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THE PERSONAL AND PROFESSIONAL:

# Nurses' Lived Experiences of Adoption

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## Abstract

**Background:** Nurses provide healthcare services to members of the adoption triad (AT; birth parents, adoptive parents, and the child) in a number of settings. However, nurses' perceptions of and interactions with members of the AT have not been investigated.

**Purpose:** This study describes the lived experiences of nurses and the care rendered to the AT using a descriptive phenomenological approach.

**Method:** In response to an invitation published in a national electronic newsletter, nurses were asked to submit narratives about their experiences in caring for members of the AT. Researchers coded 17 narratives using Colaizzi's phenomenological method.

**Results:** Four themes emerged from the texts: (1) Where the personal and professional selves meet ("I see so many issues from both sides"); (2) The paradox of adoption ("…an emotional rollercoaster"); (3) Unique contexts of adoptive families ("We all have a story"); and (4) Reframing nurses' perceptions surrounding adoption ("There are several areas we could improve").

**Clinical Implications:** Nurses often have a personal connection to adoption and this potentiates the care delivered to AT members. Serving as role models for their peers and advocates for a better understanding of the dynamics of relinquishment and placement, nurses can improve clinical practices for these patients.

**Conclusions:** Themes reflected insights gained from both personal and professional roles and offer specific interventions that enhance care of the AT. Nursing education and practice guidelines should include care rendered to the AT.


**Keywords:** adoption, mental health, nurses, qualitative research

Approximately 1.8 million children who have been adopted (not living with a biological relative) live in the United States (Vandivere, Malm, & Radel, 2009). The adoption triad (AT) is composed of the birth parents, the child who is adopted, and the adoptive parents. Each member presents with different emotional and physical needs that are contextualized through the relinquishment of a child. Unlike the social worker whose profession has traditionally been aligned with caring for the AT, the nursing profession has yet to examine the perceptions of nurses involved in the individual interactions that occur between nurse and the patient involved with adoption. To begin to fill this gap in understanding, we proposed to explore and understand the lived experiences of nurses who care for members of the AT.

Often, the cultural practice of adoption begins with birth parents when faced with an unintended pregnancy. In contrast to media presentations of the high school teenager who becomes pregnant, birth mothers are more likely to be in their 20s and have other children. Only 25% of unintended pregnancies that result in adoption occur in the teenage population (Evan B. Donaldson Adoption Institute, 2006). Regardless of circumstances, women and men who are faced with an unintended pregnancy are often in crisis and confronted with a life-changing decision. One of the options is to prepare an adoption plan.

There are three types of adoption in the United States: private domestic (38%); foster care/public welfare system (37% ); and international (25%) (Vandivere et al., 2009). Adopted children come from diverse backgrounds and can have varying degrees of special needs as a result of their risk categories, often more so than the general population (Wind, Brooks, & Barth, 2007). Specifically, 54% or 355,000 children adopted through the foster care system have some special healthcare need (Vandivere et al., 2009). Adoption is a journey that continues far beyond the date of legal finalization.

## Where Nurses Interface

Significantly, when parents interact with healthcare professionals, they frequently identified the importance of healthcare providers and counselors to be "adoption-competent," or cognizant and empathetic to the unique journey taken by adoptive parents and children, and aware of services that may help (Atkinson & Gonet, 2007; Foli & Gibson, 2011). Clearly there is a need for nursing support and advocacy in the lives of those who have been influenced by adoption. Based on the unique developmental issues facing adoptive families, nursing care is needed to facilitate these families whenever possible, wherever nurses are likely to meet them. We explore three significant issues: (1) the notion of "adoption-smart" or "competent" caregivers, (2) where nurses are likely to interface with adoptive families, and (3) how nurses are best poised to facilitate this population upon interaction.

Adoption competence is particularly important considering the number of families that may be unaware of services available. Dhami, Mandel, and Sothmann (2007) encouraged healthcare professionals to educate themselves and disseminate information regarding adoption services to their clients to increase potential use. With increased adoption competence, nurses are able to help to make adoptive parents aware of the services that are available. Maternal postadoption depression has also been cited in the literature with rates of depressive symptoms at 18% to 26%, which are equal to or higher than those found for postpartum depression (Foli, South, & Lim, 2012). Disenfranchised grief may be present after relinquishment of a child (Aloi, 2009), and birth parents may benefit from informed mental health nursing interventions.

Nurses are also in a unique position to recognize and assist in teaching for major milestones in children's lives and in determining whether the experience is a "normal" milestone or an adoption issue (Atkinson & Gonet, 2007; McKay, Ross, & Goldberg, 2010). With education in child development and a role in patient teaching, nurses are in a unique position to assist adoptive parents and children with these distinctions. Nurses are also situated to help adoptive families recognize the need for proactive health promotion strategies as opposed to reactive approaches (Dhami et al., 2007). Based on certain adopted children's risk for health, cognitive, behavioral, and school-based problems (Beverly, McGinness, & Blanton, 2008; Welsh, Viana, Petrill, & Mathias, 2007), nurses may also contribute to the adoptive family in school-based nursing settings.

Despite this review, we found no literature that described the AT patient-to-nurse interface and assume an exploratory position in approaching this study. Therefore, the purpose of this phenomenological study was to describe the meaning of nurses' experiences in caring for members of the AT.

## Methods

### Procedure

We collected data through a web-based survey in the summer/fall 2010. Through the electronic newsletter, *Nursing Insider*, published by the American Nurses Association ([ANA], 2010), the principal investigator (PI) placed an advertisement for approximately 1 month to solicit participants to the web-based survey link. Inclusion criteria into the study were that respondents be, or have experience in, rendering care to members of the AT, understand English, and have Internet access. Part 1 of the study ($n$ = 97 nurses) focused on the nursing process as it is applied to the members of the AT, including nursing interventions (Foli, 2012).

In the current study (Part 2), using a constructivist approach, a subset of the participants ($n$ = 17) described their own experiences (through stories or narratives) related to members of the AT. Beck (2005) explained the benefits and validity of Internet interviews. Because of the challenges in locating nurses who interface with members of the AT and influences that inhibit candid disclosure, we believe the Internet provided a credible

Nurses interface with individuals whose lives have been touched by adoption, and nurses themselves may have a personal connection to adoption that offers them insights into their patients' unique experiences.

approach to data collection. Two of the investigators determined which narratives were suitable for analysis. For example, we viewed comments that were not conceptually coherent as unsuitable (e.g., "Adoptive parents who have concerns when the child becomes a teenager and they are unsure what to do in parenting."). We received data that ranged in length from long, single-spaced narratives to several pages in length, and coded 17 narratives.

Fourteen of the nurses who forwarded narratives were members of the AT, indicating that these individuals had a vested interest in participating in the study and personal experience with adoption. There were two nurses who identified themselves as birth parents, 11 adoptive mothers, and one person who was adopted. A total of 17 narratives were analyzed with complete demographic data available for 14 of the respondents. All participants were female ($n$ = 14); all were older than 40 years, with half of the respondents ($n$ = 7) between 40 and 49 years of age; all were married but two people; and most were employed full time ($n$ = 11, 78.7%). Nine of the 14 nurses worked either in labor and delivery, pediatrics, or mental health.

### Data Analysis and Results

We analyzed the data using Colaizzi's (1978) phenomenological method in order to capture a richer, deeper understanding and appreciation of the narratives. After reading and re-reading the text, we extracted significant statements as expressed meanings related to the phenomenon, and identified clusters and themes, which were re-validated with the original narrative text. Member checks were not possible since the narrative data were collected anonymously. We maintained an audit trail throughout to promote study rigor and trustworthiness of results, including reflexive notes and discussions; one researcher is an adoptive mother. The same two investigators who determined the suitability of the texts discussed patterns that emerged from the data, looked for confirming and disconfirming data, and reached consensus on which thematic patterns reflected the participants' lived experiences.

Our analyses of the text identified four themes: (1) Where the personal and professional selves meet (caregiver and receiver of care); (2) The paradox of adoption: an emotional rollercoaster (loss and joy; grief and healing); (3) Unique contexts of adoptive families: "We each have a story"; and (4) Reframing nurses' perceptions surrounding adoption (education, advocacy, and support/communication). In order to facilitate reader interpretation, the narratives have been edited for spelling and grammar where necessary.

**Theme 1. Where the Personal and Professional Selves Meet: "I see so many issues from both sides" (caregiver and receiver of care).** Nurses described the duality of self as they perceived their roles as both professional and AT family member. Participants perceived these dual roles as instrumental in generating unique insight into their nursing care of the AT. The duality of self appears to extend beyond social roles and into the identity of the individual, and it is this identity that allows the nurse/AT member to render care to members of the AT as well as be the recipient of care. Their awareness is informed and refined by personal experience and professional education. The unique perspectives also allow these individuals to critique the existing system and to see how a lack of education and awareness may impact the care given to members of the AT. One individual articulated these two perspectives:

> *As an adoptive mother and a nurse practitioner I see many issues from both sides. A basic educational approach would help in nurses training (so you don't hear things like "oh, you don't have any real children of your own?" etc etc). Issues for adopted children are complex and often combine with issues of special needs, both areas much misunderstood with many unfair assertions made by the uninitiated.*

A neonatal educator and member of the AT reflected on how she was able to understand adoption from being a participant in the adoption process.

> *I am an adoptive parent of two grown children who were both placed with me and my husband from the hospital where they were born…. I am very conscious of how the process works not only as an adoptive mother, but as a nurse who has been in maternal-child nursing for 23 years.*

Personal experiences, and "emotional ups and downs, but no one to talk to," spurred this individual into action. She felt hesitant to disclose her needs, fearful of repercussions, or the chance the child would be taken from her. The two roles merged as she acted as both nurse and adoptive parent through a class she designed and taught:

> *…. I had the same emotions that I think all new parents go through..."will I be a good parent", " have I made the right decisions?", etc. but when you build*

*your family through adoption, the resources are very limited. Because of this, I wrote a curriculum and taught an adoptive parent class… It was a very exciting class where I taught them about newborn care, feeding, diapering, bathing, etc. and because I am an adoptive parent, I could also address the emotional battles they were facing.*

**Theme 2. The Paradox of Adoption: "… An emotional rollercoaster": (loss and joy; grief and healing).** Participants, whether members of the AT or not, described the emotional ups and downs that they have experienced as being part of an AT and/or caring for those members of the AT. One adoptive mother and nurse described her emotional journey.

*My experience as an adoptive mother has been an emotional roller coaster, depression, and the whole nine yards. Every day is a challenge and some days more than most are a struggle... I have had personal hurt and pain as an adoptive mother, and in providing support or education, but I also have met challenges in all and rolled with the punches and remained positive and proactive in all that I did personally & professionally...*

A midwife, birthparent, and adoptive parent, working with clients and their families who relinquish infants for adoption, described her unexpected feelings of postadoption depression. The lack of preadoption education impacted her ability to express the emotional turmoil she was feeling. In contrast, she also described the peace that came as a result of placing her own child for adoption:

*… I have also experienced the fact that "normal parent complaints about being tired, having a fussy baby, anxiety about parenting" are not socially acceptable either because "you asked for this to have a child or children." …Placing my child for adoption as a young person was overall a wonderful decision and experience for me as well as being an adoptive parent to two beautiful daughters.*

A nurse and grandmother to a child whose birth mother abused drugs and alcohol during pregnancy described the family's journey, and how the participant's own health needs were influenced by the "blessing" of adoption. The child, who showed signs of fetal alcohol syndrome at birth and was premature, demonstrated behaviors that caused the parents "much anxiety and stress," behaviors that increased in severity as the child entered first grade. Yet this participant described the positive influence the boy has had on her:

*…The father has had difficulty accepting him and his behavior and is often negative. The mother is overly protective and often does not discipline him properly and is extremely critical when the father tries to discipline the child. He does great with the grandparents and is making great progress with them. He is a special gift to all of us. We got him two days before I was diagnosed with breast cancer. So God sent him to give me hope and joy before the dreaded diagnosis...What a blessing adoption is even with the emotional and psychological trauma.*

**Theme 3. The Unique Contexts of Adoptive Families: "We each have a story".** Several participants described specific clients that they had cared for and the unique needs and contexts of these clients. The narratives reflect self-awareness that each adoption story is unique and multidimensional. Participants voiced strong feelings about individualized care and approaches to AT members. One nurse summed these descriptions by stating:

*Lastly, just as no two finger prints are the same, neither are there two children, two couples, situations, or circumstances. We are far too quick to judge and to assume when we should be far quicker to listen and to be present in order to promote the well-being…*

In contrast to stories of struggles and challenges, a nurse and adoptive mother of 1 year shared a story that was very positive, with nurses allowing and respecting her role as a parent:

*The nurses included us in every step of the way; allowed us to be nearby as our daughter was being delivered... Immediately following the delivery, we were able to follow the nurses and our daughter to the newborn nursery, and were standing next to her bassinette as she was banded, bathed, and printed. We fed her her first bottle and were provided a hospital room in which to stay during our daughter's hospitalization. I was also provided with an armband and was able to take our daughter to and from the nursery, as well as to take her to visit birth mom…*

Stories were shared by nurses who were not members of the AT, yet felt moved by the experience of having cared for those clients who are intimately touched by adoption. One nurse related a story of an "older" adoptive mother, who had been adopted herself, had met her birthmother, and was open to discussing her experiences. Her narrative reveals how she was surprised by the positive outcomes of the adoption, given the child's significant medical needs:

*Their baby daughter has a serious life-threatening heart defect... It seemed a very difficult situation with a lot of medical care and many unknowns. But Child's mom had such a positive outlook, and such resolve, that in spite of the odds Child is doing very well. The relatively advanced age of Child's adoptive parents has not been an issue, and the family is a source of inspiration to all who*

Becoming "adoption-smart" professionals allows nurses to positively influence clinical practices.

*know them….. Everyone has different styles, unique situations, needs that can be met if efforts are made, and that there is hope for even apparently daunting special-needs children.*

A nurse and adoptive mother of three children struggled with infertility and three failed adoptions. Through her professional and personal experiences, she articulated several foci of nursing care that captured the diverse needs of this population, including problems with maternal-infant bonding and how to offer support. The participant also described birthparents' issues with substance use and mental illnesses whose children have been taken into protective custody or relinquished at birth. She related how healthcare workers often would place blame on the birthparent, communicating that "this was their own fault" rather than acknowledging their pain and grief. Given the high-risk nature of infants and children born to birthparents struggling with these issues, she related how nurses needed to be more educated about these needs in order to educate adoptive parents. Older children and adolescents who have been in foster care or adopted needed nurses to understand the transient nature of placement in foster care and the needs created by their own mental illnesses.

*… Because adoption is a deeply emotional experience filled with tremendous pain and great joy, it is a mystery to most people who have not experienced it. Nurses are there with birth parents, adoptive parents, adopted children in their most intimate needs; we must be willing to acknowledge issues and offer support.*

**Theme 4. Reframing Nurses' Perceptions Surrounding Adoption: "There are several areas we could improve." (education, adoption-friendly language, advocacy, and support/communication).** Many respondents' narratives contained numerous ways in which nursing care for members of the AT could be improved. Participants advocated for changing existing language to more adoption-friendly terminology, integrating information about adoption in nursing curricula and reframing the process as positive for the AT. They emphasized that often birthmothers are in an active grieving process and adoptive parents may be hesitant to express that they are struggling. Moreover, they reported that children who are adopted should be able to have full medical history information available to order to plan their healthcare. Respondents conveyed basic rights of the AT members. Nurses described themselves as healthcare professionals who are present at vulnerable periods and attend to intimate needs, as educators, advocates, information-seekers/gatherers, and knowledgeable about psychosocial aspects of adoption. An adoptive mother and neonatal educator emphasized how words impact the reality of experiences:

*One of the MOST distressing comments I hear is "giving up a child for adoption". I have tried over the years to help staff rephrase this by saying, "The birth mother (parent) has made an adoption plan for this infant". "Giving something up" sounds like giving old clothes to Goodwill. Positive adoptive language is very important not only to the adoptive parents, but to the child who is adopted. Knowing that a "plan" was made for their welfare, and that the birth parents choose who/how/where/when is a very positive thought for these children.*

Participants discussed the lack of integrating learning about adoption into nursing education. One nurse's passionate response described the need for education:

*I write as an adoptive parent whose career happens to be that of nursing….As I reflect on "just" the adoption process and the past two years and how nursing could have assisted, there are several areas we could improve. First and foremost is education. Training shouldn't have to come through another agency through the offering of continuing education units; it ought to be a part of the nursing curriculum and not just a week or so. The history, the legalities, the language, and resources of adoption should be explored as well as the desired outcomes for all involved.*

This nurse and adoptive mother described conflict and confusion created by interactions with her child's birthparents (in an open adoption) that had created financial debt in order to "protect the children's rights." Yet in her professional role, she offered insight into issues of denial with adoptive parents:

*As a nurse case manager working in more than one setting, and a school, I encountered even more challenges: mother's who refuse therapy as an outlet for themselves; dislike and expressions of hate/misperceptions as to why a birth parent would give up a child; the adoptive parent is and will be the*

*better parent and can provide everything; disappointment when school or other professional point out flaws or common issues with the adopted child (ADHD, learning disorders, conduct disorders, RAD, etc.).*

A nurse called for equality for birth parents, adoptive parents, and children: "all parties of the adoption triad are equal in status." She spoke to advocacy and empowerment for children who are adopted with disclosure of their pasts. Similarly, acknowledgment of weaknesses and needs, according to this nurse, should be extended to all members—birth and adoptive parents and the child:

*… Also, by realizing that all people are equal we can begin to address the problems of drug and alcohol abuse or other forms of abuse that exist with adoptive parents. Historically, it is only the birth family that is "looked down" on if they have such problems, when the reality is that these problems exist with adoptive parents too…And do we only value life when it is "perfect" or a reflection of ourselves, instead of adopting a baby or child that is truly in need, rather than manipulating people and systems to get what we think we want at sometimes perilous cost?*

Specific AT clinical situations were also described. One nurse working on a mental health unit cared for a birth mother who was diagnosed with schizophrenia and bipolar affective disorder. The birth mother, Deborah, was in her eighth month of pregnancy when she was admitted to the acute psychiatric unit. Other children had also been relinquished through adoption, and the adoption plan was to place the baby in protective custody at birth, eventually severing maternal and paternal rights because of the parents' inability to care for the child. Deborah was nonadherent with her medications, which had resulted in her being repeatedly admitted during her pregnancy. The nurse described how the other staff interacted with Deborah:

*Nursing staff talked in report about how Deborah would just go out and get pregnant again and couldn't understand why she did that. Some expressed empathy for her but for the most part, nursing staff were uncomfortable with the situation. I recall one nurse saying we probably shouldn't discuss her upcoming delivery or the baby with her because we didn't want to upset her.*

The respondent described her first meeting with Deborah as she went to assess her status. She found Deborah was lucid and oriented, but "her affect was quite flat," and the she had isolated herself, not interacting with the nurse or other patients. The nurse listened for fetal heart sounds and asked Deborah if the baby was moving:

**TABLE 1: SUGGESTED CLINICAL IMPLICATIONS:**

- Identify a resource pool of adoption-competent experts in your organization.
- Provide continuing education addressing the needs of the adoption triad and emphasizing mental health interventions, including the use of adoption friendly language.
- Implement easy-to-follow protocols that focus on the unique needs of individuals touched by adoption. These protocols are particularly beneficial on units that commonly care for members of the adoption triad, such as labor and delivery and pediatrics.
- Become familiar with referral resources at the local, regional, and national levels for members of the adoptive triad. These may include support and bereavement groups, adoption agencies, and community-based adoption-smart healthcare professionals.
- Commit to self-reflection to avoid negative responses, and to personal mental health as a means to augment empathic communication with members of the adoption triad.

*She moved my hand to where I could feel movement. I smiled and said that's beautiful isn't it? She nodded yes in agreement. I felt awkward discussing the baby knowing what was going to happen but I kept thinking she needed support right now, not avoidance. I asked if she knew the sex of the baby and she said it was a boy…. I knew she was oriented enough to her situation that she was totally aware of what was going on and what would happen, but she never talked…..*

After seeing Deborah again postdelivery, the respondent ended her narrative with her own sense of loss and inadequacy in providing care to this birth mother. She again found Deborah's affect to be flat and the patient again isolated herself from patients and staff:

*No one talked about the baby, about Deborah, about any intervention with her to assist with grief, nothing. I felt helpless. I was only the prn nurse and thought, my goodness, we need to offer her better support but I wasn't sure how to go about making change. I think staff struggled with the difficulty and pain of this situation without having any tools or training to know how to support Deborah, so we just ignored it.*

As these data reflect, nurses need to be provided with the opportunity to understand their own feelings of loss, potential biases toward the practice of adoption, to learn

about best practices, and be educated in caring for members of the AT.

## Limitations

One potential limitation of this study is that the majority of the nurses who participated in the study had personal experience with adoption. Therefore, participants do not represent the average labor and birth, postpartum, or pediatric nurse who cares for the AT population. Nonetheless, this study would indicate that select nurses have intimate knowledge of adoption, both as receivers and givers of care.

## Clinical Nursing Implications

We identified four themes through phenomenological description: (1) Where the personal and professional self meet; (2) The paradox of adoption: a rollercoaster of emotions and attitudes; (3) Unique contexts of adoptive families; and (4) Reframing nurses' perceptions surrounding adoption. Each of these themes has implications for nurses who care for members of the AT and themselves as they render this care (Table 1).

Nursing care interventions for both the adoptive and birth parents included respect by the nurse, patient advocacy, caring and compassion, support and encouragement, open-minded communication, knowledge of parenting, grief and loss, role change, and thorough nursing assessment for depression and other mental health issues. The rollercoaster of emotions and unique needs of the AT may also explain the different uses of postadoption services and which ones are deemed helpful by parents. "Listening" to the lived experiences of the respondents reminds us that while the AT is linked by adoption, the dynamics of each family member (including the birth parents) drive the contents of the care plan.

In order to improve our care as a profession, adoption competent nurses are needed (Foli & Gibson, 2011). This competence is underscored by comprehending that adoption family dynamics are different from families created by birth; that adoption is lifelong, not a one-time event; that adoption is beneficial to parent, child, and society; and that society is responsible for supporting and preserving adoptive families (Atkinson & Gonet, 2007). Although the notion of adoption competence encompasses empathy, it also implies a certain amount of knowledge of services available to adoptive families, and an appreciation of the diversity and unique challenges facing adoptive families (Atkinson & Gonet, 2007). Further, nurses need to perform self-reflection and personal mental health work to enhance empathy and help avoid projections based on unfounded biases. We list several Internet sources in Table 2 that nurses may use to increase their own knowledge about adoption and as referral resources to patients.

## Conclusions

Adoption is much more than a one-time event bookmarked by legal documents. Adoption is a lifelong process characterized by a wide spectrum of emotions and reactions. As such, nurses have myriad opportunities to interact with adoptive families and base interventions on the needs of the AT. Adoptive triad members seek out adoption-competent professionals to understand and assist them on their journeys within their family dynamics as well as through the social system. Nurses, with unique insights, talents, and skills, and in diverse areas of practice, can function as health promoters, educators, and advocates for the adoptive triad. ✣

### TABLE 2: INTERNET RESOURCES:

**AdoptUsKids:** This website is a tool for connecting foster and adoptive families with waiting children throughout the United States and offers a number of resources for adoptive families. Web site: www.adoptuskids.org

**Attachment Disorder Network:** Resources for parents of children with attachment challenges. Web site: www.radzebra.org

**Center for Adoption Support and Education (C.A.S.E):** C.A.S.E. provides support and education for everyone in the adoption community. Web site: www.adoptionsupport.org

**Child Welfare Information Gateway**: Information Gateway offers information on all aspects of adoption for professionals, policymakers, and the general public. Web site: http://www.childwelfare.gov/adoption/adopt_parenting/depression.cfm

**Evan B. Donaldson Adoption Institute:** The Adoption Institute seeks to improve the quality of information about adoption, and to advance policy and practice. Web site: www.adoptioninstitute.org/index.php

**Joint Council on International Children's Services**: Joint Council assists orphaned and vulnerable children to live in permanent and safe families. Web site: www.jointcouncil.org

**North American Council on Adoptable Children:** This organization is committed to meeting the needs of waiting children and the families who adopt them. Web site: www.nacac.org

**National Council on Adoption:** The Council is involved in research, education programs, and advocacy to promote sound, ethical adoption policies and practices. Web site: www.adoptioncouncil.org/

**Pact, an Adoption Alliance**: Pact's goal is to maintain the Internet's most comprehensive site addressing issues for adopted children of color. Web site: www.pactadopt.org

**United States Department of State, Bureau of Consular Affairs, Office of Children's Issues:** The office produces and maintains information about intercountry adoption and issues adoption notices and alerts to inform prospective adoptive parents. Web site: http://adoption.state.gov


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