM-centered adoption conferences, and interviews with IAM providers.

First, I locate IAM within the history of pediatrics, tropical medicine, and immigrant health in order to highlight the forces that inform contemporary pediatrics in general, and IAM in particular. Second, I describe the medical purview of IAM, with the goal of orienting the reader to epidemiology of adoptee health. Third, I briefly describe the early days of IAM and the field's emergence from general pediatrics, as well as detail the current landscape of the field. Finally, I describe, in detail, the role of IAM in the adoption process. By locating the history, practice, and expertise of IAM within contemporary biomedicine, I show how childhood, adoption, and the adoptive family are understood as medical matters. Details about the function of IAM—its purview, role in the adoption process, and everyday routines—provide background that is vital to understanding the arguments I make in upcoming chapters about family feeling, attachment, and physical caretaking.

Broader Context of IAM

Development of Pediatrics

The IAM clinic in which I did my research is located in the suburbs of a large Midwestern city, a satellite site of a major pediatric research hospital. Families travel from throughout the region to bring their children to this nationally-known health care system.

I consider practices associated with a hospital system or university to be clinics.

During the time when I was visiting the satellite hospital, a new building for treating cancer with proton therapy was being built on the campus. This facility, its reputation, and its advanced tools stand in contrast to the characteristics of child health care before the 18th century.

Until the 18th century, child health care in Europe and America was a matter for parents, and maybe midwives. Most people, and especially physicians, believed infant and child mortality was unavoidable: “Infancy, like old age, was seen as a time to die” (Pawluch 2009, 11). Also, physicians did not have the knowledge or tools to adequately treat children’s diseases; neither did parents and midwives, but they acted on the folk advice available to them. It was not until the 19th century that technological (vaccines) and public health advances (sanitation, ban on child labor, improved nutrition) led to the reduction of childhood diseases. Finally, doctors had tools at hand to deal with illness in children, and a field of authoritative experts—pediatricians—emerged. (For histories of pediatrics, see Colón and Colón 1999;³³ Cone 1979; Golden et al. 2004; Halpern 1988; Mahnke 2000; Meckel 1990; Pawluch 2009; Prescott 1998.)

In addition to new tools and knowledge, early pediatrics can also be understood in terms of the changing social status and meaning of children and childhood. Zelizer (1985) describes how, at the turn of the 20th century, children went from being valued because of the labor they could provide—in family-run industry, in factories, and in reproductive labor in the home—to being economically useless, but emotionally priceless. As a category, childhood is imbued with a sense of the sacred, that children should not labor, are not sexual, and should not experience violence (Stryker 2010, 40–41). New tools and technologies, as

³³ Colón and Colón (1999) is unique in that they examine the history of child health care globally, not just in Europe and America.

well as new attitudes about children and childhood, pushed physicians to attempt to address children's health and advocate for children (Pawluch 2009).

As a new specialty in the 1800s and early 1900s, pediatrics focused largely on treating and preventing infectious disease in children through vaccination, medical intervention, and advocacy. Examples of such advocacy efforts include child welfare clinics where children's health was monitored and mothers given advice (Meckel 1990, ch. 5), aiding milk certification programs by checking dairies for cleanliness and pasteurization (Mahnke 2000, 711; Meckel 1990, ch. 3), efforts to improve the housing and environment of the urban poor (Meckel 1990, 35), and health care in schools (Sutherland 2008, 21). In addition to the treatment of diseases, early pediatricians were concerned with medical, public health, and social reform projects (Cone 1979; Halpern 1988, 51; Mahnke 2000, 713; Meckel 1990, 47). Social reform efforts such as milk pasteurization and public education joined with pediatrics in the goal of raising children scientifically (LeVine 2007, 248). From its inception, pediatrics was concerned with more than just the body of the child. One of the earliest pediatricians, Abraham Jacobi, described pediatrics: Pediatrics, he says, "does not deal with an organ but with an entire organism" (quoted in Meckel 1990:47). Pediatrics is a "holistic specialty" (Meckel 1990, 47).

After World War II, with widespread use of antibiotics and vaccination, as well as improved public health, pediatricians began seeing fewer sick patients. Though they saw sick children during their rotations in medical school, the general practice pediatrician saw few cases viewed as "interesting." Instead, they saw well children and mothers who asked for advice on everything from bed-wetting to tantrums. They became involved in well-child care and routine and easily treated childhood illnesses. This led to a phenomenon described as

“Dissatisfied Pediatrician Syndrome.” In short, the doctors were bored and were concerned they would lose the skills needed to treat complex (or “interesting”) patients. They complained of “endless discussions with endless mothers of problems that are self-righting anyhow” (Pawluch 2009, 46).

As a response to this crisis, many pediatricians branched off into specialties such as cardiology and endocrinology. Specialization within pediatrics had been limited before this time, but the growth of medical schools, research clinics, and funding allowed increasing numbers of pediatricians to move away from general practice. Support for research in pediatric cardiology, for example, led to the development of new diagnostic procedures and techniques that made it possible to treat many more children with heart defects. Later, practitioners working in such focused areas achieved authority over their fields as accreditation organizations professionalized their specialties (Halpern 1988, 122-123).

General practice pediatricians also expanded their authority. Just as the growth of academic research, clinical medicine, and research grants led to specialization, these processes also led to increased attention on development and behavior. They began including the “new morbidity” (Pawluch 2009, 1) of psycho-social and development issues in their practices. Although pediatricians’ concern with these issues was not new, they took on increased importance. Inside and outside of pediatrics, there was debate about whether or not a focus on psycho-social issues would decrease the authority of pediatrics in general, but by the 1980s, pediatricians had established their authority over and embraced their new role as advisers on problems including bed-wetting, tantrums, hyperactivity, and family dynamics (Halpern 1988, 128-148). The development of pediatrics is the medicalization of childhood and parenting, supplanting the previous’ centuries experts, mothers and midwives (Meckel

1990, 48).

The history of general pediatrics is relevant to understanding international adoption medicine not just because it is a sub-specialty of the general pediatrics, but also because its interdisciplinary nature and concern with institutional and structural change in the form of social reform are central to international adoption medicine. Moreover, the history of pediatrics demonstrates how one specialized medical authority has evolved and consolidated itself, affirming its own authority within biomedicine where technical specialization is increasingly central to professional status (Halpern 1988; Pawluch 2009).

Tropical Medicine

International adoption medicine also has roots in tropical medicine, the medical specialty that focuses on the diagnosis and treatment of diseases specific to tropical regions of the world, particularly infectious disease. While not all historic sending countries are in tropical regions—Russia, Korea, and most of China are not—many are, including Guatemala, Haiti, Vietnam, and Ethiopia. Some of the earliest publications of IAM material is focused on the infectious diseases that IA children may have. IAM doctors needed to highlight measles, hepatitis, and parasites because these are diseases that may go unrecognized by U.S. pediatricians because they are tropical (re: found elsewhere) or have been largely eradicated in the relatively prosperous U.S (Hostetter et al. 1991).

Tropical medicine developed in response to diseases and illnesses Europeans encountered as they colonized Africa, Asia, and South America. Historians and social scientists interested in colonialism have demonstrated how the exercise of and resistance to colonial power frequently engaged with the physical bodies of both the colonizers and the colonized: disciplining and “[d]iagnosing the bodily ills of the indigenous peoples of empire

as part of its wider cultural, political, and economic projects” (MacKenzie 1997, vii; also see W. Anderson 1995, 1996, 2006; Arnold 1993, 1996; de Leeuw 2009; Vaughan 1991; on colonial power and sex/reproduction see L. Briggs 2002; McClintock 1995; Stoler 2002).

The uses of tropical medicine were varied: it was employed first to insure the health of military and expeditionary colonial forces (W. Anderson 2006, Ch. 1), and it was later used to improve the health of local populations. Colonial forces were interested in the health of the local population as laborers, (including the potential of children as future laborers (Power 1999, 167). Medicine was also a vehicle for Christian missionary groups to access colonized populations (MacKenzie 1997, vii).

While tropical diseases originated in the tropics, they did not remain there. Tropical medicine also attempted to address the fear that immigrant laborers from colonies would bring infectious diseases to the homelands of colonizing powers (Palmer 2009).

Management of excrement was a key project of colonial public health efforts (W. Anderson 1995; Gerling 2012). Scholars of tropical medicine and colonialism note that attempts to deal with feces and the diseases that accompany feces are heavily racialized, usually portraying the people of colonial powers as clean and in control of excrement and the people of colonized lands as filthy and not in control of excrement. Warwick Anderson (1995), writing about the management of sanitation in the colonial Philippines, shows how Filipinos were represented as defecators, disgusting and promiscuous.

Although colonization was an important catalyst in the development of tropical medicine, it was not the only one. Changing beliefs about disease causation (germ theory), the development of public health, evolutionary theory, and clinical parasitology were also key factors (Cook 2007, 34). Tropical medicine was not just a way for colonial

administrators to prepare a docile population of native laborers; it was also an attempt to understand and treat the very real maladies endemic to tropical regions.

Pediatric tropical medicine is a relatively recent subspecialty within tropical medicine. The Liverpool School of Tropical Medicine created a specific department for tropical medicine and pediatrics in 1966 because existing pediatric training was based on European epidemiology, and pediatricians had not been exposed to diseases specific to the tropics. They assumed that childhood diseases such as measles, mumps, polio and diphtheria were rare, when in reality they were still quite common outside of Europe. Pediatric training also failed to take into account nutrition deficits, lack of access to clean water, and sanitation as problems of childhood (Power 1999, 161; also see Shulman 2004)

In the midst of the Dissatisfied Pediatricians crisis, the American Pediatric Society's president L. Emmett Holt, Jr. (1961) addressed problems of the field in his presidential address to the Society. Holt's "prescription" for pediatricians looking to overcome boredom and have experience with complex and interesting disease?: "Foreign service" (675). The "so-called underdeveloped countries" have major pediatric health problems and few tools with which to solve them, while U.S. pediatricians "have the refined investigative tools and often only minimal problems to which to apply them" (675-676). Inspired by the Peace Corps, Holt wanted to see a "pediatric corps" which would expose doctors to serious disease, relieve them of well-child care duties, foster good will among other countries, and save children's lives: "We must take our tools abroad and apply them to our neighbors' problems" (676).

In addition to boredom, ever specialized subfields—"the cardiologists are now subdividing...there are signs that the hematologists, too are splitting..." threatened the holism

of pediatrics (672). He reflected on increasing globalization: “It is time we realized that pediatrics, too, is international business. It is a responsibility we cannot escape...” (676). He encouraged pediatricians to think beyond the “minutiae” of U.S. pediatrics. Rather than work only toward reducing the U.S.’s (at the time) relatively low infant mortality rate from “19 per thousand to 18.5 per thousand,” Holt implored pediatricians to look to other countries with infant mortality rates of “200 to 300 per thousand” (676).

Holt’s call is multi-purpose. Through attention to global pediatrics, physicians will become more engaged, they will reacquaint themselves with pediatrics’ original mission of addressing infectious disease and reducing child mortality, and they will save lives. Such a “pediatric corps” would combine adventure for U.S. doctors with good works of aiding children. For Holt, this was the responsibility of the field; to improve health for all children.

Staffed primarily by infectious disease and development/behavior pediatricians, international adoption medicine is a combination of “old” pediatrics—infectious disease—and the “new” pediatrics—development and behavior, as well as tropical medicine and immigrant health care. In the sections that follow, I describe IAM as an interdisciplinary specialty that draws from its parent discipline, pediatrics, in its concern with global child health, interest in and engagement with other countries, and desire for change to social structures that impact child health.

Purview of International Adoption Medicine

What do we mean when we talk about the “health of internationally adopted children?” How is their health any different than any other child? In the following sections, I briefly review the epidemiology of disease and illness among internationally adopted

children that IAM clinicians are address in their care (table 5).

Table 5. Conditions/problems treated by IAM
Infectious disease
Tuberculosis
HIV
Hepatitis
Intestinal parasites
Growth and nutrition
Malnutrition
Failure to thrive
Development
Speech and language delays
Delays in fine and gross motor skills
In utero exposure to alcohol and/or drugs
Effects of toxic stress
Effects of lead poisoning
Mental health and behavior
Identity
Anxiety
Depression
Attachment disorders
Learning differences
Hyperactivity
Special needs and congenital conditions
Cleft lip and/or palate
Limb differences
Spina bifida
Down Syndrome
<i>Source:</i> Compiled from American Academy of Pediatrics et al. 2014; Albers et al 2005; Miller 2005; Schwarzwald et al. 2015

Infectious Disease

Infectious disease risk in internationally adopted children was the first focus of early IAM practitioners. Physicians and medical researchers have identified specific diseases and illnesses that disproportionately affect children born outside the U.S., especially those living in institutional settings.

Under current recommendations, pediatricians seeing internationally adopted children for the first time after their arrival in the U.S. should test all children for Hepatitis B and C, HIV, syphilis, tuberculosis, stool parasites, stool bacteria. Additional testing is recommended for children born in particular regions or those with specific symptoms: children with fever who previously lived in areas with malaria should be tested for malaria; children from rural Latin America should be tested for Chagas disease; and children from areas with endemic parasitic infections should be screened for these parasites. Six months later, repeat tests should be done for HIV and Hepatitis B and C. (American Academy of Pediatrics 2015; E. Schulte and Springer 2014, 168–69; Schwarzwald et al. 2015, 26–27; Staat and Burke 2017).

Children awaiting adoption are also thought to be potentially at risk for emerging and reemerging infectious diseases and spreading infectious disease within the U.S. (Darr and Conn 2015; Krilov 2004). When Severe Acute Respiratory Syndrome (SARS) came to worldwide attention in 2003, adoptions from Asia were held up and adopted children evaluated for the disease (Barnett and Chen 2005, 1272). The spread of measles within the U.S. has also been linked to internationally adopted children (Centers for Disease Control and Prevention 2002a; “Measles Outbreak” 2004; Su et al. 2015).

Beyond screening for specific infectious diseases, the pediatrician should, to the extent allowed by adoptive parents, ensure that the child is fully vaccinated according to the

CDC schedule (Centers for Disease Control and Prevention 2018b). Most children have received some vaccinations, but the effectiveness of the vaccination is questionable because the vaccines may have been expired, improperly stored, or rendered ineffective if the child was malnourished or stressed. For children under 1 year old, this means giving (possibly repeating) all recommended vaccinations. Doctors should draw titers to ascertain whether older children received enough vaccination for adequate protection (E. Schulte and Springer 2014, 168-169; Schwarzwald 2015, 28).

Growth

Growth delays occur in internationally adopted children, particularly those who have spent significant time in institutions. Researchers posit that for every three (Miller 2005, 29–30, 2016, 189) to five months (Albers et al. 1997) children are in institutional care, they “lose” or are delayed about a month on in terms of physical growth. When meeting adoptive families at the first visit, Dr. Smith primarily addresses growth delay through diet. “Think about what you would avoid if you were dieting, and feed her those things” and “You can’t feed him too much. He needs calories” are frequent pieces of advice. Dr. Smith’s common suggestions include full fat dairy such as milk, ice cream, and cheese; putting cream in their cereal or eggs; and giving older children unlimited access to healthy snack food such as fruit, vegetables, and cheese.

Rapid-catch up in growth is common after adoption because of improved diet, feeding habits, and attention (Juffer and Van IJzendoorn 2016; Van IJzendoorn and Juffer 2006). In instances when children are not catching up, IAM clinicians will do additional testing to rule out diseases that can impact growth and refer the child to specialists for treatment targeting growth (E. Schulte and Springer 2014, 172).

Development

Developmental delays are common in internationally adopted children and are apparent when evaluating a child's gross motor skills, fine motor skills, social and emotional development, and speech/language acquisition (Miller 2005, 198; E. Schulte and Springer 2014, 173). Most delays are attributed to the orphanage environment in which stimulation and exposure to diverse experiences is lacking. As with physical growth, rapid developmental catch-up is the norm. Adoption is argued to be the most important intervention for developmental delay resulting from maltreatment or institutionalization: "Mistakenly, credit is given to a medical therapy, rather than the most profound intervention of all: adoption" (Miller 2005, preface, 203; also see Juffer and Van IJzendoorn 2016; Van IJzendoorn and Juffer 2006). Family serves as a catalyst for rapid development through caring interaction, improved diet, exposure to a variety of environments (Home! Daycare! Grocery store!) and increased opportunities for speech and physical activity.

Children who are severely delayed or do not show improvement over time in one or more of these domains should be referred to an occupational therapist, physical therapist, or speech-language pathologist. While removal from an orphanage and placement in a family setting with adequate food, attention, and play does help children "catch-up," IAM practitioners are clear that "time, love, and the care of their parents alone" is not sufficient (Miller 2005, 206; also see Nalven 2014). Quality health care and expert knowledge in the form of trained pediatricians and therapists aid these children and their families in recovering from the effects of early deprivation.

Pre-Natal and Environmental Exposure

IAM practitioners are also concerned with pre-natal and pre-adoption environmental

exposure to toxins. Exposure to alcohol and other substances in utero is a key concern of IAM practitioners. The detection of fetal alcohol syndrome or fetal alcohol spectrum disorders is part of pre-adoption reviews, the child's initial visit with the provider, and long-term care (Coles 2014; J. Davies and Bledsoe 2005; Miller 2005, ch. 5). While FAS has been identified in children from all over the world, adoptees from Russia, Ukraine, and other former Soviet countries have the highest rates of FAS and FASD (Miller 2005, 89). One study found that half of children in one Russian baby home exhibited facial features indicating pre-natal alcohol exposure. Their review of available birth mother social histories found that 40% had consumed alcohol while pregnant (Miller et al. 2006).

IAM clinicians are also concerned about post-natal environmental exposures such as lead (Centers for Disease Control and Prevention 2000; Centers for Disease Control and Prevention 2017; Miller 2005, ch. 24; Miller and Hendrie 2000) and melamine (Musinski 2009). Adoptees from China are generally at greatest risk among internationally adopted children for high blood lead levels (Centers for Disease Control and Prevention 2000; Miller 2005, 318-9).

Behavior, Learning, and Mental Health

IAM clinicians diagnose and treat children for a range of behavior, learning, and mental health issues. Early experiences of neglect and malnutrition may lead to learning differences (Dole 2005; Harwood, Feng, Xin, and Yu 2013; Miller 2005, 394; Prock 2014b; Schwarzwald et al. 2015, 43), behavior designated as problematic by families and schools (Juffer and Van IJzendoorn 2005; Miller 2005, ch. 32; Prock 2014a; Weitzman and Albers 2005), and mental illness (Bramlett, Radel, and Blumberg 2007; Juffer and Van IJzendoorn 2005; Miller 2005, 369; Schwarzwald et al. 2015, 43; Tan and Marn 2013). Attachment, or

developmentally appropriate bonding to family members, occupies a central place in the epidemiology of adoptee health (J. Castle et al. 1999; Chisholm 1998; Chisholm et al. 1995; Mason, Alvarado, and Mason 2014; Miller 2005, ch. 29; O'Connor, Rutter, and English and the Romanian Adoptees Study Team 2000; Perry 2001; Rutter et al. 2007; Van den Dries et al. 2009; Van den Dries et al. 2012; Zeanah 2000; Zeanah et al. 2005). I explore attachment in chapter 6.

Adopted children do utilize mental health treatment at greater rates than non-adopted children (Bramlett, Radel, and Blumberg 2007; Miller 2005, 369), though internationally adopted children utilize mental health services less frequently than domestic adoptees (Bramlett, Radel, and Blumberg 2007; Juffer and Van IJzendoorn 2005). Adoptive parents are believed to be more likely to seek preventive and specialized health care for their children (Bramlett, Radel, and Blumberg 2007). Etiology of mental health problems in internationally adopted children is unknown, though clinicians and researchers have linked such illnesses to the effects of institutionalization (Juffer and Van IJzendoorn 2005; Miller 2005, ch. 30; Shah 2014), loss of birth family, adjustment to an adoptive family, and identity issues (Brodzinsky 2014; Cox et al. 2005); and genetics (Picker 2014).

Development of International Adoption Medicine

In the late 1980s and the 1990s, physicians and other medical professionals began publishing articles in scholarly journals highlighting the medical needs of internationally adopted children and providing epidemiological data on these populations. Infectious disease was one of the earliest foci of IAM. An early founder of IAM, Dr. Terry Jones, told me in an interview, “the incidence of things like Hepatitis B, Hepatitis C, HIV, tuberculosis, intestinal parasites, things like that really got a lot of our attention.”

These early authors noted that physicians were missing important diagnoses (Hostetter et al. 1989; Miller 1999a, 1999b) and called on other practitioners to become familiar with the literature on these health needs so they could better meet the multiple needs of internationally adopted children they encountered in their practices (Hostetter et al. 1991; Hostetter and Johnson 1989; Jenista and Chapman 1987; D. Johnson 1998; Miller 1999a, 1999b; Quarles and Brodie 1998). In addition to infectious disease, these early publications³⁴ focused on overall adoptee health, the health of adoptees from specific countries or regions, nutrition, speech and language, and development and behavior. (See appendix A for a chronological listing of these early publications.) At least one medical school has developed an elective course in adoption medicine (Henry, Pollack, and Lazare 2006).

As physicians began providing epidemiological data on the health of international adoptees, they also highlighted the demographic shift in American family-building by international adoption. The late 1980s and early 1990s were a time of tremendous growth in the number of international adoptions, and the professional writings of doctors reflected this. Most medical articles (most anything anyone writes about international adoption) begin by noting the growing practice of international adoption and provide the overall number of international adoptees who have entered the U.S., the percentage growth in international adoption, or percentage of families affected by international adoption in a given time period (e.g. (Hershow, Hadler, and Kane 1987; Hostetter et al. 1989, 1991; Hostetter and Johnson 1989; Jenista and Chapman 1987; Lange and Warnock-Eckhart 1987; Miller 1999b; Miller and Hendrie 2000; Quarles and Brodie 1998; Saiman et al. 2001; Smith-Garcia and Brown 1989). The increasing number of internationally adopted children and growth of IAM soon

³⁴ I define “early” IAM publications as those appearing in the literature before the publication of the first comprehensive texts on IAM: Miller’s 2005 *The Handbook of International Adoption Medicine* and the 2005 special issue on IAM published by Pediatric Clinics of North America (Albers et al. 2005).

hit the popular press, with *The New York Times* heralding IAM as a field that “brings new parents answers and advice” (Tuller 2001).

This common introduction to articles about international adoption in medical journals stresses two things that pediatricians should recognize: that internationally adopted children are a significant population, and that this population has specific medical needs. The epidemiological data serves as the scientific evidence of disease prevalence in this population of children. These data, with the accompanying calls for pediatricians to recognize the specific needs of internationally adopted children, mark the beginning of what has coalesced into international adoption medicine. Moving beyond the academic press to *The New York Times* (Tuller 2001), and later other popular publications (Greene 2011; Strauss 2005) indicates public recognition of the need for IAM. IAM stakes its claims for expert authority in discipline-specific and popular press.

Social Change and Advocacy

Like pediatrics, IAM is understood by many of its practitioners as social reform that extends beyond the individual child or family to challenging social institutions and structures.

Miller’s (2005) text on international adoption medicine highlights the need for IAM clinicians to advocate on behalf of all children. In her introduction to the only book on international adoption medicine, she argues, “Internationally adopted children remind us of our obligations as pediatricians to provide care and advocacy for the world’s needy children—especially those without families” (Miller 2005, 3). Miller dedicates the text: “To all children of the world who wait for families—you are not forgotten.” Miller understands her professional responsibility to include both care for individuals and to champion for

broader social change, specifically the deinstitutionalization of children.

The desire to “make a difference” was clear in my interviews with IAM practitioners. Interviewee and nurse practitioner Libby Wagner sees her work with both adoptive families and local HIV-positive children as part of “making a difference.” Similarly, several practitioners were involved in medical missions; their goal is to “have an impact” and apply their skills to the neediest children and improve child health on individual, local, and sometimes global levels.

Nowhere is the link between IAM and social reform more clear than through the work of IAM doctor Jane Aronson. Aronson is probably the most well-known international adoption specialist. One of the first IAM clinicians, Aronson became well-known after treating actor Angelina Jolie’s daughter who, adopted from Ethiopia, was critically ill (Strauss 2005). While Aronson still works as an IAM clinician in New York City, her public focus has shifted from the problems faced by individual children to the problems faced by all children who are without parental care. She is greatly admired in the adoption community as a humanitarian; she created a “peace corps” of “Orphan Rangers” who travel the globe to better the lives of children in orphanages through education, health care, supporting deinstitutionalization of children, and developmental play (Worldwide Orphans n.d., “About”). I briefly met Aronson at the 2012 JCICS conference, where she presented on the work of her Worldwide Orphan initiatives to set up “toy libraries” in impoverished countries.³⁵

³⁵ “Toy Libraries” are collections of toys that children and their caregivers can “check out” to play with. Aronson’s focus is providing toy libraries in institutions serving children (orphanages, schools, community centers), but toy libraries are found in many settings (Björck-Åkesson and Brodin 1992; Mayfield 1993). The goal of toy libraries is to provide “children and adults with access to play-based experiences and learning to support child development and school readiness, heal trauma and create healthy, connected and vibrant communities” (Worldwide Orphans n.d., “Element of Play”).

Beyond Breakfast and Love: Contemporary IAM Practice

As I described in chapter 3, international adoption to the U.S. hit a peak in 2004 and has been in decline ever since. Currently, fewer children are available for adoption and those who are available are sicker. As birth countries change regulations and bolster domestic adoption programs, healthy infants and young children are more likely to be cared for by birth families or adopted within their birth country. This leaves three primary, but overlapping, categories of children available for international adoption. The first are those born with congenital problems such as cleft lip and palate, heart defects, limb differences, genito-urinary problems, and spina bifida. The second are older children who are likely to have spent more time in institutions, so are at greater risk for developmental delays, malnutrition, and attachment problems. Finally, sets of siblings are available for adoption.

Of the 75 children I observed in The Clinic, only 7 were classified as “healthy referrals,” meaning they had not been diagnosed with a known problem before adoption. Twenty individuals were part of sibling groups. The children were diagnosed with a wide range of infectious diseases, special needs, congenital problems, mental health needs, and developmental delays. Table 6, “Diagnoses of children observed in Clinic fieldwork,” details the diagnoses of the 75 children I met during fieldwork in The Clinic. Appendix B details the diagnoses and circumstances of each child.

Table 6: Diagnoses of children observed in Clinic fieldwork

Diagnosis	Number of individuals with diagnosis
Infectious Disease	
Gastrointestinal problems and intestinal parasites	13
TB and related respiratory problems	9
Respiratory problems (no TB diagnosis)	5
HIV+ (includes 1 child tested HIV+ at birth but now HIV-)	3
Other infectious disease (malaria, syphilis, hepatitis B, meningitis, bone infection, necrotic sores on feet, ear and sinus infections)	10
Growth and nutrition	
Malnourished	9
Other growth and nutrition issues (failure to thrive, anemia, rickets)	5
Development	
Developmental delay	11
Enuresis (bed-wetting, incontinence)	5
Language delay	4
Hearing deficit	3
Other development issues (fetal alcohol syndrome, high lead level)	2
Mental health and behavior	
Mental health or behavioral problems (depression, anxiety, ADHD)	13
Attachment problems	3
Learning or school issues	2
Special needs and congenital problems	
Ear/eye/other facial deformities (not including cleft lip/palate)	13
Limb/hip differences or deformities	11
Cleft lip and/or palate	8
Congenital heart defect	8
Kidney disease	6
Genito-urinary system problems	5
Spina bifida	3
Down Syndrome	2
Other special needs and congenital problems (hydrocephalus, microcephalic, scoliosis)	6
Other	
Skin problem or rash	6
Uvula removed (discussion in chapter 5)	4
Injury/accident/scar	4
Dental and oral issues	3
Suspected sexual abuse	2
Other (high blood pressure, nosebleeds, hernia, abnormal lab results)	7

Notes: I observed 75 children in Clinic fieldwork. Most children were diagnosed with more than one disease or disorder so are represented more than once on this table. Therefore, totals will not equal 75.

There was a sense of wistfulness among IAM clinicians about the days when healthy infants and toddlers were the primary population of adopters. “The kids that are coming through [now] aren’t the same kind of kid. It used to be this awesome, healthy, just deliciousness that you could really see making a difference in their lives, not that you can’t make a difference, but the kids are older and they’re special needs. And it’s a different kind of family that’s adopting them,” said Dr. Melinda Stein. None of the other clinicians were as direct or expressed the nostalgia as Dr. Stein, but several did note that these shifts had dramatically changed their practices. They are now seeing children with complex medical needs, with congenital defects on top of the myriad effects of institutionalization. Libby Wagner, a NP, described her current patient population: “rarely is there a kid where we say, is the only special need malnutrition? Is that all there is?”

As IAM has developed as a sub field and the characteristics of adopted children have changed, attention has shifted from infectious disease to development, common congenital defects such as cleft lip and palate, the effects of institutionalization, and mental health. Dr. Terry Jones reflects on the early days of IAM: “when Romania opened up there was still a very strong feeling that, you know love and good food will make all these kids better.” This perspective was naive, as the long-term health needs of institutionalized children are far more complex and extensive than nutrition and hugs. The website of one IAM clinic uses this shift in understanding to encourage parents to consult an IAM clinician:

While it was once thought that ‘a good breakfast and lots of love’ will cure the ills created by from institutional living conditions, it is now very clear that is not completely true. Many medical problems can arise in these children, and parents need to have an unbiased resource to help them make the right decision. A hasty, uninformed decision to adopt a particular child at the recommendation of an adoption agency may be a mistake that the family will carry for the rest of their lives (Adoption Doctors Online Services n.d., “About Us”).

In this articulation of the need for IAM care for children, “medical problems” stand in for the physical and psychological. This clinic links the epidemiology of IAM—that internationally adopted children are at greater risk for some infectious disease and mental health problems—with family formation. Families need IAM care because it can prevent families from making “mistakes” and instead lead to the creation of healthy, successful families.

Role of IAM in Adoption Process

IAM practitioners have the opportunity to become involved in a specific family’s adoption process at multiple stages (American Academy of Pediatrics et al. 2014; Chambers 2005; Miller 2005). Table 7 highlights the stages at which the IAM doctor might become involved and notes the key activities of each stage.

Table 7: Roles of IAM clinicians in the adoption process

<p>Pre-adoption period</p> <ul style="list-style-type: none">• Counsel prospective adoptive parents as the parents decide whether or not to adopt• Educate prospective adoptive parents about adoption and health risks common among institutionalized children• Advise prospective adoptive parents about the health risks common in birth countries
<p>Referral period</p> <ul style="list-style-type: none">• Review referral files received by adoptive parents• Counsel prospective adoptive parents on the health concerns apparent in the referral materials• Review photos and videos of referred children for evidence of pathology
<p>Pick-up trip</p> <ul style="list-style-type: none">• Advise and administer vaccinations for traveling families• Advise traveling families on what first aid and health care supplies they should pack; may include prescriptions for antibiotics, scabies cream, and anti-diarrheal medicine• Respond to phone calls and emails from traveling families about health, behavior, and transition issues• Evaluate health materials sent by parents from birth country; may include photos, videos, and medical records
<p>Transition period</p> <ul style="list-style-type: none">• Meet child and family for initial visit• Screen child for infectious disease, developmental delay, and attachment and adjustment issues• Advise family about child's health and wellbeing, adjustment, and attachment• Provide referrals to specialists for children with physical problems in need of additional treatment
<p>Long-term support</p> <ul style="list-style-type: none">• Provide referrals to specialists to address developmental, mental health, and educational concerns that become apparent in the years after adoption• Advise families about the emotional and mental health issues common in adopted children: attachment, identity, and learning disabilities

Source: In addition to ethnographic data, this table is compiled from Chambers 2005; Miller 2005.

Adoption medicine doctors may enter into the process in the pre-adoption period, consulting with people considering adopting internationally, helping evaluate their expectations and make decisions about whether to adopt, which adoption program (birth country) would best meet their needs, and whether they have the resources and desire to parent a child with known special needs (Chambers 2005; P. Lee and Sagor 2014; Miller 2005, 67). This involvement marks IAM unique in that many practitioners provide medical advice before ever meeting the patient, sometimes even before a patient exists.

Here, I use “pre-adoption” to describe the period when prospective adoptive parents are considering adoption, selecting an agency, and completing all of the applications (agency, governmental, etc.) necessary to be approved as an adoptive family and proceed with adoption. I use “referral” to refer to the event(s) when approved prospective adoptive parents are matched with a child and given a packet of information about that child. In this way, “referral” is both an event (the agency notifying parents that they have been matched with a child) and a descriptor of the set of information parents receive about the child they have been matched with.

Upon parents’ acceptance of a referral for a specific child, the legal and bureaucratic process of adoption continues in the U.S. and in the birth country. Adoption and government agencies finalize the documentation needed for the child to travel between countries and be adopted. This process usually takes months, but can take over a year. When all documentation is complete, parents travel to the birth country to meet their child, complete the adoption, and return to the U.S. with their child. This is colloquially termed the “pick-up” trip by adoptive parents and others involved in adoption.

Much like the period after a family welcomes a child by birth, the months after returning to the U.S. is a time of transition for both parents and children. It is a time of many “firsts” for the family: the first time the child meets grandparents and extended family, the first time the family eats together at home, the first visit to the doctor. This is a critical period of involvement for IAM clinicians.

Just as adoption is not a one-time event, but a familial status and process, the health care of adoptees by IAM doctors can continue into late childhood and adolescence. Parents of internationally adopted children may consult an IAM clinician on issues that arise years after the child has joined the family.

It is important to note that IAM is not used in the same way by all families. As I show in other chapters, IAM is used unevenly by parents. Some opt to involve IAM clinicians at all stages of their adoption process, while others consult an IAM doctor for only one or two stages in the adoption process. The variation in use of IAM by parents should not be read as rejection of the discipline. All parents were aware, at some level, of the existence of the field, and relied on some knowledge produced by IAM, especially the field’s contributions to understanding the effects of orphanage life on children. I see parent practices around their child’s health and body to be in conversation with IAM, even when IAM clinicians are not official partners in the parents’ adoption process.

Pre-Adoption Period

U.S. adults considering international adoption may consult with an IAM clinician about the adoption process. As advisers in these instances, adoption doctors are expected to be knowledgeable about the general health issues associated with institutionalized children, malnutrition, and disease common in children outside the U.S. They are also expected to be

knowledgeable about the health status and risks associated with the birth countries of international adoption.

Many clinicians see themselves as educators, teaching parents about the adoption process and the effects of institutionalization on children. One doctor I interviewed calls these pre-adoption consultations “primers.” Dr. Jane Everett spends a significant amount of time “working directly with parents who are either thinking about adopting, so we have a program where I go through a huge 117-item checklist of medical conditions and talk to them about what that means for children who are being adopted.”

IAM clinicians also frequently help prepare parents and other family members traveling to pick up their child born abroad. These services include giving vaccinations based on CDC recommendations for travel to specific regions (Staat and Burke 2017), instructing them what over-the-counter medications to bring, and providing prescriptions for often-needed drugs such as antibiotics and scabies cream. Table 8 lists medical supplies IAM clinicians Barnett and Chin (2005) recommend for adoptive families traveling to meet their child.

Table 8. Medical supplies for adoptive family members traveling to meet child

Oral antibiotic for traveler's diarrhea
Antimotility drug
Anti-inflammatory/antipyretic
Antihistamine
Decongestant
Topic antibiotic, steroid, antifungal
Scabicide
Adhesive bandages
Thermometer
Insect repellent
Sunscreen (if indicated)
Hand sanitizer
Oral rehydration packets
Needles/syringes/oral syringes
Bulb syringe, nasal saline spray
Pediatric formulations of medications
First time parents: consider medical kit for adopted child

Source: Barnett and Chen 2005, 1278

Decisions About "Special Needs"

In the pre-adoption period, prospective parents must make decisions about the variety of health needs they can accept or deal with in an adopted child. In the broadest sense, prospective parents must decide whether they can parent a child with "special needs" and if so, the type and degree of special needs that are acceptable.

The definition of "special needs" and the distinction between what counts as "minor and correctable" and "major" is not well defined. In the world of domestic child welfare, "special needs" is used to designate children with characteristics that may make placement and permanent adoption successful. These characteristics may include medical, developmental, and mental health diagnoses but more often include having had experiences such as severe abuse or neglect; with being a racial or ethnic minority, being an older child or

adolescent, or being a part of a sibling group in need of adoption (Tan, Marfo, and Dedrick 2007). In international adoption, the meaning of “special needs” is similar, but ill-defined. Birth countries have latitude in defining “special needs” so there is great variability. That said, special needs related to physical disease or impairment is the most common marker of the special needs label. Physical disease and impairments can be broadly categorized as “minor and correctable” and “major or severe.”

Clinicians and parents may have different understandings of categories such as “minor and correctable” and “major”. Generally speaking, both groups see congenital deformities such as cleft lip and palate, minor limb malformations, and some infectious diseases as “minor and correctable.” The key here is that these things are correctable in the relatively resource-rich U.S. These conditions may not be correctable everywhere. It is helpful to think of “minor and correctable” impairment as a spectrum. Conditions such as cleft lip and palate may require one surgery or may require multiple surgeries. Limb malformations may be as simple as a missing toe or clubbed digit, or involve whole limbs, necessitating amputation and extensive accommodation.

Families who do not feel they can care for a child with major health difficulties may feel they can care for a child with “minor and correctable” problems such as limb differences or cleft lip/palate. In these cases, the doctor might steer them to adopt from China’s “special needs” adoption program, which includes many children with minor maladies.

One IAM doctor told me that many parents consider congenital heart defects minor and correctable. The implication of the doctor’s comment is that congenital heart defects should never be considered minor, as they are not always completely correctable, usually require lifelong follow-up care, and may indicate corollary conditions, such as midline

defects. Also, the institutions that care for children in need of adoption (and perhaps the broader communities the institutions are located in) probably do not have access to the same sets of medical imaging that insured families in the U.S. do. Additional imaging may show that the “minor and correctable” condition is actually far more complex, perhaps requiring multiple surgeries and lifelong care. In counseling families on “special needs,” Dr. Maggie Schneider tells parents, “most of the time these are isolated defects, but we always talk about the possibility that they’re not.”

“Major” issues are generally those that are known to necessitate lifelong care. Some conditions, such as HIV, deafness, or blindness, require lifelong medical care or accommodation but do not necessarily preclude the child from developing into an independent adult. Other conditions, such as spina bifida, severe developmental or cognitive impairment, and some genetic syndromes such as Down Syndrome, may mean that the individual will, as an adult, not be able to live independently (P. Lee and Sagor 2014; O’Dell, McCall, and Groark 2015; Schwarzwald et al. 2015).

While discussions of types of special needs are quite broad, the application process asks parents to think through specific conditions. One component of the adoption application is to complete a checklist detailing the types of “special needs” the parent will consider. Figure 2 is a portion of the checklist provided by Dillon International, a Tulsa, OK-based agency that has been in existence since 1972. The full checklist is included as appendix C.

Figure 2. Sample special needs checklist

Please mark Y for Yes, N for No or M for Maybe.

HEART AND PULMONARY

Murmur-unknown prognosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Patent Foramen Ovale	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Atrial septal defect	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Ventricular septal defect	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Tetralogy of fallot	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Pulmonary atresia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Patent ductus arteriosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Lung disease or damage	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

INFECTIOUS DISEASES

Hepatitis B-carrier	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hepatitis B-active	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hepatitis C	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
HIV+	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Syphilis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Tuberculosis-latent infection	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Tuberculosis-active	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
CMV	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

NEUROLOGICAL

Autism-suspected unknown	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Brachial plexus injury	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cerebral Palsy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hydrocephaly	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Macrocephaly	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Microcephaly	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Schizencephaly	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Neurofibromatosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Polio history	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Spina Bifida	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Meningocele/myelocele	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
History of meningitis/brain infection	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Other brain abnormality	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

CRANIOFACIAL/ORAL

Cleft lip-unilateral	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cleft lip-bilateral	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cleft palate	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cleft lip & palate	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Facial palsy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

Source: Dillon International n.d.

While figure 2 and appendix C is one example, it is representative of other special needs checklists I have viewed. In cases where prospective parents consult an IAM clinician at this pre-adoption state, it is the role of the IAM clinician to guide the family through this checklist, educating them about the conditions listed, the level of severity of the conditions listed, and the potential impact a child with specific conditions may have on the family.

Van Wichelen’s (2014) analysis of these checklists is informative. Van Wichelen observes that these checklists attempt to standardize the wide range of conditions that might

affect the body so that the bureaucracy of adoption and medicine can move forward. She observes, “Both scientific and institutional practices now constructed the child’s life before adoption as a series of life events (such as histories of violence, lengths of time spent in institutions, and abandonment at birth) classified and medicalized as episodes or conditions: at risk for fetal alcohol syndrome, at risk for developmental delays, at risk for lower IQ, and so on” (119). Doctors and families interpret this standardized information in order to make decisions about whether a given child should be adopted by a specific family.

Prospective parents have a range of reactions and thoughts about completing this form and making decisions about special needs in a child. Several parents I interviewed found it “ridiculous” or “overwhelming.” That said, they recognized that the choices they make on that form could have lasting impact on their family and also individual children they will never meet.

Parents also revealed a variety of motivations behind their decisions. When Millie Porter and her husband were in the process of adopting their children from China, their decisions were shaped by what they felt they could and could not “handle” as a family. “We felt like we could handle any kind of orthopedic or like the cleft lip. We felt like we could handle one of the things just like birth marks or any kind of webbed feet or hand. We felt like we could handle those sorts of things. Things that weren’t on our list were any kind of contagious disease or heart issues. We just didn’t feel like we could handle that.” Millie is specific in listing the conditions they considered and classifies them by her (and her husband’s) perceived abilities, but is very general in defining what it means to “handle” specific health problems.

Considering various health conditions in adoptable children in Ukraine, single mother

Gail Mullins, a clinician and professor, “wasn’t afraid of physical disabilities” like limb differences and cerebral palsy because she “worked with individuals” with these conditions. But she did not “as a single mom, think it was appropriate to [adopt] a child with cognitive issues, because what would happen to the child when I was gone?”

Interviewee Katie Gabaldi described the process she and her husband went through as they made decisions to adopt from Ukraine:

We knew we wanted an older child, though we knew they would come with baggage. And we knew that there would be unforeseen things that you can’t prepare for. That could be the same if you got pregnant. We felt like whatever it would be would be okay. But we decided that there were some diseases that we couldn’t handle. We couldn’t handle it if the child was terminal. Some people can do that. We wanted a child who would live. It’s a different calling to adopt a terminal child. We wanted a relatively healthy child, but there were [conditions] we were willing to take on [like] if [the condition] could be treated and the child could become a functioning, contributing member of society, we knew that if this kid could love the Lord and love other people, they’re great.

The factors influencing decisions about special needs acceptance range from the medical (“we could handle any kind of orthopedic”) to the developmental [and economic?] (“a functioning, contributing member of society”), to the spiritual (“love the Lord and love other people”). The Parkers, Dr. Mullins and the Gabaldis thoughtfully considered the types of conditions they felt their family could cope with. The Parkers prioritized their sense of what they were capable of, or could “handle” as parents. For the Gabaldis, the ability of the child to connect, to be a member of the family, and to grow into an independent person were the criteria they used to make decisions about special needs. For Dr. Mullins, the criteria was based on planning for the future and considering what would be fair or “appropriate” to an adopted child. Not all of these factors are spelled out on the special needs checklist—there is no tick box for “loving the Lord.” Rather, parents read the non-medical in the possible diagnoses. Conditions that impact connection and cognition are presumably understood as

impeding a child's ability to "be a member of the family" or "society."

In pre-adoption consultations, IAM clinicians use their medical expertise, but in ways that go beyond the usual work of a pediatrician. They participate in a process of discernment in which parents make decisions about the ethics, morality, and practicality of adopting a particular type of child.

Referral

Once prospective parents have made the decision to adopt, they contract with an adoption service provider, as adoption agencies are now called, that has a program in the desired country. Often, two agencies are involved—a local agency that will conduct the home study and approve or deny the potential parents, and the larger agency that has a relationship with birth countries and makes the actual referral. The process by which referral agencies receive the files of children available for adoption varies by country. Agency staff then match specific children to waiting prospective parents. Parents' requests concerning gender, age, and health status are usually considered by the agency, but the Hague Treaty dictates that the "best interests of the child" are primary: "placement involves the identification of the prospective adoptive parents (from among those approved as eligible and suited to adopt) who can best meet the needs of the child based on the reports on the child and on the prospective adoptive parents" (Hague Conference on Private International Law 2008, 86).

Once a family has selected an agency and been approved for adoption, they wait for an appropriate child to become available. Once such a child is listed with an agency, social workers match the child with a family and send the family information on the child; this compilation of social history, medical history, photograph, and growth measurements is

called the “referral.”

While receipt of the referral is exciting for adoptive parents, information contained within it is often sparse. While the health information included in the referral varies by country and child, most include growth parameters, documentation of some infectious disease screening (e.g. Hepatitis B & C, syphilis, and HIV), and the vaccinations the child has received. Social history is included, but is usually very brief. Korea is thought to provide the most accurate and complete referral information because they have “the resources and a good medical system” according to one doctor. The referral information provided by most other countries is “less reliable.”

Many, but not all, prospective adoptive parents have the referral reviewed by a medical professional. Adoption agency professionals at the JCICS national conference stated that, in recent years, some agencies have begun requiring prospective adoptive parents to have the referral file reviewed by a specialist in international adoption medicine. While I was not able to ask individuals about this, the context of the conversation leads me to believe that this requirement is in place so that medical jargon and country-specific practices can be explained to the adoptive parents, who typically have no background in medicine. This review is also protective for the adoption agency, as having a medical expert advise families about specific placement may prevent adoptive parents from expressing dissatisfaction with their agency because they adopted a child with unknown or concealed physical and psychological problems. This points to IAM as functioning as a source of protection for adoption agencies as well as adoptive families.

Adoptive parents and IAM clinicians both center the referral as a key piece of information on the child, and as a milestone in the process of adoption. However, they use

this collection of information differently.

How IAM Clinicians Use a Referral

Adoptive parents contract with IAM clinicians to review the referral file and advise them about the child's health and possible needs. Dr. Stein approaches her review as a "risk assessment," assigning the child to one of four risk categories, from low risk of poor health outcomes to high risk of poor health outcomes. Using this information, she talks with the family to make a decision about whether the child is a "good fit for the family." Similarly, one IAM clinic website uses the three-tier system to establish risk (see figure 3). In a guide for doctors on pre-adoption counseling, Chambers (2005) counsels that doctors and parents need to understand that internationally adopted children "should never be considered low risk" (1248).

Figure 3. Risk assessment

Risk Assessment

RISK ASSESSMENT

LOW Risk

- No worrisome data
- Enough social info to eliminate major risks (maternal alcohol, drug use, mental illness, major medical problems)
- Growth & Development in 'normal range'

MODERATE Risk

- One or more features likely to impact future health
- moderate growth or developmental delay – -Involuntary termination of parental rights
- Small-for-gestational age
- Known correctable conditions

HIGH Risk

- Known medical diagnosis of Fetal Alcohol Syndrome or other irreparable genetic defects (ex. Down's, achondroplasia)
- SEVERE growth or developmental delay
- Premature delivery < 30 weeks
- Birth weight < 1000g
- SEVERE growth or developmental delay

Source: Adoption Doctors Online Services n.d., “Risk Assessment”

A key question parents have for IAM clinicians is whether or not the medical information received from the birth country can be believed. One clinician I interviewed, Sandra Thompson, was much more blunt in her assessment: “China lies.” For the most part, however, clinicians understand these records as partial attempts to describe and categorize

the child's health. Nurse Practitioner Libby Wagner describes her perception of the referral records:

We can only go with what we have, with what is written down. We always have to say at the beginning, at the outset, we don't have any idea of the veracity of this information so we just do the best we can. We have to take the records seriously. But we have to just try to read between the lines and take our experience on what we have seen in other children. We just try to read what they are saying and not saying... I mean, literally the translation is sometimes off. And then you think how it has been translated by someone who may be totally off on what is actually going on. We try our best. We don't discount them and we take them very seriously and try to read between the lines and understand as best we can what is being said, knowing that it may or may not be true.

Libby's repeated reference to "read between the lines" is important here. Rather than take the information at face value or discount it entirely, Libby notes the multiple layers of translation the records have gone through.

Most clinicians also recognize that the health care infrastructures in birth countries are under resourced. They are hesitant to undermine or demean the caregivers and clinicians who collect and record the information that goes in the referral. Dr. Terry Jones approaches referral records believing that the birth country caregivers are "doing the best they can with what they have." In many initial visit with adoptive families at The Clinic, Dr. Smith explained why they had to check the child's antibodies (via titers) even when a complete vaccination record is included in the referral material: "It's not that we don't believe the records or think people at the orphanage are lying. We don't know if the vaccines were stored properly, maybe the power went out on the fridge, or they were expired, so we have to check titers to make sure your child is protected."

While no interviewees mentioned this in taped interviews, a few conversations at conferences and at The Clinic indicate that some doctors suspect that orphanages and in-

country staff might “fudge” records to benefit a child so they are adopted more quickly. This may involve stating that the child is less impaired than they are, but also involves noting “little things” like a slightly abnormal blood test so that the child is classified as minor special needs and more likely to be adopted to the U.S. then within the country.

Clinician comments about the use and reliability of foreign medical records indicate uncertainty. Medical records may be wrong because someone has intentionally lied, or because of an error in translation, or because available diagnostic tools are unreliable. Clinicians incorporate all of this uncertainty in their review of medical records.

How Parents Understand the Referral

I explore adoptive parent use of the referral in greater depth in chapter 5 but want to briefly touch on the matter here. While adoptive parents are thrilled to receive the referral, as it matches them with a specific child and is a milestone in the adoption process, they may not have the referral reviewed by a clinician, or put little stock in the information included in the referral.

Parents who opt not to have the referral reviewed by a doctor indicate a number of reasons for this. The first is cost; review is not covered by insurance programs and usually costs between \$250-\$500. Other families are motivated by a higher authority; in the case of the families I observed, a Christian God. For families adopting because they feel called to do so as Christians, review may be unnecessary because they trust that God is guiding the process. Still other families feel that there’s not enough information in the file to make paying for a review “worth it.”

When I asked Alex, who with partner Katherine, adopted Lucas and David from Guatemala, what sort of information was in the referral, Alex laughed and replied: “That’s

hilarious, the medical information was like a couple of sentences, basically it was like insert name here. And it was hysterical because it wasn't just [physical] health but it was like emotional [health] too. I'm like really, he is 3 days old! [laughs]" Linda, who adopted Natalie from China, described the information this way: "I think they said the same thing to everybody. She's healthy, happy." Alex, Linda, and other parents perceive the referral medical information as a sort of form letter.

In-Country Consultations

IAM clinicians usually offer consultations while the parents are in the child's birth country to pick them up (the "pick-up trip"). These services can range from a single phone call or email or multiple contacts with the doctor for advice. IAM clinician Dr. Maggie Schneider describes the in-country services she offers: parents can pay "for an hour of time to pick my brain [or] review a medical record and then we're done, or they can [put] me on retainer for a year and they have access to me as much or as little as they want." Similarly, Dr. Melinda Stein makes herself completely available to parents while they are on the pick-up trip: "Once they are in the country, I am at their beck and call. They have my cell phone, my home phone, my email. In a perfect world they have everything they need." The social workers in The Clinic, my primary field site, were also available for consultation with families on their "pick-up trips."

Transition and Initial Visit

The initial visit families have at the IAM clinic is one of the central events and activities of the discipline and is the focal point of my research. These "new-off-the-plane kind of visits," as Dr. Maggie Schneider describes them, are the most common type of visit at

most IAM clinics. The American Academy of Pediatrics recommends that internationally adopted children be seen by a doctor “as soon as possible after arrival in the United States, preferably within the first 2 weeks” (American Academy of Pediatrics 2015). At the initial visit, practitioners follow the AAP recommendations for assessing child, with particular focus on infectious disease, overall physical health, and family adjustment.

In the following section, I describe the daily rhythms of The Clinic. This snapshot of IAM highlights the interdisciplinary nature of IAM. While my focus is on one specific clinic, my interviews with IAM clinicians from across the country reveal that most clinics address the same matters, though there is variation in whether a formal developmental evaluation occurs and if social work services are offered within the office or involve referrals elsewhere.

Routines of The Clinic

The Clinic sees children and families with a diverse range of issues. Appendix A summarizes the children I met in The Clinic. Each child and family is unique, but the routine of The Clinic is applied to nearly all of them.

When a family arrives, they check in at the waiting room registration desk where the registrar prints the patient-specific stickers commonly used in hospitals to track and charge for patient use of resources (lab work, medication, etc.). The Clinic is generally not crowded, as there are only three exam rooms. Most commonly, only one family at a time will be in the waiting room. The registrar brings the printed stickers to the nurse’s station that occupies the center of The Clinic space.

First, the nurse practitioner, Carol, steps into the waiting room and warmly greets the family: “Good morning! Are you the Bradley family? Welcome and congratulations!” Congratulations are nearly always in order because the family has welcomed a new member

within the last few weeks. Carol brings the family to the small triage area where either she or a trainee take the child's vital signs: temperature, blood pressure, height, weight, and head circumference. Predictably, younger children usually cry. While this is not unusual behavior in children, Carol is quick to tell the child: "Mom is right here, Mom will not leave, and you can go right back to mom in a minute."³⁶ The explanations staff often offer for the child's crying function to comfort the parents about the child's health, their attachment to their adoptive parents, and the child's need for rescue or care: "Well, you can tell she's got a great set of lungs on her! And she certainly knows who Mommy is." In cases where a child has had significant medical procedures in their birth country, Carol may interpret the crying as a sign of "all that [the child has] been through" medically. The child is returned to her parents as quickly as possible. When a child is severely distraught and fighting the staff member, Carol sometimes moves the family to an exam room and gathers vital signs later, once the child has calmed and hopefully becomes more trusting of the staff.

Almost every child who visits this clinic sees each member of the team—nurse, occupational therapist, social worker, and doctor. First, Carol takes as complete a history as possible. Four questions are asked of nearly all parents: "How is your child eating? Sleeping? Pooping? And bonding?" These questions are deemed so important that Dr. Smith had the hospital system customize The Clinic's electronic intake form to include them. Carol tries to gather information about the child's birth, birth family, and medical and social history: birth weight, full-term or pre-term, birth mom's age, circumstances of relinquishment, how the child came to be eligible for adoption. Carol is careful not to push parents on these questions. Usually parents do not have this information, or they have conflicting information from

³⁶ A mother was present at every clinic visit. Often, the father was present too, but a father was never the only parent accompanying the child.

various sources. The official medical record from the child's birth country often includes these details, but parents are often given new or conflicting information from orphanage staff when they travel to the birth country to pick up their child. Carol completes the social history, asking about the parents' plans for daycare or school. She then conducts a full body exam, checking the child's eyes, ears, mouth, throat, hair, skin, arms and legs. She listens to the child's heart, lungs, and belly. When she sees something unusual on the skin, she swabs a sample to check for fungal infections. Carol always checks for a BCG scar.³⁷ Carol performs genital exams on babies and young children; this exam is done only by Dr. Smith in older children.

Molly, the occupational therapist, enters the exam room next. Her role is to assess the child's development and determine whether they are delayed or on schedule. She usually uses an instrument (usually the Denver) to evaluate multiple developmental domains: fine motor skills, gross motor skill, language, and personal/social development. Molly usually spends the greatest amount of time in the exam room, as the developmental assessment includes nearly 100 items. The assessment is a combination of parent interview—"Can your child follow two-step directions?" and asking the child to do various tasks, from hopping on one foot to drawing a circle, to identifying a horse in a picture. Upon finishing, Molly provides a developmental age for each domain. For example, Mariah, adopted from Haiti, was 47 months old (almost 5 years old) at her first Clinic appointment. The Denver assessment showed her to be at 51 months for fine motor skills, 36 months for gross motor skills, 27 months for language, and 36 months for personal/social. Delays in internationally adopted children are common, but referral to speech, occupation, or physical therapy was

³⁷ Most children born outside the U.S. are vaccinated for TB with the BCG, or bacille Calmette-Guerin shot. Often mistaken for a smallpox vaccine scar, the BCG usually leaves a scar on the upper arm (Centers for Disease Control and Prevention 2018a).

rare after the first visit. The results of the first evaluation are compared to the results of the evaluation that is done 6 months later, when the child comes in for a re-check. If the child has not significantly improved, they are referred to an appropriate therapist.

One of the two licensed clinical social worker therapist, Patty or Caitlyn, meets with the child and family next. When I began my research in the clinic, Patty was the only therapist. Several months later, Dr. Smith received funding to hire Caitlyn because the demand for therapy for older adopted children was more than Patty could handle on her own. At a child's first visit, the therapist asks questions about the child's transition—"how is sleeping going?" "Do you feel like your child is bonding to you?" "do you have any concerns?" Patty and Caitlyn advise parents on the primary problems that all new families face, encouraging them to do what works for their family, but also educating them on the special needs adopted children might have. For example, 11-month-old David's parents are concerned because he doesn't seem to miss them when they leave the room. "He only cares if we feed him," reports dad. Patty counsels them that "it's okay if bonding occurs through food." David's mom asks if only one parent should provide primary care so that he attaches more easily. Patty counsels them that both parents are very important. Both should provide care and attachment to both will come over time.

At least once for each child, the team gathers in the conference room (really just a large exam room with a table) and briefs Dr. Smith on their findings.

Dr. Smith takes all of the information her staff has provided and enters the exam room. After introducing herself, she recaps what the team has reported to her, highlighting the major findings around physical health, development, attachment, and then performs a physical exam. She nearly always asks the parents how the pick-up trip went, and how they

“feel like the adoption is going.”

More than any other staff member, Dr. Smith tries to make a personal connection with the parents, congratulating them on the adoption, and sharing her own experience as an adoptive mother. She also tries to connect with each child, talking directly to them as she crouches down to their height.

Dr. Smith ends each meeting by educating the parents about next steps in their internationally adopted child’s health care: the NP will return to give shots and place a TB skin test; you’ll go down to the lab for blood work (warning them that they take a lot of blood and it looks scary, but won’t hurt the child and is necessary to get a good picture of their health); some of the bloodwork for blood parasites has to go to the CDC, so takes a long time to get the results back; The Clinic will call with results of blood work and stool sample analysis; come back to The Clinic in 6 months for a checkup. “It’s rare,” she cautions, “but the local health department sometimes gets results for reportable diseases (TB, lead exposure, etc.) before we do so don’t panic if you get a call from them,” she advises, “we’ll be right behind them to talk about results and make a plan for treatment.”

After meeting with Dr. Smith, Carol returns to the exam room to administer vaccines and a TB skin test. She then directs the family to the lab on the first floor of the hospital.

Another individual is present throughout most portions of this initial visit: the translator. For children old enough to talk (usually about 2 years old), the hospital provides a translator fluent in the language of the child’s birth country. The translator tells the child what the nurse, doctor, and OT are doing, and can ask questions on behalf of all of the staff members. The translator is particularly important during OT Molly’s developmental assessment, as the child is asked to perform specific tasks, and if they cannot understand

what they are being asked to do, the assessment is inaccurate and not a clear indicator of development. Social workers Patty and Caitlyn talk mostly with the parents, but rely on the translator to ask the child gentle questions about where they lived before they came to the U.S. (the pre-adoption environment), what they remember, if they have any questions, and to reassure children about their new family, as well as the medical visit itself. Parents often ask the translator to ask the child specific questions about their preferences and needs (food, usually) and to reassure the child about things that seem to scare them (the family dog, the bathtub, or dad's beard). Parents occasionally ask the translator for advice on keeping the child connected to their birth culture, again, especially through food. Generally speaking, the medical translators at The Clinic visits were born outside the U.S., usually sharing the child's country or region of origin. As local representatives of the child's birth culture, translators could tell parents where to buy specific food and connect them to local resources (social and faith groups that serve as opportunities for the child to maintain their first language).

Frustrated that their child may not be able to understand their expressions of affection, parents sometimes want the translator to communicate these ideas to the child ("Mama loves you very much and will always take care of you") or teach them how to say a few key things in the child's first language. In one particularly memorable exchange (memorable to me, at least), a mom asked the translator to teach them how to say "my sweet boy" in Mandarin Chinese. This was the sweet, affectionate phrase mom wanted to be able to communicate to 4-year-old Aaron. The translator looked puzzled and said, "well, we wouldn't say that. We don't have words for that."

Long-term Care

Internationally adopted children typically see a general pediatrician (not an IAM

specialist) after evaluation by an IAM doctor. But parents concerned about children adopted three, five, ten years earlier—long past the transition period—sometimes return to an IAM clinic. These “long-term” visits usually concern behavior, mental health, or learning difficulties. Dr. Maggie Schneider describes one such visit: “I see our kids who are struggling with some type of adjustment problem and usually it’s a school issue that maybe just started. It usually pertains to something that is happening in school. It could be [they] hit a wall with learning. Last week my new patient was having, the chief complaint on my schedule just said ‘anger issues’ [chuckles]. And I was like, ‘uh oh, what could happen with this?’”

Behavioral, emotional, and learning problems may be related to the child’s early life experiences, so parents view IAM clinicians as a possible resource. Indeed, it is not always clear that the problem is related to adoption or past institutionalization. But the growing literature on the long-term effects of institutionalization on brain development, etc., often leads parents to see the IAM provider as a possible expert in the efforts to address all of their children’s needs. It is in these situations that we see the extension of general pediatrics into child development, education, and family dynamics. In the case of IAM, pediatricians are experts in the “old” pediatrics of infectious disease and vaccinations, as well as in the “new” pediatrics of education, mental health, and family dynamics.

Risk, the Unknown, and the Unpredictable

IAM clinicians are asked, in a sense, to imagine the future of internationally adopted children in their advice to adoptive parents. IAM clinicians are attempting to balance the facts of diagnosis and likelihood of outcomes related to the child’s life circumstances with the parents’ desire to have a sense of what their child’s life will be like. This combination of fact and imagination (Kirmayer 2003, 168) is used in advising adoptive parents about the risk

of adopting a specific child, and the most likely outcomes.³⁸

Writing about the protocols that guide decision-making in neonatal intensive care units, Coeckelbergh and Mesman (2007) note that individual patients and families do not match protocols. Instead, clinicians bridge the gap between reality and the ideal type of protocol cases with imagination. IAM clinicians must use their imaginations in similar ways. If we consider IAM literature and accompanying guidelines from the AAP and CDC as suggested protocols, IAM clinicians balance what is known about the general epidemiology and expectations of adopted children from specific countries and life circumstance with the knowledge that children are individuals and outcomes will vary accordingly. My fieldwork in the clinic revealed several instances when the expected outcomes Dr. Smith had based on epidemiological facts differed from the outcomes she imagines for specific children.

One morning when I arrived at The Clinic, Dr. Smith and NP Carol were talking about an email The Clinic had received over the weekend. A mother had emailed, expressing dissatisfaction with a referral review Dr. Smith had done for her three years before. Dr. Smith was clearly bothered by this email. She and Carol had gone back through the records and Dr. Smith was “confident I was thorough,” but she still disliked feeling like she had in some way failed a family. The conversation soon turned to other families Dr. Smith “felt bad” about.

She had convinced one family to adopt through China’s minor special needs program as opposed to Bulgaria because China had much lower rates of FAS. The family applied for the China program and received a referral which Dr. Smith reviewed. The child had no major problems and showed no signs of intellectual or developmental disabilities (IDD).

³⁸ Kirmayer (2003) is concerned with conflict between refugee’s narratives, psychiatrists’ assessment of such narratives, and immigration officials’ failures to imagine the experiences of refugees, resulting in stereotyping, dismissal, and psychiatric diagnosis. Though outside the scope of this project, a fruitful research question might concern clinician understanding of adopted children’s narratives in the psychotherapeutic setting.

“Something happened,” Dr. Smith said, between the referral and the time the family picked up the child from China. The child was severely impaired: “maybe he was shaken, or had something like meningitis or cerebral malaria” (though she noted that cerebral malaria was unlikely in China). Though she did not go into details and I did not ask, her description of the outcome for the family: “it did not turn out well.”

A different family adopted a 7-month-old boy from Guatemala. Dr. Smith reviewed that file as well, and saw the him in The Clinic. Over time, it became clear that the boy had significant attachment problems, to the extent a possible diagnosis of Reactive Attachment Disorder (RAD).³⁹ Given his pre-adoption history—he was young when he was adopted, and the Guatemalan foster care system is considered better for children than large institutions—he was at low risk for attachment problems. “I never would have guessed he’d have attachment problems,” reported Dr. Smith.

Poor outcomes, in the form of dissatisfied families, severe attachment problems, and radical deterioration in the health of a child seemed to weigh on Dr. Smith. Her distress at failing a child or failing a family highlights her desire to help make successful, healthy families through her IAM practice. These instances also highlight that there are times when Dr. Smith’s expectations as to what is possible fail to accurately predict the outcome .

Medicalization and IAM

IAM provides a unique view into processes of medicalization. As I reviewed in chapter 1, medicalization is the process through which human problems come to be understood as medical problems. The adopted child and adoptive family are indeed medicalized (also see Leinaweaver 2009). In its early years, the specialty of IAM managed

³⁹ While adopted children are known to be at risk for attachment-related problems, among IAM clinicians, a RAD diagnosis is generally applicable to only the most severe cases (Miller 2005, 356).

the physical problems of internationally adopted children—malnutrition, infectious disease, immunization, and developmental delay. Just as general pediatrics expanded to include psycho-social concerns such as sleep, toilet training, and behavior, IAM broadened to include child behavior, education, and attachment.

As the specialty matured and more U.S. families were formed through international adoption, the adoptive family as a whole was medicalized. Though the focal point remains the body of the internationally adopted child, IAM clinicians are also concerned with how the family as a whole is doing. Key questions IAM clinicians ask of parents include, “How are you all doing?” and “How is the family adjusting?” The psycho-social issues faced by the child extend to the family, and IAM clinicians give advice on whole family adjustment and mental health.

In IAM we also see that medicalization is not a monolithic process. While the health of internationally adopted children is an explicit concern of pediatrics in the U.S. (V. Jones and Committee on Early Childhood, Adoption, and Dependent Care 2012; V. Jones et al. 2012) and the specialty of IAM exists to address this concern, families do not use IAM in uniform ways. The knowledge produced by IAM structures popular and clinical understandings of internationally adopted children and their health, but the use of medical expertise is uneven and dynamic. Adoptive parents elect to make use of some IAM services while not using others.

Conclusion to Chapter 4

As an evolving interdisciplinary subfield, IAM cares for internationally adopted children and their families by helping prospective parents make decisions about the adoption process, reviewing referral materials, counseling parents while they are in their child’s birth

country, screening for infectious disease, assessing development, working with other specialists to manage complex health conditions, and providing long-term support with mental health. Through these activities, IAM extends the specialization of pediatrics to internationally adopted children and their families, and employs both “old” and “new” pediatrics by combining preventive and infectious disease care with developmental and behavioral medicine.

IAM is intimately involved in the constitution of some adoptive families, as clinicians provide input on country-specific risks, the diagnoses given to individual children, and the advisability of adopting a given child into the family. This involvement is tempered, however, by uneven and changing use of the field by adoptive parents. In the chapters that follow, I argue that this aid and related practices of child health serve to support the creation of families and familial identity.

CHAPTER 5: REALIZING THE CATEGORY OF FAMILY THROUGH HEALTH CARE: IAM AND THE FORMATION OF FAMILY

International adoption medicine, as a pediatric subfield and a key part of the international adoption process, aids in the creation of families. My central argument is that the field of international adoption medicine and the interactions of individuals within this discipline help constitute families as actual units and as an important category in the social imagination. Adoption medicine helps constitute the family in numerous ways. First, and quite literally, adoption medicine practitioners counsel parents about which countries to adopt from and, ultimately, whether or not to accept the referral of a specific child. Advice from the doctor is often key in deciding who the members of the family will be.

Second, adoption medicine practitioners aid in the creation of families by encouraging and praising the children and parents they see as families. As I explore in greater detail, “family feeling” is Bourdieu’s (1996) “cognitive” and “affective principle” of family cohesion and belonging (22). This kindling of “family feeling” is most visible at the child’s initial visit to the clinic, a stressful period for most families. The first weeks and months after the child joins the family can be difficult, as the child may be grieving lost caregivers and familiar surroundings. Both parents and children are attempting to communicate across languages. Everyone is suffering from jet lag. Just as when a newborn infant joins a family, established routines of sleeping and eating are thrown into disarray. By welcoming the family, as well as providing practical advice about sleep, food, attachment, and grieving, the medical practitioner helps the family make the transition from “new adoptive family” or

“adjusting adoptive family” to simply “family.” This encouragement continues at future visits, as clinicians help parents manage unexpected diagnoses and chronic conditions.

Finally, I extend the application of “family feeling” to the global category of “adoptive families.” Adoption medicine practitioners aid in creating a “global adoptive family,” or an imagined community (B. Anderson 1991), that encompasses adopted children and their adoptive families.⁴⁰ They do this by advocating for institutionalized children, becoming adoptive parents themselves, sharing their knowledge with adoption social workers, normalizing multi-racial and multi-ethnic families through discourse and advice, and talking about adopted children as “our kids.”

In this chapter, I show how IAM enters into specific stages of the adoption process and aids in the creation of families through clinical care. This occurs in two specific ways: by helping to establish who belongs and who does not (a kind of boundary maintenance), and to reinforce family feeling.

In this chapter, I treat boundary maintenance, family feeling, and the imagined global adoptive family as separate phenomena in order to better describe and understand each one. In reality, these are overlapping experiences.

Belonging and Not Belonging Through IAM

IAM is key in the extension and maintenance of familial boundaries. Adoption medicine practitioners directly help create families as they counsel parents about which countries to adopt from and, ultimately, whether or not to accept the referral of a specific child. Advice from the doctor is often key in deciding who the members of the family will

⁴⁰ Adoption social workers speak of the “adoption triad”—birth parents, children, and adoptive parents, but for the most part, birth parents are invisible in the imagined community of adoptive families (Manley 2006). Beyond the scope of my project, but would be interesting to explore how birth parents figure into this imagined community.

be. IAM encourages and supports the inclusion of new members of the family, while also allowing for the exclusion of certain prospective members. I explore the role of IAM in boundary maintenance in the pre-adoption process, the acceptance or decline of a referral, and the use of photographic images.

Welcoming New Members Through Pre-Adoption and Referral

In the Chapter 4, I detailed the general process of international adoption and how the IAM clinician fits into various stages of the adoption process (see table 7, “Roles of IAM clinicians in adoption process” in chapter 4). In the pre-adoption and referral period, IAM clinicians consult with people considering adopting internationally, helping them to evaluate their expectations and make decisions about whether to adopt, which adoption program (birth country) would best meet their needs, and ascertaining whether they have the resources and desire to parent a child with known special needs (Chambers 2005). Generally, IAM clinicians engaging in this type of advising see themselves as educators teaching parents about the adoption process and the effects of institutionalization on children.

As advisors, adoption doctors are expected to be knowledgeable about the general health issues associated with institutionalized children, malnutrition, and disease common in children outside the U.S. They are also expected to be knowledgeable about the health status and risks associated with the birth countries of international adoption. The conditions of institutionalization and foster care, social practices, and access to health care vary by country. As experts in this variation, IAM clinicians advise prospective parents accordingly. If a family cannot care for a child with major health difficulties, but can care for a child with “minor and correctable” problems such as limb differences or cleft lip/palate, the doctor might advise them to adopt from China’s special needs adoption program, which includes

many children with minor maladies.

Once a family has selected an agency and been approved for adoption, they wait for an appropriate child to become available. Once such a child is listed with an agency⁴¹, social workers match the child with a family and send the family information on the child; this compilation of social history, medical history, photograph, and growth measurements is called the “referral.” Many, but not all, prospective adoptive parents have the referral reviewed by a medical professional. Some adoption agencies require prospective parents to have referral files reviewed by a doctor as part of the referral acceptance process.

For prospective adoptive parents, receipt of the referral file is a long-awaited moment in their process of becoming adoptive parents. After many months or years, they now have a tangible artifact—the photograph, the medical and social history—of the child who may join their family. Receipt of the referral—the photo in particular— is momentous. Despite this usual joy of receiving the referral, there is a chance that the family will decide that they cannot adopt this particular child, usually due to the child’s medical or psychological needs. At this point, the prospective adoptive parents must affirmatively accept or decline the referral. To accept means that they will proceed with adopting the specific child in the referral. To decline means that they will not proceed with adopting the specific child in the referral. Deciding whether or not to accept a referral, particularly a referral of a child with known medical needs, is fraught for most parents and the doctors they consult.

Dr. Stein discusses how she sometimes has to request additional information from adoption agencies and orphanages:

Sometimes I can’t move on with the file. For example, there was this kid from Bulgaria or India, the kid has terrible respiratory stuff. It looked like it could be

⁴¹ The process by which this happens varies by country.

major. Even had a trach[eotomoy tube]. I want to test this kid for cystic fibrosis. We really need a sweat test. Because we can't move on without this test. We can't work with this referral unless we know. Because [if the child has cystic fibrosis] that's not going to work for this single mother. Sure enough, we got the test. You just have to work with them, poke around and ask for the right things.

In this case, Dr. Stein is a liaison between the parent and agency, lobbying for additional information. In this case, the doctor's findings will determine whether a specific child is adopted by a specific family.

Dr. Schneider, in contrast, finds that sometimes the focus on the chronic physical conditions may miss the bigger picture:

The biggest challenge [reviewing referrals and counseling parents] has always been that the parents are too focused on the medical diagnosis and nobody's really spoken with them about the long-term effects of malnutrition and neglect. Although, I have to say that's a lot better than it used to be and I don't know if it's just people are more savvy or the requirements at the adoption agency if they really being met, or both, or you know something unrelated. But, nowadays, all of these medical referrals, everybody wants to know the details of having a cleft lip and a palate. Nobody's talked with them about the risks of being hospitalized in China when they had their lip repaired and what that means. And then, nobody's also talked to them about the trauma of having a surgery when you're a baby, and then, oh yeah, there was that abandonment and malnutrition and neglect issue.

For other families, the opinion of a medical professional does not hold weight. Some families want to adopt a child with medical problems or are motivated by humanitarian or Christian principle to help the needy. Libby Wagner, a nurse practitioner, described to me how she relates to some families, especially those adopting children with significant special needs and motivated to help the neediest: “[the families] are driving the bus...[s]o they come and ask us for what they need. Not ‘should we do this?’, but ‘we are gonna do this, so can you help? Or just get out of the way?’ So, that is kind of how it is. So, uh, I mean it's cool to help.”

A nurse, Kelly Denver adopted her first daughter, Anna, from Kazakhstan as a single

woman. After marrying Greg, they adopted another daughter from Kazakhstan. At the time of both adoptions, Kazakhstan handled child referrals differently than most other countries. Rather than provide adoption agencies and adoptive parents with referrals prior to travel, parents are matched with a child once they arrive in the country. As we see in Kelly's second adoption, there is some degree of parent choice and selection in this process. The moment she met her first daughter, Anna, Kelly knew she was sickly. But Anna immediately clung to and snuggled her. They were meant to be together, Kelly says. They "belonged to each other."

As Kelly was leaving for Kazakhstan to adopt her second daughter, the adoption doctor advising her called to tell her that no one was leaving Kazakhstan with healthy babies. She was told that she should not expect adopt a healthy child. Panicked, Kelly called another adoption doctor whom she had worked with on her first adoption, and they agreed to do an urgent review when Kelly met the child. Once in Kazakhstan, Kelly went to the Baby Home. She was shown 4 babies, all of whom she could tell were sickly. When she was shown the fifth baby who was clearly fat and healthy, she says she knew this was her daughter, whom she named Alice. She did not have the child's records reviewed by either adoption doctor. She was certain the child was healthy. In Kelly's case, she initially valued the input of adoption clinicians, even seeking a second opinion from a clinician more supportive of her decision to adopt from Kazakhstan. In the end, however, she proceeded with the adoption without review or approval of an IAM clinician.

Adoption professionals report that some prospective adoptive parents do not want to hear bad news or negative information. At the JCICS conference of social workers and medical practitioners, a social worker complained, "It doesn't matter what we say. We can

have them take classes on attachment, nutrition, and what the effects of orphanage life are on a kid, have a doctor look at the file. We can talk until we're blue in the face. Some people don't want to hear. They think if they love the kid enough everything will be okay.”

How do IAM clinicians perceive their role in this pre-adoption and referral period? In official publications, experts writing about adoption medicine for other medical professionals are clear that it is not the job of the reviewing physician to make a decision for the prospective family:

When reviewing records with a family, it is important to recall that it is not the pediatrician's role to choose a child for the family or to judge the advisability of a proposed adoption. Rather, the clinician should help the family make a fully informed decision. Are they capable of parenting this specific child? Can they identify resources in their community for any medical, rehabilitative, or educational needs the child may have? Can the family tolerate the uncertainties involved in the process? (Bledsoe and Johnston 2004, 247)

Rather, the physician should “guide the parents' expectation of the adoption” and translate medical terminology for the family (Chambers 2005, 1264). By asking questions designed to make prospective adoptive parents think critically about their capacity to adopt, rather than explicitly sanction or discourage a specific adoption, some IAM doctors try to avoid controlling the process.

In the documentary *The Dark Matter of Love* (McCarthy 2012), which follows a U.S. family as they adopt three Russian children, Dr. Robert Marvin discusses his role serving an adoptive family: “I don't see it as my role to tell a family what to do. When I found out they were going to adopt three Russian orphans at the same time, my job at that point wasn't to go to them and say, ‘no, no, don't do it’. It's my job, and it's [my colleague's] job to help them understand some of the special things that we've discovered about kids who have been neglected and then adopted.” While adoption doctors affirm that the decision to adopt a child

is ultimately the parents', they recognize the weight their review holds.

There is no single dominant way that families and doctors approach and make use of referral files. Rather, there are a variety of ways the files are read and used. Some families do not engage an IAM clinician in the pre-adoption and referral period, as they have consciously decided to prioritize other factors. It is through this back-and-forth among parents and practitioners that families with specific members are made. Depending on the family, the doctor's comments on the referral file may be the determining factor in whether a specific child joins the family. For others, the medical review is unnecessary or a simple formality that will have little to no bearing on family make up. Motivation to adopt internationally, as well as diverse expectations for what counts as healthy individuals and healthy families are key in understanding how parents and clinicians perceive and use referral information.

The Bradley's Referrals

The story of the Bradley family is helpful for understanding the process of making decisions about a referral. The Bradleys are a married, white, heterosexual couple who live in the Midwestern part of the U.S. They have two biological sons and completed two international adoptions. The catalyst for the Bradley's adoptions was their Christian faith and a desire to help needy children. They began the process of adopting 5-year-old Diya from India. They were given referrals for Diya and two other girls. Diya had been classified as HIV positive at birth, but later testing reclassified her as negative. One of the other girls had severe delays, could not talk, and was blind. The third was missing both hands and had malformed legs.

Heather, the mother, says, "We talked about it, our choices, but we decided it was not fair to our [bio] boys or to those little girls to take on that level of responsibility. We gladly

would have accepted a referral for one of the other girls if not for our boys' ages. We knew someone would get left behind." With Diya, while she had subsequently tested negative for HIV, the family was told that because of testing standards and practices in India, she could still be HIV positive. However, since she had no physical disabilities they considered time-consuming, they accepted her referral. "HIV could work for us, as a family," Heather said.

While they received some information in English, most of Diya's records were in Tamil. The family opted not to have the file reviewed by a physician. They had heard stories of families being discouraged from adopting a particular child by adoption doctors. "We took a leap of faith," Heather says. "We decided that whatever it is we get, we will accept it and work through it."

In the pre-adoption and referral process, Heather and her family are contending with "what will work for the family." These decisions are made based on both biomedical descriptors and faith. The Bradleys did not consult an IAM clinician, but what the Bradleys know about physical differences and medically fragile kids certainly plays a role in their decisions. The decisions based on this knowledge and the referral information they received are the groundwork for what their family will look like. Who will the members be and what types of caregiving will be needed?

Pictures: Belonging and Family Feeling Made Visible

Prospective adoptive families see the receipt of a referral as momentous, but the photographs included in the packet are the most prized by prospective adoptive parents. The photo can serve multiple purposes for prospective parents: they treat it in a way that creates "family feeling" through bonding with an image of a specific child, and the photo is used to ascertain the health of the child.

When Gail adopted a child as a single woman in the late 1990s, she was able to view a listing of multiple children available for adoption in Ukraine. As a health professional, she was open to adopting a child with physical disabilities. “I wanted an infant because I’m well aware of issues with attachment [in older children]. But I learned about the costs and thought I would be 60 before I could ever afford to adopt. I was paging through the pictures and saw the picture of an infant with physical disabilities. I wasn’t ready. I couldn’t afford it. I thought, I have to pass but someone else will adopt him. But then I turned the page and saw my daughter”—a six-year-old who had spent her life in an orphanage. For Gail, the kinship connection she felt upon seeing the photo overrode her “rational” self who was concerned about money and her ability to parent an older child. Despite her lack of preparation, she adopted Olena. Born with multiple limb differences, Olena is now a para-Olympian who competes in multiple sports. As I interviewed Gail in her office, she showed me the many pictures of Olena, training for athletic events and with winning medals around her neck and arranged throughout the room.

Other adoptive parents also felt they bonded with their referral photos. Though Jill and her husband had the child’s referral file and photo reviewed by a family member who was a doctor, Jill recognized that she might not have been able to decline the referral: “Yes, we had the file reviewed by [my husband’s uncle, a doctor]. But once you saw that picture, I don’t know how you could have declined it.” For Gail and Jill, there is instant certainty that this child is their child and their affection for the child is such that they could not decline the referral. Most parents who experienced such a connection felt that this child was destined to join their family. Some parents declined referrals, but they did not tell stories about viewing these photos.

Viewing the referral photo goes beyond emotion and connection to biomedical diagnosis. IAM doctors are frequently asked to evaluate referral photos for signs of pathology, particularly Fetal Alcohol Syndrome (FAS). Children with FAS may have distinctive facial features called the “FAS face.” Other syndromes are also believed to be identifiable in photos. While they frequently assess photos, some medical professionals find these evaluations difficult. Their findings can have critical implications for individual children and adoptive families, and while they are considered important, single photos may have limited diagnostic value⁴². In publications, IAM clinicians are clear that photos should be considered as one piece of evidence among many contained in the referral. Despite this official stance, photos frequently take center stage in referral review.

In an article in *Good Housekeeping*, journalist Melissa Greene (2011) showcases Jane Aronson, a nationally-known adoption doctor. Aronson is probably the most well-known international adoption specialist. She received publicity after treating actor Angelina Jolie’s daughter who, adopted from Ethiopia, was critically ill (Strauss 2005). I briefly met Aronson at the 2012 JCICS conference, where she presented on the work of her non-profit, Worldwide Orphans Foundation. In person, she is gruff and no-nonsense, a persona that comes across in the story below. She is also greatly admired in the adoption community as a humanitarian; she created a “peace corps” of “Orphan Rangers” who travel the globe to better the lives of children in orphanages (Worldwide Orphans n.d., “About”). Greene (2011, 45) relates a scene in which Aronson is reviewing a referral photo for signs of pathology.

⁴² Studying children who had had a pre-adoption video review and post-adoption developmental assessment at an international adoption clinic, Boone, Hostetter, and Weitzman (2003) found that pre-adoption video review is of limited value. The video review correctly identified children who were diagnosed as having moderate to severe developmental delays 43% of the time. The video reviews were able to correctly identify children who did not have such delays 85% of the time. Similar research on the reliability of still photos has not been published, though Miller (2005) emphasizes the importance of photo review for IAM clinicians (75).

One day, when I visited Aronson at her office, a package arrived from Chicago. In it were a photograph of a Chinese baby girl and a medical report. Aronson studied them, and then got the adoption-agency caseworker on the speakerphone.

Dr. Aronson: “Susan? Dr. Aronson.”

Adoption agency caseworker: “Dr. Aronson! Thank you for calling! Did you get it? We don’t think this baby is normal, so I didn’t call the family.”

Dr. Aronson: “What’s the problem?”

Adoption agency caseworker: “The tongue,” the caseworker said. “Did you see the tongue?” In a small, square, color photograph, a tiny head was squinting and yawning, and the tongue looked short and blunt, malformed.

Dr. Aronson: “I don’t see that this baby is different from many others we see.”

Adoption agency caseworker: “But did you see the tongue?”

Dr. Aronson: “I’ll tell you what I see, Susan: I see a moment in time. I see a baby who has just woken up from a nap. I’m not scared by this picture. The science of it isn’t there.”

Adoption agency caseworker: “You’re saying she’s all right?”

Jane Aronson was thinking that the baby’s height, weight, and head circumference at the time of admission to the orphanage and at her last exam were normal, that she’d been full term at birth, that she was Chinese and therefore not likely to suffer from fetal alcohol syndrome. Of course, she didn’t know anything about the child’s genetic history or about the birth mother’s prenatal care and exposure to infectious diseases. But, even if the baby were lying on a table in front of her, there was a limit to the predictions science could make about human personality, and about human resilience. “Get a better picture of this baby,” Jane Aronson told the caseworker, “and let’s save a life” (Greene 2011, 45).

Aronson notes the arbitrary nature of still photography; a photo captures a single moment and may fail in accurately representing the individual. Despite this limitation, photos have utility for IAM doctors. The second picture, perhaps, will tell Aronson what she needs to know. It is, of course, true that two still photos do not reveal all there is to know about pathological disease processes affecting the child. Two pictures are seen as better than one

picture. Aronson is acutely aware of the consequences of her assessment. If the child's tongue is, in fact, interpreted as pathological, the prospective parents may decline the referral and the child will remain in institutional care. Aronson imagines the child's future: continued orphanage life, no family, and death.

Taking up photos of waiting children (listings of children available for adoption), Lisa Cartwright (2003) offers one of the most detailed analyses of one of the core practices of international adoption medicine. She takes up the field's use of images and of screening photographs and videos for pathology, connecting such imaging practices to how children are categorized by race and nationality. Cartwright is concerned with how waiting children pictures are classified, and on problems related to medical and "special needs" classification. Photo listings of waiting children, then, can be seen as a means of both identifying individuals and of ascribing identities such as "waiting child," "special needs child," or "adoptable child" onto the individual pictured.⁴³

Cartwright's assessment can be extended to the family level. Individual identities are ascribed onto the children in referral photos, but familial possibilities and identities are projected too. Assessment by an IAM doctor may lead to an unwanted diagnosis, and the child will not join the family.⁴⁴ Alternatively, the assessment may find an absence of pathologies, and the parents accept the referral. Or, the potential pathology may no longer matter. Viewing a referral photo, a prospective adoptive parent may feel affection, bonding, and love. They are certain that *this child is their child*.

⁴³ The use of waiting children listings has changed since the publication of this article. Because the number of available children has plummeted, few agencies use such a list.

⁴⁴ While this did not occur among the families I talked with, several clinicians reported that their feedback about photos resulted in referrals being declined.

Creating Family Feeling

There's a tension in adoption medicine between the lack of information parents have about their children and the understanding that they know their children because they are their parents. Adoption medicine practitioners recognize this tension and try to help negotiate it. Both of these things are true. Parents of newly adopted children do not know everything that their child has experienced. They gather as much as they can from medical records and orphanage staff, but they usually only get bits and pieces.

IAM witnesses and often nurtures the "family feeling" Bourdieu (1996) discusses in his essay, "On the Family as a Realized Category". He argues that family feeling is a "cognitive principle of vision and division that is at the same time an affective principle of *cohesion*,⁴⁵ i.e. the adhesion that is vital to the existence of a family group and its interests." Family feeling comes from "practical and symbolic work" such as "the exchange of gifts, service, assistance, visits, attention, and kindnesses." He argues that this work "transforms the obligation to love into a loving disposition and tends to endow each member with a 'family feeling' that generates devotion, generosity and solidarity" (22).

I take from this that family feeling is at once the feeling of being in a family and the affection, or "loving disposition," that one feels toward other family members. Family feeling is important in delineating who does and does not belong in a family and in encouraging members of the family to articulate belonging with one another through cohesion. And for Bourdieu, it is through repeated action that family members express and feel affection for one another (not necessarily in that order).

While Bourdieu is instructive here, it is important to note that family and the members of families are contested categories. As Ariès (1962) and Zelizer (1985) show, the

⁴⁵ Emphasis in original.

meaning of childhood and position of the child within the family is not static and is often a point of contention. The idea that affection is part of family life is not universal. That said, for the parents and clinicians I encountered, family feeling and affection were important.

IAM clinicians see and support these expressions of family feeling. I argue that family feeling is not just about feeling between members of a family, but also how family members feel about themselves as part of the family unit.

Family Feeling at the Initial IAM Visit

The official, stated goal of the initial IAM visit is for the child to receive a physical, be screened for infectious disease, and provide guidance to the family in order to make the adjustment period easier. Indeed, those things are accomplished at every initial IAM visit I observed. The initial visit accomplishes more than this, as the narrative and actions surrounding the visit nurture and encourage family feelings of belonging and togetherness.

In many cases, the initial visit is not the first time the parents have interacted with the IAM clinic staff. The parents may have consulted with Dr. Smith during the lengthy pre-adoption and referral process. In these cases, there is a sense of familiarity between the medical practitioners and parents. The doctor knows the parents' story—she knows that they have been waiting for four years, that they lost a referral, and that they rejected another referral because they felt they could not meet the child's medical needs. The doctor also knows the child's story—at least as it is told through the photo, life history, and medical records included in the referral. More than one parent entered the clinic exclaiming, "We're finally here! We made it!" Others would beam as Dr. Smith entered the exam room: "Oh my God, it's great to finally meet you!"

Clinic staff are similarly excited to see the family, greeting them with

“Congratulations!” and “Great to finally meet you too!” If the clinic was especially busy, the doctor would often go out to the waiting room to apologize for the wait, but also to greet the family, congratulate them, and tell them that she looks forward to talking to them a little later. In this way, the IAM clinic is very different than other medical appointments. I can’t remember a doctor ever greeting me with such enthusiasm. Nurse Practitioner Libby Wagner’s adoption clinic calls these initial medical appointments “celebrations” because the purpose is to celebrate the new family and learn about how the child came to be part of that family. Such enthusiasm is generally rare in encounters between clinicians and patients. That this reaction is common in The Clinic and other IAM clinics implies that this is more than a simple medical exam.: the clinicians and parents are engaged in the joyful creation of a family.

The initial visit provides an opportunity for the clinic staff to affirm the addition of the specific child to the family. On my first day doing fieldwork in the clinic, I met the Ritter family, who had adopted Braydon, 14 months old, from Ethiopia. Braydon had a complicated health history: his medical records from Ethiopia stated that he had been diagnosed with meningitis and malaria and had a history of severe respiratory issues. He was very small for his age, and was reportedly called “the tiny one” by orphanage staff. In the clinic, however, he was a rambunctious toddler. He was alert, constantly in motion, and made his feelings known when he could not have what he wanted. At one point, his dad put away the cereal puffs that Braydon had been periodically snacking on. This resulted in a full blown tantrum. When Dr. Smith met the boy, she exclaimed, beaming, “I can’t believe he looks so good!” Later in the visit, she explained that many children who have experienced meningitis as infants do not have good outcomes, so she is happy to see how well he’s doing: “I’m so glad

you took a chance on him,” she said.

At the initial clinic visit, the staff recognizes the family as a unit. They are welcomed as a family, congratulated, and the choices that led to the addition of this specific child are affirmed.

Mother’s Intuition

The story of Ann, Brian, Kayla, and Wei Tan Fargen illustrates how a doctor-parent exchange about health works to solidify the status of adoptive parents as authorities, thus cementing family feeling and affection. After having two children by birth, Ann and Brian Fargen adopted Kayla and, later, Wei Tan, from China’s Special Needs Program. Both girls had been diagnosed with various abnormalities of the genito-urinary and colorectal systems. I met 5-year-old Wei Tan and her mother Ann in The Clinic during her 6-month post-adoption follow-up evaluation. Although Kayla was not present at the appointment, much of the discussion centered on her because of her unique medical history. Weeks before Ann and Wei Tan visited, Dr. Smith related to me how Kayla’s parents and medical providers discovered a much more serious problem with Kayla’s heart. Like Wei Tan, Kayla’s problems with urination and defecation were being managed successfully with surgery and monitoring by the hospital’s colorectal team. Still, Ann felt that something was “not right.” Kayla had a persistent cough and seemed to have a “hitch in her breathing.” Dr. Smith told me that she “didn’t think much of it. I figured she was being a worried mother and reading too much into those symptoms. But since mom was concerned and the other problems were midline defects⁴⁶ I went ahead and ordered more cardiac testing. Sure enough, she had a

⁴⁶ Midline defects are congenital abnormalities that occur on the vertical axis of the body. Midline defects often occur together (a child with a cleft palate may also have a congenital heart problem, or a neural tube defect (Khoury et al. 1989). Given Kayla’s genito-urinary problems, other midline defects might be suspected

vascular ring that was restricting her trachea⁴⁷. I was shocked.” Surgery was performed and the defect was corrected. Dr. Smith uses this story highlight the importance of listening to parents, especially mothers.

While this story is unusual because a rare undiagnosed condition is involved, IAM clinic staff frequently counsels adoptive parents to “trust themselves” and to do “what is right for your family” when making decisions about feeding, sleeping, bonding, and health care. “You are the parent, so you make those decisions,” advise clinic social workers and clinicians.

The importance of the mother in discerning the children’s medical problems by “gut instinct” is common in stories of biological motherhood. In her study of Australian mothers,⁴⁸ Lupton (2013) highlights how mothers claim knowledge at the “subconscious or visceral level” about their children’s illnesses. Lupton argues, “it is the mother’s unique relationship with her child which underpins her special knowledge of her child’s body: Only *she* is able to respond instinctively to her child’s needs”⁴⁹ (237). In popular discourse, “maternal instinct” is used as shorthand for the natural love, affection, and knowledge biological mothers have about their children (also see Hrdy 1999; Wolf 2003 with the discussions that follow).

By highlighting the role of “maternal instinct” and reinforcing the adoptive parents as the parents, Dr. Smith and staff join kinship and health care. Parents are encouraged to be the experts about their own children. Dr. Smith listened to Ann’s concerns, acted on them, and a

(Cincinnati Children’s 2018).

⁴⁷ A vascular ring is a congenital heart defect that occurs when arteries encircle the trachea and esophagus, often impacting breathing (Mayo Clinic 2018a).

⁴⁸ Lupton does not specify that the mothers in her study were the biological parents of their children, but the lack of the “adoptive” qualifier leads me to assume this is the case.

⁴⁹ Emphasis in original.

correct diagnosis was the result. Dr. Smith tells this story for several reasons, I believe. First, it is medically interesting and viewed as a sign of her skill as a physician (or her relatively easy access to imaging technology). Rare congenital heart conditions are usually diagnosed in infancy (or the child dies), so to discover one in an older child is notable. But more importantly, this story serves to emphasize the role of the mother regardless of biological relationship, or in spite of the absence of shared genetic material. Although she did not give birth to her daughter, her care for Kayla was key in making this diagnosis. Family feeling is experienced though Ann's attentive observation, Dr. Smith's recognition of Ann's expertise, and reinforcement of the importance of "maternal instinct."

The Global Adoptive Family

I want to draw attention to two instances in which "family feeling" of the global community of adoptive families is made visible in the practice and language of international adoption medicine. The first is the use of "our kids" in talking about internationally adopted children, the children served by adoption medicine practitioners. Second, I will look at how physical and cultural differences apparent in multi-racial and multi-ethnic families are managed and negotiated in the clinic.

IAM practitioners often refer to the population they serve as "our kids":

- "We often see this in "our kids."
- "'Our kids' sometimes start to have trouble in school in 3rd or 4th grade when learning becomes more abstract."
- "When we think about 'our kids' we have to remember that they did not get the same nutrition as U.S.-born kiddos."
- "The brains of 'our kids' didn't develop normally."

This “our kids” language accomplishes several things. First, the phrasing constructs a specific and seemingly homogeneous population out of children adopted from many different countries, and thereby constructs the clinicians as having expertise about this population. Second, it highlights the medical practitioner’s intent to care for the adopted child. Finally, it references an imagined community (B. Anderson 1991) of adoptive parents and children.

This language is particularly common at the initial clinic visit, when parents bring their newly adopted child to the clinic for evaluation. In discussing Braydon’s adjustment and attachment, social worker Tina repeated that what the parents were experiencing was “expected” and what “we often see in our kids.” Clinicians help parents feel better about the sparse medical history by talking about what “we often see in our kids” or in “our population.” Here they note experiences that are common among internationally adopted children. These reassurances serve several functions: they help parents fill in blanks and they help the parents parent more confidently.

Inclusion of IAM clinicians in the imagined “global adoptive family” goes beyond language. Many are adoptive parents themselves: 4 of the 10 practitioners I interviewed had adopted internationally and 5 of the 15 practitioners who completed my survey are parents of internationally adopted children. Another clinician I interviewed was adopted across national borders as a child. Dr. Smith, the head of The Clinic, often shared stories of her own adoptive family in her discussions with parents. As adoptive parents themselves, IAM clinicians often use their authoritative knowledge (Browner and Press 1996; Jordan [1978] 1992) as clinician-parents in their work with other adoptive families.

Dr. Sandra Thompson began treating internationally adopted children before she adopted, but believes that once she adopted, “just by virtue of having gone through the

adoption process, the interest in people coming to me increased.” She was able to create a designated IAM clinic through her local university medical system. Though she started in foster care medicine, Dr. Maggie Schneider was similarly inspired to develop an IAM clinic because the experience of her own family and other adoptive families. During her second adoption, she was observing all of the other adoptive families: “I sat in a hotel lobby and I just looked at all these people who were struggling and I’m like ‘Wait a minute, this shouldn’t be so hard.’ So when I came home I took maternity leave and when I came back from maternity leave I said to my Chair, ‘Um, can I start an adoption program?’” Dr. Jason Horlander, father of several children adopted from China, was also introduced to IAM practice through his family’s adoptions: “Mid-way through adopting the first one I got interested in [IAM]. I spent a day [at one of the first IAM clinics] and it was off to the races or whatever it is and it’s been an incredible journey. It continues to be an incredible journey.” IAM clinicians see the children they treat as “their kids,” a population in need of treatment and a group they understand because of their own experiences as adoptive parents.

Adoptive parents who were not clinicians appreciated that their IAM practitioners were also parents of internationally adopted children. Several parents articulated this as a benefit, as they perceived that the clinicians had “been through the same thing.” For these parents, expertise is located in both the clinician’s training but also in their lived experience as parents. Family feeling is nurtured because IAM recognizes families formed through international adoption, and these families in turn see families “just like theirs” in their community, including in the local health care system. This shared identity as parents of internationally adopted children fosters family feeling—that sense of cohesion and connection—at the individual, family, and community levels.

How IAM Helps Form Multi-racial and Multi-ethnic Families

Families formed through international adoption are frequently transracial. That is, non-white children from Asia, Africa, Central and South America are adopted by white U.S. adults. Indeed, of the 100+ parents I met in the course of this research, only two were not white. Adoptive families are often both transracial and transcultural, though, as I will show with the Taggart family, the extent and type of cross cultural exchange is determined by the parents. Often, race, ethnicity, culture, and nationality are conflated and may be used interchangeably. Other scholars have noted this conflation to be especially true in the world of adoption (Marr 2011). I agree that parents often do conflate these complex identifiers, but they do so in ways that highlight some aspects of race, ethnicity, and culture while sublimating others. Some aspects of culture are included in family life, thus overriding other aspects.

By race, I mean the physical differences such as skin color and hair texture used to categorize individuals into separate—and supposedly mutually exclusive—groups. We know that as a biological concept, race is not a workable concept (Goodman 2010; Lassiter 2009, ch.. 1; Mukhopadhyay, Henze, and Moses 2013). But we also know that as a social concept, race is central to politics, power, and identity in the U.S. today. In writing about race here, I want to recognize the salience of race categories for many people but, at the same time, highlight that these categories are culturally constructed and always shifting. To recognize this combination of race, ethnicity, nationality, and culture, as Barbara Katz Rothman (2006) does, I use the term “ethnicity-race-culture complex” in my discussion of families formed across said boundaries.

There is extensive research on transracial adoptions. Scholars have evaluated the psychological and social implications of transracial adoption (Marr 2011; S. Patton 2000; B.

Rothman 2006; Smith et al. 2011). Smith et al (2011) report that negative outcomes results when transracial adoptees perceive themselves as different and have struggles fitting into their family and community (62). This is problematic, as “[r]acial identity development is thus a profoundly important process for children of color because it connects them to a community full of received wisdom from past generations about successfully coping with racism and discrimination” (63). Transracially adopted children may have to navigate racism and discrimination without adult models in their family who have also experienced these challenges.

Noting Difference

Adoptive parents I spoke with describe how living in a nearly all-white community could be difficult for their children. Heather Bradley discusses her daughter Diya, adopted from India: “She sticks out because she’s so different...especially when we’re at Walmart or eating out and people just stare.”

One mother related that she and her husband chose to adopt white children from Russia because they had seen a television program about now-teenage Korean adoptees who felt that they were “missing something,” having been raised by white U.S. adults. They instead adopted from Russia, where the majority of the children appear white, and would therefore “look like” them.

The Taggarts adopted siblings so that they would not have a single child who did not look like his other siblings (the Taggart’s biological children).

Keeping Culture

Race, ethnicity, and culture are tied together in family traditions, as well as in discussions of the body. In her book, *Keeping Culture*, Heather Jacobson (2008) argues that recognizing and honoring a child's birth culture in the home becomes women's work and is a sign of being a good mother. One mother told her, "You are not only adopting a child, you are adopting a culture. You need to know that" (54). Culture keeping is "part of creating a healthy individual child" and has become part of mothering responsibilities (67). Several of my interviewees described practicing some "culture keeping" traditions such as cooking and buying food common in their child's birth country and celebrating Chinese New Year. The Clinic itself participated in this to some degree, holding an annual fundraiser that featured a fashion show of clinic patients dressed in the "traditional dress" of their birth country.

While "culture keeping" is common, it does not usually extend to changing the family's religious practice (or allowing the children to practice a different faith) or learning the child's first language. Some parents, however, are more intentional about their recognition of racial/ethnic/ancestral difference between themselves and their children. Interviewee Alex's perspective on Guatemala-born sons Lucas and David's race/ethnicity is unusual, as it is shaped by their decades of involvement in local anti-racist activism. Alex celebrates Lucas' and David's ancestry, notes both the social and biological implications of this, and recognizes the discrimination the children will face because of the color of their skin and perceived race/ethnicity. Asked about the boys' race/ethnicity, Alex responded:

Let's see, it depends on how the question is framed. So, obviously they were born in Guatemala but they and we talk about them as having both Spanish and Mayan heritage and they are pretty keyed in and proud of their indigenous heritage which is ironic because in Guatemala that's not okay at all. Like people [in Guatemala] don't talk about that [racial mixing] and but they definitely both, we've actually done the

DNA testing so we know their heritage so yeah... Around 6th grade children start studying genetics and I was like I don't want my kids doing their genes on their white parents, that's not cool. I want them to know who they are and what the information is and it's fascinating. So, they'll say Latino, they'll say Native American. Indigenous is kind of a hard word for them, they'll say Mayan."

Alex and partner Katherine are intentional about educating their children about civil rights leaders, especially Latinx leaders. They recently met Delores Huerta, labor and civil rights activist, at a local documentary screening. One of their sons wore a t-shirt proclaiming, "I am my ancestors' wildest dream."

Alex recognizes the contingent nature of race and ethnicity, understanding that these concepts change over space and throughout time. But Alex also notes that ancestry in some form can be measured and described through popular DNA testing. Both of these are important to Alex and Katherine in raising their children. Alex's knowledge about transracial and transcultural parenting does not stem from the expertise of psychologists or clinicians. They are a family for which family feeling—cohesion—is linked to justice movements, recognizing difference, and the expressed obligation that Alex and Katherine have as parents to honor their sons' ancestors.

Cultural Difference: "We Used to Go to Mosque, but Not Here"

The process of consolidating family belonging and identity is often witnessed by IAM practitioners, though they may have little input. Lane and Robert Taggart, with their six biological children, adopted four brothers from Ethiopia. At their clinic visit, Lane described the family's adoption process: "We have been talking about this for nineteen years. The Lord had put it on our hearts and minds and eventually the time was right. But what really pushed us was our daughter, Beth [biological, age 19]. We heard an adoption ministry speaker at church and Beth was like, 'Are we going to just talk about this or are we actually going to do

it?” They adopted from Ethiopia because they “felt drawn to Africa.” While Lane had not envisioned adopting a group of four siblings—“we wanted to adopt more than one, because we didn’t want to have only one child who looked different”—they ended up adopting Hadji (age 10), Ahmed (age 8), Hakim (age 6), and Amari (age 4).

The brothers had been placed in orphanage care about a year and a half before they were adopted. Their biological father had died of AIDS four years before the children were adopted. Their birth mother was HIV positive; it was unclear to me whether she had died, or if she was alive but unable to care for the children. The boys had two biological sisters who were not placed for adoption. Asked by the translator to describe what life was like in Ethiopia, Hadji, the oldest, described how they lived in an area with no lakes or rivers in a hut made of earth with a dirt floor. The adults in the area farmed potatoes and corn. He recalled that they had to buy water, and did not have running water in their house. Hadji did not think he or his brothers had ever had broken bones, been in the hospital, or suffered from malaria.

In the referral information the family received and shared with the IAM clinic were the following bits of information on the boys: standard questions reported on whether the child can count, identify colors and animals, if they show respect for authority. For the brothers, the answer was ‘yes’ for all of these questions. The form also reported on whether the child was a leader or follower (though I’m sad to say I didn’t capture this detail about the brothers). When they arrived at the orphanage, they had birth dates, but when they first met the Taggarts, the boys did not know their own ages. This, along with their overall good health and size, led Dr. Smith to speculate that they were actually a little older than their birth dates indicated. The Taggarts had not had the referral information reviewed by a doctor

before accepting the referral: “We decided we’d deal with what we got,” reported Lane.

I met the family at the boys’ initial visit (they had been in the country for about three weeks) and saw them again at their 6-month follow-up visit. At the first visit, the room was packed with people: Lane, the four brothers, sister Beth, a medical translator to help translate between Amharic and English, me, a medical student, and, at different times, the doctor, nurse, and occupational therapist. It was overwhelming. The adults talked in English and the boys talked in Amharic, and giggled a lot.

Overall, the boys had no significant or chronic health conditions. All had been exposed to HIV, but tested negative. Hakim and Amari wet the bed, on occasion (official diagnosis, enuresis). At the follow up visit, Ahmed and Amari were diagnosed as microcephalic, meaning that their heads were small, but in their cases this diagnosis was not associated with any other pathology (such as developmental or cognitive impairment). Hadji and Amari had intestinal parasites, and Hadji has evidence of a past Hepatitis B infection (resolved). The three oldest boys, Hadji, Ahmed, and Hakim, had had their uvulas removed. Amari’s uvula was still present.⁵⁰

As we see from Lane’s description of the family’s adoption process, Christianity is key to their identity. In addition to feeling that they were called to adopt by God, Lane talked about having the boys copy Bible verses during sermons at church services. Although I do not know for certain, as Lane declined to be interviewed at length (she felt she was too busy), the language she uses around adoption marks the family as evangelical Christian, probably at least partially motivated by the orphan ministry movement. The boys, by contrast, are

⁵⁰ The limited literature on uvula removal indicates that the procedure is done by traditional healers for “cultural“ or health reasons (prevention of throat and respiratory illness) (Hunter 1995; Jarvis and Mwathi 1959). Hunter (1995) argues that the procedure may have started as a logical health practice, but also functions as a ritual important to cultural identity. The practice is marked as a “harmful traditional practice” by several scholars (Ajibade, Okunlade, and Kolade 2013; Assefa et al. 2005).

marked as non-Christian by virtue of the region of Ethiopia they are from, and their birth names of Muslim-Arabic-Swahili origin. One of the first, and key actions of the Taggart parents was to rename the boys with names from the Old and New Testament of the Christian Bible. Hadji became John, Ahmed became Solomon, Hakim became Abraham, and Amari became Michael. At the first IAM clinic visit, Lane primarily used the boy's birth names, but by the second visit, used both names: Hadji-John, Ahmed-Solomon, etc. At this second visit, Lane reported that the boys had embraced their new names and preferred them over their birth names.

The removal of the uvulas also marked the boys as Muslim. Having seen this in other children adopted from east Africa, Dr. Smith stated that this was a traditional, often Islamic practice.⁵¹ She speculated that because Amari-Michael was born around or after the time of his father's death, his father was not around to ensure that the procedure was done. Discussion of the uvula removals sparked a conversation about Islam between Dr. Smith and Lane. Dr. Smith stated that she thought the boys were probably raised Muslim, as "we usually don't see [uvula removal] in kids of Christian heritage." Lane said she didn't know, as she had not "seen any Muslim behavior" in the boys. The translator asked Hadji if their birth family was Muslim. He replied, "We used to go to mosque, but not here. We don't anymore." And while there was no discussion of continuing to the boys' Ethiopian/Muslim identity, Lane did ask the translator where she could buy injera, a traditional Ethiopian bread, as she thought the boys would be comforted by this. (The translator offered to bring the family injera.)

By the second clinic visit, the boys seemed to be integrating into the family well.

⁵¹ Note the distinction but slippage between "traditional" and "Islamic." In a sense, it does not matter whether the tradition is rooted in a major world religion or in "traditional" tribal societies. Both are different and marked as "other."

Lane and the clinicians felt this might be because they had had the experience of being part of a family: “They had a family, they know how to live in a family, so they do better than kids who spend their lives in an orphanage.” Lane felt good about her relationship with the boys, saying, “We prayed that they would trust us and for the most part they do.” One of her primary concerns was that she felt like the oldest, Hadji-John, did not respect her authority as his mother. The three youngest were being home schooled by Lane; Hadji-John was enrolled in a local private Christian school.

We see family feeling and shared identity at several junctures in this story. First, and most clearly, it is imperative to the Taggarts that they are integrated into the Christian identity of the family. In the clinic, there was no discussion about continuing the boys’ Muslim faith practices. Instead, they began copying Bible verses and took on Christian names. The designation and acceptance of Christian identity was central to my interactions with the Taggarts.

The translator even joined in on the creation of family affection and bonding. At the end of the first clinic visit, the translator instructed Hadji-John: “You might have problems, but English will get easier. You might feel emotional, but know that your parents love you and will take care of you. They might feel emotional too.” Through this advice, the translator communicates to Hadji-John that the adjustment to life in the U.S. and to the Taggart family will be difficult but that these changes—this adoption—was done out of love, care, and affection of the parents for the boys.

Notably, I did not observe the part of the appointment with the social worker, so I am missing what could be key information about the family. It is unclear in my notes whether Lane declined to have the social worker meet with the family, or if I was with a different

family during that portion of the Taggarts' visit. Lane seemed on edge, rather defensive; Clinic Occupational Therapist Molly Sanders agreed with this perception. Lane could easily have seemed this way because she was overwhelmed. A multi-hour clinic appointment with your 4 new children who speak a different language is exhausting.

Although there was no discussion among clinic staff about the composition and size of the Taggart family, their adoption process, or Christian identity, raised eyebrows and questioning looks indicated to me that the staff was somewhat uncomfortable with this situation. While I cannot be certain of the un verbalized thoughts of the staff, my ethnographic work in The Clinic and among IAM clinicians leads me to suspect that this discomfort is linked to worry about whether the Taggarts, adopting four boys at the same time, will be successful. They are also worried about the transition the boys have had to make from Ethiopian and Muslim cultures to Christian and American cultures. As we have seen previously, IAM clinicians are loathe to tell families what to do, particularly when it comes to family size, the advisability of adopting more than one child, and family practices such as religion. For the Taggarts, the central family practice is Christianity, and while the clinical staff may worry about this as one of the many transitions the boys will face, the staff perceives that spiritual practice is the business of parents, not health care practitioners.

We see the limits of culture keeping, at least for the Taggarts. Lane expresses interest in obtaining injera bread for the boys, but more enduring cultural practices such as Islamic faith are clearly excluded from the Christian Taggart family.

Race-Ethnicity-Culture in the Clinic

On the surface, it may seem strange for pediatricians to concern themselves with race, but in the broader world of adoption experts, addressing the racial and ethnic identity is

considered necessary for the emotional health of the adoptee (Brodzinsky 2014; H. Castle, Knight, and Watters 2011; Vonk, Lee, and Crolley-Simic 2010; Vonk and Massatti 2008). Culture, identity, and race warrant attention in key IAM publications: a section in Miller’s *Handbook of International Adoption Medicine* (Miller 2005, ch. 34), in a recent article written on behalf of the American Academy of Pediatrics (V. Jones et al. 2012), and in a chapter of the edited volume on IAM by the American Academy of Pediatrics (Brodzinsky 2014). Jones et al counsel pediatricians that adoptive “[f]amilies need to acknowledge openly the racial differences that exist between their child and themselves” (V. Jones et al. 2012, e1045).⁵²

Perhaps most obviously, the ethnicity-race-culture complex is read on the body, presumably the focal point of the clinical encounter. This happens in a variety of ways. Here, I’ll explore discussions of physical features linked to ancestry, explanations of developmental differences, and parents’ use of stereotypes or assumptions in discourse about racial, ethnic, and cultural difference.

Physical Difference

The majority of clinic visits with a non-white child included a discussion of congenital dermal melanocytosis, though the common name—Mongolian spots—was always used. Mongolian spots are bluish spots commonly found on the back and buttocks of children of Asian and African descent. Though harmless, pediatricians should document the locations of Mongolian spots on an individual child, as they look like bruises and can cause concern about possible child abuse (Medline Plus 2013).

⁵² More broadly, health professionals have called for clinicians to recognize structural racism and its impact on people of color (Alang et al. 2017; Bailey et al. 2017; Bassett 2015; Charles et al. 2015; Hardeman, Medina, and Kozhimannil 2016; White Coats for Black Lives (WC4BL) National Working Group 2015).

Indeed, several adoptive parents remarked that the first time they undressed the child and saw dark blue patches on and above the buttocks, they were immediately concerned that the child had been beaten in the orphanage. Discussion of Mongolian spots is usually framed in this way: “Mongolian spots are common in non-white children. What you’re seeing is totally normal and not something to worry about. I’m going to document the location of the spots so that if someone who doesn’t recognize them as normal is concerned, we can show that they’ve always been there.” This explanation and precaution is necessary, partially because white U.S. adults are not aware of this common physical feature.

Hair texture and skin difference is also discussed in the clinic, with dryness and the need for moisturizing the primary focus of conversation. Nurse practitioner Carol is usually the staff member who educates white parents on how the care of their children’s hair and skin differs from how they care for their own body. Her advice concerns hair—“you’re going to want to use a leave-in conditioner and you don’t need to wash it everyday”—and skin—“black and brown skin gets dry much faster than yours or mine. I recommend a good thick lotion, one in a jar, not a tube.” Carol frames her advice around the parent’s task to provide physical caretaking, her expertise in caring for ethnically and racially diverse children, and her understanding that parents need to be aware of the implications of physical difference.⁵³

Differences in Development

The ethnicity-race-culture complex also has implications for motor, social, and language development. As discussed in the introduction, internationally adopted children are usually developmentally delayed when assessed using U.S. standards. The reasons for these

⁵³ The ability of white parents to care for the bodies of black and brown children is important outside of IAM too. Adoptive parents have written books such as *Chocolate Hair, Vanilla Care* (Mullen 2014) and adoption agencies offer advice (Adoption Star 2013) and discussion about the politics of black hair care (Rollins 2008; B. Rothman 2006).

delays are varied, but Molly, The Clinic's OT, often explains these delays in terms of cultural practices (as reflected by national origin). "In the U.S. we put babies on the floor a lot. In China, they consider the floor to be dirty and kids don't get to crawl around on it." In this formulation, these children are delayed because Chinese childcare practices do not give them the opportunity to exercise the gross motor skills prioritized in U.S. biomedical assessments. Here, culture is written on the body in the form of gross motor development. Similarly, the OT reports that children adopted from China often have high-level fine motor skills; she attributes this to the use of chopsticks. Again, culture is written on the body in the form of fine motor skill development.

The concept of "the normal child" is in play here (Béhague and Lézé 2015; Landsman 2003; Leiter 2007; Timmermans and Buchbinder 2012, 123). After all, the instrument Molly uses to assess development is based on behavior and actions understood as "normal" for a given age. The Clinic, and Molly in particular, are trying to accomplish two things. First, they recognize that child development is a "situated biology" (Lock discussed in Béhague and Lézé 2015) in which the child's body is shaped by cultural practices, specific living environments (institutions), the opportunities a given child has, and the physical features (strengths and weaknesses) of an individual. Second, they locate the child within the empirical framework of child development. Situating the child's development in relation to culture works to reassure parents that their child is normal for what they have experienced. At the same time, the child is measured in relation to the norm established by pediatrics and occupational therapy so that progress can be observed (or not observed). Over time, explanations of cross-cultural differences in development become background; decisions about therapies and interventions are made based on "the normal child."

Exploring Difference Through Stereotypes

In order to explore how racially diverse families are constituted in the clinic, I am going to delve deeply into one example I witnessed in the clinic.

Tricia and John adopted 20-month-old Henry through the China special needs program. Diagnosed with syphilis, Henry is also very small and Dr. Smith was concerned that he had a bad cough and she could not hear one of his lungs clearly. Several times during the visit, John asked about Henry's physical features with reference to his Asian-ness. Meeting with the occupational therapist, John commented on his son's "nice little Asian squat" and asked if Henry's "flat feet" were an "Asian thing." The therapist responded with non-responses: she shrugged and laughed uncomfortably. Her evaluation also found that Henry was five to six months delayed in comparison to his U.S. peers. Here, the therapist assured the parents that it "culturally and situationally" understandable that he is delayed, meaning that he did not have the opportunity to develop the skills U.S. babies generally have by 20 months: "In the U.S. we put babies on the floor a lot so they get that strength. In some countries, babies just aren't put down."

As the appointment was wrapping up, John expressed his concern that because of Henry's diagnosis of syphilis and time spent in an orphanage, he could have difficulty with learning. John asked Dr. Smith, "so, what should we be watching for?" As she started to answer, John interjected, "I mean he's Asian so I know he's already smarter than me, but..." and he trailed off. All of the other adults in the room laughed uncomfortably. Dr. Smith nodded and said, "Well, that's a stereotype, but in my family we sometimes joke about stereotypes too. Like one of my kids [all adopted from Central and South America] is good at Latin dance and another is terrible." She then answered his question seriously, telling John

that if Henry did have problems with education, it would not be because of syphilis, but would likely be attributed to early malnutrition, stress, and neglect. Here, Dr. Smith uses the example of her own family to diffuse discomfort with John's use of stereotypes in describing his son, but also provides the family with the answer to his question with evidence from IAM.

I think there are several things going on here. John is grappling with the physical differences between himself and Henry, partially through joking, but also by asking those who are experts on the body: medical practitioners. He's trying to sort out which of Henry's characteristics and features are "Asian thing[s]" and which are not. I should note that although John was unusual in the number of times he referenced physical differences and stereotypes linked to race categories, many other parents made similar comments. The responses of the therapist and doctor are attempts to recognize physical difference, but to try to avoid stereotyping and objectification.

My observations and discussions with adoptive parents demonstrate several points related to international adoption medicine, family feeling, and the ethnicity-race-culture complex. Physical difference is conceptualized in relation to phenotypical differences in populations (such as Mongolian spots, hair texture, and skin dryness), the effects of various care practices on the body (delayed gross motor skills in Chinese children), and assumptions that parents hold about race and ethnic categories. This is indeed a complex: ethnicity, race, and culture are intertwined in the clinic and in the family.

There are specific things about their child's bodies that adoptive parents need to know, from the perspective of IAM clinicians: parents need to be aware of Mongolian spots

and ready to explain their existence to others. Parents must also know how to care for their child's body through washing and moisturizing seen as appropriate for the child's race, ethnicity, and physical characteristics. There are other things—stereotypes and assumptions about the bodies of their non-white children—that adoptive parents may be aware of, such as Henry's "Asian squat" and intelligence. Dr. Smith and her staff witness parents' expression of such assumptions, and refocus parents what the field of IAM knows about the commonalities of "our kids." Though adopted from all over the world, representing all race categories, and exhibiting diverse physical characteristics, internationally adopted children often have shared experiences of early deprivation.

In initial patient visits to The Clinic, race and ethnicity is primarily filtered through the physical body. IAM clinicians may attempt to refocus parent stereotypes, but they do not offer advice about the racial and ethnic identities the children may hold or are perceived to hold.

Conclusion to Chapter 5

In this chapter, I have shown how adoptive parents and IAM clinicians work, usually in concert, but sometimes in uneven ways, to make decisions about who will be adopted into a particular family, to articulate "family feeling" among family members and within the broader community of adoptive families, and grapple with the formation of families across racial, ethnic, national, and cultural lines. Like the other social institutions Bourdeiu (1996) sees as contributing to "family feeling"—bureaucratic recognition through demography, routines of reciprocity, etc.—IAM is a dynamic field of family recognition. Clinicians (often adoptive parents themselves) see their role as helping families be successful. This includes enthusiastic welcoming and recognition of the new family, providing expert knowledge at

periods of transition, and affirming the parents as parents. IAM practitioners project the feeling that the adoptive family is a family, however new it may be. For the clinicians who are also parents, there is a sense that they see their own families reflected in their patient families. Dr. Smith uses stories of her own children to make connections with families, and to diffuse tension around the use of stereotypes.

I use IAM as a lens to understand how adoptive families are constituted through practice, action, and talk, but the subfield is not used in uniform ways among adoptive families. While the expert knowledge of IAM—in the form of information about the effects of early deprivation, diagnoses common among internationally adopted children, and country-specific risks—aids families in making decisions about whether a specific child joins a family, parents may or may not have a clinician to review a specific referral file. In addition to the cost of physician review, factors such as religious faith, a sense of futility (i.e. a review won't tell us anything), and the decision to “accept what we get” also impact whether a family has a referral formally reviewed by a clinician. Although not every parent officially consults an IAM clinician, I see the decisions they make to be in conversation with the field of IAM. Most parents are aware that the field exists, or are at least aware that internationally adopted children have common experiences (institutionalization, loss, early deprivation) that could affect their physical, mental, or emotional health. The act of not having a referral file reviewed is not a rejection of the expertise of IAM. Rather it is an act of prioritizing other things—money, trust in faith or fate, or their own sense of knowing—over a specific professional service.

The limits and boundaries of IAM authority can also be understood through the ethnographic cases I have shared. Like “new pediatrics” (Pawluch 2009) broadly, IAM

clinicians are experts in behavior, development, and identity, as well as infectious diseases. The work of IAM goes beyond general pediatrics, as its practitioners are directly engaged in helping prospective parents decide whether or not a specific child should join the family. They do not, however, extend their authority to directly instructing parents about adoption or to the advisability of how a family should be. While the Taggart family was somewhat unsettling to The Clinic staff, the clinicians did not comment on the erasure of the boys' Muslim faith in service to the parents' Christian faith.

CHAPTER 6: BALANCING CONNECTION AND SCIENCE: ATTACHMENT IN IAM

The moment adoptive parents meet their children is a central part of most families' stories (Sawin 2017). Most interviewees and parents in The Clinic referenced this moment without prompting. Parents experienced a range of emotions and responses from the children they had just met. These moments, as told by parents, were described as beautiful, anxious, funny, and heart-breaking.

For some parents, the bonding and attachment are immediate. Kelly, a mother adopting from Eastern Europe, describes the moment she met her daughter Anna: "I met Anna in the doctor's office at baby house.⁵⁴ She was fresh from a bath. They handed her to me and she grabbed right in. She grabbed my hair and shoulder and snuggled right in. We knew each other. I knew she was the one and she knew I was the one. It was perfect." Kelly's account of meeting Anna shows attachment that is seemingly immediate and intense for both mother and daughter.

The Tiven family's experience with bonding with their new daughter was starkly different. I met Karen, Chris, and Lucy Tiven at The Clinic. Karen and Chris had adopted Lucy from China just weeks before. Two-year-old Lucy had been diagnosed as special needs because as an infant some of her bloodwork appeared abnormal and she once had a cyanotic episode. Her bloodwork has since come back completely normal and other than some signs of malnutrition, she appeared to be in good health. Also the parents of two biological sons, Karen and Chris had gone through the required training to be adoptive parents, which

⁵⁴ Orphanages and residential institutions are referred to as baby houses in Eastern Europe.

included some training on attachment and the grieving behaviors common among adopted children. They had also consulted with the doctor at The Clinic who told them what they might expect in the first hours and days of taking custody of the child. Karen and Chris were cautioned that grieving is normal and they should expect the child to engage in any of the following behaviors: crying, resisting leaving caregivers, resisting contact with adoptive parents, difficulty sleeping, decreased eating, night terrors, and flat affect, or “checking out”—a period of non-responsiveness. In a later interview, Karen confirmed that they had completed several hours of training, had gone through a “refresher course” on attachment and adoption over the phone, had talked to the doctor, and read all of the “recommended books and readings” the agency told them to read.

Upon meeting her adoptive parents and returning to the hotel with them, Lucy was inconsolable. Karen says, “It was really bad. She was traumatized...[B]ecause she could walk, she would pick up her shoes and coat and stand and beat on the hotel room door. It was heart-wrenching.” Lucy cried for hours. The next day, Karen called The Clinic to speak with one of the licensed clinical social workers. She was panicked: “I don’t think we can do this” she said. While she had been taught about what a grieving child might do, she felt lost when faced with the intensity of the emotions Lucy was displaying and seemed to be feeling. Karen was worried that Lucy was one of those “cases you hear about”—a child so damaged by years in an orphanage that they cannot form a bond with an adoptive family. The therapist counseled Karen that Lucy’s behavior was within the range of normal, if intense, for “our kids.”

In fact, the therapist counseled, it could be good that she is grieving. Lucy’s behavior could be a sign that she formed a bond with an orphanage caretaker, and that she knew how

to love. Karen agreed to give it a few days and see if the child calmed down. The Clinic staff didn't hear anything more from the family, except that they were proceeding with the adoption and would bring Lucy in for her exam as scheduled.

Before the family showed up for their initial appointment, the doctor said, "Oh, I'm really curious to see how they're doing. They had such a hard time in China. I was worried they might not make it." "Not making it" means that the adoption would be disrupted,⁵⁵ meaning that the Tivens would not complete the adoption, leaving China without Lucy. When the family arrived at The Clinic for their initial appointment, Karen and Chris said that they couldn't believe that they had panicked in China. Slowly, Lucy had begun interacting with them and stopped crying. While she remained wary of her dad for several additional months, she bonded to her mother after a few days. Karen and Chris said that they felt as though Lucy had always been a part of their family. Reflecting back on her early experiences with Lucy, Karen says that she felt prepared by her agency and The Clinic staff, but that "even though they tell you, it's hard to be really prepared for that. You hear it, but to live through it...You just can't understand until you live through it."

In Lucy's story, we can see the importance accorded attachment and the key role it plays in constituting the adoptive family. Parents, clinicians, and social workers recognize that difficulty with attachment and bonding may indicate that the adoption will not be successful; the pre-adoption training of prospective adoptive parents demonstrates this. Karen's story of meeting and adopting Lucy also makes it clear that knowing the literature on attachment is not enough; you have to live through it.

In this chapter, I describe the development of attachment theory and its application to

⁵⁵ Child welfare experts differentiate between adoption disruption, when prospective parents elect not to complete an adoption in process, and adoption dissolution, when adoptive parents sever the legal ties created by a completed adoption (Child Welfare Information Gateway 2012).

institutionalized children, discuss critiques of the concept by anthropologists, and show how the concept of attachment is used in the discourse of the adoptive family. For both parents and clinicians, talking about attachment is both a literal and figurative proxy for whether a family is functioning successfully. When we talk about attachment, we are talking about whether love is experienced and expressed by all members of the family.

Attachment Theory

As I note in chapter 4, one of the primary concerns about the health of internationally adopted children revolves around the psychological concept of attachment. Attachment theory is concerned with how and why children attach, or form bonds, to their parents, especially the mother⁵⁶ (Van der Horst 2011, 1). British psychologist and psychoanalyst John Bowlby articulated the idea in the 1960s and refined the concept through the remainder of his career. John Bowlby originally defined attachment as “the bond that ties” (Bowlby 1982, 177). His work influenced psychologists who came after him; indeed, attachment theory remains a central subject of inquiry in the field of psychology. After observing children in institutional settings and who had been diagnosed with psychopathology, Bowlby’s work centered on this question, “What is this bond that creates so much distress when ruptured?” (Van der Horst 2011, 53). International adoption medicine specialist Laurie Miller describes attachment as “the reciprocal affectionate relationship that binds two people deeply together, or, more simply, love” (Miller 2005, 353).

⁵⁶ Bowlby does note, in a footnote, that he intends to include “mother-figures” as well as “mothers”: “...although this book refers usually to mothers and not to mother-figures, it is to be understood that in every case reference is to the person who mothers child and to whom he becomes attached rather than to the natural mother” (Bowlby 1982, 29n). Nearly all of the research on attachment, however, has been on biological mothers and their infants (Quinn and Mageo 2013, 19).

The staff of The Clinic are concerned enough about attachment⁵⁷ that it is one of the first four questions asked of parents: “How is your child eating? Sleeping? Pooping? And bonding?” Similarly, adoptive parents are well aware of the importance accorded to attachment, with most familiarizing themselves with attachment theory before adopting. Adoption advocates (social workers, policy makers, etc.) use popular science representations of attachment to garner support for adoption as a practice and for the creation of individual adoptive families. Because attachment is such a central concern of clinicians, adoptive parents, and advocates, it is important to examine how and why this concept is used. Bowlby developed attachment theory based on his work with populations similar to international adoptees: children separated from their parents and who had experienced neglect or other hardship.

Attachment Theory Defined

Bowlby and his intellectual heirs argue that the bond between the mother figure and infant serves as the basis for relationships across the lifespan and that normal human development depends on successful attachment. Bowlby (1982) details,

A young child’s experience of an encouraging, supportive and co-operative mother, and a little later father, gives him a sense of worth, a belief in the helpfulness of others, and a favourable model on which to build future relationships. Furthermore, by enabling him to explore his environment with confidence and to deal with it effectively, such experience also promotes his sense of competence... Other types of early childhood and later experience have effects of other kinds, leading usually to personality structures of lowered resilience and defective control, vulnerable structures which also are apt to persist (378).

Expanding on these ideas, attachment theorists developed instruments designed to measure attachment. Originally Bowlby’s research assistant, and later a leading researcher in

⁵⁷ In the clinic, “attachment” and “bonding” are used interchangeably.

her own right, Mary Ainsworth attempted to operationalize the concept of attachment by developing the Strange Situation Procedure (SSP). Initially tested on children in Baltimore and Uganda, the SSP is still the primary way psychologists attempt to measure attachment.

In the SSP protocol, a 12- to 20-month-old child is exposed to an unfamiliar situation—the lab—and the proctors try to induce mild stress in the infant by separating the child from her or his parents (usually the birth mother) and exposing the child to interaction with a stranger. Researchers also observe the extent to which the child uses the parent as a “secure base,” a figure they return to after exploratory play (Solomon and George 2016, 369).

The child is then classified based on the behaviors they display. Ainsworth originally developed three categories: securely attached, insecurely attached-avoidant, and insecurely attached-ambivalent/resistant. Children who are classified as *securely attached* explore the environment while using the parent as a secure base, demonstrate that they miss the parent upon separation, and are easily comforted by the parent when distressed. Children who are classified *insecurely attached-avoidant* explore the environment, but do not refer back to the parent as a secure base. Not distressed upon separation, these children also avoid physical and visual contact with the parent. Children who are classified as *insecurely attached-ambivalent/resistant* are stressed upon entering the strange room and do not explore. Distressed upon separation from the parent, children in this classification are not comforted when the parent returns (Solomon and George 2016, 370). In order to account for children whose behavior does not conform to one of the three original categories fourth category was added. *Insecurely attached-disorganized/disoriented* children demonstrate inconsistent and contradictory attachment behavior. To the rater, these children show a “lack of a coherent

attachment strategy” (Solomon and George 2008, 387; also see Main and Solomon 1990). Insecure attachment is most likely to occur when a child has been mistreated, abused, institutionalized, or have unreliable parental care (Van IJzendoorn, Schuengel, and Bakermans-Kranenburg 1999; Van den Dries et al. 2009).

Roots of Attachment Theory

The origins and development of attachment theory are important for understanding anthropological critiques of the concept. Built on analysis of the orphaned and institutionalized children of Bowlby’s day, and linked to human evolution and adaptation, the origins of attachment theory are instructive as we consider its contemporary use in IAM.

Attachment theory has its roots in the history of abandoned and orphaned children in Western Europe and the U.S. In World War II Britain, the number of children orphaned and separated from parents had become an obvious social problem. Bowlby biographer Van der Horst (2011) details this history. In order to protect them from German air raids, hundreds of thousands of children were evacuated from London to the British countryside (32-34). In the post-war period, orphaned and separated children lived in orphanages known as “residential nurseries” (34-35). At the same time, doctors were publicly debating whether children in hospitals should be able to receive visits from parents, or if they should remain isolated. Parents, after all, carry germs and are anxious. Hospital staff were concerned that contact with their germy, anxious parents would slow children’s recoveries (35-48). Bowlby and colleagues were concerned with all of these situations and warned that separating young children from their mothers would lead to psychological harm and, perhaps, delinquency (33–34).

Observing the effects of evacuations, institutionalization, and hospitalizations on

children, Bowlby began to believe that the importance of the attachment bond is most noticeable when the relationship between parent and child has been disrupted (Cassidy 2016, 4). Bowlby became interested in the question of a child's bond to its mother in the early days of his career, when he worked at a school for "disturbed children" who, it was thought, were troubled because of "inadequate" parent-child relationships (Van der Horst 2011, 11). Bowlby went on to work with and write about juvenile thieves. Noting that many of the delinquents had "disrupted childhoods," Bowlby compared his group of thieves with a control group of non-thieving children, finding that those in trouble with the law were significantly more likely to have been separated from their mothers during their first five years of life (Van der Horst 2011, 23–24).

Compelled by Bowlby's work with the juvenile thieves, the World Health Organization (WHO) asked him to complete a study on the mental health of homeless children. The resulting report was titled "Maternal Care and Mental Health." In order to compile this report, Bowlby traveled in Western Europe and the United States, visiting local professionals and national experts working with children who were separated from their parents. He concluded, "the evidence is now such that it leaves no room for doubt regarding the general propositions—that the prolonged deprivation of the young child of maternal care may have grave and far-reaching effects on his character and so on the whole of his future life" (quoted in Van der Horst 2011, 31). In his report to WHO, Bowlby argued: "What is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother-substitute)" (Bowlby 1982, xxvii).

After writing the WHO report in which he documented the common experiences of

separated children in various countries, Bowlby turned his attention to explaining the mechanism behind the attachment bond. While Bowlby's observations of abandoned children served as a catalyst for his development of attachment theory, he drew on multiple intellectual fields in his lifelong work constructing attachment theory: psychoanalysis, animal studies, and evolutionary theory. Trained as a psychoanalyst, Bowlby connected Freudian concepts to the behaviors he was seeing in children separated from their parents. Freudian psychoanalysis attempted to explain adult behavior and mental health by exploring the patients' childhood experiences (Van der Horst 2011, 11).

Through friends, Bowlby became acquainted with leading European ethologists and learned about studies in animal behavior. He built on their work and made it his goal to remake psychoanalytical theory "in light of ethological principles" (quoted in Van der Horst 2011, 100). His nascent work on ethology culminated in a long period of what Van Der Horst (2011) describes as "cross-fertilization" (104) between Bowlby and Harry Harlow. Harlow is best known for his experiments on the effects of isolation and artificial mothers on the infant rhesus macaques. He found that infants kept in isolation had difficulty joining a social group of macaques. The isolated monkeys were anxious, did not interact with others, and some failed to eat normally. In his experiments on artificial surrogate mothers, Harlow exposed infant macaques to two "mothers": one was made of terry cloth but did not provide food and the second was made of wire and did provide food. While the macaques obtained food from the wire "mother" they would immediately scamper back to the cloth "mother," presumably for comfort (Vicedo 2009, 2010). Harlow was inspired by Bowlby's work on the effects of separation from the mother on human infants to develop experiments on isolation in monkeys and Harlow was similarly influenced by Bowlby (Van der Horst, LeRoy, and Van der Veer

2008). Bowlby extrapolated from Harlow's completed experiments, using them to support his arguments that human infants similarly suffer if isolated and that they needed the psychological comfort and security of a mother or primary caregiver.

Bowlby also drew from evolutionary theory as he tried to understand the strength of the mother-child bond. Bowlby came to believe that attachment evolved as a mechanism to protect infants from predators. Individuals who engaged in close attachment behavior such as increased mother-child proximity were more likely to live to reproduce and then pass this behavior (through genes, teaching, etc.) to their offspring (Cassidy 2016, 4–5). Bowlby understood attachment to be critical to the continuation of the species: “Attachment behavior is regarded as a class of social behavior of an importance equivalent to that of mating behavior and parental behavior” (Bowlby 1982, 179).

Scholars following Bowlby have continued to highlight the role of social relationships in the survival of humans as individuals and as a species:

Human beings evolved as social animals, and the majority of the biology of the brain is dedicated to mediating the complex interactions required to keep small, naked, weak, individual humans alive by being part of a larger *biological*⁵⁸ whole—the family, the clan. Indeed, it is the primary caretaking relationships of infancy and childhood that determine the core neurobiological organization of the human individual, thereby allowing this incredible social specialization (Perry 1997, 126).

This articulation of attachment as absolutely essential to humans as individuals and as a species highlights why anthropologists should be interested in attachment and the application of the theory.

Anthropological Critiques of Attachment Theory

Anthropologists generally agree that attachment behavior is rooted in evolutionary

⁵⁸ Emphasis in original.

adaptation (Keller 2016; Otto and Keller 2014; Quinn and Mageo 2013, 18). There is also agreement that institutionalization is bad for children and makes it difficult for them to form relationships with others (Quinn and Mageo 2013, 13).⁵⁹

Anthropologists find attachment theory compelling because it is seemingly evolutionarily adaptive—perhaps universal—and culturally specific. For anthropologists, attachment theory becomes problematic when attachment behavior is classified as secure, insecure, or disorganized, with most of these categories marking or pathologizing behavior that depends on cultural practices around parenting and childcare. Not only do parenting and care practices vary widely, perceptions of “secure,” “insecure,” and other descriptions of attachment also vary.

Critics describe attachment as a “folk theory” because it assumes experiences common among a particular culture are universal experiences among all humans. Attachment theory, the critique goes, uses the child rearing practices and experiences of contemporary middle-class U.S. women as the basis for defining ideal child rearing practices among all cultures (Keller 2014; Quinn and Mageo 2013, 5). When attachment researchers administer the Strange Situation Procedure to mothers and children outside the U.S., they often end up labeling significant numbers of children as insecurely attached. An early 1980s study of attachment among children in Northern Germany found that nearly two-thirds of the children were labeled insecurely attached. Babies in this study did not display enough distress when the mother left the room and so were labeled insecurely attached. The original researchers and later ethnographers note that children may behave in this way because their mothers

⁵⁹ With the exception of Stryker (2000, 2004, 2010, 2011, 2012, 2013a, 2013b), there is a lack of literature by anthropologists considering attachment AND institutionalization. Quinn and Mageo (2013) argue that institutionalization is “exceptional and never locally normative” (13). This begs the question, how many kids need to be institutionalized for a care practice to become normative? Stryker (2000) argues that while attachment is culturally contingent, so is deprivation and abandonment (80).

placed a high value on independence (LeVine and Norman 2001, 89). Similarly, a study of children and their mothers in Japan classified a high number of children as insecure-resistant because they displayed extreme distress when separated from their mothers (Keller 2013; Quinn and Mageo 2013). In both cases, the authors attribute children's attachment behavior to cultural norms and practices. In Japan, however, practices such as near constant holding and sleeping with their infants led to greater distress when the mother left the room. These children were labeled as insecurely attached because they displayed too much stress and could not easily be comforted once the mother returned to the room. As anthropologists LeVine and Norman (2001) suggest, if a classification system results in a lot of people being classified as pathological, then there might be something wrong with the system, not with the people.

Further, the method for assessing attachment, the SSP, is culturally biased, the existing attachment categories are value-laden, and the existing attachment categories cannot account for the range of behaviors seen among human infants and their parents (Gaskins 2013, 37–40). Quinn and Mageo (2013) argue, “[t]o label children raised according to a certain set of cultural practices as ‘insecurely attached’ on the basis of their performance in an experimental situation, without understanding the meaning of the children’s behavior both to their adult caregivers and to the children themselves is bad scientific practice” (10).

Anthropologists also question attachment theorists’ focus on a single caregiver, usually the mother. Sarah Hrdy’s (2009) cooperative breeding hypothesis posits that fertility and child survival are increased and maternal burden is decreased when multiple adults share in the care of children. Evidence of shared caregiving is found in the ethnographic record; for example, the Hazda (Crittenden and Marlowe 2013), the Aka (Meehan and Hawks 2013), the

Alorese, and Northern Indians (Seymour 2013) all engage in varied forms of shared childcare.

For anthropologists, this is the core problem with attachment theory and attachment research: it uses a classification system based on middle-class U.S. understandings of parenting to organize all mother-child relationships without any attention to the cultural context. In this way, attachment theory fails to recognize that there may be a wide range of infant-mother behaviors that demonstrate healthy attachment.⁶⁰

Balbernie (2010) goes beyond this critique, arguing that like the basic human inclination to attach, even “pathological” attachment styles may be adaptive. “Indiscriminate attachment behaviour,⁶¹ from this proposed evolutionary perspective, is less a syndrome of mental ill-health than an astute survival manoeuvre following being orphaned, abandoned or fecklessly reared” (265). In other words, for children reared in institutions, survival may be increased when they demonstrate feeling or attachment to multiple caregivers.

Other “pathological” styles of parent-child interaction may also make sense for particular conditions. Attachment theory fails to address the broader economic, social, and political conditions that shape parent-child relations. Nancy Scheper-Hughes’ (1993) classic ethnography *Death Without Weeping* illustrates just this point, arguing that economic scarcity is linked to the scarcity of maternal attention and investment (also see Scheper-Hughes 1985, 292). Quite simply, “women whose cumulative experiences lead them to resignation with respect to high fertility *and* to an expectation of frequent failure to rear healthy, living

⁶⁰ Vicedo (2017) argues that despite anthropology’s sustained criticism of attachment theory, psychology continues to prioritize lab research such as the Strange Situation Procedure over contextual, ethnographic data.

⁶¹ By “indiscriminate attachment behavior” Balbernie is referring to children who do not seem to distinguish between adults they know and trust and strangers. Balbernie cites one study that found that of post-institutionalized children, “61% would approach strangers and, of these, 52% would go home willingly with them” (267).

children will respond differently to their newborn than middle-class mothers with both greater control over their fertility *and* a high expectation for the health and viability of their children” (1985, 310).⁶² Living in Northeast Brazil in the 1980s, Scheper-Hughes talked with women about their past experiences giving birth and parenting. In an environment of extreme poverty, scarcity, and malnutrition, the infant mortality rate is extremely high:

“conditions...are hostile to child survival” (1985, 314). Mothers do not bond with their infants until they get old enough and strong enough to live through infancy and childhood. This too is rational, possibly adaptive behavior. Mothers who can reasonably expect to have several children die may preserve material, psychological, and emotional resources by not investing in the infant until survival is likely (Scheper-Hughes 1985, 1993, 2013). “Triage and survival” (2013), rather than innate, immediate bonding between mother and infant also drives attachment behavior.

Scheper-Hughes’ (2013) recent update on the Brazilian town where she did her original research demonstrates how attachment behaviors change over time. With a steep decline in infant mortality rates, mothers’ attachment behavior has changed. Mothers now expect to have healthy babies, and reportedly bond after birth, instead of waiting for signs of likely survival.

An Ethnography of Attachment Disorders

Anthropologist Rachael Stryker (2010) explores the social meaning of attachment disorders in her book *The Road to Evergreen: Adoption, Attachment Therapy, and the Promise of Family*. She describes the Evergreen model of therapy for children diagnosed with Reactive Attachment Disorders (RAD), almost all of whom were adopted from

⁶² Emphasis in original.

institutional care settings. Children diagnosed with RAD have often experienced physical and sexual violence, as well as material deprivation. As a result of these experiences, as well as abuse, neglect, or time in certain types of institutional childcare, children diagnosed with RAD do not form an attachment to a parental figure in the first few years of life. Children with RAD can be violent, have difficulty with hygiene, display a lack of interest in family members and events, are seen as irrational, and evidence attachment problems—either they are unable to form any attachment or attach to anyone, even near strangers (70).

Stryker argues that because of these behaviors, children diagnosed with RAD are unable to participate in the roles and rituals that constitute ‘family’ (12). Adoptive parents largely base their expectations on existing discourse about adoption and family in which parents are altruistically providing children with love, material comfort, and a ‘good home,’ and in which children perform as “emotional assets” (41). Adoptive parents were surprised and unprepared for children unable to attach, so parents turned to medical discourse of pathological attachment to preserve their families. The Evergreen Clinic, and other therapies focused on attachment, developed in response to the challenges parents faced in caring for abused and formerly institutionalized children.

The therapeutic practice of the Evergreen model affirms parents’ expectations of family and disciplines family members to make this modern family a reality. Children are treated and trained so that they display attachment or “child love” (13) to their adoptive parents. Parents are treated and trained to alter their parenting behavior and households so that RAD children can be a part of it; such changes include setting strict boundaries for children’s behavior and configuring the physical space by installing alarms and door locks, and making safe spaces for family members and pets who might be targets of violence by a

RAD child (133).

In a later article, Stryker (2013b) argues that RAD serves as a “signal symptom” that “denotes a specific type of symptom choice, one that embodies the deviant’s inner state in a social form that serves the same function both for the identified deviant and for society, namely, to displace and project elsewhere the location of the shared conflict ... Through a signal symptom, deviant and society focus and distract themselves” (1185). If RAD diagnosis is a “signal symptom,” then it masks the systems of inequality, isolation, and violence that produce children who cannot attach by focusing on the pathology of an individual.

As with many other medical practices, there is much diversity among attachment therapy practices. The Evergreen model, centered on the town of Evergreen, Colorado, is characterized by a combination of “psychotherapy, confrontation therapies most often referred to as ‘holding therapy,’ and therapeutic-parent training” (Stryker 2010, 3). Considered the “last hope” for children with attachment disorders, the Evergreen method is controversial, as several children have died in incidents related to this therapy. The Evergreen model is starkly different from the approaches used by The Clinic and most other IAM clinics. Rather than “holding” and confrontational therapies, the therapists at The Clinic, my primary field site, rely primarily on Parent-Child Interaction Therapy which involves therapist-coached play between child and parent (Allen, Timmer, and Urquiza 2014) and cognitive behavioral therapy with children and their parents.

Critiques of attachment theory and ethnographic examination of therapies related to attachment and bonding highlight the dynamic and context-specific nature of parent-child relationships. In the sections that follow, I explore how attachment theory is operationalized

in IAM. As an ethnography of attachment and medicine, my research shows how attachment knowledge is used by clinicians and parents alike in the formation of adoptive families.

Attachment Theory, Institutional Care, and IAM

Children's experiences in orphanages are heterogeneous (Miller 2005, 39; Weitzman and Albers 2005, 1395). Adoption medicine specialists agree that while there is no such thing as a "great" orphanage, some are better than others at meeting children's nutritional, educational, and psychosocial needs. It is also the case that children in orphanages often receive better nutrition and education than their peers not in institutions: "[U]nder the best circumstances, long-term permanent orphanage care may provide nurturing, stable, and consistent care and be a realistic alternative for children in some circumstances" (Miller 2005, 39). Quality of care is related to the institution's philosophy, training of the staff, availability of resources, the child's personality and "individual experience" of health, pre-orphanage care, genetics, and environment in utero (Miller 2005, 39–40). That said, it is common that children's needs for "emotional sustenance" are not met (V. Jones and Committee on Early Childhood, Adoption, and Dependent Care 2012, e215). "The life experiences of most internationally adopted children prior to placement conspire to interfere with this process" of attachment (Miller 2005, 353)

Despite this heterogeneity and the fact that not all children who have spent time in institutions develop disordered attachment, the potential effect of institutionalization on adopted children's attachment behaviors, intelligence, and mental health is well documented (J. Castle et al. 1999; Chisholm et al. 1995; Chisholm 1998; O'Connor, Rutter, and English and the Romanian Adoptees Study Team 2000; O'Connor et al. 2000; Rutter et al. 2007; Van den Dries et al. 2009; Zeanah et al. 2003, 2005). Children who have spent time in institutions

such as orphanages, baby homes, or residential care display symptoms of insecure and disorganized attachment. Generally speaking, the longer a child is in institutional care, the more severe these symptoms will be (Weitzman and Albers 2005, 1398). The younger the child is when adopted into a family, the greater the improvement in the effects of institutionalization (O'Connor et al. 2000).

Within the last 15 years, researchers have used the “natural experiments”⁶³ created by Romanian orphanages to study the links between institutionalization, mental health, attachment, and cognitive ability in depth. As I described in chapter 3, Romania’s state regulation of reproduction impacted adoption flows,; Romania’s pronatalist policies by Romania’s Nicolae Ceaușescu set the stage for demographic disaster (Kligman 1995, 1998) and led to large numbers of children being abandoned to institutions.

The policies of Ceaușescu had, in effect, created “natural experiments.” Some children were institutionalized and other children were not. Those in orphanages were exposed to neglect, deprivation, and lack of primary caregivers. Those not in orphanages were not exposed to these experiences.

Although there have been several contemporary research projects concerning the outcomes of institutionalized children, the most recent and salient study is the Bucharest Early Intervention Project (BEIP), a joint project of Tulane University, University of Maryland, and Boston Children’s Hospital (Bucharest Early Intervention Project n.d.; C. Nelson, Fox, and Zeanah 2013, 2014). The investigators describe the BEIP as “a scientific and humanitarian project designed to document the effects of institutionalization on the

⁶³ A natural experiment is “defined as a naturally occurring circumstance in which subsets of the population have different levels of exposure to a supposed causal factor, in a situation resembling an actual experiment where human subject[s] would be randomly allocated to groups” (McGuinness and Dyer 2006, 276).

development of young children, to determine the degree of recovery from early adversity that foster care can provide, and to assist the government of Romania in building an infrastructure to support alternative forms of care beyond institutionalization for children in difficulty” (Zeanah et al. 2003, 885). To determine the effects of orphanage life on children and the degree to which placement in foster care can ameliorate the deleterious effects, researchers followed 136 institutionalized Romanian children and 72 Romanian children who had never been institutionalized. Of the 136 institutionalized children, roughly half remained institutionalized while the rest were placed in high quality foster care with foster parents recruited and trained by BEIP staff. The BEIP then followed each cohort, measuring outcomes related to cognition, intelligence, attachment, physical growth, and stress. Children in the community who had never been institutionalized fared the best. Children who had been placed in foster care before 24 months of age were comparable to those who had never been institutionalized. Those who were placed in foster care after 24 months of age showed more positive outcomes than those who remained institutionalized, but did not fare as well as the community or children placed before 24 months of age.⁶⁴

The results of the BEIP demonstrate, through a randomized trial, what Bowlby argued decades earlier: institutionalization and parental separation is bad for children in multiple domains. Institutionalization effects children’s growth, cognition, stress, and attachment. The investigators found that early intervention through placement with a family before age 2 was effective in improving outcomes on all domains (Almas et al. 2012; Bick et al. 2015; Drury

⁶⁴ There has been debate about whether research on abandoned children is ethical (Zeanah et al. 2003, 885, 2006; Zeanah, Fox, and Nelson 2012). Bioethicists disagree about whether the BEIP team violated ethics standards in their work on Romanian orphans. Several argue that the researchers are not responsible for the conditions of the orphanages in which they live and that research with such a vulnerable group the benefits of such research outweigh the potential harm, as the results could be used to change policy and practices (Millum and Emanuel 2007; Wassenaar 2006). Fins (2013, 2014) disagrees, arguing that the researchers already knew that these orphanages were toxic, and it was therefore unethical to design a study that depended on the continued suffering of subjects.

et al. 2012; Fox et al. 2011; Ghera et al. 2009; K. McLaughlin et al. 2014; C. Nelson 2007; C. Nelson et al. 2007, 2011; C. Nelson, Fox, and Zeanah 2013, 2014; Sheridan et al. 2012; Smyke et al. 2007, 2010, 2012; Windsor et al. 2011; Zeanah 2000; Zeanah et al. 2005).

Using Attachment Research

At a 2013 conference of adoption agency staff, adoption medical specialists, and child welfare advocates, the presenter, a well-dressed white man representing USAID (the U.S. Agency for International Development), asked the group to: “Give me a show of hands if you’ve gone to an orphanage and had children run up to you and cling to you?” Most of the people in the room raised their hands. The presenter continues, “Look at this. This is an attachment problem.” The attendees respond with murmurs of “um hum,” “yes,” and “yeah.” Understanding the presenter’s point requires some knowledge of attachment. In describing children running up and clinging to strangers, he situates their behavior as insecure attachment—disorganized/disoriented. Because they do not have a healthy bond with a primary caregiver, they show affection to people they do not know.

Rather than letting “attachment problems” stand as diagnosis made of individuals, the presenter highlighted the systemic nature of disordered attachment. He continued his presentation, arguing that, as child welfare advocates, our primary goal should be solving this attachment problem by reducing the use of orphanages and getting children into family settings—adoptive, foster, and reunited birth families. Just as Stryker shows how RAD diagnosis can be understood as a “signal symptom” of violent and isolating institutions, this presenter positioned attachment problems as collective social problems.⁶⁵

While Bowlby could not explain exactly *how* separation from the mother caused

⁶⁵ Similar to Buchbinder’s (2015a) work on pain as a sign of a sick society (146).

adverse effects in the child (Kobak and Madsen 2008), contemporary neuroscience attempts to provide an explanation by looking at how brain structure and function change in response to neglect. Results of the BEIP, along with the English and Romanian Adoptee Study,⁶⁶ were shared in some form at nearly every adoption-related conference I attended as part of my research. The message of these studies is clear: institutionalization damages the brain. Bruce Perry (2008) summarizes the effect of neglect on the brain: “Simply stated, neglect results in dysfunctions in the neural systems that do not receive appropriately timed and patterned stimulation, and abuse/trauma results in alterations in brain systems that mediate the stress response” (94). In short, stress and trauma physically alter the brain. Also, the brain fails to get the input it needs for typical development (the nurture in nature and nurture) when the child is neglected.

Why were the BEIP data, brain scans, and neural imaginings so central to adoption discourse during the time of my research? The purpose of presenting this information about what I call attachment evidence at adoption-related events is two-fold. First, sharing this information is a form of advocacy on behalf of children in institutions. Children’s brains develop optimally only in families; therefore, children should be expediently placed with families.⁶⁷ In a conference session summarizing the keynote presentations and plotting the organization’s future advocacy, the executive officer of a national adoption advocacy

⁶⁶ The English and Romanian Adoptees Study Team in the UK is a similar longitudinal project on post-institutionalized Romanian children (J. Castle et al. 1999; Mehta et al. 2009; O’Connor et al. 2000; O’Connor, Rutter, and the English and Romanian Adoptees Study Team 2000; Rutter et al. 2007; Rutter, Sonuga-Barke, and Castle 2010).

⁶⁷ What counts as appropriate family is not surprisingly contentious. For evangelical Christians, a proper family is a heterosexual, married, Christian couple. For most non-evangelicals involved in adoption, having a family means that the child has at least one adult whom they can rely on and with whom they are bonded. This adult can also be depended on to ensure the child’s health and wellbeing. I directly asked one presenter what sort of family he means and he gave a definition he said was generally accepted in the international aid community: a family includes at least one adult looking out for child.

organization had this to say about the link between advocacy and research: “We’ve been saying this forever—we know children need families. Now we have the science to prove it.”

Second, sharing data from the BEIP and similar projects tells parents and social workers to approach children’s behavior problems as rooted in the physical structure of the brain damaged by institutionalization, as opposed to being rooted in the child’s personality or moral center. The keynote speaker at a conference for those parenting children who have experienced trauma and neglect counseled, “You need to know this, that our children’s brains are damaged. Our kids are not bad kids. They are brain damaged kids.”

Neuro Images and Neuroimaginings

Neurological images were used by presenters to illustrate the effects of trauma, abuse, and neglect on the brain. Over the last decade, researchers have turned to fMRI and other imaging technologies in an attempt to understand the effects of childhood neglect on the brain itself. Change in imaging technology has contributed to this growing field of the neurobiology of attachment. CT, PET, MRI, and fMRI scans have been used to show brain structure and function. The utility and accuracy of using brain imaging to measure function is debated (Dumit 2004; Rose 2010; Whiteley 2012). That said, neurological images are powerful. Saunders (2010) argues that the CT image stands for medicine itself (3): “...seeing is so far toward believing—that we have come to value medical images as Evidence at its quintessence” (5). I draw on this assertion to show the power of brain scans for adoption advocates.

Like Dumit (2004), I am concerned less with the actual facts being produced, than with the “people who interpret, rephrase, and reframe the facts for us” and the media forms used to communicate these facts (5). It is noncontroversial to state that neglect, abuse, and

institutionalization are bad for children and affect the brain. Those facts are not at issue here. I am interested in how these facts, as represented in medical imaging, are marshalled for persuasion and policy-making (also see Goldstein and Hall 2015).

Clinicians and advocates used images of brains to “prove” their point about the effect of neglect and trauma on the brain, but often made the leap from neural imaging to “neural imagining,” a concept developed by Buchbinder (2015b). Neural imagining is used to describe how the brain is used as a rhetorical object to explain what cannot be visualized. In Buchbinder’s work, doctors represent the brain in terms of electrical engineering, wires and circuits, “smart neurons,” and “stickiness” in order to help explain chronic pain experienced by adolescents (also see Buchbinder 2012).

One particularly memorable example of neural imagining comes from an IAM doctor presenting at the JCICS Symposium. In describing the brains of children with Fetal Alcohol Syndrome, he asks the audience to imagine the FAS brain in this way: “Imagine you have an old laptop. It’s loaded with malware, you have too many open programs, the hard drive needs to be defragmented, and then someone spills a drink on it. Kids with FAS have brains like this, overwhelmed by the demands being placed on it.” As a form of neglect that impacts the brain, this clinician imagines (and gets the audience to imagine) the brain as broken computer.

As I will show in the sections that follow, parents take in these imaginings of their children’s neurology in their uses of attachment knowledge and theory.

Attachment Expertise in the Family

Adoptive parents employ a mix of approaches in dealing with attachment. Like the adoption advocates, they refer to attachment evidence, familiarizing themselves with it and

making use of attachment-informed therapy programs. They also rely on the affective connection they have with their child. Using these tools, parents exert themselves as experts about their children and how they should attach. They employ this expertise in order to help their children navigate the world, and to help themselves be confident parents and create family.

Indeed, adoptive parents are often the experts. At a JCICS conference, a leading adoption doctor implored the gathered social workers and adoption advocates: “when parents tell you attachment is a problem, listen to them!”

Asserting Expertise Through Affective Connection

At a conference centered on teaching parents how to parent children who have experienced trauma and neglect, Dr. Karen Purvis, a well-known expert on attachment gave this advice: “We know that it seems like your kids have wounds that won’t heal. But I’m here to tell you that scientists now know how to help these kids heal. I want to tell you what science knows, but that some of you already know in your hearts. I want to give you permission to parent from your heart, not from a book.”

Like Karen and Chris—the parents whose story introduced this chapter—read books, consulted with medical professionals, and completed training through their adoption agency, most adoptive parents become knowledgeable about attachment and bonding.⁶⁸ Parents recognize that signs of grieving are expected for most children, that attachment to the adoptive parents will take some time, and that signs of disordered attachment may also be expected. But again and again, adoptive parents emphasize that while understanding the

⁶⁸ This is true of most of the parents I observed and spoke with, but those who adopted more than 5-10 years ago were likely to report that they had not been trained by their agency and felt that agencies should do a better job helping families with attachment and other psychosocial issues.

literature on attachment is important, learning from one's experience parenting a post-institutionalized child is key.

As parents get to know their children, they watch for evidence of the child's ability to attach and how the child is bonding to them. Observation and explanation are common in adoptive parent discourse about attachment. Karla, with her then-husband Daniel, adopted Sonia as an infant from Russia. She evaluates Sonia's attachment and bonding by eye contact: "Bonding was fine, no problem. When she was put into Daniel's arms she had immediate eye contact with him. At our layover in JFK people would stop and say, that is an amazing child—look at that eye contact. She just glommed on to people in an eye contact way." Karla also explains why she thinks Sonia attached to her and Daniel so easily: "I think this is because she had what I assume is individual care in the hospital because she was so little. I assume Sonia had lots of holding and individual contact because of how she responded to us and other people."

Jessica interpreted her son Jordan's attachment behavior in the same light:

We read so many stories about attachment disorders, with kids struggling. And I understand why, if a kid doesn't have opportunity to attach to a caregiver at an early age, of course there's ramifications. We've had Jordan for 11 months now. Everything we expected to happen, didn't happen. He understandably had meltdowns and tantrums because he couldn't communicate and his life was upside down. So there's got to be some grieving, frustration, sadness, sorrow and pain. All of these I expected. But he didn't reject us. Those things never happened. He was loved and knew how to love. That was abundantly clear to us.

Jessica is clearly familiar with the literature on attachment and uses it to make sense of her experiences with her son.

Attachment Knowledge and Non-Family

Parents often express frustration that teachers, family members, and neighbors "don't

get” the needs their children have related to attachment. I introduced the Bradley family in chapter 5. Heather Bradley talked with me about the experiences she has had with her daughter Diya’s teachers. Adopted from India at age 6, Diya attend the local public kindergarten. Heather reported that as a mother she had always been well-liked by staff at the school, where her biological sons had been enrolled. This changed when Heather had to step into the role of advocate and attachment expert for Diya: “I’m not a favorite parent now” Heather reports. The teachers and volunteers in Diya’s classroom were not listening to Heather about how to help Diya develop appropriate boundaries with people she does not know.

They are allowing her to sit on laps...I told the teacher she can’t sit on people’s laps, especially adults. And when I found out she sat on the lap of a high school boy, I was not a happy mother. [When I complained] I was told I was overprotective and irrational in thinking this boy would cause her harm. I told them yes, but we’re trying to teach her boundaries. She’s coming from orphanage where multiple people have touched her body in very personal ways; she doesn’t understand inappropriate and appropriate touch.⁶⁹ And then the teacher said she hugs [Diya] every day and will not stop. I had to go to the principal about that.

Heather had similar problems with other parents in her community. In response, she encourages them to put themselves in her shoes:

It’s hard for [other parents]. Here’s this is a sweet little girl who comes up and smiles and hugs. But I ask them, would you want your child to come up to me, not knowing me, sit in my lap, and hug me? No, you would not. It’s the same for my daughter. I think a lot of it’s ignorance. They just don’t know. I try to educate them but until you’re in the situation you don’t understand.

In these conflicts, Heather has to situate herself as the expert on her daughter and on her family. This expertise comes from the lived experience of parenting a child who has spent time in an institution. For those in the adoption world, the way one raises adopted children is

⁶⁹ Diya was exhibiting what attachment clinicians would call indiscriminate attachment. Discussed above, indiscriminate attachment includes showing affection to strangers or near strangers and is considered a sign that the child does not know that such behavior should be reserved for family.

not necessarily the same as how one raises biological children.

Parents' discourse about attachment shows how they construct themselves as knowledgeable people who have educated themselves about attachment. This parental expertise and intuition is also used to resist or counter expert advice.

Linda and her husband adopted Natalie from China at 10 months of age. Linda reports that Natalie was healthy, with the biggest challenge being that she “got up two to five times a night...she didn't sleep through the night for the first three and a half years with us.” Desperate for sleep, Linda consulted Natalie's pediatrician:

Our pediatrician, he's a wonderful guy. He said that Natalie needed to learn how to put herself to sleep so I might want to read up on various approaches to sleep training. I have a social work degree and have a friend who is a counselor and she has worked with kids. I went to see her and she gave me wonderful advice. She said that Natalie has learned how to put herself to sleep. She has that lesson down pat since she was two days old. No one put her to sleep for the first ten and a half months of her life. She knows how to do that. The lesson she is now trying to learn is that there is someone there for her when she wakes up. So that was the end of anyone saying anything to me about letting her cry it out.

Linda sought advice from two different professionals and ultimately followed the advice that she felt made the most sense for parenting a child who had spent time in an orphanage. An adoption medicine doctor presenting to social workers at a JCICS conference agreed: “Do not Ferberize⁷⁰ these kids. They may want to sleep with siblings, they're used to sleeping with other kids. And that's okay.”

Some parents find that their local experts may “get it”—understand attachment and adoption—but still not be able to help. Parents must often rely on their own experiences. Upon adopting Ivana, a 6-year-old girl from Ukraine, mother Katie periodically consulted with an acquaintance who was a child development specialist at the local university. Bonding

⁷⁰ The doctor is referring to the “cry-it-out” method of sleep training associated with Richard Ferber (Healthline 2015).

for their family was “slow and hard” but Katie eventually “made peace” with her family’s difference:

It was weird. Once we got home, I would call the folks at [the university]. After a few months of this, my contact said, ‘Look Katie, your daughter is the textbook. We don’t know what normal is for kids with her background. We don’t have research on older kids. We don’t know what normal bonding will be for her.’ And that advice settled me. I had to learn not to compare her to her classmates or to [my biological son]. I had to not worry about normal. I had to ask myself, ‘Is she better off than she was six months ago?’ That’s how I reasoned it. That’s how I made peace with it.”

Attachment Knowledge as a Parenting Tool

Alex and Katherine’s experience with son Lucas, adopted from Guatemala at 7 and a half months, shows how knowledge about attachment and brain science radically altered their parenting and their sense of selves as parents. Alex described what it was like when they learned about Empowered to Connect⁷¹ (Purvis, Cross, and Sunshine 2007), a well-known program for families who have children with attachment issues:

Oh my gosh it was such a relief and it was funny, it was like...when you see it on television and it’s like this is my life!...But there is just something about...seeing your family reflected back, like that’s exactly what I’m talking about. We are not crazy. That kid [in the video] is just like our kid and everything she is talking about, all the risk factors.

Alex’s realization that “we are not crazy” and “that kid is just like our kid” gets to the heart of why knowledge about attachment and the science behind it is critical for many adoptive parents. Alex describes this newly found knowledge as “a relief” because it provided them with a blueprint for action:

it was kind a relief to know that here is what it is and here is what you can do...the challenge for me [because I] worked with kids for so long, I feel like everything I’ve ever known to do is not what to do with Lucas. So, we don’t do time outs, we do more of like reparations or if he flies off the handle he can’t hear during any of that. But once he comes down we give him a chance to make amends or whatever but it’s more like doing a task or folding the laundry or something to help the family.

⁷¹ Empowered to Connect (ETC) is a counseling intervention based on trauma-informed care. ETC has been reworked/translated so that it speaks to Christian adoptive families (Purvis, Monroe, and Monroe 2010).

Despite being a former camp counselor who had worked with at-risk and special needs children, Alex had to learn new parenting skills in order to meet Lucas' needs related to attachment. Time-outs and separation won't work for him, as he's already experienced abandonment. Instead, he remains in the family unit, eventually making amends by helping with housework. Alex shared that some members of the extended family do not understand Lucas' behavior in terms of troubled attachment. Alex tries to explain that he is not a "bad kid" and that more typical disciplinary measures aren't appropriate.

Popular media about adoption also makes the link among attachment, institutionalization, the attachment science, and the healing effects of belonging to a family. The documentary, *The Dark Matter of Love* (McCarthy 2012), combined science and training for adoptive parents. Director Sarah McCarthy follows the Diaz family—married couple Claudio and Cheryl and their teenaged biological daughter, Cami—as they incorporate 3 Russian orphans into the family. After years of infertility, the Diazes adopt Masha (age 11), and twins Marcel and Vladim (age 5). The movie's tagline, "Science Can Change the Way You Love," highlights how the film is framed around an intervention program designed to help children and families attach to one another. Under the guidance of Dr. Robert Marvin⁷² and his colleague Nicole Milliren, the family is coached through an intervention program to help them attach to one another (Leydon 2013; Traster 2013)⁷³ The film opens with text across a black screen: "Professor Emeritus Dr. Robert Marvin has spent a lifetime developing

⁷² Dr. Marvin is the director of the Ainsworth Attachment Clinic and creator of The Circle of Security, another intervention program to aid parents and children struggling with attachment (The Ainsworth Attachment Clinic and The Circle of Security n.d.) .

⁷³ It's worth noting that Michael Rutter of the English Romanian Adoptee study served as scientific consultant and Charles Zeanah of the BEIP is thanked in the credits of the film.

a scientific intervention to help children learn to love. His framework draws on experiments into the attachment patterns of monkeys, birds, and humans,” recalling Bowlby’s connection to the work of Harlow.

Scenes of the Diaz family are interspersed with film footage documenting experiments on attachment and bonding, especially Harlow’s monkey experiments and waterfowl imprinting studies. Dr. Marvin and his crew coach the family through the attachment process using coaching and play therapy and by analyzing video footage of family members interacting within their own home.

In one particularly striking scene, Dr. Marvin analyzes footage of the family watching Masha perform in a school musical. Masha had not told her parents that she would have a solo singing part. Masha sang a line from a song in *Suessical the Musical*: “When the news is so bad, when you’re sour and blue, when you start to get mad, you should do what I do. Tell yourself how lucky you are....”⁷⁴

Once the performance was over, Masha rushed up to her parents to ask them what they thought. Father Claudio tells her that he’s proud of her and gives her a hug. Masha then seeks out mother Cheryl, who tells Masha, “you did a great job, I loved it” but is not effusive and makes no move to hug her. Distracted, Cheryl briefly turns away from Masha. The camera zooms in on Masha, no longer smiling, looking disappointed. Masha gets up and walks away. We then see Dr. Marvin and his colleague Robin reviewing the video.

Dr. Marvin: “What do you think?”

Nicole: “Well, I definitely think she brought her excitement to mom so she’s accepting all of this relationship with dad, and she’s like, ‘I want to go see mom’ and then she comes over and brings it to mom...”

⁷⁴ There’s a lot to be said about the fact that these are the lyrics she chose (or was chosen) to sing, as the words seem connected to trope of adoptees as “lucky” because they have been saved.

Dr. Marvin: “And mom was the one who had a hard time. There’s so much of a message there from Masha, ‘I need you to delight in me. Were you delighted?’ And mom says the right words that she was but then attention shifts and [Marvin shakes his head] Masha hadn’t gotten enough. What is it in mom’s history that puts her in the position of having that reaction?”

We then see Cheryl reviewing the video with Nicole.

Cheryl: “I wanted to give her a hug but I was afraid. Claudio gives hugs and doesn’t even think and I always am apprehensive...I think she could use a hug there, that she wanted a hug there and believe me, I love to hug, I just know that she’s pu- she’s pushed me away but you know, the door was open and I could have walked in and I didn’t know that at that time, you know”

Nicole: “What else, when you say the door’s wide open and she says, here I am, what else is she bringing to you and Claudio?”

Cheryl: “Emotion. She’s bringing everything that was kind of closed in...even later that evening, she showed us that she could cry too”

Nicole: [hushed tone] “Wow.”

Cheryl continues: the first time I’ve seen her cry. Even leaving Russia, we did not see her cry. When she was leaving somebody, who was very influential in her life⁷⁵ we did not see her cry. That night [of the performance] she cried and it’s not like she was trying to hide it.”

In this and other scenes, Cheryl and Claudio are being directly coached on how to parent children who have spent most of their lives in institutions. We never hear whether the children are formally diagnosed with an attachment disorder; the state of being attachment-troubled seems inherent in the fact of their orphanage life.

Throughout the film, the way that biological daughter Cami interacts with her parents serves as a mirror for how the adopted children should interact with their parents. Cami’s warm, enthusiastic, and physical interactions with Cheryl and Claudio stand in contrast to Masha’s reserved and distant demeanor. Going back to the anthropological critique of

⁷⁵ Cheryl is referring to an older caretaker from Masha’s orphanage who had also served as a sort of foster mother at times, bringing Masha home with her periodically.

attachment, we see that the U.S. style of parent-child interactions is considered the norm, while variations are pathologized.

For the families I've discussed in this section—Alex and Katherine's and the Diazes—parenting programs grounded in the science of attachment and tested through the scientific method are “lifesavers.” Therapies based in attachment science aid them in being more skilled at parenting children with attachment problems.

Conclusion to Chapter 6

In these examples from my ethnographic observation and interviews, parents draw on a variety of types of attachment knowledge in understanding their children. Attachment theory and knowledge operates on multiple levels for adoptive parents. Parents use what they know to make observations and interpret their experiences with their children. They use this knowledge in interacting with those outside the immediate family, trying to ensure that their children get what they need. Finally, attachment theory and knowledge comes with tools that parents use to parent their children. It is this combination of empirical knowledge about neuroscience, advice from experts, lived experience, and intuition that characterizes parental expertise on attachment and adopted children. There's push and pull among affective connection (cuddling and gazing into eyes), parents (making decisions about parenting and discipline), and interacting with those outside the family (teachers, relatives, doctors).

This ethnographic data about attachment in adoptive families and in IAM is linked to many of the anthropological critiques of attachment. As Scheper-Hughes (1985, 1993, 2013) demonstrated, attachment and bonding happens over time and is not the result of an innate “maternal instinct.” Children exhibit a wide range of attachment behaviors that are linked to the social conditions they have experienced—Diya's bonding with strangers made sense in

an orphanage, but this behavior is seen as not suitable for family life.

As a keystone of IAM, attachment knowledge foregrounds how adoptive parents parent, understand their children, and advocate for their children's needs. In this chapter, I have described the concept of attachment and its development, reviewed anthropological critiques of the concept, and demonstrated how attachment knowledge is used by adoptive parents.

CHAPTER 7: PARENTING AND BODY WORK

“When looking to find parents and children, words are only a small part of the accumulated evidence” (Weismantel 1995, 694).

My goal in this chapter is to explore how acts of physical caretaking play a role in the establishment of family. In the introduction, I reviewed how medical anthropologists have considered the family in the clinical encounter. In chapter 5, I showed how the clinical encounter itself aids in establishing “family feeling” for adoptive parents. In chapter 6, I showed how the concept of attachment operates for the clinical experts of adoption medicine and for adoptive parents themselves. Here, I show how caretaking, specifically the work of caring for children’s physical needs by parents, contributes or challenges family feeling.

Bourdieu (1996) discusses how individual family members reinforce “family feeling” through action and practice (22). He lists “the exchange of gifts, service, assistance, visits, attention, and kindnesses”—often women’s work— as ways the family is made real through action (22). In other words, family is made real because we engage in gift-giving, is real because we go through rituals like funerals and weddings together, and is real because we take and curate family photos documenting our existence as a family.

Adoptive families practice these rituals just as non-adoptive families do, as well as rituals specific to adoptive families. For example, Patricia Sawin (2017) shows how the stories we tell about how adoptive families came to be, their “origin stories,” are important in solidifying the family’s “collective identity” (415). “Gotcha Day”—the day adoptive parents take custody of their child—is often noted and celebrated in adoptive families. Recognizing

“Gotcha Day” is both literal and figurative—it is the day the family was physically formed, and the ritual celebration of it reifies the family as a realized category. As I described in chapter 1, Howell’s (2003) concept of “kinning” is helpful here. Howell demonstrates how internationally adopted children become part of Norwegian families through practice and discourse. “Kinning” activities such as dressing the adopted child in Norwegian traditional dress (bunad) and photographing the child in locations important to adoptive parent descent enfold the son or daughter into the family.

In her 2008 *Keeping Culture*, Heather Jacobson argues that recognizing and honoring an internationally adopted child’s birth culture in the home becomes women’s work and is a sign of being a good mother. Examples of this “culture keeping,” as Jacobson terms these activities, include serving meals traditional in the child’s birth country, decorating with birth country artifacts (such as a flag), and celebrating birth country holidays. For the families Jacobson interviewed, these activities are “part of creating a healthy individual child” and are seen as part of mothering responsibilities (67).

These adoptive family rituals and practices are key to how family is made real through action. In the world of health, however, action often involves the corporeal. The “clean” practices I note are public and largely divorced from individual bodies. In this chapter, I am interested in what we might consider “dirty” processes, particularly those related to diapering and toileting. Practices that occur in private and are focused on the body aid in making the family real just as much, if not more so, than “clean” practices. All of these practices can be understood under the umbrella of caretaking.

Anthropology of Caretaking

Recent anthropological work on caretaking highlights the centrality of care to the human experience and the formation of families. Care, for anthropologists, is difficult to define. Care involves “social, labor, and material resources...with the potential to sustain life and sociality” (Buch 2015, 278). Caring “for” someone is distinct from caring “about” someone, with the former referring to the everyday practices and actions of care and the latter referring to the affective state of concern for others (Buch 2015, 279; also see Barg et al. 2014, 180). As an action, care can be a commodity, industry, social service, governmental policy, and the everyday practices that kin do for and with one another (Barg et al. 2014, also see Drotbohm and Alber 2015). As a feeling, care can be an affective state or a moral or social obligation (Buch 2015, 279). Body work, a specific kind of caregiving, involves touch. Twigg et al (2011) describes body work as “work that focuses directly on the bodies of others: assessing, diagnosing, handling, treating, manipulating, and monitoring bodies, that thus become the object of the worker’s labor” (171). While Twigg (2000) and Twigg et al (2011) include only paid labor in their analysis (the type done by nurses, aides, sex workers, hairdressers, etc.), I extend the concept to parents and other caregivers who do body work on behalf of the children in their care.

Care is necessary for human survival and evidence for care of dependent individuals is found in the archaeological record (Hublin 2009). “The individuals who figure in the logic of care would die if they were left alone. They owe their very ability to act to others” (Mol 2008, 62). The necessity of care in human relationships is critical, but just as important are the ways care is central to connections between people. Care “entails the capacity to make, shape, and be made by social bonds” (Drotbohm and Alber 2015, 2). It is both of these

aspects of care that interest me here. Adoptive parents caring for their children is quite necessary for the survival of children, but care work also performs and reifies social bonds and relationships. In other words, care is about both resources and relations (Buch 2015, 279).

Julie Livingston's (2012) work on oncology care in Botswana makes the case for how critical care is for the survival of people with cancer and in relationships among people affected by cancer. In her ethnography of the only cancer ward in Botswana, Livingston argues that the "microprocesses of biomedical care" such as "...nasogastric tubes, bone-marrow aspirates, wound care, and the suctioning of tracheotomies" are important to understanding the entity that is cancer in Botswana (22). Going beyond the "big" cancer moments such as diagnoses, cure, and high-tech intervention, Livingston shows how the "little" care moments—cleaning a necrotic wound, counseling families, changing diapers, filling out forms, and making beds—make cancer something that "happens *between* people"⁷⁶ (6). Cancer is a social experience. In these moments, relationships among patients, family members, nurses, aides, and doctors are made and remade. Sociality is central to care itself. In the cancer ward Livingston writes about, doctors, nurses, and relatives work together to "enact care for their patient" (115).

In addition to highlighting the centrality of the social in biomedical care, Livingston also shows how care and relationships can be intensely focused on the physical body. Livingston argues that the family is central to cancer care: "family members are critical actors, not passive recipients of these processes" (115). Not only do patients come to biomedical interactions with existing family relationships, but family members also provide critical care. In the underresourced and understaffed cancer ward Livingston writes about,

⁷⁶ Emphasis in original.

family members often do jobs that hospital staff do in other contexts: feeding their sick loved ones and cleaning their bodies. Giving care often involves tasks such as cleaning infectious skin, cleaning bodies, and feeding.

Care-for-survival and care-as-social practice link the anthropological literature on care to the ‘new kinship studies’ described in the introduction. Challenging kinships studies that rely on genetic or blood relationships as the “natural” basis for all kin relationships, contemporary kinship scholars understand that kin relations are made in multiple ways, including care and nurturance (Carsten 1997, 2004b, 310). Indeed, for some groups, nurturing infants is seen as key to how the children become persons (Conklin and Morgan 1996; Gottlieb 2004).

The ‘new kinship studies’ sees care as activities that “presumes, produces, of confirms kin relations or perceptions of relatedness” (Drotbohm and Alber 2015, 7). Janet Carsten’s (2004b) ethnographic work with the Malays of Langkawi island shows the importance of care in creation of kinship relationships. She argues that it “is through living and consuming together that people become complete persons—that is, kin” (310). Shared breast milk and meals of rice are intended for family and usually consumed within the family home.

Mary Weismantel’s (1995) study of kin making in Zumbagua, in highlands Ecuador, is key here. Weismantel shows how kinship relations are made, over time, through sharing substance such as food, sharing living space, and caretaking. Relating the informal adoption of a young boy by the Iza family, she argues that they “will make this boy theirs by talking to him, sleeping near him, feeding and clothing him, and nursing his injuries” (695).

It is important to note that international adoptions by U.S. families are markedly

different than those in Zumbagua, Ecuador. U.S. international adoptions are marked by bureaucracy, legal processes, and payment of money (Herman 2002). Zumbaguan adoptions occur outside of bureaucracy and are created through acts of caretaking of children by adults. Parental relationships are “achieved and ongoing” (Weismantel 1995, 696), rather than strictly legal or linked to shared genetic material.

Following Livingston, Twigg, Weismantel, Carsten, and Bourdieu, in this chapter I will show how the small moments of body work or physical caregiving that parents perform for their children are key in establishing identity as parents and as a family. The overall focus in this chapter is on caretaking related to feces, as this is an under explored area of anthropology, and my observations in the world of IAM often concerned feces. Before I move on to matters of poop, however, I return to the Bradley family, and mom Heather’s care work to bathe and feed her daughter.

Meeting Diya’s Needs

In chapter 6, I introduced the Bradley family. The Bradleys had adopted two children, teenager Marta from Eastern Europe and 5-year-old Diya from India. Their adoption of Marta was dissolved but, as of the time of my interview, mom Heather considered Diya’s integration into the family successful.

Diya’s integration into the family has been largely successful, but Heather has experienced challenges when it comes to caring for her. Bathing was in issue from the beginning. Heather described to me how most kids in India take “bucket baths,” standing and pouring buckets of water to get clean. Heather’s attempts to bathe her at the hotel “did not go well.” “I got in my mind that I would have to bathe with her. I even put bubbles in. She was okay, but wouldn’t sit down. Finally, I had to give her a modified bucket bath. She stood in a

tub full of water and I poured water over her body.” For Heather, a “bucket bath” was not a proper bath, but a compromise.

Feeding was also a challenge for the Bradleys. For the first six months, Heather cooked mostly Indian food for Diya and tried to introduce new fruits and vegetables. This approach was intentional: “we were trying to be sensitive to her. American food is so different. For the first 6 months, I cooked strictly Indian and slowly introduced fruit and veggies.” Heather remembers: “It was a comfort thing for her in a new place. I remember preparing it and her getting excited. Now, I don’t cook Indian food nearly as often, but when I do, she’s a different child. It’s like she goes, ‘ahhh, I remember this.’”

Heather introduced “American food” slowly, but the fact that Diya still “refuses hot dogs and french fries” is both surprising and pleasing to Heather. Heather is proud that Diya “eats tomatoes like apples” and loves carrots and celery. In my interview with her, Heather clearly took pleasure in being able to provide this health and security, through familiar and healthy food, to Diya.

In both instances—feeding and bathing—Heather saw it as her role as a mother to provide comfort and support while her daughter transitioned to American life. These are, of course, typical activities for an American mom. But like the Zumbaguans Weismantel (1995) discusses and the Langkawians (Carsten 1997, 2004b) discusses, food and caretaking is about more than meeting basic needs. Heather’s slow transition from bucket baths to bathtub baths and from Indian food to American food and her desire to “be sensitive” to Diya, work to slowly draw Diya in to the Bradley family practices of cleaning and eating. It’s Heather’s compromise and Diya’s transition that work to make Diya part of the family, and Heather understands herself as a “good mother” doing what she can to care for Diya.

Dirty Practices of Poop and Parasites

Recall also, from chapter 4, how the field of pediatrics became involved in the “new morbidity” (Pawluch 2009, 1) of psycho-social and development issues in children, including toilet training. IAM clinicians provide expertise on the mundane and universal in potty training and on the specialized in parasites and gastrointestinal pathology. In the next section, we see how parenting, care work, and health come together in IAM.

Anthropology of Poop

Anthropology has had little to say about poop and defecation (Jervis 2001; Lea 1999; Van der Geest 2007a, 2007b); this is surprising given the universality of the process and product. Defecation is a “meaningful, recurring activity, continually experienced by bodies of all ages” (Lea 1999, 7).

A handful of anthropologists do take up the matter of feces, often building on Mary Douglas’ (1984) work linking pollution and danger to dirt, including feces (Jervis 2001; Lea 1999, 2001; Van der Geest 2007b; Van der Geest 2009; also see Abrahamsson 2014; Al-Mohammad 2007; Van der Geest 1998; Van der Geest 2007a; Wolf-Meyer 2017). For Douglas, feces, along with dirt, blood, etc., are “matter out of place.” Looking closely at how different cultures deal with such out of place matter highlights social norms and beliefs. Through the regulation of dirt (including shit), people create order and delineate borders such as good and bad, and wrong and right. Material from inside the human body is perhaps the “most strongly felt ‘matter out of place’ and therefore the most informative pointers of cultural boundaries” (Van der Geest 2007b, 381).

In addition to the universality of poop, defecation is a social activity: “Yes, shit may happen. However, it rarely happens alone or without effort, and it always happens

somewhere. Happenings are staged and enacted through the collective work of actors in various localities” and is caused by a combination of “voluntary and involuntary muscles, foodstuff, medication, therapies, systems and so on” (Abramson 2014, 125).

Van der Geest (2007b) shows how the social position and relationships of those dealing with dirt shapes feelings of disgust, arguing that they are driven by degrees of relatedness. He argues that, on the whole, we are not disgusted by our own feces. The feces of infants are similarly acceptable, especially to their mothers, though the same is not true of adult children dealing with their parents’ feces. The feces of lovers and relatives is usually less disgusting than that of mere acquaintances. Working against this positive association between closeness and lack of disgust, Van der Geest argues that the shit of “unknown others” is less disgusting than that of known others/acquaintances.

The work of Warwick Anderson (1995) and others writing about tropical medicine in the colonies highlights a problem with Van der Geest’s argument about social position, relationships, and disgust. Van der Geest fails to address the relationship between colonizer and colonized and the racialized portrayals of poop found in colonial archives.

Parenting and Poop

Dealing with continence issues is a place where parenting and care work comes together. This is especially true of parents of children with disabilities who require “tangible support” for daily activities. including bathing, cleaning, toileting (bowel routines, catheterization) (Antle, Montgomery, and Stapleford 2009; also see Fischer et al. 2015). But this is also true of parents of all children. Mothers, especially, deal closely with children’s excrement (Ortner discussed in Lea 2001, 166). Feces of children often literally pass through hands of the mothers (Van der Geest 1998, 8). In the UK (and I’d add the U.S.), it is expected

that parents help their children become “full persons” through potty training. Controlling their children’s bodies and teaching their children to control their own bodies is key to being a “good parent” (Lea 2001, 197).

Lea (2001) takes up the idea of intimacy in “shared acts of excretion” (74). Actions such as a mother changing a child’s diaper, a doctor conducting a rectal exam on a patient, a caregiver manually removing stool from a sick relative, and a relative using the toilet in the same room as another relative taking a bath are described as intimate by Lea: “These acts are both constituting a bond of intimacy between participants and allowed to take place because the relationship is already intimate. Intimacy is created partly through the exclusion of other people and partly through the shared understanding that defecation and faeces are usually hidden” (74).

IAM and Poop

IAM is a broad, interdisciplinary field, but one of the primary reasons for its development is the need for screening internationally adopted children for infectious disease, including intestinal parasites. While examinations in an IAM clinic include some features common in most general pediatric visits—vaccination, for example—the regular, routine, and repeated testing for intestinal parasites is not common in general pediatric settings. Screening for intestinal infections and parasites is one of the unique services of IAM. General pediatricians do, of course, collect fecal samples in order to detect intestinal infections, but this testing is not routine. Instead, general pediatricians order such tests only when a child exhibits symptoms of intestinal infection. Fecal screenings are not included in guidelines for well-child care (Committee on Practice and Ambulatory Medicine 2014). In IAM, fecal tests are done as a screening measure, regardless of the presence or absence of

symptoms. Further, general pediatricians treating middle class children will not see intestinal parasites as often or in such variety as those treating internationally adopted children.

In the event that a child tests positive for intestinal parasites or bacterial infection, the intervention is generally simple. A course or two of the right anti-parasite or antibiotic medication generally solves the problem. These “quick fixes” can spare a child from months or years of gastrointestinal pain, diarrhea, and chronic illness.

As I reviewed in chapter 4, fecal management and IAM have roots in tropical medicine developed in the context of colonial exploration and domination. Warwick Anderson (1995) and Gerling (2012) demonstrate that colonial discourse about feces are frequently heavily racialized. I want to note that in the space of The Clinic and other IAM spaces, talk of feces is not racialized. There is not a perception that the feces of children born outside the U.S. are somehow more offensive than those of U.S. citizens. There is, however, concern that intestinal diseases will be passed from adopted child to other family members.

The Fecal Sample

As I reviewed in chapter 4, internationally adopted children are at greater risk for a variety of intestinal parasites and infections. A 2011 study showed 27% of children examined in an IAM clinic between 1999 and 2006 tested positive for intestinal parasites (Staat et al. 2011).

The AAP recommends that the feces of all children adopted internationally be tested for intestinal pathogens shortly after arrival and suggests repeat testing six months later for children who are symptomatic (American Academy of Pediatrics 2015). In order for the feces to be tested, the child’s parents are required to obtain three samples produced 48 to 72 hours apart. When a parent calls to make an appointment for their child’s initial visit, clinic staff

mails them a box containing a fecal kit: instructions, three jars with preservative and labeled with the future patient's identifying information, and a "hat", a plastic container designed to fit across the seat of a toilet. The "hat" catches the feces, which the parent puts in one of the jars. The sample cannot be contaminated by urine. Samples from young children still in diapers can be collected from the diaper, but cannot be contaminated by urine. Parents are instructed to bring the samples to their first clinic visit.

There's little human behavior that is truly universal, but U.S. adoptive parents' handling of fecal samples surely comes close. After checking in for their visit to the Clinic, families wait in the large, sunny waiting area. They are called back to the triage area before being taken to an examination room. Carrying the required three jars of fecal samples in a plastic grocery bag (usually double-bagged), the parent tries to give the bag to the nurse. "Here," mom says, "you can have this." Unfailingly, Carol, the nurse practitioner, smiles brightly and responds, "No, you can keep that for now. Once we're done up here you'll take it down to the lab on the first floor." Parents are disappointed and respond with a shudder or sigh; "Ugh, I just want to be rid of this!," or "Really, I have to keep holding this?"

For the first half of my fieldwork, I didn't take note of what I eventually came to think of as "the attempted hand off"—parents trying to give the fecal samples to the first clinician they encounter, and their disappointment when they hand to keep holding it. There's very little in my early field notes about this. After all, this seemed a minor social interaction. It often occurred in the hallway during the walk from the triage station to the exam room. If it occurred in the exam room, it was before Carol has started taking the child's history, which seemed to be the most interesting part of IAM. But as I saw the seeming non-event of the attempted hand off happen over and over again, I eventually caught on that this negotiation

between parents and practitioners over poop was an event I should pay attention to.

Why such a strong reaction from parents? This is matter out of place. No one is that disgusted by changing a baby's diaper, but there are specific locations and times where and when a baby's diaper should be changed. In the U.S., it is most common for parents of babies carry around a diaper bag full of the items necessary to handle urine and feces: disposable diapers, disposable wipes, a changing pad, butt cream, a change of clothes, and hand sanitizer. Diaper changes take place behind closed doors, a bathroom or bedroom, never in places like the floor of a restaurant or the tray on an airplane (I found that one out the hard way). Parents about to birth a child are taught how to change a diaper in hospital parenting classes.

In contrast, fecal samples are outside the norm. There are strict guidelines as to the number (3), condition (not contaminated with urine) and timing (48-72 hours apart) of appropriate fecal samples, but no one teaches parents how to collect one. Van der Geest (2007b) would agree that feces outside the norm contributes to disgust. Van der Geest also says that generally, the feces of children are not objectionable to their mothers. Of course, he's thinking of biological children, not adopted children, new to the family and not infants.

Often, parents are unable to get the three samples needed because of contamination, constipation, or resistance by the child (some kids don't like pooping in a hat). If the diaper or hat includes urine, the feces cannot be tested for parasites. Sometimes the child does not have enough bowel movements between the time they arrive in the U.S. and their clinic appointment. When parents are unable to bring enough samples to the clinic visit, they are told to let the clinic staff know if the child has a bowel movement while at the appointment. Staff: "We'll try to get it today. We love poop!"

Why such an enthusiastic, non-disgusted response from the clinical staff? An infectious disease doctor, Dr. Smith genuinely loves finding a worm or parasite, though it is generally nurse practitioner Carol who does the actual collection from diapers. The enthusiasm of Dr. Smith and the other clinical staff is also about normalization. Collecting and analyzing poop is part of their job, as is dealing with other bodily fluids. In an ethnography of a nursing home, anthropologist Jervis (2001) finds that lowest status jobs (aides) are those charged with handling feces and other bodily waste. Those with higher status are more distant from such waste.

It's more complicated in The Clinic. In The Clinic, the collection of feces is related to specialization more than status. In cases where a child defecates at the clinic appointment and it can be used as a sample for testing, most often nurse practitioner Carol takes the diaper from the parent and transfers the feces to a sample jar. In most hospital settings, nurse practitioner is a relatively high-status job and the task of dealing with bodily fluids is likely delegated to lower status employees such as nurses aides. But The Clinic does not have its own aide. The other staff are either higher status (doctor) or in a specialization that does not deal in bodily fluids (OT and social workers). Temporary nursing staff are occasionally present, and they may deal with the diaper.

The goal of collecting the fecal sample also differs from the primary job of low-status aides: cleaning. Instead, this care act—removing feces from a soiled diaper—ensures the health and wellbeing of the child, but is done in pursuit of information for the healthcare record.

The Clinic staff is also enthusiastic and positive about fecal samples because screening for intestinal infections is one of its core *raison d'être*. IAM is unique in pediatric

practice in its use of fecal samples as a screening tool for all of their patients, rather than a diagnostic tool for patients who are symptomatic.

The anthropology of shit helps locate IAM practices within broader social and historical contexts. Parents' management of feces is shaped by expectations connected to social position and relationship, what it means to be a good parent, and the proper handling of "matter out of place" or dirt. Examining the routine IAM stool sample highlights the unique contribution the field makes to pediatric health care and the health care of children born outside the United States.

In the sections that follow, I examine specific themes related to shit that emerged from my ethnography of IAM.

Mother or Aide

Beyond handling feces in order to get a sample for testing by The Clinic, parents also must contend with bodily waste in the care they provide for their children. In the following ethnographic vignettes, I explore how dealing with children's incontinence interferes with bonding for some parents, and can come to dominate their lives.

Dr. Barrett and "Complicated is Good"

At the 2013 JCICS meeting, a Canadian adoption specialist, Dr. Barrett, presented several cases to the gathered social workers and adoption doctors. Her goal was to explore the medical portion of the referrals parents had revived of potentially adoptable children through several case studies. In the second case, a Canadian family adopted a 4- to 5-year-old

boy from China. As they prepared for adoption, the family stated to Dr. Barrett that they were motivated by a “desire to help” and were “ready for a challenge.” They asked Dr. Barrett to review the referral file they had received. The file described the child’s health status as “complicated.” Diagnosed with an imperforate anus and other genito-urinary problems, feces were passing through the child’s penis, causing frequent infection. The problem was compounded by incontinence; the child had no muscle control over defecation so feces were passing through his penis near constantly. Dr. Barrett confirmed to the family that the child was, in fact, “medically complicated” and that he would require complex surgery as well as long-term care from his parents. Dr. Barrett reported to the audience that the mother had responded, “That’s fine. Complicated is good.” The social workers and medical professionals gathered in the conference audience gasped and groaned. Dr. Barrett nodded. “I know, I know” she said. Parents who are motivated to adopt in order to save or rescue a child may be looking to adopt the neediest child possible. From the perspective of Dr. Barrett and the professionals at the conference, such parents may not fully understand the level of caretaking that will be required.

The family had adopted the boy, and as Dr. Barrett predicted, mom’s job was to keep up with the never-ending diaper changes and cleaning. Dr. Barrett argued that this situation made it difficult for the parents and child to attach. The mom, she says, “has a hard time seeing herself as anything other than a caregiver.”

As I showed in chapter 6, on attachment, IAM specialists agree that “the life experiences of most internationally adopted children prior to placement conspire to interfere with this process” of attachment (Miller 2005, 353). In this case, the child had experiences typical of international adopted children—orphange care, severed tie with birth parents,

possible neglect, and possible abandonment. Dr. Barrett argued that his medical experiences also set him up for attachment problems. He had been repeatedly hospitalized in China, and having no primary caregivers, was basically alone in the hospital. Dr. Barrett: “If you think the orphanages are bad, visit a hospital.” Once in the U.S., the boy experienced additional hospitalizations. Sometimes, Dr. Barrett said, hospitalization in the U.S. can help children attach to their adoptive parents, but it did not in this case.

The family is still struggling. The boy, now six, is experiencing learning difficulties. Though some of his medical issues have improved, he is not fully continent.

In this example we see how parental caretaking of children’s bodies intersects with other concerns of adoption medicine. As he was no longer at an age when he is “supposed to be” in a diaper, the child’s needs crossed the boundary between parenting and nursing, affecting attachment and the bond between parents and child. It was this combination of the child’s health needs and the mother’s role in relation to his care that created difficulties.

Struggling to Meet the Challenge—Aiden

Families I met in the clinic struggled with this as well. Aiden, 29 months old, was adopted by the Shuster family. His mother, Elizabeth, brought Aiden to The Clinic for his initial evaluation. Aiden has a congenital heart condition that will require additional surgery, but is energetic and currently shows no symptoms related to his heart condition. Elizabeth is obviously pregnant. Addressing Aiden, but probably for the benefit of everyone in room, she apologizes for her lack of lap: “Sorry kid, this was not the plan.”

While Aiden’s heart condition is stable, he has great difficulty with bowel movements. When the Shusters first took custody of Aiden, his poop was exceptionally smelly and had “stinky diarrhea blowouts” six to eight times a day. This has improved over

time, Elizabeth reports. His poop is now the consistency of peanut butter rather than pure liquid and “the smell of his poo is a lot better than it was in China but it’s still not normal.” Elizabeth describes Aiden’s attempts to have a bowel movement: he “shakes, cries, and sweats when he’s trying to go. He has always seemed like he’s in pain.”

When asked about how attachment with Aiden is going, Elizabeth says that she’s felt more like a caretaker than a mother, largely because of the sheer amount of diaper changes and cleaning Aiden needs. She says this is improving. The amount of time Elizabeth has had to spend taking care of Aiden has also impacted her relationship with her biological son, Colton. Elizabeth gets teary and says, “I feel like I’m cheating on my son, I mean my biological son.” Dr. Smith reassures her that these feelings are common and should improve over time.

Like the story Dr. Barrett told, Elizabeth is challenged by Aiden’s needs related to feces, diapering, and cleaning, and these struggles are exacerbated by her pregnancy and the needs of other family members. Elizabeth perceives that this feeling—more like a caretaker than a mother—is problematic and shares her concern with Dr. Smith. In her role as expert, Dr. Smith comforts Elizabeth with her knowledge of family-making.

“All About Poop and Pee”—Bella

Claire and her husband adopted two girls from China in 2005 and 2011. Although both were classified as “non-special needs” both have been plagued by poor health and delayed development. “When we met Bella in China, we knew there was a problem,” Claire reports.

“With our oldest, everything [in the medical record] had been wrong. With Bella, the only thing her file said was that she was a healthy little girl but when she got sick, she was

sick longer than the other children. This concerned me, but I figured it was something like asthma. But when we met her, it was clear she was a sick little girl. We got home on her [first] birthday at the end of June. By the first weekend in August she was in the hospital with sepsis.” Over the next few months, Bella continued getting sick.

She kept getting infections. Ear, sinus, UTIs [urinary tract infections]. She didn’t have an immune system. We thought it was malnutrition and that she was just slow to recover from malnutrition. Between August and December she was on antibiotics 4 or 5 times. And they thought she had renal reflux⁷⁷ and that she would outgrow it, but we had to watch her closely. We had to bag her urine⁷⁸ but she had a strong bladder! She could hold it and then let it all go in a gush! The bag would fall off and urine would be everywhere.”

In December Bella had her first seizure and was hospitalized for several days. Bella underwent “a gamut of tests” and saw “tons of specialists.” Bella tested negative for Celiac disease, but her parents removed gluten from her diet anyway. Claire says the results were “astounding”: “she’s a different kid.” Bella’s development accelerated, seizures stopped, and her immune system improved, ending the cycle of recurrent infections Bella has experienced. No specific cause has been identified, but the dietary changes so dramatically improved Bella’s health that her doctors agree that some gluten intolerance or allergy was behind Bella’s early ill health.

The period when Bella was acutely ill was difficult for Claire: “I felt like because of her symptoms, I am all about poop and pee. I had a master’s degree and all I did was talk about pee and poop...for a year.” Here, Claire juxtaposes her level of education—a master’s degree—with the caretaking practices of parenting a sick child. Unlike Aiden’s mother, Elizabeth, Claire does not report problems bonding with Bella. Also unlike Elizabeth caring

⁷⁷ Renal reflux, or Vesicoureteral reflux occurs when urine flows back into the ureters rather than the bladder. This problem allows bacteria to build up in the urinary tract, causing UTIs (Mayo Clinic 2018b).

⁷⁸ Collecting urine with a catheter and plastic bag.

for Aiden, Claire does not seem overwhelmed by Bella's needs, possibly because Claire is reflecting on events that took place several years before, while Elizabeth is currently impacted by Aiden's needs. But her interview shows the extent to which caretaking around elimination is a challenge. Claire became "all about poop and pee" until Bella's health improved.

In each of these cases, the parents are taking on and perhaps struggling with the degree of physical body work parenting their specific children requires. The parents of Dr. Barrett's patient with fecal incontinence and Elizabeth Shuster, mom of Aiden who has painful bowel movements, express distress that they are more caretakers than mothers. What does "caretaker" mean or signify in these cases?

Further, diapering and toileting are tasks that generally all parents are expected to engage in in order to care for their children. What makes these situations remarkable and worthy of discussion?

First, we can see how "matter out of place" is distressing to these mothers. Dr. Barrett's client contends with constant feces coming from her child's penis. Aiden's bowel movements occur in the expected location (a diaper), but stand out because of the unexpected smells, consistency, and pain. Bella's catheterization leads to leaks and messes, very much matter out of place.

Because matter is out of place, it seems, requiring significant levels of body work, some parents feel that they are doing low-status work. Feeling like a caretaker rather than a mother is indicative of feeling they are occupying a social position lower than the one they signed up for. Even Claire, Bella's mom, describes herself as "all about poop and pee." We

do not get the sense that being “all about poop and pee” interfered with Claire and Bella’s relationship, but it was a notable situation for Claire. Though the outcome for Bella and Claire’s relationship was not particularly negative, Claire’s sense of self was altered. She went from a relatively high status position—with a master’s degree—to a relatively low status position—being “all about poop and pee.”

Parasites

I have examined the role of the fecal sample in clinician-parent-child relations and highlighted the impact of body care work concerning elimination on the family. What happens when a pathology, in the form of a parasite, is found in (or on) an adopted child?

Parasites and “Good Mothers”

In chapter 6 I introduced the Tiven family. Karen and Chris Tiven adopted two-year-old Lucy from China just weeks before. Though there was some evidence of past poor health in her medical record, and the family had struggled with bonding the first few days, Lucy was mostly healthy.

At the end of Lucy’s initial visit at The Clinic, Dr. Smith conducted her usual physical exam. With Lucy across Karen’s lap, Dr. Smith took off the child’s diaper to do a genito-urinary exam. “Looks good,” Dr. Smith started to say. “Oh, wait. Hold on. Let me get this.” As she reached for a swab and sample container, Dr. Smith pointed out a tiny worm on Lucy’s vulva. Karen gasped, “Oh god, really? I can’t believe I didn’t see that.” Dr. Smith comforted Karen: “It’s just a pinworm. They’re very common.” Karen continued, “You must think I’m a bad mom.” “Not at all!” said Dr. Smith as she tried to convey that the pinworm was not a big deal, but Karen remained visibly disturbed.

Karen's reaction here is a combination of disgust and concern that the existence of parasites in their children's bodies indicate a failure at mothering. In response, Dr. Smith comforts Karen by trying to normalize the pinworm. Her expertise as an infectious disease doctor and IAM clinician is meant to reassure Karen about both the relative clinical insignificance of the worm and what it means about her performance as a mother.

Leah and The Worm

I met Marcia Singer in The Clinic, when she brought her newly adopted daughter, Cecilia, born in China, in for her initial evaluation. A focal point of this clinic visit and a later interview with Marcia was the story of her older daughter, Leah, and The Worm. When I interviewed Marcia, I asked her to tell me more about Leah's experience with the parasite.

It was horrible, I wish I could erase it from my memory. I think Leah was about two, but maybe not quite that old yet. Anyway, that night she ended up in our bed. And thank goodness she was in our bed. She started coughing this horrible cough, like she was choking. Then I saw what it was. And I was screaming to Mike [her husband]! He grabbed it and pulled it and put it in a plastic bag. We called the pediatrician and went in that morning. I can't remember what it was, but he said it was from the digestive system and was fairly common worldwide. And he said, 'She did not get this in your backyard.' He said that it's rarely seen [in the U.S.] but that it's becoming more common because people are coming from elsewhere. Her pediatrician at the time was the chief of staff at [a large children's hospital] and he was a little excited. He wanted to keep it to show it to students. He actually remembers her because of the worm.

Indeed, Dr. Smith, part of the same large children's hospital as Leah's pediatrician, also remembered Leah because of the worm.

As I wrapped up the interview, Marcia brought up the worm incident again. "Still, it's like a dream. And Leah went right back to sleep. Thank goodness she'll never remember this. Or she will think it was a horrible nightmare. I wish I could go back to sleep and forget about it. But luckily there were no ill effects." Not only did the worm not harm her child, but

Marcia credits the worm for Leah's robust immune system. "I forget to schedule her regular check-up because she's never sick." Despite this seeming positive benefit, Marcia continues to be disturbed: "It was so upsetting, just knowing that all this time, it was in there. Ugh."

Marcia is relieved that Leah will not remember this. But the existence of the parasite and its relative rarity causes all of these adults and clinical professionals to remember Leah because of the worm. Unlike Karen, Marcia does not explicitly worry that she is a "bad mother" because Leah had a worm, but experiences distress "knowing that all this time, it was in there."

Like feces, parasites can be understood as "matter out of place." Parasites, especially intestinal parasites, are highly objectionable creatures to find in their child's body.

Parasites also draw our attention to the role of parents. Marcia is haunted, in a sense, by the very idea that a worm has been in her child's body. Karen is not haunted, but is disturbed by the pinworm and concerned that its presence indicates she is a "bad mother."

Conclusion to Chapter 7

Attention to feces and parasites draws us back to one of the reasons IAM exists—to monitor and treat children for the intestinal parasites uncommon in the U.S. To extend this idea, the centrality of parasite screening through stool samples points to the importance of examining feces and parasites as unexplored sites of social interaction.

These ethnographic examples illustrate the impact of continence problems and parasites on parenting, care work, and the adoptive family. Bourdieu (1996) argues that "clean practices" and labor around gift giving, photographs, and visiting aid in the formation of family. He does not reflect on the physical body work that occurs primarily in private

spaces. Through this ethnography, we see the key role of parents, particularly mothers, in the dirty work of toileting, diapering, and managing intestinal maladies such as parasites. The impact of dirty work on family feeling varies. For some parents, the contending with poop all the time—being “only” a “caretaker”—makes it hard to bond with their child. Other parents may feel their lives are consumed by their children’s physical needs, but this does not interfere with bonding.

As Lupton (2013) found in her ethnographic analysis of Australian mothers caring for children with minor illnesses, caretaking work is hard physically and emotionally. The level of care work that is required of parents of children with continence issues is high. Beyond simply the labor required, some parents may experience difficulty bonding with their child. Van der Geest’s (2007b) argument that the feces of infants and children are usually not regarded as disgusting is challenged here. Van der Geest, of course, is considering the biological children of mothers, not children who are adopted by adults who did not birth them.⁷⁹ He is also considering generally healthy children, not children with physical conditions or intestinal parasites that lead to incontinence, diarrhea, and odor.

It is disgust, as well as the burden of labor, that lead some mothers to feel as though they are more caregivers than mothers. Rather, these ethnographic data suggest a more complicated relationship among parenting, care, and feces than Van der Geest posits. Further, guarding children’s health and exercising control over their bodies is key to perceiving oneself as a “good mother.”

These “dirty” practices that occur in private may evoke disgust and discomfort but are important in understanding how the family is made real through practice. Shit happens, and

⁷⁹ I don’t want to imply that adopted children are not “real” children to their adoptive mothers or that biological mother-child relationships are somehow better (more attached) than adoptive ones. That’s not accurate, nor is it the point.

shit matters when it comes to family feeling and the consolidation of family.

CHAPTER 8: CONCLUSION

My ethnographic analysis of IAM and its actors shows how one biomedical sub-specialty helps to produce, consolidate, and make visible families. Using the domains of “family feeling,” attachment, and physical caretaking, I demonstrate how IAM and practices of health and medicine aid adoptive families as they “do family.” Through talk, action, and repetition “family/families” are real units and institutions, as well as ideas and discourses.

I’ll end with the story of Douglas, the child who sticks with me the most, and who has been hardest to write about, in all of the 80+ kids I saw in the clinic.

Douglas

Douglas was one of the first kids I met at The Clinic. Age 5, adopted from Hungary, he was probably the most damaged child I met. At his first visit, four days after he entered the U.S. with his adoptive parents, Bill and Linda Hill and 6-year-old brother Seth (the Hill’s biological child), Linda described how they came to adopt Douglas. They had received referral information about him and traveled to Hungary to complete the adoption. When they met him, he was significantly more delayed than they expected and they decided they could not parent him. But it was too late—they had fallen in love with him and could not send him back to the foster home. The Hill family stayed in Hungary for a month, waiting for the adoption to be approved and for Douglas to receive a visa.

Douglas is a cute kid. He has olive skin, dark hair, and dark eyes. Linda reports that he’s “a Gypsy” (Roma) which is why no one local wanted to adopt him and he was treated poorly in the foster home. He also does not have the abilities of a typical 5-and-a-half-year-old child. Molly, the occupational therapist, assesses his speech and personal/social skills as

typical of a 36-month-old child (3 years old). He's closer to typical on fine and gross motor skills, but still delayed.

Linda doesn't know for sure, but thinks Douglas was in "3-4 foster homes" before being adopted. When they met Douglas, he was in a foster home with 8 other children. Linda thinks he spent lots of time alone in a room or crib. "I think the reason it takes him so long to eat a meal," Linda says, "is because in the foster home, as long as he was eating, he could stay in the kitchen. When he was done, he had to go back to his room."

His body reflects this neglect. He has low muscle tone everywhere, including his mouth. The right side of his body is weak and he has trouble "crossing the midline."⁸⁰ When the Hills first took custody of him, he ran bowlegged, "like a monkey," though this has greatly improved. He seems to have a speech deficit in both English and Hungarian; the translator has a hard time understanding him. Linda believes he has "no intellectual curiosity," as he doesn't ask questions and only does things when he is explicitly told to do them: "he's completely externally motivated," she reports. It was clear that he'd never been to a playground before the Hills took custody of him; he didn't know what to do with all of the equipment and structures. His front teeth seem okay, but his back teeth are broken and eroded from lack of dental care. All of that said, Linda thinks someone cared for him, at least some of the time. When they first took custody of him, he cried for his "aiya."⁸¹

In addition to the malnutrition, lack of stimulation, poverty, and neglect common in institutional care, it seems likely he was abused physically and sexually. The first time they

⁸⁰ The ability to "cross the midline" is important in assessing development. "The body's mid-line is an imaginary line down the centre of the body that divides the body into left and right. Crossing the body's mid-line is the ability to reach across the middle of the body with the arms and legs" (Kid Sense Child Development n.d.; also see Cermak, Quintero, and Cohen 1980).

⁸¹ This is what I heard and wrote in my notes. The Hungarian word for 'mother' is 'anya,' so it's likely I misheard.

bathed him, he shook uncontrollably and held his hands over his genitals. Linda saw an older boy with his shirt off in the pictures the foster home sent with Douglas. She says they “were creepy and made my stomach hurt. Something doesn’t seem right.” His first reaction to any sensation is “ow” or “ouch.” Linda says, “I assume not nice things happened to him.” When the nurse went to look in his ears with an otoscope, he looked terrified and said “ouch!” Linda believes his extreme compliance and desire to please those around him is linked to abuse. “He probably got by [in the foster home] by being cute” and doing what he was told. The translator asks Douglas a few questions about the foster home, but she reports that he seems afraid and doesn’t want to talk about the other kids.

The OT and translator comment that they are optimistic about Douglas’ ability to grow and thrive in the Hill family. “Me too,” Linda says, “I wouldn’t have brought him here [the U.S.] and make him learn all new things if I thought he couldn’t learn.” Indeed, Linda and the other Hills have worked hard the last 40 days they’ve had Douglas to improve his strength and exercise his muscles. Linda gives him exercises that require crossing the midline. Seth gives him pieces of candy to unwrap so that he gets practice using both hands. Linda works for a medical supply company, and her co-workers have used their connections to people with expertise in speech, physiotherapy, and development; Linda has gotten advice from these experts.

Dr. Smith is astounded when she meets Douglas: “He’s a different kid!” She had reviewed some of the medical records and had talked to Linda about Douglas while they were in Hungary. “Really, he’s doing much better developmentally than we thought.” Like the OT and translator, Dr. Smith is reassuring: “I think he’s gonna be okay. She tells Linda, “What a blessing you are to him and vice-a-versa.”

At his next visit, the 6-month follow up, Douglas has made significant gains as measured by the developmental assessment. He now exhibits the speech/language skills of a 45-month-old (3 years and 9 months) and the personal/social skills of a 42-month-old (about 3 and a half years old), though skills in both of these domains are described as “scattered” by the OT, which means these skills are disorganized and not progressing in a linear way. His fine motor skills have nearly caught up, and his gross motor skills have improved slightly.

Linda reports to Dr. Smith that Douglas doesn’t know how to play. “I sent the boys to the backyard to play. I’m at the kitchen sink doing dishes and I look up. Seth is playing on the swing set, running around. He’s playing. Douglas is standing there, staring into space. He looks toward the house and sees me watching and he starts pretending he’s playing. Jumping up and down, running, and checking to make sure I see.” Linda reported other oddities in his play-related behavior: “When you tickle his feet and he sees you tickle his feet, he rolls around like he’s laughing, I think because he’s seen Seth be ticklish. When you tickle his feet and he doesn’t see you, no reaction. I think he’s pretending to be ticklish because he knows that’s what he’s supposed to do.” In Linda’s words, “he’s trying so hard. It’s like he’s looking for a script.”

I came to think of Douglas as “the boy who doesn’t know how to play.”

At both visits, Linda points out things she finds strange about his body. In addition to his low tone and inflexibility, she thinks his body is unusual. His posture: “he has an old man belly and his lower back sags.” (Dr. Smith: “yes, his posture is unusual.”) His ear: “It doesn’t look right. Could that be anatomy that’s found in Gypsies?” (Dr. Smith: “I can’t see very well, but that just looks like a physical variation. And I doubt it’s connected to his ethnicity.”) His organs: “his kidneys seem big.” (Dr. Smith, palpating his lower back: “They

do seem low.”) His genitals: “something seems amiss, they look different.” (Dr. Smith: “There’s a lot of variation in genitals. I think he looks fine.”) Though she is mostly reassuring about his physiology, even Dr. Smith observes that he has a “really interesting body.” They catalog his birth marks: two on his chest and one small on his face. “If we find enough oddities,” Dr. Smith says, “we can refer him to Genetics.”

At his second visit, Dr. Smith and Linda talk about the best way to get him intervention services like speech, occupational, and physical therapy. Insurance has denied paying for speech therapy. The local school system didn’t want to assess him because his developmental gains over 6 months had been so great. “I feel like I’m being punished for working so hard with him,” Linda says. Dr. Smith wants to get an MRI of Douglas’ brain. “Maybe we can find evidence there’s something wrong. Like he doesn’t have a corpus callosum or he was shaken.” She didn’t say this callously or rudely. Linda agreed: “that would be awesome!” For Dr. Smith and Linda, an abnormal brain MRI is the ticket to intervention services. If there’s something structural to point to, Douglas’ global delay can’t be explained away as “adjusting to the U.S.” or “learning a new language.”

The last 6 months have been hard on the whole family: “Sometimes it feels like there’s a little stranger in my home,” Linda says. Seth, the Hills’ biological son, has had to “mature really fast” because his parents are absorbed with meeting Douglas’ needs. One night he woke up because he had to pee. He went to his parents’ bedroom room and asked mom if he could go. She didn’t wake up, so he urinated on the floor. While Douglas is still very compliant, wanting to please them, he has started to misbehave a bit. Linda is a little pleased about this, as she wants him to show some sign of internal motivation or independence. “One morning I told him to get dressed and left the room. When I came back,

he'd gone back to bed." Linda sees this as progress, though she'd rather he show independence that does not involve directly disobeying her. Douglas has lied, blaming Seth for incidents. The vacation to visit family had been rough. Douglas did not do well with travel, meeting new people, and the change in routine. While traveling, he exhibited tics of his head, neck, and tongue.

Linda is worried about the future: "I hope he can live independently, but he's so vulnerable. And I worry that he lacks empathy." She worries about safety, as he doesn't fear cars or strangers. He might be hit by a car or influenced by people who intend to harm him. For Linda, the worst-case scenario would be if they couldn't care for him and he had to be institutionalized.

I don't know what happened to Douglas. I don't know the results of the MRI or if insurance paid for speech therapy. I don't know what his behavior is like now, if he's adjusted to preschool, and whether he can cross his midline yet.

Douglas isn't the typical kid I saw in The Clinic. Many of the kids had one or two problems, maybe language delay and dental problems, or attachment problems but no cognitive problems. In contrast, Douglas has been impacted by institutionalization at all levels.

Family in the IAM Clinic

The Hills provide a window into international adoption, IAM, and the parenting of internationally adopted children, but what are we to make of their story?

It's taken me a long time to write about Douglas. More than once, I've sat down intending to write about Douglas and I end up closing my laptop and walking away, "this is too depressing," I think. The first time I met Douglas, I intellectualized him. I was new

enough to The Clinic and to the literature on the effects of institutionalization that I was fascinated by Douglas. At the time I met Douglas, my first son was about a year older than him. I could see how Douglas was very delayed when compared with my (mostly) typically developing son. I could compare him to my 6-year-old, comfortable knowing that my son has passed all of these developmental milestones. Reading these notes again, five years later, I have a toddler, and thinking about Douglas is sobering. My toddler hasn't passed all of the milestones that Douglas struggled with, but I can see them happening, with growth and development almost daily. My son climbs on playground equipment, laughs because he genuinely thinks something is funny, defies his parents, has started to fear strangers, and is incredibly curious. My son has not had the experiences Douglas probably had—lack of stimulation and physical affection, abuse—so his development continues as expected.

Indeed, I can still intellectualize Douglas' story, as it highlights the theories that underpin this ethnography. We see the repeated talk and action that Linda, her husband, and Seth engage in order to make Douglas part of the family, and to make him a healthy part of the family. The Hills meet his physical needs by cleaning him when he wets himself, bathing him, and teaching him to dress himself. More than anything, they want Douglas to attach to them, and to avoid unhealthy attachments to strangers or "bad influences."

Douglas' story also reveals how cultural health capital can operate in IAM. Linda has the "cultural health capital" (Shim 2010) to intervene on Douglas' behalf. She has connections in health care from whom she seeks advice. The knowledge and connections she has underpin her understanding of her role as a mother: to do everything she can for Douglas, to exhaust the therapies he might need.

Douglas too, is engaging in action that consolidates his belonging in the Hill family.

He wants to please them, and he wants affection from them. He's not used to playing or being tickled, but "performs" playing and giggling because he knows his family expects him to.

We see anxiety about Douglas' belonging in the family too. Linda and her husband initially worried that they could not parent a child with the severe, global delays Douglas exhibited. Linda worries about the effect of Douglas, and his belonging in the family, on Seth. She does not know if Douglas will be able to develop the skills necessary to be a healthy member of a healthy family—empathy, self-care, curiosity, and physical fitness. In spite of these worries and even as she casts Douglas as a "little stranger" in "her home", Linda's goal is to make Douglas whole, healthy, and to make her family work.

The Clinic staff help the Hills as they try to be a family. They are reassuring, but honest, at every turn. They believe in the Hills' ability to give Douglas what he needs. The Hills don't depend on IAM to make their family, but they do make use of the field's tools to bring their family to health. Dr. Smith, in particular, is pleased to see Douglas with the Hills. More than anyone in this story, she has seen the effects of neglect on children and their adoptive families. Even knowing that they have a difficult and uncertain road ahead, she sees them as "blessings" to one another. She wants this family to work too.

Risk and Medicalization

Douglas and the Hills also highlight the complexity of medicalization and risk management in contemporary biomedicine. Linda and her husband understand that adopting Douglas comes with a great deal of risk: risk that they cannot provide the care he needs, risk that he will be unable to be a part of a family, risk that Douglas' needs will negatively impact Seth, risk that his impairments are severe and untreatable, and risk that he will suffer as he

grows up.

Dr. Smith and IAM help Linda manage risks, to a certain extent. Dr. Smith's expertise about the effects of institutionalization and children gives some credence to her declaration that she thinks "he's gonna be okay" and praise for the work the Hills have done to help him catch up.

Beyond this expertise and verbal comforting, Dr. Smith has tools at her disposal to help manage the risks of raising Douglas. By ordering an MRI and possible genetics screen, Dr. Smith hopes to give Douglas the diagnosis that will help him access educational and therapeutic services. Douglas, and his family, come under medical authority and expertise. Dr. Smith uses this process of medicalization as a tool for good—to ensure that Douglas will get all that he needs. Neither medicalization nor risk are monolithic and nonnegotiable. Instead, they are managed in concert by the family and IAM.

Contributions to Anthropology

Inside and outside of the clinic, IAM and the knowledge it produces are used by adoptive families as they form themselves, negotiate what it means to be an internationally adoptive family, and produce health. IAM, in turn, builds its expertise on the experiences and needs of adoptive families.

As part of a larger ethnography, Douglas's story contributes to the anthropological literature on biomedicine and kinship. Challenging the centrality of the bio genetic in kinship, ethnographies of adoption contribute to our understanding of the diversity of family forms and formation. Ethnographies of biomedicine highlight how clinical spaces both produce and are produced by broader society. This ethnography is distinct in that it layers

kinship and biomedicine, exploring how the two realms interact and mutually shape each other.

APPENDIX A: EARLY IAM ARTICLES, 1975-2003 ^{82,83}

<u>Topic</u>	<u>Title</u>	<u>Author(s)</u>	<u>Year</u>	<u>Journal</u>
Nutrition	“Malnutrition and Environmental Enrichment by Early Adoption”	Winick, Meyer, and Harris	1975	<i>Science</i>
Nutrition	“Early Malnutrition and ‘Late’ Adoption: A Study of Their Effects on the Development Of Korean Orphans Adopted Into American Families”	Lien, Meyer, and Winick	1977	<i>American Journal of Clinical Nutrition</i>
Infectious disease	“Incidence of Hepatitis B Carriers among Adopted Korean Children” (Letter)	Greenblatt and Khoo	1985	<i>New England Journal of Medicine</i>
Infectious disease	“Selected Infectious Disease Risks in International Adoptees”	Lange and Warnock-Eckhart	1987	<i>Pediatric Infectious Disease Journal</i>
Infectious disease	“Adoption of Children From Countries With Endemic Hepatitis B: Transmission Risks and Medical Issues”	Hershow, Hadler, and Kane	1987	<i>Pediatric Infectious Disease Journal</i>
Overall adoptee health	“Medical Problems of Foreign-Born Adopted Children”	Jenista and Chapman	1987	<i>American Journal of Diseases of Children</i>
Infectious disease	“Transmission of Hepatitis B Virus From Adopted Asian Children to Their American Families”	Friede et al.	1988	<i>American Journal of Public Health</i>
Infectious disease	“Results of Screening Adopted Korean Children for HBsAg” (Letter)	Murray et al.	1988	<i>American Journal of Public Health</i>
Infectious disease	“Unsuspected Infectious Diseases and Other Medical Diagnoses in the Evaluation of Internationally Adopted Children”	Hostetter et al.	1989	<i>Pediatrics</i>
Overall adoptee health	“International Adoption: An Introduction for Physicians”	Hostetter and Johnson 1989	1989	<i>American Journal of Diseases of Children</i>

⁸² I define “early” IAM publications as those appearing in the literature before the publication of the first comprehensive texts on IAM: Miller’s 2005 *The Handbook of International Adoption Medicine* and the 2005 special issue on IAM published by *Pediatric Clinics of North America* (Albers et al. 2005).

⁸³ Notes: I have excluded the handful of articles on the health of children adopted into countries other than the U.S. I have excluded articles about orphans who are not adoptees. I have included clinically-based letters, but have excluded correspondence in response to articles.

Infectious disease	“Mycobacterium Tuberculosis Infection in Foreign Born Adoptees”	Lange, Warnock-Eckhart, and Bean	1989	<i>Pediatric Infectious Disease Journal</i>
Country-specific, general health	“The Health of Children Adopted from India”	Smith-Garcia and Brown	1989	<i>Journal of Community Health</i>
Infectious disease	“Infectious Disease Risks Among Filipino Adoptees”	Ascher and Montez	1991	<i>Journal of Tropical Pediatrics</i>
Overall adoptee health	“Medical Evaluation of Internationally Adopted Children”	Hostetter et al.	1991	<i>New England Journal of Medicine</i>
Country-specific, general health	“The Health of Children Adopted From Romania”	D. Johnson et al.	1992	<i>JAMA: The Journal of the American Medical Association</i>
Infectious disease	“Chronic Hepatitis B In Adopted Romanian Children”	Zwiener, Fielman, and Squires	1992	<i>Journal of Pediatrics</i>
Infectious disease	“Chronic Active Hepatitis B Infection in Romanian Adoptees”	DeVoid et al.	1994	<i>Journal of Pediatric Gastroenterology and Nutrition</i>
Nutrition	“Developmental and Nutritional Status of Internationally Adopted Children”	Miller et al.	1995	<i>Archives of Pediatrics & Adolescent Medicine</i>
Infectious disease	“Horizontal Transmission Of Hepatitis B From Children to Adoptive Parents” (Letter)	Sokal, Van Collie, and Buts	1995	<i>Archives of Disease in Childhood</i>
Country-specific, general health	“Health of Children Adopted From the Former Soviet Union and Eastern Europe: Comparison With Preadoptive Medical Records”	Albers et al.	1997	<i>JAMA: The Journal of the American Medical Association</i>
Mental health/Development	“Sensory Processing in the Post-institutionalized Child”	Cermak and Daunhauer	1997	<i>American Journal of Occupational Therapy</i>
Infectious disease	“Infectious Diseases in Internationally Adopted Children: The Past Five Years”	Hostetter 1998	1998	<i>Pediatric Infectious Disease Journal</i>
Infectious disease	“Immunization Status of Adoptees from China, Russia, and Eastern Europe”	Hostetter and Johnson	1998	<i>Pediatric Research</i>
Overall adoptee health	“Primary Care of International Adoptees”	Quarles and Brodie	1998	<i>American Family Physician</i>
Mental health/Development	“Institutionalization, Behavior, and International Adoption”	Groza	1999	<i>Journal of Immigrant Health</i>

Infectious disease	“Infectious Diseases in Internationally Adopted Children: Findings in Children From China, Russia, and Eastern Europe”	Hostetter	1999	<i>Advances in Pediatric Infectious Diseases</i>
Language	“Speech and Language Problems in International Adoptees”	McGuinness and McGuinness	1999	<i>American Family Physician</i>
Overall adoptee health	“Caring for Internationally Adopted Children” (Letter)	Miller	1999a	<i>New England Journal of Medicine</i>
Infectious disease	“Internationally Adopted Children—Immigration Status” (Letter)	Miller	1999b	<i>Pediatrics</i>
Mental health/Development	“Elevated Blood Lead Levels Among Internationally Adopted Children -- United States, 1998”	Centers for Disease Control and Prevention	2000	<i>MMWR: Morbidity & Mortality Weekly Report</i>
Mental health/Development	“International Adoption of Institutionally Reared Children: Research and Policy”	Gunnar, Bruce, and Grotevant	2000	<i>Development and Psychopathology</i>
Mental health/Development	“Competence of Children Adopted From the Former Soviet Union”	McGuinness and Pallansch	2000	<i>Family Relations</i>
Country-specific, general health	“Health of Children Adopted From China”	Miller and Hendrie	2000	<i>Pediatrics</i>
Nutrition	“Vitamin D–Deficiency Rickets in Adopted Children From the Former Soviet Union: An Uncommon Problem With Unusual Clinical and Biochemical Features”	Reeves et al.	2000	<i>Pediatrics</i>
Mental health/Development	“Parental Assessment of Behavior in Chinese Adoptees During Early Childhood”	Rojewski, Shapiro, and Shapiro	2000	<i>Child Psychiatry and Human Development</i>
Mental health/Development	“Disturbances of Attachment in Young Children Adopted From Institutions”	Zeanah	2000	<i>Journal of Developmental and Behavioral Pediatrics</i>
Infectious disease	“Tungiasis in North America: A report of 2 Cases in Internationally Adopted Children”	Fein et al.	2001	<i>Journal of Pediatrics</i>
Infectious disease	“Immunization Status of Internationally Adopted Children”	Miller, Comfort, and Kelly	2001	<i>Pediatrics</i>
Infectious disease	“Prevalence of Infectious Disease Among Internationally Adopted Children”	Saiman	2001	<i>Pediatrics</i>

Infectious disease	“Measles Outbreak Among Internationally Adopted Children Arriving in the United States, February-March 2001”	Centers for Disease Control and Prevention	2002a	<i>MMWR: Morbidity & Mortality Weekly Report</i>
Infectious disease	“Pertussis in an Infant Adopted From Russia”	Centers for Disease Control and Prevention	2002b	<i>MMWR: Morbidity & Mortality Weekly Report</i>
Language	“Language Development and Delay in Internationally Adopted Infants and Toddlers: A Review”	Glennen	2002	<i>American Journal of Speech-Language Pathology</i>
Language	“Typical and Atypical Language Development in Infants and Toddlers Adopted From Eastern Europe”	Glennen and Masters	2002	<i>American Journal of Speech-Language Pathology</i>
Infectious disease	“Evaluating Acceptability and Completeness of Overseas Immunization Records of Internationally Adopted Children”	J. Schulte et al.	2002	<i>Pediatrics</i>
Infectious disease	“Infectious Disease Issues in Internationally Adopted Children”	Staat	2002	<i>Pediatric Infectious Disease Journal</i>
Infectious disease	“Preventing Infectious Diseases During and After International Adoption”	Chen 2003	2003	<i>Annals of Internal Medicine</i>
Infectious disease	“Tinea Capitis Due to Trichophyton Soudanense in Cincinnati, Ohio, in Internationally Adopted Children From Liberia”	Markey et al.	2003	<i>Pediatric Dermatology</i>
Infectious disease	“Serologic Prevalence of Antibodies to Helicobacter pylori in Internationally Adopted Children”	Miller et al.	2003	<i>Helicobacter</i>

APPENDIX B: DIAGNOSES AND CIRCUMSTANCES OF INDIVIDUAL CHILDREN OBSERVED IN CLINIC FIELDWORK ⁸⁴

<u>Continent</u>	<u>Age range</u>	<u>Sex</u>	<u>Diagnosis/Circumstances</u>
Africa	under 1 year old	Female	intestinal issues, sibling set
Africa	1-2 years old	Female	malnourished, suspected parasite, small hernias
Africa	1-2 years old	Male	history of respiratory issues, meningitis, and malaria. Dx as malnourished, no uvula
Africa	2-3 years old	Male	history of malaria and intestinal parasites, suspected ricketts, malnourished
Africa	3-4 years old	Male	enuresis, congestion (resolved), sibling set, intestinal parasites, possibly microcephalic
Africa	5-6 years old	Female	intestinal issues, scarring on arm and belly (possible cooking fire?), sibling set
Africa	6-7 years old	Male	enuresis, no uvula, sibling set
Africa	8-9 years old	Male	no uvula, sibling set, microcephalic
Africa	10-11 years old	Male	no uvula, history ear infection, sibling set, resolved Hep B, intestinal parasites
Asia	under 1 year old	Male	healthy referral, reactive skin
Asia	1-2 years old	Female	healthy referral
Asia	1-2 years old	Female	developmental delay, catching up
Asia	1-2 years old	Female	healthy referral, but had tear duct surgery after adoption
Asia	1-2 years old	Female	cleft lip and palate
Asia	1-2 years old	Female	healthy referral, scratches self, left eye may be slightly turned in (ptosis)
Asia	1-2 years old	Female	healthy referral, currently has cold and fever
Asia	1-2 years old	Female	abnormal liver function test, blue spell in China, history respiratory issues, pinworm on vulva
Asia	1-2 years old	Female	cleft lip and palate
Asia	1-2 years old	Male	syphilis dx (treated), chronic cough, malnourished
Asia	1-2 years old	Male	cleft lip/palate, scleral freckle, mild developmental delay, malnourished
Asia	1-2 years old	Male	cleft palate, facial asymmetry, failure to thrive
Asia	2-3 years old	Female	cleft palate, polydactyly, hearing loss
Asia	2-3 years old	Female	Congenital heart (PDA and VSD) (repaired),
Asia	2-3 years old	Female	hemangioma of the ear (repaired), rash (possible chicken pox exposure)

⁸⁴ Notes: Diagnoses and descriptions are drawn from fieldnotes, not official medical records. In order to protect the privacy of participants, I have listed children by continent/region, rather than individual country.

Asia	2-3 years old	Female	cleft lip and palate
Asia	2-3 years old	Male	Tetralogy of Fallot, digestive issues (painful diarrhea)
Asia	2-3 years old	Male	scoliosis, spina bifida, compressed left lung, horseshoe kidney, clubfoot, lesion on back, history UTI, hernia repair, failure to thrive, possible heart issues (due to organs shifting), sibling set
Asia	3-4 years old	Female	HIV positive, sibling set
Asia	3-4 years old	Female	Downs Syndrome, Congenital heart defect (ASD, repaired), anemic, malnourished, oral sensitivity, developmental delay, open Fontanelle,
Asia	3-4 years old	Female	spina bifida, suspected hydrocephalus, kidney issue, possible facial dysmorphism, sibling set
Asia	3-4 years old	Female	nephrotic syndrome, respiratory issues, treated for suspected TB, history of edema, blood pressure issues, possible Cox disease (can't match this to a disease definition)?, sibling set
Asia	3-4 years old	Female	cleft lip/palate, reported history of heart murmur (resolved)
Asia	3-4 years old	Male	HIV positive, sibling set
Asia	4-5 years old	Female	Downs Syndrome, congenital heart defect (not repaired), leg problem, developmental delay
Asia	4-5 years old	Male	congenital eye deformity, indentation on forehead
Asia	5-6 years old	Female	Suspected heart problems (China dx of vesicular aneurysm), eye malformation/vision problems (strabismus), limb (leg) differences
Asia	5-6 years old	Female	anal atresia, persistent cloaca
Asia	5-6 years old	Female	tested HIV positive at birth, now tests negative
Asia	5-6 years old	Male	ear tubes, Behavior--aggressive, sensory issues
Asia	5-6 years old	Male	repaired cleft lip, partially deaf, speech delay, hyperactive
Asia	6-7 years old	Female	upon adoption, had parasites. Now, post-adoption: constipation/bathroom issues, behavior, insecurity
Asia	6-7 years old	Female	Club feet, depressed, anxious, attachment problems (ignores family)
Asia	6-7 years old	Female	respiratory issues, asymptomatic nephrotic syndrome, treated for suspected TB, history of pneumonia, sibling set

Asia	8-9 years old	Male	Malformed ear ("little ear"), hearing loss, ear tubes, tics, anxious and fearful, suspected sensory issues, suspected ADHD, developmental delay
Asia	8-9 years old	Male	history UTIs, history of TB, respiratory issues, scar on foot from campfire, sibling set
Asia	9-10 years old	Female	hydrocephalus, but stable, history of TB meningitis (US docs doubt), possible cognitive delay
Asia	9-10 years old	Female	limb differences, scleral freckle, treated for TB
Asia	9-10 years old	Female	Behavior issues, unresolved pediatric pain, possible Ehlers-Danlos syndrome, "family in crisis"
Asia	14-15 years old	Female	spina bifida (needs confirmation because missing some symptoms like incontinence), necrotic sores on feet, history of frostbite,
Asia	17-18 years old	Female	history of TB, limb (arms and hands) differences, anxiety, attachment difficulties
Central/South America and Caribbean	2-3 years old	Female	Healthy
Central/South America and Caribbean	3-4 years old	Female	overall healthy, slight malnutrition, sibling set
Central/South America and Caribbean	3-4 years old	Male	speech issues, possible hearing loss, lactose intolerant,
Central/South America and Caribbean	4-5 years old	Female	TB, abnormal labs (elevated SED, anemia), mild language delay
Central/South America and Caribbean	5-6 years old	Female	Suspected FAS features, digestive issues (suspected parasites)
Central/South America and Caribbean	6-7 years old	Female	Anxious
Central/South America and Caribbean	6-7 years old	Male	healthy referral, but is not. Developmental delay, not yet potty trained, anger issues, sibling set
Central/South America and Caribbean	6-7 years old	Male	overall healthy, slight malnutrition, sibling set

Central/South America and Caribbean	7-8 years old	Male	concern about school/cognition
Central/South America and Caribbean	8-9 years old	Male	developmental delay, limb differences (arms and legs), anger issues, dental issues, sibling set
Central/South America and Caribbean	8-9 years old	Male	at time of adoption, had nephrotic syndrome, now resolved. Now anxious and trouble with self-esteem
Europe	1-2 years old	Female	birth mom was HIV+, now PCR negative
Europe	1-2 years old	Female	mild developmental delay
Europe	2-3 years old	Male	limb differences, chronic diarrhea, feeding and digestion problems
Europe	4-5 years old	Male	Hypotonic, dental issues, suspected indiscriminate attachment, suspected sexual abuse, global delay
Europe	5-6 years old	Male	limb differences (arms and legs)
Europe	7-8 years old	Male	TB
Europe	7-8 years old	Male	preadoption: heart issues, UTI, hip dysplasia, birth mother had syphilis, "doubling of the kidney", post adoption: enuresis, behavior, halitosis, sinus issues, high lead level
Europe	8-9 years old	Male	history bronchitis, pneumonia, and respiratory issues, nosebleeds, rash
Europe	10-11 years old	Female	skin issues, sibling set
Europe	11-12 years old	Female	recurrent herpes outbreak (face), suspected PTSD, speech delay, developmental delay, facial deformity, surgery on face and eye
Europe	12-13 years old	Male	Overall healthy, but had bone infection post adoption, history of head trauma, chronic enuresis, sibling set
Europe	13-14 years old	Female	recurrent herpes outbreak (face), on bioidentical hormones (progesterone and estrogen), high BP, need to retest vision for high pressure
Europe	13-14 years old	Female	treated for TB but otherwise healthy, test anxiety, sibling set
Europe	14-15 years old	Male	suspected sexual abuse

APPENDIX C: DILLON INTERNATIONAL CHECKLIST



Checklist of Special Care Conditions

As you build your family through adoption, it is important to thoughtfully consider the various special care conditions that may affect the child you adopt.

Our experience is that different people have different feelings about their ability to care for a child with various conditions. What is considered a major challenge to one person is accepted as a minor special need by another.

Your decisions will be influenced by your life experience, the financial and health care resources available to your family, the accessibility to knowledgeable doctors, the ages and needs of other children in your family and your support network.

Dillon International staff are not medical professionals

and do not provide medical advice. **Please take the time to discuss the checklist with a medical professional so that you receive adequate information to assist your decision making process.**

Another educational resource is the medical encyclopedia at <http://www.nlm.nih.gov/medlineplus/encyclopedia.html>. The checklist will be discussed during your adoption process and can be altered at any time.

Noting a willingness to consider a special care condition does not obligate your family to adopt a child with that particular condition.

We recognize this is not an easy task and deeply respect your family's considerations.

Please mark Y for Yes, N for No or M for Maybe.

GENDER

Female	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Male	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Either	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Siblings	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Twins	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Special needs	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

AGE (check all that apply)

<input type="checkbox"/> 6-24 months
<input type="checkbox"/> 24-36 months
<input type="checkbox"/> 36-48 months
<input type="checkbox"/> 4-5 years
<input type="checkbox"/> 5-7 years
<input type="checkbox"/> 7-9 years
<input type="checkbox"/> 9-12 years
<input type="checkbox"/> 12-16 years

BIRTH CONDITIONS

Premature	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Low birth weight (under 4.5 lbs)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Poor weight gain	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Respiratory distress syndrome	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

BIRTH FAMILY BACKGROUND

Smoking during pregnancy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Drinking during pregnancy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Drug use during pregnancy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Medication use during pregnancy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Birth mother HIV+	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Birth mother Hepatitis B+	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Incest	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Mental illness	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Mental retardation	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
History of genetic disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Physical disabilities medical conditions	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Conceived by rape	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

BLOOD CONDITIONS

Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hemophilia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Thalassemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

HEARING/EAR

Ear atresia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Microtia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Partial hearing loss	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Deafness	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

HEART AND PULMONARY

Murmur-unknown prognosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Patent Foramen Ovale	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Atrial septal defect	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Ventricular septal defect	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Tetralogy of fallot	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Pulmonary atresia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Patent ductus arteriosus	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Lung disease or damage	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

INFECTIOUS DISEASES

Hepatitis B-carrier	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hepatitis B-active	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hepatitis C	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
HIV+	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Syphilis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Tuberculosis-latent infection	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Tuberculosis-active	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
CMV	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

LIMBS

Extra or webbed fingers	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Partial or missing fingers, hand, arm ...	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Extra or webbed toes	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Partial or missing toes, foot, leg	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Club foot	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hip dysplasia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Radial club hand	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

MUSCULOSKELETAL

Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Arthrogyposis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Funnel chest or pigeon breast	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hemiparalysis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Multiple sclerosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Osteogenesis imperfecta	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Rickets	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Scoliosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Small stature (dwarfism)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Torticollis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Paralysis-paraplegia or quadriplegia ...	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Crutches or braces-current or future ...	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Wheelchair confined	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

NEUROLOGICAL

Autism-suspected unknown	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Brachial plexus injury	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cerebral Palsy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hydrocephaly	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Macrocephaly	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Microcephaly	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Schizencephaly	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Neurofibromatosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Polio history	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Spina Bifida	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Meningocele/myelocoele	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
History of meningitis/brain infection	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Other brain abnormality	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

CRANIOFACIAL/ORAL

Cleft lip-unilateral	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cleft lip-bilateral	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cleft palate	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cleft lip & palate	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Facial palsy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

DEVELOPMENTAL

Developmental delays	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Failure to thrive	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Fetal alcohol spectrum disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Language delays	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Learning disabilities	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Mental deficit-suspected	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Mental deficit-confirmed	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Verbal apraxia/mute	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

EMOTIONAL-BEHAVIORAL

Emotional issues	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Behavioral issues	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hyperactivity	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Physical abuse-suspected or known ..	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Sexual abuse-suspected or known	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

GASTROINTESTINAL

Anal atresia/imperforate anus	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Bowel incontinence/chronic diarrhea	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Colostomy	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Feeding/swallowing issues	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Feeding tube	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Gastroschisis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Intestine malfunction/disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Liver malfunction/disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Malnourishment	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Megacolon	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Metabolic malfunction/disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Pancreas malfunction/disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Pyloric Stenosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Stomach malfunction/disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

REPRODUCTIVE-URINARY

Bladder incontinence	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Bladder malfunction/disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Kidney malfunction/disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Ambiguous genitalia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Genital malformation	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Concealed or inconspicuous penis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hypospadias	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Undescended testicles	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

SEIZURES

Seizures-transitory, unknown cause ...	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Seizures-controlled with medication ..	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Seizures-uncontrolled	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

SKIN

Albinism	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Angioma birthmarks	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Burns	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Congenital blue nevus	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Congenital nevus birthmarks	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Ectodermal dysplasia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Epidermolysis Bullosa	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Hemangioma birthmarks	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Ichthyosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Port-wine stain	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Other skin diseases	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

SYNDROMES

DiGeorge Syndrome	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Down Syndrome	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Fragile X Syndrome	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Noonan Syndrome	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Turner Syndrome	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

VISION/EYE

Blindness	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cataracts	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Loss of sight in one eye	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Missing one eye	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Nystagmus	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Ptosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Strabismus	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Vision impairment	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M

CANCER

Cancer in remission	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Cancer-active	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
Other: _____			

OTHER

Adoptive placement disruption	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> M
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Signature of Applicant 1 Date

Signature of Applicant 2 (if applicable) Date

Source: (Dillon International n.d.)

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