



Infant Adoption Training Initiative

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*Understanding Infant Adoption
By Spaulding For Children*

Participant Guide

UNDERSTANDING INFANT ADOPTION (UIA 6)



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In Acknowledgement

Spaulding for Children would like to acknowledge and thank the many trainers, faculty members and other content experts who provided guidance and feedback about the revisions to the Understanding Infant Adoption (UIA) Curriculum. Special thanks to project partners Harmony Family Center and Public Research and Evaluation Services for their ongoing collaboration in the implementation and evaluation of the UIA curriculum.



The Understanding Infant Adoption (UIA 6) Curriculum is comprised of six modules designed to educate health care and helping professionals and enhance their ability to provide adoption information and referrals to pregnant women, teens, and men, who are experiencing an unplanned/unintended pregnancy. The curriculum was revised and updated through a grant project funded by the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1135. Project partners included Spaulding for Children, Harmony Family Center and Public Research and Evaluation Services.

The intention of this training program is to ensure not only that expectant parents have adoption information presented with other options, but also to ensure that pregnant women who wish to place a child for adoption have access to well-trained staff and comprehensive supports in hospital settings throughout the adoption process.



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EXECUTIVE SUMMARY

The goal of the Understanding Infant Adoption (UIA) training is to enhance the ability of health care and helping professionals to provide adoption information and referrals to pregnant women, teens, and men, who are experiencing an unplanned/unintended pregnancy. The intention of this training program is to ensure not only that expectant parents have adoption information presented with other options, but also to ensure that pregnant women who wish to place a child for adoption have access to well-trained staff and comprehensive supports in hospital settings throughout the adoption process.

In July of 2001, a notice and request for proposal was issued by the U.S. Department of Health and Human Services (HHS) to develop and implement an “Infant Adoption Awareness Training Program” (IAATP). Spaulding for Children was awarded the grant for the 2001 to 2004 period. Over the 10+ years that followed, additional grants were awarded to Spaulding for Children and Understanding Infant Adoption curriculum was developed and refined over those years. Most recently, in July of 2017, a notice and request for proposal was issued by HHS to develop and implement a Hospital Based Adoption Support and Services (HBASS) program. Spaulding for Children partnered with Harmony Family Center and Public Research and Evaluation Services (PRES) on a proposal which was funded for a total of 33 months between October 2017 and September 2020.

The UIA curriculum was updated as part of the activities of the HBASS program to include current issues in infant adoption and trauma-informed care principles. In addition, a new module was added to provide more detailed information to help hospital staff and administration learn about best practices and policies relating to adoption. The new module contains a tool that hospitals can use to guide a review of their current policies, identify areas of strength, and highlight gaps that may exist.

A live pilot test of UIA 6 took place in October 2019 in Louisiana. Feedback was provided by the trainer regarding gaps or suggestions. The UIA 6 curriculum revision process also included triangulated data from a number of trainers and faculty members. To ensure that the revised UIA 6 curriculum is aligned with Best Practice Guidelines from the Infant Adoption Awareness Training Program (IAATP), a Best Practice Checklist was developed and then adapted into a form that was distributed to reviewers. Based on the feedback of both groups (faculty and trainers) it was determined that UIA 6 is well aligned with and is applicable to the needs of hospital-based staff.

INTRODUCTION

BACKGROUND INFORMATION

Unintended pregnancies are a significant occurrence in the United States. Around 45% of the 6 million annual U.S. pregnancies are unintended (Guttmacher, 2016). Research has shown that unintended pregnancies can have long-term implications for children and parents.

Births resulting from unintended pregnancies are associated with adverse maternal- and child- health outcomes such as delayed pre-natal care, premature birth, increases in the neonaticide rate (the killing of infants within 24 hours of birth) (Kaplan, 2014), and negative physical and mental health effects for children. In 2015, 65% of pregnancies nationwide resulted in live births (Center for Disease Control and Prevention, 2014). However, in 2014 only 0.5% of infants born were released and placed with adoptive families compared to an estimated 18.9% of pregnancies that ended in abortion, miscarriages excluded (Guttmacher Institute, 2016). This data suggests mothers may not be fully advised of the adoption option.

Hospital staff often serve as the first and only opportunity for expectant mothers to receive family planning information, making it critical for medical professionals to be aware of adoption information and agencies within their area so they can refer parents interested in learning more about adoption. Based on research done by the Guttmacher Institute (Guttmacher) and the Center for Disease Control and Prevention (CDC), unplanned pregnancy is one of the primary reasons women seek options counseling. However, hospital staff often do not have access to adoption information nor are they aware of resources that exist within their community. The sheer number of hospitals nationwide makes it difficult to ensure all staff are aware of adoption information. Currently, there are 6,146 registered hospitals in the U.S. (American Hospital Association, 2020). Some urban hospitals offer Centers for Family Planning, which provide an array of pregnancy services; however, most hospitals nationwide have no specialized family planning centers. Thus, it is critical that information about adoption be readily accessible to medical professionals and that connections with adoption experts are made so staff can continuously receive adoption information. This will help ensure that families experiencing unplanned pregnancies receive support and comprehensive information on the options available. While hospitals are where patients come for healing, they also present a perfect setting for learning. For these reasons, hospitals must cultivate trained staff who are knowledgeable on all options including adoption and who can present the information in a non-coercive and non-directive manner.

ISSUES FACED BY PREGNANT WOMEN AND EXPECTANT MOTHERS

Most expectant parents contemplating adoption find themselves responding to an unplanned pregnancy. Often, they are not in a committed/stable relationship and are unable to cope with the responsibility that comes with raising a child as a single parent. Some married couples consider adoption because they are unable to financially support the child. Many expectant parents considering relinquishing their child because they believe the child will have a better life in an adoptive home. Other reasons include family/societal pressure, personal goals, and socioeconomic situations.

Parents exploring options for their unborn child often experience a roller coaster of emotions including denial, anger, guilt, frustration, sadness, anxiety, shame, relief, and joy, which will not disappear after they decide to make an adoption plan. In fact, these emotions will likely continue and even intensify as

they work through the process. No matter how sure expectant parents may seem of their plan for adoption, they often struggle with the decision. They may receive lower levels of sympathy and support because their loss is viewed as a choice. Their complex emotions can be overwhelming to hospital staff, especially if staff do not have specific training on how to best support expectant parents and are not aware of the potential supportive resources that exist within their community. Navigating through these intense emotions requires training and knowledge of resources available to support the expectant parents' decision.

SPECIAL CONSIDERATIONS WITH TEENAGE PREGNANCY

Teenagers account for around 20% of unintended pregnancies in the U.S. (CDC, 2014). In 2014, 249,078 babies were born to adolescent females between the ages 15-19. That represents 24.2 births for every 1,000. In 2014, 1 in 6 births (17%) of those aged 15-19 were to females who already had one or more babies. Statistics reveal that women who became pregnant as teenagers are often at risk of economic and social disadvantages for the rest of their lives. Teen mothers are more vulnerable to health problems due to lack or delayed onset of prenatal care, poor nutrition, pre-term delivery fetal distress, low birth weight babies, and other problems associated with bearing children at an early age. Teens tend to have unrealistic views about how much help and support they will get from the baby's father, extended family, friends, and the welfare system. Research shows that pregnant teens present unique challenges to hospital staff because of their young age, developmental and maturity level, "minor" status, tendency to be easily influenced, family/friend pressures, and unrealistic expectations about parenting and extent of support needed.

TRAINING AND TECHNICAL NEEDS OF HOSPITAL-BASED STAFF

When expectant parents approach hospital staff regarding making an adoption plan, they believe staff are knowledgeable and capable of helping them make an informed decision. However, most hospitals specialize in treating acute/chronic illnesses and injuries, and staff are not equipped with the infant adoption information necessary to support families considering relinquishing their babies. Staff working in hospital settings typically have limited knowledge on adoption and minimal opportunities to examine their role in the complex issues of biases related to unplanned pregnancies. This puts staff at risk for providing incomplete or inaccurate information and making unintentional, insensitive missteps, which can inadvertently distress or alienate parents. Hospital staff play a critical role in providing support to expectant parents exploring options. These professionals are trained to consider the unique circumstances and perspectives of expectant parents, they are more likely to show empathy toward them and be better equipped to empower decision making based on accurate, fact-based, and unbiased information.

WHAT IS THE BENEFIT OF THIS CURRICULUM?

Women who find themselves with an unplanned pregnancy are under a great deal of stress (Gutmacher Institute, 2016). The hormonal changes and emotional rollercoaster they may feel about the pregnancy makes them vulnerable. Some women may not disclose the pregnancy to family/friends, making it more difficult to obtain support/assistance. They may turn to hospital staff for direction/assistance in understanding available options. Staff who have received training and are aware of adoption resources existing within their community will be more comfortable providing adoption information and referrals on an equal basis with all other courses of action included in nondirective counseling. This can help expectant parents consider all options so they can make informed decisions. Even if parents decide not to pursue adoption prior to delivery, it provides an option they can consider post-birth. Providing adoption information during pregnancy may prevent child abandonment, abuse, and neglect. If the circumstances post-birth are not working as planned, parents may consider an adoption plan for their infant after the child is born.

What did hospital professionals have to say after participating in the Understanding Infant Adoption Curriculum?

“
ADOPTION IS NOW
PART OF AN OPTION I
CAN HELP
PROSPECTIVE
PARENTS EXPLORE.
”

“
It helped me
BETTER EDUCATE
our patients on other
options.
”

“
I feel
**BETTER EQUIPPED
TO ANSWER THEIR
QUESTIONS**
and give them fact-based
information.
”

“
I have become more
knowledgeable about all the
options that are available for
pregnant women.
”

CLASSROOM TRAINING PRODUCTS

“

I'm excited about the incorporation of trauma-related information, the information on substance use/exposures, and the discussion of hospital policy. These are all excellent additions that are timely and important.

”

~Michael Hill
UIA Trainer
New York

As a trainer, you will have access to the following:

TRAINER GUIDE – This Guide will provide you with all of the content you will need to successfully facilitate the Understanding Infant Adoption training. It includes trainer preparation tips, the content that you will deliver with accompanying PowerPoint slides, the handouts you will need to support either discussion or activities throughout the training, and a pre/posttest that includes correct responses.

PARTICIPANT GUIDE – This Guide is for those who are attending the training as participants. The guide contains the handouts that will be used throughout the training. The Participant Guide also includes a copy of the pre/ posttest for their completion. Only the Trainer Guide has a copy that contains the correct responses.

STATE SPECIFIC RESOURCE GUIDE – This Guide provides state specific information about the laws that govern adoption. It also includes a listing of community-based adoption agencies, pregnancy counseling centers, and adoption attorneys to assist hospital-based professionals in making referrals.

“The resources we got during the session were full of great info.”

“I agree—now that I have a better understanding and knowledge of resources and the adoption process, I feel like I can be more helpful to patients.”



MODULES AT A GLANCE

Module	Method	Session Description
1 – Introduction	Lecture Activities	Provides an overview of the content of the curriculum, reviews professional standards, and offers an opportunity to begin to look at personal and professional values about adoption.
2 – Adoption as an Option	Lecture Activities	Focuses on the evolution of adoption practice, outlines standard adoption practice and defines the types of adoption. Reviews how both state and federal laws govern adoption to help participants better understand the legal implications of the adoption option.
3 – Presenting Adoption as an Option and Making Referrals	Lecture Activities	Provides guidance about how to present adoption as an option. Informed consent and the principles of non-directive and non-coercive counseling are discussed. Trauma-informed counseling principles are reviewed and making referrals is introduced.
4 – Influences on Decision Making	Lecture Activities Video Presentation	Explores the many influences that may impact a woman experiencing an unplanned/unintended pregnancy. The principles of culturally responsive services are reviewed. Special issues to consider when working with teens and approaches for engaging expectant fathers are also presented.
5 – Adoption Best Practices: Implications for Health Care Settings (Optional)	Lecture Activities	Best practice guidelines for adoption-related practice in hospital settings are reviewed. Participants are given an opportunity to reflect on their hospital's current policy in comparison to best practice guidelines
6 - Pulling it all Together	Lecture Activities Video Presentation	Participants watch a video depicting the story of Nicole and hear from experts about how to incorporate all of the information learned in previous modules into an approach that supports women, men and teens who are facing an unplanned/unintended pregnancy.

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MODULE ONE—INTRODUCTION

Handouts

None

Resources

114 STAT. 1101 PUBLIC LAW 106–310—OCT. 17, 2000

Public Law 106–310 106th Congress

An Act to amend the Public Health Service Act with respect to children’s health.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Children’s Health Act of 2000”.

TITLE XII—ADOPTION AWARENESS

Subtitle A—Infant Adoption Awareness

SEC. 1201. GRANTS REGARDING INFANT ADOPTION AWARENESS.

Subpart I of part D of title III of the Public Health Service Act, as amended by section 801 of this Act, is amended by adding at the end the following section:

SEC. 330F. CERTAIN SERVICES FOR PREGNANT WOMEN.

(a) INFANT ADOPTION AWARENESS.—

(1) IN GENERAL.—The Secretary shall make grants to national, regional, or local adoption organizations for the purpose of developing and implementing programs to train the designated staff of eligible health centers in providing adoption information and referrals to pregnant women on an equal basis with all other courses of action included in nondirective counseling to pregnant women.

(2) BEST-PRACTICES GUIDELINES.—

(A) IN GENERAL.—A condition for the receipt of a grant under paragraph (1) is that the adoption organization involved agree that, in providing training under such paragraph, the organization will follow the guidelines developed under subparagraph (B).

(B) PROCESS FOR DEVELOPMENT OF GUIDELINES.—

(i) IN GENERAL.—The Secretary shall establish and supervise a process described in clause (ii) in which the participants are—

(I) an appropriate number and variety of adoption organizations that, as a group, have expertise in all models of adoption practice and that represent all members of the adoption triad (birth mother, infant, and adoptive parent); and 42 USC 254c–6.

(II) affected public health entities.

(ii) DESCRIPTION OF PROCESS.—The process referred to in clause (i) is a process in which the participants described in such clause collaborate to develop best-practices guidelines on the provision of adoption information and referrals to pregnant women on

an equal basis with all other courses of action included in nondirective counseling to pregnant women.

(iii) **DATE CERTAIN FOR DEVELOPMENT.**—The Secretary shall ensure that the guidelines described in clause (ii) are developed not later than 180 days after the date of the enactment of the Children’s Health Act of 2000.

(C) **RELATION TO AUTHORITY FOR GRANTS.**—The Secretary may not make any grant under paragraph (1) before the date on which the guidelines under subparagraph (B) are developed.

(3) **USE OF GRANT.**—

(A) **IN GENERAL.**—With respect to a grant under paragraph (1)—

(i) an adoption organization may expend the grant to carry out the programs directly or through grants to or contracts with other adoption organizations;

(ii) the purposes for which the adoption organization expends the grant may include the development of a training curriculum, consistent with the guidelines developed under paragraph (2)(B); and

(iii) a condition for the receipt of the grant is that the adoption organization agree that, in providing training for the designated staff of eligible health centers, such organization will make reasonable efforts to ensure that the individuals who provide the training are individuals who are knowledgeable in all elements of the adoption process and are experienced in providing adoption information and referrals in the geographic areas in which the eligible health centers are located, and that the designated staff receive the training in such areas.

(B) **RULE OF CONSTRUCTION REGARDING TRAINING OF**

TRAINERS.—With respect to individuals who under a grant under paragraph (1) provide training for the designated staff of eligible health centers (referred to in this subparagraph as ‘trainers’), subparagraph (A)(iii) may not be construed as establishing any limitation regarding the geographic area in which the trainers receive instruction in being such trainers. A trainer may receive such instruction in a different geographic area than the area in which the trainer trains (or will train) the designated staff of eligible health centers.

(4) **ADOPTION ORGANIZATIONS; ELIGIBLE HEALTH CENTERS;**

OTHER DEFINITIONS.—For purposes of this section:

(A) The term ‘adoption organization’ means a national, regional, or local organization—

(i) among whose primary purposes are adoption;

(ii) that is knowledgeable in all elements of the adoption process and on providing adoption information and referrals to pregnant women; and

(iii) that is a nonprofit private entity.

(B) The term ‘designated staff’, with respect to an eligible health center, means staff of the center who provide pregnancy or adoption information and referrals (or will provide such information and referrals after receiving training under a grant under paragraph (1)).

(C) The term ‘eligible health centers’ means public and nonprofit private entities that provide health services to pregnant women.

(5) **TRAINING FOR CERTAIN ELIGIBLE HEALTH CENTERS.**—

A condition for the receipt of a grant under paragraph (1) is that the adoption organization involved agree to make reasonable efforts to ensure that the eligible health centers with respect to which training under the grant is provided include—

(A) eligible health centers that receive grants under section 1001 (relating to voluntary family planning projects);

(B) eligible health centers that receive grants under section 330 (relating to community health centers, migrant health centers, and centers regarding homeless individuals and residents of public housing); and

(C) eligible health centers that receive grants under this Act for the provision of services in schools.

(6) PARTICIPATION OF CERTAIN ELIGIBLE HEALTH CLINICS.—

In the case of eligible health centers that receive grants under section 330 or 1001:

(A) Within a reasonable period after the Secretary begins making grants under paragraph (1), the Secretary shall provide eligible health centers with complete information about the training available from organizations receiving grants under such paragraph. The Secretary shall make reasonable efforts to encourage eligible health centers to arrange for designated staff to participate in such training. Such efforts shall affirm Federal requirements, if any, that the eligible health center provide nondirective counseling to pregnant women.

(B) All costs of such centers in obtaining the training shall be reimbursed by the organization that provides the training, using grants under paragraph (1).

(C) Not later than 1 year after the date of the enactment of the Children’s Health Act of 2000, the Secretary shall submit to the appropriate committees of the Congress a report evaluating the extent to which adoption information and referral, upon request, are provided by eligible health centers. Within a reasonable time after training under this section is initiated, the Secretary shall submit to the appropriate committees of the Congress a report evaluating the extent to which adoption information and referral, upon request, are provided by eligible health centers in order to determine the effectiveness of such training and the extent to which such training complies with subsection

(a)(1). In preparing the reports required by this subparagraph, the Secretary shall in no respect interpret the provisions of this section to allow any interference in the provider-patient relationship, any breach of patient confidentiality, or any monitoring or auditing of the counseling process or patient records which breaches patient confidentiality or reveals patient identity. The reports required by this subparagraph shall be conducted by the Secretary acting through the Administrator of the Health Resources and Services Administration and in collaboration with the Director of the Agency for Healthcare Research and Quality.

(b) **APPLICATION FOR GRANT.**—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.’’.

Subtitle B—Special Needs Adoption Awareness

SEC. 1211. SPECIAL NEEDS ADOPTION PROGRAMS; PUBLIC AWARENESS CAMPAIGN AND OTHER ACTIVITIES.

Subpart I of part D of title III of the Public Health Service Act, as amended by section 1201 of this Act, is amended by adding at the end the following section:

SEC. 330G. SPECIAL NEEDS ADOPTION PROGRAMS; PUBLIC AWARENESS CAMPAIGN AND OTHER ACTIVITIES.

(a) SPECIAL NEEDS ADOPTION AWARENESS CAMPAIGN.—

(1) IN GENERAL.—The Secretary shall, through making grants to nonprofit private entities, provide for the planning, development, and carrying out of a national campaign to provide information to the public regarding the adoption of children with special needs.

(2) INPUT ON PLANNING AND DEVELOPMENT.—In providing for the planning and development of the national campaign under paragraph (1), the Secretary shall provide for input from a number and variety of adoption organizations throughout the States in order that the full national diversity of interests among adoption organizations is represented in the planning and development of the campaign.

(3) CERTAIN FEATURES.—With respect to the national campaign under paragraph (1):

(A) The campaign shall be directed at various populations, taking into account as appropriate differences among geographic regions, and shall be carried out in the language and cultural context that is most appropriate to the population involved.

(B) The means through which the campaign may be carried out include—

(i) placing public service announcements on television, radio, and billboards; and
(ii) providing information through means that the Secretary determines will reach individuals who are most likely to adopt children with special needs.

(C) The campaign shall provide information on the subsidies and supports that are available to individuals regarding the adoption of children with special needs.

(D) The Secretary may provide that the placement of public service announcements, and the dissemination of brochures and other materials, is subject to review by the Secretary.

(4) MATCHING REQUIREMENT.—

(A) IN GENERAL.—With respect to the costs of the activities to be carried out by an entity pursuant to paragraph

(1), a condition for the receipt of a grant under such paragraph is that the entity agree to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs.

(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under subparagraph (A) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(b) NATIONAL RESOURCES PROGRAM.—The Secretary shall (directly or through grant or contract) carry out a program that, through toll-free telecommunications, makes

available to the public information regarding the adoption of children with special needs. Such information shall include the following:

(1) A list of national, State, and regional organizations that provide services regarding such adoptions, including exchanges and other information on communicating with the organizations. The list shall represent the full national diversity of adoption organizations.

(2) Information beneficial to individuals who adopt such children, including lists of support groups for adoptive parents and other postadoptive services.

(c) OTHER PROGRAMS.—With respect to the adoption of children with special needs, the Secretary shall make grants—

(1) to provide assistance to support groups for adoptive parents, adopted children, and siblings of adopted children; and

(2) to carry out studies to identify—

(A) the barriers to completion of the adoption process; and

(B) those components that lead to favorable long-term outcomes for families that adopt children with special needs.

(d) APPLICATION FOR GRANT.—The Secretary may make an award of a grant or contract under this section only if an application for the award is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(e) FUNDING.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.”

Clinical Guidelines for Nondirective Counseling of Pregnant Women

Organization	Guideline Type	Non directive	Language	Cite	Mention Adoption
Bureau of Primary Health Care	Policy Information Notice: 98-23	N/A	“...Health center clinic protocols should reflect the current guidelines established by health agencies or professional organizations such as the Agency for Health Care Policy and Research, the American College of Obstetrics and Gynecology...”	Part II.7.a	N/A
American College of Obstetricians and Gynecologists	Guideline for Women’s Health Care	Y	“In the event of an unwanted pregnancy, the patient should be counseled about her options: 1) continuing the pregnancy to term and keeping the infant, 2) continuing the pregnancy to term and offering the infant for legal adoption, or 3) terminating the pregnancy.”	Routine Assessments: Under 18 Years of Age	Y
Child Welfare League of America	Standard of Excellence: Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents	Y	“The pregnant adolescent should be provided with individual and group counseling about her options: 1) continuing the pregnancy to term and keeping the infant, 2) continuing the pregnancy to term and offering the infant for legal adoption, or 3) terminating the pregnancy.”	Standard 4.10	Y

Organization	Guideline Type	Non directive	Language	Cite	Mention Adoption
Council on Accreditation for Children and Families	Standard: Pregnancy Counseling and Supportive Services	Y	“The organization offers counseling to help expectant parents decide if they want to parent the child, plan for adoption, transfer custody of the child, or terminate the pregnancy.”	Standard S13.2.01	Y
American College of Nurse-Midwives	Code of Ethics for Certified Nurse-Midwives	Y	“Nurse-midwives share professional information with their clients that leads to informed participation and consent. This sharing is done without coercion, or deception.”	Code Four	N
National Association of Social Workers	Policy Statement: Family Planning and Reproductive Choice	Y	“The nature of the reproductive health services that a client receives should be a matter of client self-determination in consultation with the qualified health care provider furnishing them.”	“Social Work Speaks”: Page 113, Policy Four	N
American Medical Association	House of Delegates: Adoption Policy	Y	“It is the policy of the AMA to (1) support the provision of adoption information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of adoption.”	H-420.973	Y

Produced by: The George Washington University School of Public Health and Health Services, Center for Health Services Research and Policy (CHSRP), November 2001 for the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care.

Legal and Ethical Considerations for Health Care Professionals in Pregnancy Counseling and Adoption

This article applies the law and accepted values and ethics of the health care profession to the practice of providing pregnancy options counseling. It describes conditions under which coercion can occur and defines noncoercive counseling. In addition, the article explores the concept of informed consent, as it applies to adoption. This information is intended to provide a legal and ethical framework in which to provide information and make effective referrals for pregnancy counseling and adoption services.

Background and the Law

In July of 2000, the Secretary of Health and Human Services issued regulations establishing requirements for recipients of family planning grants under section 1001 of the Public Health Service Act, 42 U.S.C. 300. The rules revoked the “gag rule” that restricted family planning grantees from providing abortion-related information in their grant-funded projects and reinforced a requirement that 1001 clinics provide information on all pregnancy options on an equal basis. Specifically, the law, as interpreted in the administrative rules, requires that the grantee:

- Provide services in a manner that protects the dignity of the individual.
- Provide services without regard to religion, race, color, national origin, handicap disabilities condition, age, sex, number of pregnancies or marital status.
- Provide neutral, factual information and nondirective counseling on any option the pregnant woman requests including:
 - prenatal care and delivery
 - infant care, foster care or adoption
 - pregnancy termination
- Provide for social services related to family planning, including counseling, referral to and from other social and medical services agencies and any ancillary services which may be necessary to facilitate clinic attendance.
- Provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies and health services projects supported by other Federal programs.

The Infant Adoption Awareness Training Program was funded by the Federal government to develop curricula that would help health care professionals provide information and support for the adoption option and make informed referrals for pregnancy counseling and adoption services for patient/clients who choose one or both of these options for further exploration.

Ethics and Values Underpinning the Provision of Public Health Services

Ethics defined: Ethics is a set, theory or system of moral principles or values. Making an ethical decision means making a choice that is consistent with a moral or professional code.

Because the health professional's own values will be challenged in this work, it is especially important to be grounded in a set of accepted professional standards of conduct or ethics that support him/her to be unbiased and objective. Some of the ethical values in public or community health care that relate to options counseling include:

- **The Value of Self-Determination:** This value respects a person's autonomy and capacity to shape his/her own life. This is based on the belief that better outcomes will result when a person's self-determination is respected, as well as the different views of self-determination among ethnic, cultural and religious groups.
- **The Value of Equity:** The value of equity means being treated equally or fairly. The principle of equity also implies that it is unjust to treat people the same who are different. Do all persons in different socio-economic and cultural groups have equal access to needed adoption information and services? Are all persons offered information on an equal basis with other options in unplanned pregnancy situations?
- **The Value of Well-Being:** This value assumes that any clinical intervention is to improve client's health and well-being. However, to determine what constitutes health or well-being for a client one must consider the client's subjective preferences. It is the health care practitioner's role to understand the patient/client's needs and present reasonable alternatives to the patient/client and/or surrogate decision-makers in a way that enables patient/clients and/or their surrogate decision-makers to choose those they prefer.

A decision-making framework that may help clarify ethical dilemmas includes:

- **Assessment:** Decide whose problem it is. Who should make this decision? Who should be included in this decision?
- **Diagnosis:** Gather additional data. Have as much information about the situation as possible. Be up to date on any related laws or organizational policies.
- **Outcome Identification:** Identify with the patient/client as many alternatives as possible. The more options identified, the more likely it is that an acceptable solution will be found.

- **Planning:** Help the patient/client choose, from the options identified, the one that best satisfies his/her needs and preferences.
- **Implementation:** Help the patient/client carry out the decision, including collaboration with referral sources to implement the decision.
- **Evaluation:** Evaluate the results of the referral. From the patient/client's perspective, what is working and not working?

What is Coercion?

Coercion occurs when someone with more perceived power or authority forces a decision upon a patient/client; talks them into a decision; provides information that is incomplete or misleading; and/or offers gifts, bribes or other incentives for making a particular choice. Coercion could occur as a result of a parent of a minor child, or a husband or birth father, exerting excessive pressure on the patient/client. And it is especially detrimental when it occurs in collaboration with a "professional" lending credence to the forceful position.

For purposes of referring persons for pregnancy counseling and adoption, it is important to understand that coercion could possibly occur in many different ways. Coercion can simply be the result of overly directive, controlling, and/or subjective counseling from someone that the patient/client trusts. In adoption, coercion may consist of offering financial or other non-financial benefits to a person who is in desperate need or particularly vulnerable because of their situation. It could also occur through threat of violence or retribution.

What is Nondirective, Noncoercive Counseling?

Noncoercive interventions include interviewing, counseling, and/or providing information and making referrals. Noncoercive methods present information and options through the use of open-ended questions designed to help the patient/client identify his/her options and preferences and make an informed decision that satisfies his/her needs and preferences. A nondirective, noncoercive intervention requires that the helping professional support the decisions made by the patient/client, including the decision to refuse information, even if he/she does not agree with these decisions.

What is Informed Consent?

Informed consent is consent given after the patient/client or patient/client's legal representative has been provided with complete information as to the conditions or situation requiring intervention, the choices/options in services or treatment, the consequences or probable consequences of each option with the patient/client freely choosing one course in lieu of another.

Informed consent in adoption is not very different from informed consent in health care. Although the health professional will not be involved directly in the consent process in an adoption matter, he/she will want to have reasonable assurances that the patient/client will not be exploited or "harmed" by the resource they refer the client to for services. In

adoption and in health care, informed consent requires knowledge, voluntariness, and competency. These elements are defined as follows:

- Knowledge: requires an explanation of the condition/situation requiring intervention; a description of the nature and purpose of all alternatives; description of any expected risks or consequences of the intervention, disclosure of the possibility that the proposed intervention will be unsuccessful, explanation of consequences of intervention or, if no intervention is given, an explanation of consequences of not receiving an intervention.
- Voluntariness: requires that the patient/client must be free to accept or reject the proposed treatment without any physical or psychological coercion.
- Competency: requires that the patient must be of sound mind and legally and mentally capable of making an informed decision.

How Can a Health Care Professional be Most Effective in Providing Information and Making Referrals?

Providing pregnancy options information will be difficult because of realistic time constraints, but it can be particularly challenging in circumstances where there are significant conflicts within a family or other conflicting factors, such as differences in the helper's and patient/client's values, cultural/religious beliefs, and/or socio-economic background. Nonetheless, most health care professionals will take the time and care to provide necessary information and referral because they know how important their actions may be to their patient/client's future. Health care professionals can maximize their effectiveness in providing information on pregnancy options and resources when they:

- understand and demonstrate compassion for a patient/client's unique situation.
- operate within the ethics and values of their profession, consistent with the policies and mission of their health care settings.
- provide information and support for patient/clients to be effective advocates for themselves and their unborn child in seeking help.
- develop a resource bank of quality, responsive and ethical referral sources.
- make referrals that are responsive to a patient/client's needs and preferences, including culture, race, religion, ethnicity, and/or language.

Adoption will not be the chosen alternative for the majority of patient/clients seen by health care professionals but, for some individuals and their children, it may be a preferred course of action.

Due to the finality of an adoption decision, it is important for health care professionals to offer their patient/clients information and help in finding a resource that meets their

service needs and preferences, guarantees protections from coercion and/or exploitation, and provides necessary information for a fully informed consent to adoption.

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February 2002

Additional Reading

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MODULE TWO—ADOPTION AS AN OPTION

Handouts

Birth Parents Rights

The Evan B. Donaldson Adoption Institute lists the following as rights that all birth parents should have:

- To make the placement decision in a fully informed manner, devoid of pressure or concern.
- To reconsider an adoption plan at any point prior to the legal finalizing of the relinquishment.
- To be informed from the start of any monetary expectations – such as repayment of financial assistance – if she changes her mind about placement.
- To exercise all parental rights he/she wishes prior to placing a child for adoption.
- To be treated with dignity, respect, and honesty.
- To have independent legal counsel to protect her/his best interests in the process.
- To receive nondirective counseling to help her/him understand all of the options and resources available and the implications of the decision.
- To be legally assured that promises and agreements regarding ongoing information or contact made as a part of the process will be adhered to. (This is not legally enforceable in all states.)

Smith, S. (2007). Safeguarding the rights and well-being of birthparents in the adoption process. Evan B. Donaldson Adoption Institute. New York, NY.

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Resources

None

Additional Reading

State Specific Laws

Access to adoption records

Child Welfare Information Gateway. (2016). *Access to adoption records*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

<https://www.childwelfare.gov/resources/access-adoption-records/>

This factsheet discusses laws that provide for access to both nonidentifying and identifying information from an adoption record by adoptive parents and adult adopted persons. Generally, the person whose information will be disclosed must consent to the disclosure, and methods of providing consent are discussed. Access to the original birth certificate by the adult adopted person also is addressed. Summaries of laws for all States and U.S. territories are included.

Consent to adoption

Child Welfare Information Gateway. (2017). *Consent to adoption*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

<https://www.childwelfare.gov/resources/consent-adoption/>

This publication presents an overview of state statutes regarding the proper execution of consent when a child is placed for adoption. Consent refers to the agreement by a parent, or a person or agency acting in place of a parent, to relinquish a child for adoption and release all rights and duties with respect to that child. The topics covered include the persons who must consent to a child's adoption, the child's consent to his or her adoption, timeframes for consent, and guidelines for revocation of consent. Summaries of laws for all states and U.S. territories are included.

Court jurisdiction and venue for adoption petitions

Child Welfare Information Gateway. (2017). *Court jurisdiction and venue for adoption petitions*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

<https://www.childwelfare.gov/resources/court-jurisdiction-and-venue-adoption-petitions/>

This publication presents an overview of state statutes that designate the appropriate jurisdiction and venue for adoption proceedings. Jurisdiction refers to the type of court

that has the authority to hear adoption cases; venue refers to the geographic location of the court. Summaries of laws for all states and U.S. territories are included.

Postadoption contact agreements between birth and adoptive families

Child Welfare Information Gateway. (2019). *Postadoption contact agreements between birth and adoptive families*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. <https://www.childwelfare.gov/resources/postadoption-contact-agreements-between-birth-and-adoptive-families/>

Postadoption contact agreements are arrangements that allow contact between a child's adoptive family and members of the child's birth family after the child's adoption has been finalized. These arrangements, sometimes referred to as cooperative adoption or open adoption agreements, can range from informal, mutual understandings between the birth and adoptive families to written, formal contracts. Topics covered include the contents of agreements; parties to agreements; the court's role; and enforcing, modifying, and terminating agreements.

Providing adoptive parents with information about adoptees and their birth families.

Child Welfare Information Gateway. (2016). *Providing adoptive parents with information about adoptees and their birth families*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. <https://www.childwelfare.gov/resources/providing-adoptive-parents-information-about-adoptees-and-their-birth-families/>

This factsheet summarizes State laws regarding the types of information that adoptive parents are provided about the background of the child they are hoping to adopt. The information generally relates to medical and genetic history, family and social background, and mental health history of the child and the child's birth family. For the adopted child or youth, it may also include placement history and any history of abuse or neglect. Exceptions for stepparent and relative adoptions also are discussed.

Regulation of private domestic adoption expenses

Child Welfare Information Gateway. (2017). *Regulation of private domestic adoption expenses*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. <https://www.childwelfare.gov/resources/regulation-private-domestic-adoption-expenses/>

This factsheet presents an overview of statutes regarding the regulation of the fees and expenses that adoptive parents are expected to pay when arranging a private adoptive placement. Some of the fees and expenses that are typically addressed include placement costs, such as agency fees; legal fees and attorney expenses for adoptive and birth parents; and some of the expenses of the birth mother during pregnancy. Requirements for reporting adoption-related expenses to the court also are addressed. Summaries of laws related to these issues for all States and U.S. territories are included.

The rights of unmarried fathers

Child Welfare Information Gateway. (2018). *The rights of unmarried fathers*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. <https://web.archive.org/web/20220122200535/https://www.childwelfare.gov/pubPDFs/putative.pdf>

This publication provides an overview of State laws related to the rights of unmarried fathers and the methods by which a man may establish a legal parent-child relationship with his child. The U.S. Supreme Court affirmed the constitutional protection of an unmarried father's parental rights when he has established a substantial relationship with his child. The circumstances in which a man may be presumed to be the father of a child, the use of putative fathers' registries, the use of genetic tests to establish parentage, and the right of rescission of paternity claims also are discussed. Summaries of laws for all States and U.S. territories are included.

Who may adopt, be adopted, or place a child for adoption

Child Welfare Information Gateway. (2016). *Who may adopt, be adopted, or place a child for adoption*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. <https://www.childwelfare.gov/resources/who-may-adopt-be-adopted-or-place-child-adoption/>

This factsheet summarizes State laws regarding eligibility for becoming an adoptive parent (in terms of marital status, age, residency, and more), eligibility for being adopted as a child or adult, and authority to place a child for adoption. Summaries of laws for all States are included.

Use of advertising and facilitators in adoptive placements

Child Welfare Information Gateway. (2016). *Use of advertising and facilitators in adoptive placements*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. <https://www.childwelfare.gov/resources/use-advertising-and-facilitators-adoptive-placements/>

This factsheet discusses State laws that permit, regulate, or prohibit the use of advertising or facilitators in private or independent adoptions in which prospective adoptive parents or birth parents want to make an adoptive placement without the involvement of an agency. Some adoptive parents choose to advertise their interest in adopting, while others may choose to utilize the services of adoption facilitators or intermediaries. Summaries of laws for all States and U.S. territories are included.

Federal Laws

Children's Bureau. (1995). Information Memorandum ACYF-PI-CB-95-23. U.S. Department Of Health And Human Services.

<https://www.acf.hhs.gov/sites/default/files/documents/cb/pi9523.pdf>

U.S. Department of the Interior, Bureau of Indian Affairs. *Quick reference sheet for voluntary proceedings.* <https://www.bia.gov/sites/default/files/dup/assets/bia/ois/ois/pdf/idc2-041401.pdf>

U.S. Department of the Interior, Bureau of Indian Affairs. (2016). *Final rule: Indian Child Welfare Act (ICWA) Frequently asked questions.*

<https://www.bia.gov/sites/default/files/dup/assets/bia/ois/raca/pdf/idc1-034295.pdf>

General Information

Smith, S. (2007). *Safeguarding the rights and well-being of birthparents in the adoption process.* Evan B. Donaldson Adoption Institute. New York, NY.

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Williams-Mbengue , N. (2019). *Adult adoptee access to original birth certificates.* LegisBrief, Vol . 24, No. 24, June 2016. Washington DC: National Conference of State Legislatures.

https://cwlibrary.childwelfare.gov/discovery/delivery/01CWIG_INST:01CWIG/1218611620007651

About 1.8 million children in the United States are adopted. In response to requests from adult adoptees who want to know more about their birth families, some states are enacting laws to allow them easier access to their original birth certificates.

MODULE THREE—PRESENTING ADOPTION AS AN OPTION AND MAKING REFERRALS

Handouts

Adoption Language Worksheet

Instead of:	Please use:	Why? (possible responses)
1. Adopt out, give away, put up for adoption	Make an adoption plan, choose adoption	
2. Keep the baby	Chose to parent her child, made a parenting plan.	
3. Real parent, natural parent	Birth parent, biological parent	
4. Not their own child	Adopted person, adoptee, came to their family through adoption	
5. Illegitimate	Born to unmarried or single parents.	
6. Birth parent	Expectant Parent	

Non-directive, Non-coercive Techniques

- **Physical Environment:** Ensure that the physical environment of your office, waiting room, or other areas of your organization reflect your clientele. Do the pictures on your wall or the magazines in the lobby match the diversity of your patient/clients? If you are working in a hospital setting, what are some of things that can be done to make sure that the environment is a safe place?
- **Rapport Building:** Involves developing trust through verbal and non-verbal means. Verbal rapport building can include the use of compliments, expressions of caring (How would you feel most comfortable?) self-disclosure and humor. Non-verbal rapport building can include touch, eye contact, nodding, and smiling.
- **Open-Ended Questions:** Are questions that allow the patient/client to tell his/her story. Open-ended questions cannot be answered by a yes or no.
- **Reflective Listening:** Is a technique that lets the patient/client know that the health care provider is listening to what he/she is saying. This technique is often referred to as paraphrasing and/or reflective or active listening.
- **Responding Nonjudgmentally:** Requires the health care provider to continually assess their own values and beliefs so that they do not interfere with their work with patient/clients.
- **Empowerment/Strength-Based Comments:** Is a technique that identifies and compliments strengths in order to help an individual take control of a situation. When responding to the patient/client communication, it is helpful to notice the strengths you can identify, not just the problems and concerns.
- **Empathy:** Involves listening respectfully to the patient/client's concerns and relating to the patient/client's situation.
- **Identifying Feelings:** Occurs when the health care professional puts words to the emotions that are being expressed and then checks with the patient/client to make sure that his/her interpretation is correct.
- **Defusing Anger:** Defusing anger can be accomplished by several techniques including identifying and responding to the issues underlying the person's anger, such as fear, acknowledging that fear, and shifting the person's perspective.
- **Summarizing:** Is a technique in which the health care provider highlights key points of the conversation with the patient/client and checks back to make sure that his/her interpretation is correct.

Open-Ended Questions

Certain types of questions support brief nondirective, noncoercive interventions. Open-ended questions invite the patient/client to tell more of their story and help to identify who and what are important to them (him/her).

Useful open-ended questions includes the use of “what,” “who,” “when,” or “how” in the question. Some examples include, “What happened when...”, “What was different...”, “Who helped you when...”

It is less useful to ask a “why” question. “Why” questions imply blame and generate a defensive response. For example, “Why were you there?” or “Why did you do that?” are not helpful.

The least useful type of question in nondirective, noncoercive interviewing is the tag question, such as “You want to do the right thing, don’t you?” or “You don’t want to do that, do you?”

Scaling questions are a very useful assessment tool you can use to gauge confidence, hopefulness, safety issues, willingness to make changes, take action steps towards a goal, assess progress to date and to approach many other topics that are often difficult to describe with words alone. Scaling steps include:

1. “If I were to ask you, on a scale from 1 to 10, “10” being you have all the skills, knowledge and resources to raise a child and “1” being you don’t have any of the skills, knowledge and resources to raise a child, where would you rate yourself on this scale?”
2. Follow up with a compliment regarding how “high” of a skills and knowledge number they chose even if “1” is the number chosen – acknowledge their honesty and “good” judgment.
3. Then ask, “What would it take to move up from 5 to 6? (If “1”, then “from 1 to a 2?”).
4. Continue with asking open-ended, “how” and “what” type questions to elicit more details regarding the skills and knowledge.
5. Continue to ask, “What else would it take to move just a bit further up the scale – from a 5 to 6?”, or ask a relationship/scaling question like: “If your mother were here right now, what number would she say?”

Open-Ended Question Examples

- How do you feel about the pregnancy?
- Tell me about how your life has changed with this pregnancy.
- How do you feel about those changes in your life?
- What impact do you think having this child will have on your future plans?
- Tell me what concerns you have about this pregnancy.
- Who will be helping you as you go through this pregnancy and how do you feel about their helping?
- There are basically three options available to you: continuing the pregnancy to birth and placing him/her for adoption by relatives or non-relatives; continuing the pregnancy to birth and parenting; or terminating the pregnancy. Which of these would you like more information on?
- What do you know about your options?
- What options have you explored?
- How familiar are you with pregnancy counseling?
- Tell me what you know about adoption.
- Tell me about a personal experience you have had with adoption.
- Tell me about the adopted persons or adoptive families you know.
- Tell me about what you have heard about adoption on television or in the movies.
- How do your friends and family feel about adoption?
- What do you know about adoption?
- What do you see yourself doing in the future? How will having this baby change that?

Resources

Brief Nondirective, Noncoercive Interventions

The history that follows sets the stage for the development of what will be referred to in this article as brief, nondirective, noncoercive interventions. The health and mental health literature uses a variety of terms including solution-focused brief therapy; nondirective interventions; client-centered treatment; and strengths-based treatment. All these terms refer to a basic paradigm of working with patient/clients that is predicated on their ability to solve their own problems with adequate access to nonjudgmental, supportive resources and supports.

The 1960s was a tumultuous time in the United States. Many societal values were being challenged, and new ways of thinking were being developed. The health and mental health fields were no exception. One major change that occurred in these fields empowered patient/clients to begin to take a more active role in their own care. They were no longer “acted upon,” but were partners in the decision-making and events of their lives.

Around the same time, medications were identified that helped to control the hallucinations and distorted thinking that accompany many mental illnesses. Individuals with diagnoses such as schizophrenia, or manic depression (now referred to as bi-polar disorder) could live productive lives and resume control over their own destiny if they took their medicine. They could return to their communities and exercise self-determination to make decisions on their own behalf.

These factors, along with the desire to curb spiraling health care costs, gave rise to the notion of brief mental health interventions. It was no longer conventional wisdom for an individual to undergo years of psychotherapy to make changes in his/her life. Instead, it was thought that a short, focused relationship with a health care or mental health professional could facilitate growth and change.

The focus was no longer on telling someone the right thing to do, but rather helping him/her discover the answers within him/herself. This marked another change in thinking that departed from the notion that the experts know best, to the belief that individuals know what is best for them and with guidance and social support, will make decisions that serve them well.

Another major change was the blurring of the divisions between physical and mental health services. Many professional roles overlapped, and each group began to develop strategies for learning about the other and working together. What resulted was of benefit to both areas. Better-trained professionals, and higher quality patient/client care.

Who can do brief nondirective, noncoercive interventions?

Health care providers, including pregnancy counselors and community nurses can utilize this type of intervention as effectively as trained mental health professionals. Good assessment skills, the ability to quickly build rapport with patient/clients while treating them with dignity and respect are key skills held by health care professionals. These skills, coupled with the ability to be good listeners and gather a lot of information in a short period of time, form the basis of brief, nondirective, noncoercive interventions.

What are the underlying beliefs of brief nondirective, noncoercive intervention?

This form of intervention is interactive and is based on the idea that change is occurring all the time. It also proposes that all individuals have strengths that they can draw upon to cope with these changes. Another core belief is that positive change in one area of a patient/client’s life can lead to positive change in others. Finally, and most importantly, there is the belief that patient/clients have ideas about how to solve their problems, and in fact, many have been successful in implementing change in the past.

What are the key components of nondirective, noncoercive interventions?

The two key components in providing nondirective, noncoercive interventions are asking open-ended questions that allow patient/clients to tell their stories and listening carefully to what is being said both verbally and non-verbally. An open-ended question is one that cannot be answered easily with “yes” or “no.”

Checking back with the patient/client, while they are telling their story, is important to ensure that the health care professional is getting an accurate picture of the patient/client’s perception of the issues. Sometimes this is called reflective listening, active listening or paraphrasing.

Helping patient/clients develop obtainable goals is another key component of this type of intervention. Goals need to be stated in the patient/client’s own language and need to be important to that individual. An obtainable goal is stated as the presence of something rather than the absence of something. An example of this is, “I will not eat fattening foods” versus stating it as the presence of something would be, “I will eat healthy food.” It is also helpful to look at goals as a step-by-step process and not just as a final result. Goals need to be stated in concrete, behavioral, measurable and realistic terms to increase the likelihood of success. The health care provider can help make goals more viable by asking open-ended questions that lead the patient/client to crystallize his/her thoughts and his/her plan for making change happen.

Identifying patient/client feelings is another component of nondirective, noncoercive interventions. This can be done by putting words to the emotions that are being expressed and then checking with the patient/client to make sure that this interpretation is correct. Change usually comes when individuals address their feelings and emotions around a particular issue. As long as they are able to intellectualize, they are able to stay stuck.

Responding nonjudgmentally is critical to nondirective, noncoercive interventions. Health care professionals must continually assess their own values and beliefs so they do not interfere with their work with patient/clients. When a particular patient/client elicits a strong emotional response or judgment from the health care professional, it is a good time to talk to a colleague or team member so that during the next meeting with the patient/client, a nonjudgmental posture can be assumed.

Are there specific types of questions that can be used in brief nondirective, noncoercive interventions?

Certain types of questions support brief nondirective, noncoercive interventions. The most useful is the open-ended question, such as, “How would you describe your strengths?” Open-ended questions invite the patient/client to tell more of their story and help to identify who and what are important to them (him/her).

Another highly useful questioning technique includes the use of “what,” “who,” “when,” or “how” in the question. Some examples include, “What happened when...”, “What was different...”, “Who helped you when...”

It is less useful to ask a “why” question. “Why” questions imply blame and generate a defensive response. For example, “Why were you there?” or “Why did you do that?” are not helpful.

The least useful type of question in nondirective, noncoercive interviewing is the tag question, such as “You want to do the right thing, don’t you?” or “You don’t want to do that, do you?”

Scaling: Scaling questions are a very useful assessment tool you can use to gauge confidence, hopefulness, safety issues, willingness to make changes, take action steps towards a goal, assess progress to date and to approach many other topics that are often difficult to describe with words alone.

For example: “If I were to ask you, on a scale from 1 to 10, “10” being you have all the skills, knowledge and resources to raise a child and “1” being you don’t have any of the skills, knowledge and resources to raise a child, where would you rate yourself on this scale?” Then, follow up with:

- A compliment regarding how “high” of a skills and knowledge number they chose even if “1” is the number chosen – acknowledge their honesty and “good” judgment.
- Then ask, “What would it take to move up from 5 to 6? (If “1”, then “from 1 to a 2?”).
- Continue with asking open-ended, “how” and “what” type questions to elicit more details regarding the skills and knowledge.
- Continue to ask, “What else would it take to move just a bit further up the scale – from a 5 to 6?”, or
- Ask a relationship/scaling question like: “If your mother were here right now, what number would she say?”

Goals: An obtainable goal is stated as the presence of something rather than the absence of something. An example of this is, “I will not eat fattening foods,” versus stated as the presence of something would be “I will eat healthy food.” It is also helpful to look at goals as a step-by-step process and not just as a final result.

Goals need to be stated in concrete, behavioral, measurable and realistic terms to increase the likelihood of success.

Even though brief, nondirective, noncoercive interventions have been given many names, the underlying themes and values are a good fit for health care providers, particularly those doing pregnancy and/or options counseling. These techniques fit with professional values and standards, with the need for brief interventions, and with the idea that patient/clients are resilient and have the capacity to make good decisions on their own behalf.

These interventions also facilitate teaming and assist helping professionals to make meaningful referrals. Speaking a common language, and holding a common set of beliefs makes networking easier and allows for more options to be given to patient/clients. Brief, nondirective, noncoercive interventions help to create an atmosphere where women can feel comfortable exploring all of their options without the fear of being judged. This climate will result in the patient/client making an informed decision that he/she can be comfortable with throughout his/her lifespan.

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Checklist for Effective Communication

Listening:

- Are you waiting impatiently for the patient/client to stop so that you can talk?
- Are you in such a hurry to offer a solution that you don't wait to hear the problem?
- Are you listening only for what you want to hear?
- Do emotional blocks get in the way of your listening?
- Do your biases interfere with your listening?
- Do your thoughts take side excursions while the patient/client is talking?
- Are you focusing on details instead of getting the main points and feelings?
- Do you quit listening when the subject matter gets difficult or repetitive?
- Do you have a negative attitude when listening?
- Do you just pretend to listen?
- Do you put yourself in the patient/client's place to understand what makes her say the things she does?
- Do you take into account that you and the patient/client may not be discussing the same issues?
- Are you alert for misunderstandings that could arise because the words don't mean the same to you as they do to the patient/client?
- Do you try to find out what an argument is about? Is it a real difference of opinion or just a matter of stating the problem differently?

Speaking:

- Are you careful to watch for signs of misunderstanding in your patient/clients?
- Do you choose words that fit the patient/client's knowledge base and background?
- Do you think out directions before giving them?
- Do you break down directives into small, easy to understand increments?
- If a patient/client doesn't ask questions about a new idea you are presenting, do you assume that he/she understands it?
- Do you speak distinctly? Are distractions controlled as much as possible?
- Do you group your thoughts before speaking so that you don't ramble?
- Do you put the patient/client at ease? How?
- Do you encourage questions? How?
- Do you assume that you know what the patient/client has in mind, or do you ask questions to find out?

- Do you distinguish between facts and opinions? How?
- Do you cause patient/clients to get defensive by contradicting their statements?
- Do you influence your patient/clients to tell you what you want to hear?

Giving Feedback:

- Focus on behavior rather than on the person.
- Focus on description rather than judgment.
- Focus on specifics rather than generalities.
- Focus on the value it may have for the patient/client, not the release that it provides for you.
- Focus on giving the amount of information that the patient/client receiving it can use, rather than the amount of information you would like to give.
- Check to be sure that the feedback was clear.
- Focus on the patient/client's feelings and perceptions, not just the facts.

Receiving Feedback:

- Ask for it when you want it.
- Be clear about the type of feedback you are interested in receiving.
- Listen nonjudgmentally when it is given.
- Maintain a climate that allows feedback.
- Check to be sure that you clearly understand the feedback that is given to you.

Utilize Techniques for Defusing Anger:

- Listen for and respond to the angry person's fear.
- Listen for and respond to the underlying issues.
- Shift the angry person's perspective.
- Use humor to keep the situation in perspective.
- Do the unexpected.
- Use emotional honesty.

Help the Patient/Client Feel More Comfortable, Empowered and in Control:

- Listen respectfully to the patient/client's concerns.
- Use the patient/client's words whenever possible.

- Empathize with the patient/client's situation.
- Reinforce the patient/client's past success in solving problems.

Do Not Take the Patient/Client's Behavior Personally:

- Identify the root cause of the patient/client's anger or resistance.
- Keep the focus on the goal of the interview.
- Avoid control battles with patient/clients.

Introducing Pregnancy Options in Fifteen Minutes or Less

Introduction

This script is directed to the health care professional who meets with the patient/client to provide her with her positive pregnancy test results. It further assumes that the health care professional has had no contact with the patient/client previously and will not be providing follow-up care. It assumes that the health care professional will discuss the need for and make referrals for health care as necessary.

The script's purpose is to:

- Provide guidance to the health care professional in raising the issue of choices with the patient/client, and
- Provide guidance on appropriate referrals to other agencies with knowledge and skills to discuss the choice to the patient/client expressed interest in pursuing.

This script is designed to have all the options raised in a non-coercive, non-judgmental manner so that the patient/client knows:

- She has choices.
- She is free to make whatever choice she wishes without judgment.
- She makes the choice of what she wishes to do about the pregnancy.
- She controls the referral contract.

This script is designed to take fifteen minutes or less. The health care professionals' recommended statements or questions are in quotation marks. Directions to the health care professionals are in italics.

Pregnancy Options Discussion Script

Greet the Patient/Client

Scenario 1: Health care professional greets patient in the client waiting area.

“Hello, Ms. Smith, my name is Sally Healthcare. Please come with me.” You may want to engage in small talk on the way to the interviewing room. Once in the interviewing or examination room say, “I will be talking with you about your pregnancy test results.”

Scenario 2: Someone else brings the patient/client to the interviewing/examination room and you enter the room after the patient/client.

“Hello Ms. Smith, I am Sally Healthcare. I will be talking with you about your pregnancy test results.”

Tell the patient/client the test result is positive

Most patient/clients are anxious to know the results, so tell them right away by saying, “The pregnancy test is positive.” Observe her behavior, listen and respond appropriately. If you cannot tell how the news affected her, ask questions such as,

- “What are you thinking or feeling?”
- “How do you feel about the test results?”
- “What do you think the child’s father will do or say when you tell him?”
- “What impact do you think having this child will have on your future plans?”

Present Options

Say: “There are basically three options to a pregnancy. Continuing the pregnancy to birth and parenting the child, continuing the pregnancy to birth and placing the child for adoption with relatives or others or terminating the pregnancy. What information would you like about any of these options?” Listen and respond appropriately.

Identify Referral Options

If the patient/client states she is clear on what she wants to do and does not want any referrals, terminate the discussion by saying: “I respect your decision. Should you change your mind, however, we welcome you to call for a referral. You can call (phone number) to get the name of an agency which can provide you with additional information and services on whatever option you choose or to help you with your choice.”

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Making Successful Referrals Checklist

- When talking with patient/clients, pay attention to both the expressed, implied and the perceived needs. What services have they requested or could they benefit from?
- I have identified the patient's unique and individualized needs related to any referral i.e., language, developmental, cultural and ethnic needs.
- I have talked with the patient/client about what her/his primary concerns are and what options exist to help address them.
- I have confirmed that he or she is willing and ready to be referred.
- I have discussed with patient/client issues that might make it difficult for him or her to follow through with the referral.
- I am familiar with the agency to which I am referring the individual, including its eligibility requirements and services.
- I have provided at least two options for each service desired/needed (when possible). I have included a direct contact name and have provided these options orally as well as in writing.
- The agency I have referred has the ability to successfully respond to my patient/clients' needs in a knowledgeable, culturally sensitive and respectful manner.
- I have provided sufficient information and "coaching" to help make the referral successful.
- I have made a plan to follow up with the patient/client (when appropriate) to see how things went and to determine next steps.
- I have a backup plan if this referral fails to work out for any reason.

Questions for Health Care Practitioners to ask Agencies and/or Attorneys

1. What are the pregnancy options and services you provide to birth parents?
2. If a patient/client decides to place her child for adoption, which of the following types of adoption do you provide?
3. If you provide open adoption alternatives, what are the degrees of openness you offer?
4. What are the characteristics of clients you typically serve?
5. What kind of financial assistance do you provide access to for expectant mothers?
6. How are the health care needs of your clients met during and after pregnancy?
7. What standards do you follow in your practice?
8. What services do you provide for birth mothers and significant others after adoption?
9. Do you have a waiting list?
10. How soon can you see my patient/client?

Questions for Patient/Clients to ask Agencies and Attorneys

1. What options will you talk with me about?
2. What services do you provide if I decide to parent my child?
3. What if I decide I want to place my child for adoption, after I take him/her home?
4. If I start the adoption process, can I change my mind? How much time will I have to change my mind?
5. I am not 18 years old. Will my parents have to be involved if I place my child for adoption?
6. Will the father of the child have to be involved if I place my child for adoption?
7. What will you need to know about me and the child's father and why? What information will be confidential and what will be shared with the child and/or adoptive parents?
8. If my baby has special needs, is adoption still possible?
9. Can I choose the people who will adopt my child?
10. How much information is known about the people who will adopt my child?
11. Can I see my child after he/she is born?
12. Can I have contact with my child after the adoption?
13. What kind of arrangements are possible?
14. Can I be sure that the adoptive parents will let me continue to have contact with my child after they adopt him/her?
15. What do most birth mothers feel after they place their child for adoption? What services will be available to help me after I place my child for adoption?
16. Can I have contact with my child after he/she is an adult?
17. Do you have a support group for birth parents who have placed their child for adoption?
18. Is there someone who has used your services that I can talk with before making a decision?
19. Will I have to pay for services?

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MODULE FOUR—INFLUENCES ON DECISION MAKING

Handouts

Lillian Scenario

Lillian is a 26-year-old Hispanic, Catholic woman who has come to your hospital-based clinic seeking prenatal care. She has recently moved back to the community where she was raised after losing her sales job and breaking up with her boyfriend, the baby's father. For the last year, she had been living in a major metropolitan area in another state with her boyfriend and her 5-year-old daughter from a previous relationship. Following the dissolution of her relationship with the boyfriend, Lillian moved back to her hometown to be near her mother. She is now five months pregnant. The ultrasound reveals that she is carrying a boy.

Despite the fact that she has been very successful raising her daughter, shortly after you became her health care provider, Lillian has begun to express doubts about her ability to raise another child on her own. She indicates that her father is deceased, and her mother has had to go back to work to support herself, and Lillian's two younger siblings are still in high school. Lillian would like to continue working toward her bachelor's degree in marketing so that she can provide a better life for her daughter, but she does not know how she can do this and take care of another child. She indicates that the baby's father is involved in another relationship and has let her know that he is not interested in being a father at this point in his life and that he has no intention of being involved in the baby's life.

Lillian's aunt and her husband have approached her regarding adopting the baby. They have been married for several years, are in their forties and have not been able to have children. Lillian seems ambivalent about the whole issue of placing her baby for adoption. She does not know how she can go on with her life if she gives her baby to someone else to raise.

- What are the influences impacting decision making?
- How can you be respectful of her culture?
- What are the other issues to consider?

Kaelyn Scenario

Kaelyn is a 17-year-old, Caucasian female. She will graduate from high school in three months. She is a smart girl though her grades have not always reflected her intelligence. Fortunately, her test scores were high enough for her to be admitted to a university that is about two hours from her mother and step-father's house. A talented artist, Kaelyn is planning on studying Studio Art.

Kaelyn has a conflictual relationship with her mother, Stephanie. Stephanie was also a teen mother. Stephanie has worked very hard to better herself while raising Kaelyn as a single mom. Stephanie worked full time and went back to school to get her nursing degree. She met Robert at the hospital where they work. They got married when Kaelyn was twelve. Robert and Kaelyn have a good relationship. He tries his best to respect his role as step-dad. Kaelyn gets along well with most adults but tends to be very sensitive to any feedback or suggestions made by her mother.

Robert and Stephanie did not know that Kaelyn was sexually active so finding out that Kaelyn was 12 weeks pregnant came as a shock. Stephanie has tried very hard over the years to talk with Kaelyn about sexual health and taking precautions. Kaelyn has always denied any interest in boys and has been adamant that she was not sexually active. Extremely concerned, Stephanie and Robert have tried very hard to talk with Kaelyn about her options. Kaelyn reacts by running to her room in tears or leaving the house abruptly to hang out with friends.

- What are some of the influences on the decisions that Kaelyn will make about her pregnancy?
- As a health care provider how can you establish rapport with Kaelyn?

Anna and Luke Scenario

Anna and Luke arrive at the hospital appearing disheveled, dirty and wearing many layers of clothing. Initially, ER staff dismissed Anna's pleas thinking she was med seeking but an exam showed she is 32 weeks pregnant and in active labor. Anna states that she did not know she was pregnant until arriving at the emergency room in serious pain and has not had any prenatal care. Anna has a very difficult time with labor and gets angry with staff because she says the meds given aren't touching her pain. Luke keeps saying he is going out to smoke every hour or so and is gone for an extended period of time and then comes back and seems to be nodding off in the corner. Anna gets really agitated every time he leaves and seems worried that he won't come back.

After the baby is born, he is rushed to the NICU due to prematurity and suspicion of substance exposure. She denies any substance use initially but after being confronted with test results admits to the hospital social worker that she and Luke live in a tent not far from the hospital and have been using heroin for the last 10 years. Anna seems primarily focused on getting out of the hospital. She says that she has to go soon, or all of their belongings will be stolen. Anna reports that she lost her three children from a previous marriage to foster care about 4 years ago due to domestic violence and substance abuse allegations. She is still very angry about that situation and does not want this baby to go to the foster care system.

Anna asks to have baby brought to her room and doesn't seem to understand that the baby is in the NICU for specialized care. After visiting baby for 10 minutes in NICU, Anna returns to her room very upset about the baby's condition. She is inconsolable and vacillates between starting to gather her things into a bag and sobbing on the bed. Luke gets frustrated and leaves. You are worried that Anna will leave the hospital AMA without making any decisions for baby.

- How is substance use likely to influence the decisions that Anna will make about her pregnancy?
- As a health care provider how can you establish rapport with Anna?
- What are some ethical considerations when providing options counseling?

Nevaeh Scenario

Nevaeh is a 20-year-old college student attending community college. Nevaeh is participating in a program that supports former foster youth who have graduated from high school and are enrolled in college or technical school. Neveah and her boyfriend, Zeb, have been dating for six months. Like Neveah, Zeb spent most of his youth in foster care.

The caseworkers who have known Nevaeh most of her life describe her as an incredibly bright and resilient kid. They are impressed that she has done so well for herself considering the abuse and neglect that she experienced as a child. These same caseworkers are extremely disappointed that she is pregnant. They are also very worried that she has partnered with someone who was also in foster care.

One of the conditions of Nevaeh's program is that she stay in school. She will lose the funding that pays for her apartment and college if she drops out of school. Neveah and Zeb just found out that she is five months pregnant. They both want to raise the baby together and are adamant that they do not want to see her end up in foster care.

- How is Nevaeh's trauma history likely to influence her decision making?
- What are other influences impacting Neveah?
- As a health care provider, how can you help Nevaeh while acknowledging her challenges?

Stages of Grief Following Delivery for Parents Planning Adoption

Birth Parents	Adoptive Parents
Early Labor: Nervous, fearful, sometimes anxious for privacy, bonds to nurses	Nervous, fearful, fearful of being “unchosen.” Worried about medical view
Mid Labor: If epidural, often wants adoptive parent included.	Thrilled to be included, some deep feelings of unexpressed envy, anticipatory, fluctuating between empathic and needed, unspoken.
Post-partum - First few hours: Elated birth is over, eager to share the beauty of the child, on somewhat of a “high.”	Elated to see the child in the flesh, flooded with feelings of gratitude, also on a bit of a “high.”
First night alone in the hospital: Often wants rooming in, has quiet, private time with child.	Beginning some anxiousness about “If she’s with the baby all this time ... she might change her mind.” Wanting to spend time with baby, not wanting to interfere, feeling envy and displaced.
Second day: Often flooded with intense mother child feelings that have perhaps not been expected. Feeling singularly” capable of a bond that “no one else” can have like “I do.”	Aware and observing of increasing connection of mother and child. Terrified mother will claim the child. Ashamed of some of their “ownership” competitiveness.
Discharge discussions: Signatures given that allow baby to leave with someone other than parent, reality beginning to skin in. Resentment can bubble up. An internal struggle around the decision. Sometimes a fear to tell the adoptive parents there are doubts. Fear of letting them down OR a re-decision to choose adoption and awareness that baby is leaving soon. Wanting to spend time with baby, sometimes mixed feelings about adoptive parents in nursery with baby, ashamed of not wanting to share.	Anxious for discharge to get underway. Wanting to hurry along paperwork. Discussions about naming. Sometimes resentment regarding the mother’s second guessing. “I thought she was so sure of this.” Hovering OR Withdrawal out of self-protection. Spending time in nursery to know new parenting skills, resentful if baby goes to mom’s room.
2 nd or 3 rd day: Grief swelling over separation. Dawdling around actual discharge. Tearful and sometimes getting last ditch “suggestions from friends and family OR a rushed departure, cut and run, needing alone time, needing to go home.	Unsure how to handle leaving with baby. Anxious at how long a discharge can take. Wanting to dress baby in their own way, also feeling sad for mother sometimes guilty.

Developed by Gayle Ward, MA Education Institute, Kinship Center

Helen Scenario

Helen is a 29-year-old woman living with her three-year-old son, Aidan, in a two-bedroom apartment. Helen works at the local utility board and makes a decent salary but still struggles to make ends meet at times. Helen has been officially divorced for a year. Her ex-husband, Ray, pays his child support but has already remarried and has a new baby on the way. Ray and his new wife maintain a different lifestyle than Helen and Aidan. Both have good jobs and are quick to criticize Helen's lifestyle and parenting.

Helen has a complicated relationship with her mother, Suzanne. Her father, Dan, passed away two years ago. Dan was the glue that held their family together. His death of a heart attack devastated the family. Suzanne and Dan adopted Helen as a newborn after years of unsuccessful infertility treatment. Helen grew up knowing that she was adopted but has never met her birth family. Now pregnant, Helen is making an adoption plan and is working with a licensed adoption agency. She has chosen a closed adoption like her own adoption. The birth father of the child has already met with the adoption agency and has agreed to consent to the adoption.

Helen has recently given birth at your hospital. The baby is doing well and is being cared for by her adoptive parents on another floor in your hospital. Initially Helen appeared to be handling the adoption very well until you began to talk with her about her discharge from the hospital tomorrow. She is now crying uncontrollably and expressing fears that her daughter will grow up thinking that she was not loved or wanted. She is also worried that Aiden will think she is going to give him away as well. You have notified the hospital social worker who has called the adoption agency representative who left the hospital a few hours ago thinking all was well.

The Hospital Interval

When a pregnant woman in labor arrives at the hospital, it is possible that nursing staff will be unfamiliar with contemporary adoption practices, given the relative infrequency of infant adoption. Smith and Brandon (2008) point out how this essential information allows nurses to provide “appropriate, sensitive, nonjudgmental care to all persons involved in the adoption process” (p. 382). Ideally, the hospital has a perinatal social worker, who has had contact with the adoption agency social worker or attorney, and a plan is in place for the birth and hospital stay (p. 385). Ideally, nursing staff and the perinatal social worker will have read Smith and Brandon’s article and undergone this training, and have a good understanding of contemporary adoption practices as a result.

Under these ideal circumstances, the *plan* is exactly that, and subject to change if circumstances render it necessary, as in a labor complication that requires an emergency intervention. The *plan* is also subject to change if the woman who is giving birth makes different decisions about adoption during this interval, which is her right. It is also possible the circumstances will be less than ideal, that the hospital does not have a perinatal social worker, or the perinatal social worker is not available when the pregnant woman in labor arrives. It is possible the adoption agency or attorney has not contacted the hospital social worker, and it is possible that no plan is in place for the birth and the hospital stay. Under all of these circumstances, labor and delivery will proceed, an infant will be born, and discharge from the hospital will occur usually within a relatively short time span. The challenge for the nursing staff is how to provide care that meets the needs of the members of the adoption triad they have contact with during this interval. The American Nurses’ Association Code of Ethics with Interpretive Statements (2001) Provision 1 states, “The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (p. 7).

The expectations of this provision are clear; application to these circumstances requires consideration of the woman’s right to self-determination, as well as sensitivity to the other members of the adoption triad who may be present. Personal feelings and values of the nurse must be separated from the nurse’s professional role and responsibilities. It is clearly wrong, hurtful, and unethical for a nurse to say something like, “How can you give up this beautiful baby?” The words and behaviors of the nurse that will best provide support are not known, though. It seems that affirming the woman’s role in giving birth is supportive and helpful when an adoption plan has been made or is under consideration, but whether it is better to say, “You have a beautiful, healthy daughter” or “You have given birth to a beautiful, healthy baby girl” or if the choice of words even matters is the subtle kind of thing that it would be useful to know.

DiCenso, Guyatt, and Ciliska (2005) define evidence-based nursing as “the conscious, explicit, judicious use of current best evidence in making decisions about the care of individual patients. Evidence-based clinical practice requires integration of individual clinical expertise and patient preferences with the best available external clinical evidence from systematic research, and consideration of available resources” (p. 565). Unfortunately, the evidence is lacking for nurses

who want to know how to best support the woman who has arrived to deliver a baby when an adoption plan has been made or is under consideration.

In her dissertation, Kobovich (2002) points out the relative absence of research-based literature describing first, the nature of the relinquishment experience for a young woman and second, nursing interventions for relinquishment in general and specifically for a time that the birth mother identifies as extremely important in the relinquishment experience—the hospital-based experience of birth and the act of relinquishment (p. 2).

In her dissertation, she used an inductive, qualitative approach to explore the experience with young women who made an adoption plan, and created focus groups with obstetrical nurses to elicit their insights about nursing actions and behaviors that are helpful and supportive. She found the birth mothers both felt “very positive about the nursing care they received” (p. 151), and one of the participants had actually anticipated a different situation, due to her circumstances. Focus groups of obstetrical nurses revealed the physical care aspects are the same, but as one nurse noted, “It’s the emotional, spiritual, and supportive care that is different” (p. 171). Instead of the joyous celebration that childbirth evokes under other circumstances, this experience is “lonely” (p. 171). The grief is different than the grief experienced by the mother of a stillborn infant, because as noted by one nurse, “that baby is always out there, that mother always wonders” (p. 172). The focus groups revealed “nurses try 1) to give the relinquishing mother as much control as possible while in the hospital, 2) to be supportive and nonjudgmental, and 3) provide mementos of the baby when asked” (p. 189). The focus groups revealed the nurses “feel that relinquishing a baby is a difficult and honorable choice and respect birth mothers for their strength and determination” (pp. 189-190). The areas identified as problematic by the nurses are how and whether to intervene related to “the relinquishing mother’s interaction with her baby”, especially if the relinquishing mother hesitates or declines close interaction and “uncertainty in the mother” (p. 193). Given the short contact the nurses have, the long-term implications of the mother’s decision, and the lack of evidence to guide them, the “tensions and sense of caution in the nurse” (abstract) regarding these problematic areas are understandable. Further research is needed.

In the absence of clear evidence, nurses can draw upon central concepts of nursing practice, *the art of nursing, caring and presence*. Describing the convergence of these concepts, Finfgeld-Connet (2008) states,

Nursing involves an intimate relationship-centered partnership between the nurse and patient. Situation-specific nursing actions result from multiple forms of personal and professional knowledge and are based on a value system of holistic beneficence and patient empowerment (p. 527))...

...The art of nursing, presence and caring take place within an atmosphere of interpersonal sensitivity and intimacy, which is characterized by open and honest interactions. Personal insights are disclosed in verbal and non-verbal ways, and the nurse unobtrusively grasps the patient’s needs and responds in a kind and compassionate way.

Empathy is expressed through words and actions, and a supportive nurse-patient partnership is cultivated (p. 530).

These inspiring descriptions fit well with the role of the nurse interacting with members of the adoption triad during the labor, delivery and postpartum interval prior to discharge from the hospital.

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Birth And Adoption Plan For Hospital

Note: Hospital policies and procedures must be followed. The expectant mother may change this plan at any time.

Birth Plan For _____ DOB _____

Plan Created By _____ Date Created _____

Name of Hospital Where Delivery Is To Occur:

Address of Hospital:

Birth Mother's Doctor and Phone Number:

Name of Agency or Attorney Handling the Adoption:

Name of Pregnancy Counselor/Adoption Worker:

Contact Information:

Name of Adoptive Parent (s) if applicable:

1. When do you want your pregnancy counselor to come to the hospital? Who will call your pregnancy counselor and when?

2. I would like the following people to be present at the birth (check all that apply):

- Partner/Boyfriend/Husband/Father of Baby _____
- Parent (s) _____
- Friend (s) _____
- Midwife/Doula _____
- Other Relatives _____

3. My preferences during the labor and delivery (check all that apply):

- I would like to bring music.
- I would like the lights dimmed.
- I would like to videotape and/or take pictures in the delivery room.
- I prefer natural childbirth (no medications).
- I prefer to have an epidural (if possible).
- Other:

4. My openness arrangement with the adoptive parents includes (check all that apply):

- The adoptive parents will be in the delivery room during the birth of the child
- The adoptive parents will be at hospital during the birth, but not in the room with me
- The adoptive parents will not come to the hospital until after the baby is born
- The adoptive parents will not come to the hospital until the baby is ready to go home
- I do not want to see the adoptive parents at all while I am in the hospital
- I want to see the adoptive parents before I leave the hospital (only once)
- I would like to see the adoptive parents as much as possible while I am in the hospital (without the baby)
- I would like to see the adoptive parents as much as possible while I am in the hospital, while my baby is also in the room (so I can see them together)
- Other:

5. I DO NOT want the following people to see the baby (if none noted, indicate “N/A”):

6. Contact with Baby (check all that apply):

- I would like to spend some time alone with my baby.
- I do not want to spend any time alone with my baby while I stay in the hospital.
- After the birth, I would like to move out of the maternity ward (if possible).
- I would like to give the baby his/her first feeding (if possible).
- I would like to change the baby’s diaper.
- I would like to breastfeed the baby at least once.
- I would like to name the baby with a name I have selected on my own.
- I have selected a name for the baby with the help of the adoptive parents.
- I would like to take some mementos from the hospital
- I would like a second set of mementos from the hospital for the adoptive parents
- I have a gift that I would like to send home with the baby (please describe)
- I would like traditions/rituals/ceremonies while at the hospital (please describe)

7. Is there any other information that you would like the hospital staff to know?

Signature of Birth Mother

Signature of Birth Father

Signature of Parent (if a minor)

Signature of Parent (if a minor)

Signature of Pregnancy Counselor

Resources

Cultural Responsiveness in Providing Options Counseling

Natalie Lyons, MSW, Spaulding For Children, February 2002

This article will provide foundational information on offering options counseling that is culturally responsive and engagement oriented. Its intent is to provide insight on how the health care professional may better operate in providing options counseling in an ever-increasing multi-cultural society and not to give a “one step” formula for culturally competent practice.

The concept of cultural competence continues to evolve, as various professions tackle this challenging subject matter. Along with its underlying issues of racism and discrimination, conversations regarding cultural competence can leave persons vulnerable to criticism and guilt. As the health care profession strives to provide equal treatment to all patient/clients, health care professionals, adoption counselors and social workers must consider their own cultural association and how it impacts their practice. Health care professionals must also take a critical look at how a patient/client’s culture may influence his/her decision-making skills and how he/she is likely to respond to the options that are offered.

Definition of Culture, Cultural Responsiveness, and Cultural Competence

According to the Office of Women and Minority Health in the Bureau of Primary Health Care (HRSA), culture refers to “...integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.” This definition can be broadened by Diller’s idea that traditional ideas and related values are “...transferred from generation to generation,” thus providing people with ways to live and cope with life’s problems. (Diller, 1999)

Some believe that culture is learned, as it is partially made up of behaviors, values, and beliefs, which are passed on from generation to generation. Culture is threaded both consciously and subconsciously throughout the workings of everyday life, and can impact day-to-day decisions. It can illustrate an individual’s personal identification such as race, ethnicity, religion, gender, class, nationality and has influence on thoughts, actions and interactions with others. (Williams-Gray, 2001)

Cultural responsiveness is an active term that requires the health care professional to treat every patient/client as an individual first and understand that he/she will not automatically respond in a manner that is consistent with his/her culture’s norms and values. Furthermore, the actions or responses of a patient/client from a represented cultural group will not provide the template of responses for all other members of the same culture.

Cultural competence requires continuous self-assessment; expansion of one’s knowledge base of other cultures; respect for cultural differences, and the ability to adapt to meet the needs of diverse populations. (Cross, 1988) As it relates to health care, the American Association of Colleges of Nursing recommends that nursing graduates have the capabilities to “...provide

holistic care that addresses the needs of diverse populations.” (American Association of Colleges of Nursing, 1998)

Cultural Self Awareness

One step in becoming more culturally responsive is to “become grounded in learning about one’s own cultural background and heritage, and then proceed to learn about other groups’ cultural values and beliefs.”(Lecca et.al, 1998). Another step would be to consciously recognize the effect of one’s culture in viewing the world. Cross-cultural misunderstanding may be evident when it is consciously or subconsciously assumed that one’s own cultural norms are the standards everyone else follows. (Diller, 1999) According to Williams-Gray (2001), “...cultural differences may produce perceptions, coping styles, or beliefs that appear strange or even irrational to practitioners.” Health professionals need to check and recheck their perceptions and interpretations of behaviors. This is particularly true when working cross-culturally. It can also be helpful for health practitioners to learn as much about other cultures as possible. Asking patient/clients to be “cultural guides” is one strengths-based technique for doing this. However, the practitioner should continue to keep in mind that one person’s views are not necessarily a representative of an entire cultural group, nor should one be placed in that representative role. Furthermore, the patient/client may possess feelings of ambivalence or resistance in being asked to “teach” the uninformed health professional.

Engagement

Health care provider’s perceptions about different cultures may impact engagement with patient/clients and the types of options that are offered. When working with people of varying cultures, it is important to make sure that the language used is universally understood. The culturally responsive health care provider needs to ensure that the patient/client understands all of the options available. This may be as simple as speaking in clear, easily understandable terms; having a translator present or referring the patient/client to an agency that can communicate in his/her native tongue.

The health care practitioner can use the same techniques to engage a multi-cultural patient/client as he/she uses with clients of similar backgrounds, being respectful, warm, and sincere. The goal is to gain the patient/client’s trust. This can be done by explaining what will happen during the interaction and such important concepts as confidentiality.

During the assessment process, open-ended questions can be useful in the avoidance of cultural stereotyping, and providing individualized treatment. The patient/client needs to be allowed to “tell his/her story in his/her own words” while the health practitioner is respectful and supportive of the emotional feelings the situation might illicit. Open-ended questions also provide answers to “...a woman’s beliefs and values, health related behaviors, and cultural rituals and practices.” (Callister, 2000) Patient/clients need to be encouraged to ask questions, while the health professional continuously checks to ensure the information that is being disseminated is understood. The health care practitioner needs to be open to including a patient/client’s family

members, close friends, and/or members of their “community” in the decision-making process as per the patient/client’s wishes.

Due to the history and current existence of racism and discrimination, health care providers must be aware that there could be perceived power differentials that exist between them and their patient/clients. Patient/clients from non-dominant, cultural groups may be mistrusting, and not fully engaged in options counseling. Culturally responsive health care providers, however, can engage a mistrusting patient/client by shifting perceived power through what is called the “ultimate connection.” (Jordan, 1998) Jordan (1998) further states “...the ultimate connection must be the need we find between us...it is not only who you are, but what we can do for each other.”

Becoming a culturally competent health care professional is a lifelong process. All humans struggle with the pitfalls of stereotyping, cross-cultural misunderstanding, and language barriers. However, when a commitment is made to provide culturally responsive services, patient/clients can receive high quality health care services that are nonjudgmental and facilitate informed decision-making.

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Cross-Cultural Skills Checklist

Use this checklist to assess how well you are applying your cultural knowledge. If you answered “Rarely/Never” or “Sometimes,” use the “Action Plan” column to start thinking about what else you need to know or do and steps you can take to improve your cross-cultural interactions.

	Rarely	Sometimes	Frequently	Action Plan
I seek information from family members and other key community informants to help me respond effectively to the needs and preferences of the culturally and linguistically diverse patient/clients I serve.				
Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to families of specific cultural groups served in my program.				
Recognizing that individuals from culturally diverse backgrounds may desire and acquire varying degrees of acculturation, I try to learn from individual patient/clients where they see themselves on the acculturation continuum.				

	Rarely	Sometimes	Frequently	Action Plan
Recognizing that “family” is defined differently by different cultures (e.g., extended family members, fictive kin, godparents), I make an effort to learn how each family defines itself.				
Recognizing that male-female roles in families may vary significantly among different cultures (who makes major decisions, activities expected of male and female children, etc.), I make an effort to learn how families view male-female roles.				
I understand that beliefs and concepts of emotional and physical well-being vary significantly from culture to culture.				
I understand and accept that the healthcare practices and preferences of culturally diverse people may be rooted in cultural traditions.				

Cultural Background Self-Assessment Worksheet

The following questions are intended as a guide for you to use in examining your cultural background and life experiences. Try to answer each question honestly and with an open mind. An honest self-assessment can help you recognize your biases – the first step to overcoming them.

Take your time to think about how certain aspects of your cultural background may have influenced your values, beliefs, and assumptions. Think about how these values, beliefs, and assumptions could contribute to your effectiveness as a helper, and also how they could possibly interfere with your effectiveness.

1. What is your cultural heritage? What was the culture of your parents and grandparents?
2. What community did you grow up in? What was the racial and ethnic composition of that community?
3. With which cultural group or groups do you identify? [*In addition to thinking of culture in terms race, nationality, and ethnicity, think about other groups you belong to that can be said to have a culture of their own – for example: “baby boomers,” urban pioneers, quilters, Rotarians, runners, Civil War re-enactors, etc.*]
4. Looking back on your childhood, which of your family’s values, beliefs, attitudes, customs, traditions, foods, etc., can be attributed to your ancestral/cultural heritage?
5. Growing up, what messages were given to you about people from your cultural group? Were you told – implicitly or explicitly – that people from your group believe in charitable giving? Have problems with alcohol? Value education? Support liberal/conservative causes? Are discriminated against by the police?
6. Growing up, what messages were given to you about establishing relationships with people from cultural groups different from your own?
7. What was the structure of the family you grew up in? Who was considered to be a member of your family? Were there people who were not related by blood but who were regarded as family (such as godparents, or fictive kin)?
8. In your household, were there roles and privileges that were determined by gender and/or age? What were men expected to do? What were women expected to do? What about elders? What about children?
9. What forms of communication were common in your family experience? Did people use jokes, teasing, sarcasm, story-telling? How loud did people talk? Was arguing tolerated? Could children disagree with adults? Was it okay to interrupt?

Common Myths and Facts for Birth Fathers

- Myth:** Birth fathers don't care.

Fact: Many birth fathers feel that their role in the process is nonexistent. Many birth fathers have reported caring and wanting to be more involved but were unsure how to.
- Myth:** The child will hate me for abandoning him/her.

Fact: Making an adoption plan is not abandonment. It is making a thoughtful decision about he believes to be in the best interest of the child.
- Myth:** I am not a "man" unless I get married and parent the child.

Fact: Again, making an adoption plan is a responsible decision if chosen.
- Myth:** The adoption process doesn't consider me in the process.

Fact: Most adoptions cannot be completed without he input of the birth father if he is willing and able.
- Myth:** Real men keep their babies. Deadbeat dads give them away.

Fact: "Real" men make adoption plans based on informed decision making.
- Myth:** Fathers don't experience loss because they never bond with the child. **Fact:** Many birth fathers feel a sense of grief and loss throughout the process and throughout their lives.
- Myth:** Birth fathers don't try to do the "right thing".

Fact: What is right for one person may be not "right" for another.
- Myth:** Birth fathers have no rights.

Fact: Birth fathers do have right specified by their state laws.
- Myth:** Birth fathers have no say in the process.

Fact: Birth fathers have a great deal of input in the adoption process. They have the right to be part of the decision making.
- Myth:** Biological fathers have no rights if the mother is married.

Fact: In most states there is a process for birth fathers to exert their right as the biological parent and typically they have the opportunity to establish paternity.
- Myth:** Birth fathers can't choose the adoptive family.

Fact: This is not true. Often times, the birth father is involved with the birth mother in choosing the adoptive family.
- Myth:** Birth fathers can't plan separately from the birth mother.

Fact: This is not always the case. In most states, both birth parents must agree to the adoption if present and able to do so. If they do not agree on the adoption plan, then generally, the adoption would not proceed.
- Myth:** There are no services for birthfathers.

Fact: It is true that services for the birth fathers is limited, more and more services are being offered as efforts are being made to engage the birth father in the adoption process.
- Myth:** Counseling is for the mother only.

Fact: Again, this is not true. Counseling is available to the birth father depending on the agency resources.
- Myth:** Birth fathers have no control in the situation.

Fact: Although it may feel that way to many fathers, they do have rights and opportunities to plan for the child.

16. **Myth:** They don't need me to do an adoption plan.

Fact: In most states, the father is needed to complete an adoption plan if he is known and available.

Techniques for Engaging Birth Father

Someone who may bear a great deal of influence on the decision to be made is the father of the baby. It is the mother of the baby's decision to determine how she wants the father of the baby engaged in the process of discussing pregnancy options with the health care professional. Once she makes the decision to include him in the discussion, it is the health care professional's responsibility to engage him in the process. It would be beneficial for all parties involved to have the father of the baby involved as soon as possible so that he can be a positive support to the mother as she makes her decisions.

Skills to engage the fathers:

Health care professionals should be welcoming and helpful in encouraging him to support the birth mother and setting the couple on the right path for getting the help they need to make options decisions together.

Health care professionals can facilitate informed decision-making by identifying birth father strengths and building on those in making referrals.

It is important for health care professionals to engage interested birth fathers using the same techniques used to engage others: treating them with dignity and respect; actively listening to their concerns and being nonjudgmental.

If the father is at all involved with the mother, he will play a significant role in her pregnancy option decision. Therefore, he should have as much information as possible to help him support her decision-making process and issues of pregnancy so that he can become a partner in informed decision-making regarding pregnancy options. However, the decision to involve him is totally within the control of the pregnant woman.

Birth fathers can be encouraged to become informed about the experiences and issues of pregnancy.

Birth fathers who release their parental rights may experience loss and may find it helpful to talk about this with others, either in a professional or peer support setting. Therefore, it is beneficial to provide referrals to local resources and support groups for fathers.

Once the choice has been made to make an adoption plan, birth fathers can be encouraged to provide information about themselves, their medical history and their interest in contact with their child when he/she is an adult.

In open adoption, birth fathers may be able to maintain ongoing contact with their child and update any personal or medical information for the adoptive family

Attending to his questions and concerns using the same nondirective, noncoercive techniques discussed previously.

Having resource information available about the role of the father in pregnancy care, birth, and parenting.

Have male-oriented items in the office including décor, magazines, coffee, and information about fathering and fatherhood programs.

Checklist:

- Are there visual cues to tell men that they are welcome?
- Are staff comfortable talking to men, of all backgrounds?
- Is staff utilizing engagement skills to welcome and involve the fathers?
- Are there strategies in place to engage fathers when they arrive at the center or clinic?
- Are there male-friendly books, magazines, activities?
- Are there father friendly posters or displays in the lobby and rooms of the clinic?
- Are there written materials specific to the needs of the fathers?
- Are there specific referrals and resources available for males?
- Are there any other supportive activities geared toward men?

Adolescence and the Adoption Option

Research indicates that 1%-5% of teens faced with an unplanned pregnancy are likely to choose adoption as an option for their child. The last 50 years has seen tremendous change in society's perception of unmarried women who elect to keep their babies and raise them as single parents. Gone are the days when family and friends routinely coerced unwed mothers to conceal their pregnancies and subsequently release their child for adoption. The pendulum has swung to the other extreme where the expectation is often that young women will raise their child. Even adolescents who are ill equipped to parent a child feel a tremendous amount of societal pressure to do so. Often teens feel that considering placing their babies for adoption signifies that they do not care about their infants and that even considering the adoption option will be seen negatively by peers and family. Research confirms this trend as very young teens are becoming pregnant and the number of teens raising their children as single parents is increasing. Adolescents who are likely to consider adoption are those who have aspirations for college or other life goals and whose family and friends support the idea of adoption.

The Impact of Adolescent Development on the Adoption Option:

Anyone raising or working with adolescents recognizes that the psychological developmental tasks of this age group bear a striking resemblance to those of preschool children. The primary task for both age groups is to separate from the family. The goal of preschoolers is to find their place as individuals within the family, while the goal of adolescents is to find their place as independent individuals within society. This developmental imperative requires that the adolescent revisit many earlier stages of development including egocentrism, magical thinking and differentiation from caregivers. Any developmental issues that were poorly handled in the preschool years may reemerge in the adolescent years.

Adolescence also serves as the staging area for teens to learn how to make decisions, often through trial and error and without the benefit of good coping skills when problems arise. Resolution of these developmental issues can result in frustration and the reemergence of control battles between teens and authority figures. Normal developmental tasks can be complicated by pregnancy and impact how the adolescent views the option of adoption.

Choosing adoption is often referred to as an unselfish act that a mother can perform for her child. This level of selflessness requires that the individual put their own needs aside to meet the needs of another. Pregnant teens, especially those in early and middle adolescence (11 – 17 years of age) or those who have experienced trauma that has impacted their development, are at a stage where they see the world as revolving around them. This level of egocentrism does not allow them to think beyond their own needs to those of their unborn child.

Egocentric thinking has adolescents viewing the child in terms of what he/she can provide for the teen including: unconditional love; a way to get out of a bad life situation; a boyfriend staying with them and/or supporting them; a disorganized or dysfunctional family staying together; a higher social status and/or increased independence. Egocentric and magical thinking also hinders a teen's ability to learn from others or take the experiences of other teens and apply them to their situation. These are the teens that have difficulty considering future planning and who refuse to

believe that they will have difficulty after the child is born. Their feeling is, “it won’t happen to me.”

Developmentally, teens are more likely to discount or reject advice and direction from parents and other adults as part of the task of establishing themselves as independent beings. Pregnant teens are being asked to follow doctor’s orders, get plenty of rest, eat nutritious foods, stop smoking, etc., all of which contradicts the adolescent’s need to test the rules and push the boundaries. Teens who perceive that adults have a ‘hidden agenda’ around adoption or are exerting pressure on them to release the child for adoption are likely to engage in control battles as a way to exert their independence. Suspicion of adoption as an adult-controlled process designed to exploit them may also be an issue for teens who are striving for independence.

Implications for Health Care Providers:

Respecting the pregnant teen and understanding her worldview is the first step in offering effective services. This perspective keeps in mind that the pregnant adolescent’s need to strive for independence during a time of crisis will bring all of her dependency issues to the surface. Often this process includes angry outbursts that may be directed toward the health care professional. Not taking this behavior personally is vital in effectively working with teens. Allowing the teen as much control over the process as possible, despite outbursts of anger and immaturity, is the key. Offering choices whenever possible will also help the teen to feel a sense of control.

Despite the fact that teens tend not to be verbal and to give superficial answers when initially dealing with authority figures, they still need information. Pregnant teens need concrete information that will help them explore options. Even if the teen is likely to initially dismiss adoption as an option, she needs information about adoption to demystify the process. Teens need to be given the message that they can ask questions about the adoption process and to know that no question they ask is going to be perceived as unimportant. Pregnant teens are being asked to consider information and make decisions that require mature decision-making skills. They need to hear all of the information and they may need to hear it more than once and in different ways to be able to utilize it. They also may need help to evaluate the information and weigh alternatives, such as looking at the pros and cons of placing their child for adoption.

Because adolescents have difficulty with future thinking and anticipatory problem-solving, they often underestimate the task of parenting until they are faced with the challenges of raising a child. Often it is not until the child is three to six months of age that the reality sets in for the teen mother. Even though the societal expectation is that teens will raise their children, the extent of the support they can expect from family and friends is changing. The mothers of very young teens who become pregnant may still be in the work force and unable or unwilling to offer the level of care that both the teen mother and her child will require. As families have become more mobile and more nuclear in nature, extended family as a support to teens raising babies may not be an option.

Peers who were supportive during the pregnancy often leave the new mother behind as they go on with their lives as adolescents, a lifestyle the teen mother no longer has the luxury of

enjoying. For the first time she may understand that she is giving up her adolescence to become a parent. Health care and other helping professionals may want to consider keeping the adoption option open for discussion after the birth of the child when the teen is faced with the reality of parenting an infant. Raising the subject of what is best for the child and the teen at this stage may be an issue the teen mother is now willing to explore. The timing of an intervention is often what makes it successful.

Adolescents who have placed their infants for adoption require long-term support. Health care providers who will be having an ongoing relationship with a teen who has placed her child for adoption will need to provide opportunities for the adolescent to process the adoption experience. Being open to the adolescent's feelings of grief and loss will help her integrate the experience and develop coping skills that serve to meet her emotional needs. Often referrals to support groups for teens that have placed their babies for adoption can be helpful.

Managing Conflict Between Parents and Teens Facing an Unplanned Pregnancy:

The very nature of adolescence is to work through the task of differentiating from adult authority figures. Pregnancy in the life of the teen may refocus this struggle and can precipitate crisis in the family. Many parents will attempt to assert control over the pregnant teen by trying to make all of the decisions. For many teens this is their cue to become defiant, rejecting the parent's attempt to control. Many regress to more infantile behavior that engages the parent and teen in a counterproductive control battle. Often the health care provider finds himself/herself in the midst of this conflict. Assessing the nature of the conflict and acting as a mediator to defuse the anger and/or negative emotions is a role that can fall to the health care provider.

The first step in this process is to allow the parent and the teen to have an opportunity to vent their feelings. This requires that the health care professional be able to take a step back and listen in a nonjudgmental way. Letting the parties know that they have been heard will make it easier to move the interaction from venting to working on the issues at hand.

A parent's anger is never the primary emotional reaction when a teen is pregnant. Anger almost always occurs after a fear reaction and is used to hide the fear. This anger can be misdirected to the helping professional, but it is important to remember not to take on the anger. This is vital for the health care provider to be able to listen for what the parents are fearful of and to be able to address that fear. The fear can be addressed directly if the parent will not feel ashamed of being afraid. A direct response to a parent's anger might include the following: "I know you are anxious about how this pregnancy will affect your daughter's future, and I want you to know that I am willing to help you look at all of the options." If the parent is likely to feel ashamed of being afraid, more anger will occur in an attempt to hide the shame if the fear is addressed directly. In this instance an indirect response might include the following: "It takes a lot of courage to ask for help in supporting your daughter. I can help you find the assistance you will need to work through the issues." Letting the parent know that help and support are available may help to lessen the fear and defuse the anger.

Listening for the underlying message in what the parent is saying may give clues to his/her self-esteem or self-evaluation, which may be the reason for his/her anger. Sometimes an angry person's words are the opposite of his/her true feelings and sometimes the words reflect a past experience in a similar situation. Shifting the parent's perspective to work on helping and supporting the teen may help to defuse the anger.

Developmentally, teens face a host of difficulties coping with an unplanned pregnancy. Health care providers will need to understand the developmental issues impacting the teen's ability to make future planning and to assist parents in helping to support the teen to make sound decisions for herself and her child. Parents may need help to avoid control battles that encourage the teen to act out around the pregnancy and interfere with the parent providing the support that the teen will need. Teens need ongoing help and support to look at all of the options available to them during their pregnancy and beyond.

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Pregnant Teens: Discussing Family Involvement

Discuss anticipated family response to pregnancy: explore with the teen what the possible reaction of her parents will be to the pregnancy. Role play these possible reactions so teen feels prepared to have a conversation with her parents about the pregnancy.

Offer to facilitate a meeting: encourage the teen to invite her family to her next appointment with an HCP. The teen can use the health care professional or social worker as a source of support when discussing the pregnancy and options with her parents.

Prepare to possibly manage conflict: If the teen's parent is in the interview, the first step in this process is to allow the parent and the teen to have an opportunity to vent their feelings. This requires that the health care professional be able to take a step back and listen in a nonjudgmental way. Letting the parties know that they have been heard will make it easier to move the interaction from venting to working on the issues at hand.

A parent's anger is never the primary emotional reaction when a teen is pregnant. Anger almost always occurs after a fear reaction and is used to hide the fear. This anger can be misdirected to the helping professional, but it is important to remember not to take on the anger. This is vital for the health care provider to be able to listen for what the parents are fearful of and to be able to address that fear. The fear can be addressed directly if the parent will not feel ashamed of being afraid. A direct response to a parent's anger might include the following: "I know you are anxious about how this pregnancy will affect your daughter's future, and I want you to know that I am willing to help you look at all of the options." If the parent is likely to feel ashamed of being afraid, more anger will occur in an attempt to hide the shame if the fear is addressed directly. In this instance an indirect response might include the following: "It takes a lot of courage to ask for help in supporting your daughter, I can help you find the assistance you will need to work through the issues" letting the parent know that help and support are available may help to lessen the fear and defuse the anger.

Listening for the underlying message in what the parent is saying may give clues to his/her self-esteem or self-evaluation, which may be the reason for his/her anger. Sometimes an angry person's words are the opposite of his/her true feelings and sometimes the words reflect a past experience in a similar situation. Shifting the parent's perspective to work on helping and supporting the teen may help to defuse the anger.

Helping Teens with Future Planning

Health care providers can adapt some of the person-centered planning techniques used by mental health professionals to help teens take responsibility for themselves and their pregnancy. These techniques are similar to brief, nondirective, noncoercive interventions in that they involve a core set of beliefs which include treating the patient/client with dignity and respect; providing them with information so that they can make an informed decision and a life plan. They also include ways to ask questions to really understand how a patient/client perceives his/her situation; listening and hearing the patient/client's story; and putting the patient/client in charge of solving his/her problems.

Strategies for working with teens will differ depending on whether they are in early adolescence (11-14 years of age); middle adolescence (15-17 years of age) or older adolescence (18 - 21 years of age). Chronological age cannot stand alone. Rather, a teen's life experiences and developmental age need to be factored in as well. While many teens appear much younger than their years, there are those who are much older and wiser. Knowing the individual pregnant teen that has come to you for guidance is vital.

Identify and increase social support:

The first step in helping a pregnant teen make a good future plan is to help her identify her resources and support. This can begin as a brainstorming exercise, and can be reviewed throughout the relationship with the health care provider. It can be expected that as the pregnancy progresses, the teen's social support network will change. This change can be a focus of discussion that will help the teen look toward the future.

This can also be a time for teens to meet other teens who have experienced pregnancy. It will be helpful to refer her to resources that will introduce her to women who chose to keep their babies, those who chose to terminate their pregnancies and those who chose adoption. If at all possible, the teen needs to have repeated contact with all of these "role models" so that as she thinks and rethinks her situation, she can ask more questions and obtain more information.

While peer support is helpful, it is also crucial for teens to talk with a caring adult about these interactions. During this process, inaccurate information can be corrected; myths can be demystified; and the teen can have the guidance of a nonjudgmental, noncoercive adult who cares. Oftentimes, the health care provider is the only such adult in a teen's life, and will be the one to play this pivotal role.

Role play and/or anticipatory guidance:

Helping pregnant teens practice how to handle difficult decisions, discussions and/or relationships can be a key factor in building trust with a health care provider. This can be done through role play, in which the teen rehearses what they will say to a parent or birth father, and the health care provider responds in the character of the parent or birth father. The process involves refining the dialogue until the pregnant teen is comfortable with her words and the potential responses they will elicit.

Anticipatory guidance is a technique in which the health care provider helps the pregnant teen identify future issues that will need to be addressed, and works with her to develop a plan that makes sense in her life. It involves asking future-oriented questions and then helping the teen see the issues that he/she will need to address. For example, asking what will change when the baby is born can help guide the teen to think about how her life may change; the increased responsibility she may take on; the ways in which relationships with friends and family may change. Each of these areas can be explored through the use of open-ended questions that are designed to help the pregnant teen make an informed decision.

Information:

As is true with adults, informed health-related decisions are key for teens. Because they are experiencing a time of great change that is heightened by pregnancy, they may need to have information presented in a number of different ways, a number of different times. It is important that the health care provider be patient, and present the options and/or facts each time as though it were the first. It is also helpful to provide written materials, videotapes and to discuss each resource to see how much the teen understands and how she sees the information applying to her.

Working with family crisis:

Pregnant teens often find themselves in conflict with their families, which creates a time of crisis. The health care provider can work to defuse some of the emotions within the family and to help them develop ways of coping with the pregnancy. Acknowledging that the family balance is out of equilibrium as a result of the pregnancy and giving them hope that they have options will result in a renewed sense of control. This control will enable them to make informed decisions.

With teens, it is especially important to let them know that they have time after the baby is born to rethink the option of adoption. Rather than pressure the teen to make an immediate decision that will result in feelings of unresolved grief, shame and/or coercion, it will be important to maintain long-term contact and revisit adoption. If the health care provider is unable to do this, perhaps a referral to a community-based program would be best.

Research shows that many pregnant teens mature quickly throughout their pregnancy and are able to be good parents. Health care providers need to assess this throughout their relationship with the teen, and continue to offer choices, hope and nonjudgmental support.

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Families in Crisis

Family crisis is a stressful and disruptive event or series of events that comes with or without warning and disturbs the equilibrium of the family. A family crisis can also occur when the usual problem-solving methods of the family no longer work. All families will experience crisis at some point.

Families respond to crisis in different ways. Some see them as challenges to be overcome. Others become overwhelmed, feel helpless, hopeless and give up. Some seek help, others do it on their own. Some emerge stronger and with a greater repertoire of resources and supports and still others suffer severe psychological damage that can be demonstrated in the form of rage, frustration or techniques to intimidate others in their lives.

Regardless of how they respond, families in crisis need help. It is also important to keep in mind that families in crisis have resources and they can build on their strengths. Helping professionals have a unique opportunity and responsibility to be of assistance to families facing crisis in a broad variety of situations.

Crisis Theory:

The nature of crises has been well documented in the literature, which applies to both behavioral health and physical health practitioners. Experts agree that a crisis occurs when some internal or external force disrupts a family's balance, altering its functioning and causing a loss of equilibrium.

Coping strategies are those actions and ways of thinking that help families deal with and survive difficult situations. In crisis, previously used coping strategies may no longer work. A crisis is not simply the event that has occurred, but rather the way in which the family perceives that event. Their perceptions are based on their previous "track record" of coping with adversity and change, and the strength of their social support system.

Crisis is usually resolved in a short period of time, and can have either a strengthening or weakening effect on the family unit. Although the crisis itself can be resolved, sometimes its effects will influence the family for years to come. The new balance of the family can result in changed relationships among its members, within its community and within each individual member.

Types of Crisis:

Developmental crises are periods of disruption that occur at identifiable, somewhat predictable transition points during normal growth and development. One such crisis can be unplanned pregnancy or parenthood, particularly for adolescents. There are many worries that accompany this new role, including the fear of the unknown, the health of the child, the ability of the teen to provide good care for the baby and the ambivalence about being responsible for the welfare of another human being and giving up personal freedom.

Situational crises arise from external events that occur suddenly, without warning. The terrorist attack upon the World Trade Center in New York on September 11, 2001 is an example of such a crisis. Not only was it traumatic for the individuals directly touched by the tragedy, but it impacted the entire nation and world. Situational crises cannot be planned or predicted and bring up feelings of helplessness in many individuals. These feelings can be overcome by participating in helping activities, such as donating blood, supporting the Red Cross or the families of those killed in the bombing.

Other, more health-related situational crises can include debilitating disease, domestic violence, divorce, or unwanted pregnancy. These are all situations where families or one of their members may seek out health care professionals to provide support and/or to intervene.

Multiple crises are those that overlap, or come in such quick succession that families are no longer successful using their previous coping strategies. Research has shown that multiple crises compound the stress, and can lead to ill health. It also points out that families who are able to work through one crisis may find that multiple crises overwhelm them and cause more stress than they can handle.

Crisis Intervention Techniques:

Nursing literature describes two methods of intervening in crisis situations, generic and individual. The generic approach addresses the nature and course of the crisis rather than the psychosocial functioning of the individual. This type of intervention does not require advanced professional counseling skills and allows health care practitioners to work with any group of people who have a crisis in common. An example would be a support group for early adolescents who are pregnant.

There are five important elements in providing generic interventions: (1) encouraging individuals and/or families to use the adaptive behaviors and coping strategies that have proven helpful in the past; (2) social support and the opportunity to be listened to without judgment; (3) the opportunity to identify strategies to cope with the practical and emotional future; (4) anticipatory guidance or the opportunity to practice the strategies identified in element three; (5) providing the family with feelings of control and hope.

The individual approach works best with people who do not respond to generic intervention. It is often wise to refer these families and/or individuals to counseling professionals who can facilitate action toward gaining insight into the crisis, developing specific coping strategies and regaining a sense of equilibrium and hope.

The Role of the Health Care Provider:

The most important tool of the health care provider is a thorough, comprehensive assessment. Asking the right questions and being a careful observer are key. In cases of domestic violence, or child abuse, following the correct reporting and recording procedures are critical. In an

unplanned pregnancy, it is critical to discover the potential impact on the family system of bringing another child into the family. A thorough assessment can be rapid if it focuses on specific issues.

Some critical questions to assist in crisis assessment can include:

- How does the family define or perceive the crisis?
- Why has the family asked for help now?
- How severe is the crisis?
- What risks does the family face as a result of their feeling out of control?
- Are others also at risk?
- How does the family think the crisis will affect their future?
- What precipitated the crisis?
- When did the crisis occur?
- Was the crisis situational or developmental?
- Were there multiple crises?
- What coping strategies have been successful for this family in the past?
- What coping strategies has the family tried in this situation?
- What new coping strategies is the family willing to try now?
- What gives the family hope that things will improve?

The health care provider can use a problem-solving model to form the basis for the family crisis resolution plan. This model includes the development of realistic future goals and perhaps some preventive planning. It also includes techniques for helping the family find ways to resolve the crisis. Assessment of the family's needs are critical to good problem-solving and are based on the type of crisis the family is experiencing; the effect the crisis is having on the family's life; the ways other important people in their lives are affected and their strengths and available resources.

While the plan is being carried out, it is important to have ongoing communication between the health care provider and the family. The plan needs to be reviewed and updated as often as possible so that it continues to be viable. Whenever possible, tasks need to be assigned with timeframes attached so the family regains a feeling of control over their life.

To stabilize the changes the family makes to successfully master the crisis, the health care provider can identify and reinforce all of the positive coping mechanisms and behaviors that were used. He/she can go on to discuss how these strategies worked and how they can be used to handle future stressors. It is important to summarize the crisis experience by emphasizing the family's success. This will reinforce their feelings of self-confidence and of their abilities to

handle adversity in the future. It will also help them grow closer and feel stronger as a result of their success. Most importantly, it will provide them with hope.

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Additional Reading

Culture

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Adolescents

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The American Academy of Child & Adolescent Psychiatry's Facts for Families provide concise and up-to-date information on issues that affect children, teenagers, and their families.

American Academy of Pediatrics. (n.d.) *Options Counseling for the Pregnant Adolescent Patient*. Itasca, IL: American Academy of Pediatrics. <https://publications.aap.org/pediatrics/article/140/3/e20172274/38291/Options-Counseling-for-the-Pregnant-Adolescent>

This American Academy of Pediatrics (AAP) policy statement explains how to help teens get prompt medical care and basic, accurate information about all their options—while respecting everyone's personal, spiritual, and cultural perspectives. These options usually include having and raising the baby, making plans for relatives or an adoptive family to raise the baby, or terminating the pregnancy.

Albert D, Chein J, Steinberg L. Peer influences on adolescent decision-making. *Current Directions in Psychological Science*. 2013;22:114–120.

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Authors review recent research suggesting that adolescent risk-taking propensity derives in part from a maturational gap between early adolescent remodeling of the brain's socio-emotional reward system and a gradual, prolonged strengthening of the cognitive control system. At a time when adolescents spend an increasing amount of time with their peers, research suggests that peer-related stimuli may sensitize the reward system to respond to the reward value of risky behavior. As the cognitive control system gradually matures over the course of the teenage years, adolescents grow in their capacity to coordinate affect and cognition, and to exercise self-regulation even in emotionally arousing situations. These capacities are reflected in gradual growth in the capacity to resist peer influence.

Duell, N., and Steinberg, L. (2019). Positive risk taking in adolescence. *Child Dev. Perspect.* 13, 48–52. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6371981/pdf/nihms-1009914.pdf>

Offers a theoretical model of positive risk taking, briefly reviews research on positive risk taking, and discusses theoretical correlates of positive risk taking based on models of adolescent risk taking.

Hartley C. A., Somerville L. H. (2015). The neuroscience of adolescent decision-making. *Current Opinion in Behavioral Sciences*, 5, 101–115.

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Adolescence is a phase of lifespan associated with greater independence, and thus greater demands to make self-guided decisions in the face of risks, uncertainty, and varying proximal and distal outcomes. A new wave of developmental research takes a neuroeconomic approach to specify what decision processes are changing during adolescence, along what trajectory they are changing, and what neurodevelopmental processes support these changes. Evidence is mounting to suggest that multiple decision processes are tuned differently in adolescents and adults including reward reactivity, uncertainty-tolerance, delay discounting, and experiential assessments of value and risk. Unique interactions between prefrontal cortical, striatal, and salience processing systems during adolescence both constrain and amplify various component processes of mature decision-making.

Reyna VF, Farley F. (2006). Risk and rationality in adolescent decision-making: Implications for theory, practice, and public policy. *Psychological Science in the Public Interest*;7:1–44.

<https://journals.sagepub.com/doi/10.1111/j.1529-1006.2006.00026.x>

Rodriguez Buritica, J. M., Heekeren, H. R., and van den Bos, W. (2019). The computational basis of following advice in adolescents. *J. Exp. Child Psychol.* 180, 39–54. <https://bits-of-information.org/DDN/wp-content/uploads/2019/04/Rodriguez-Buritica-et-al.-2018.pdf>

Investigated developmental differences in how advice, experience, and exploration influence learning. A social learning model showed that although social influence most strongly

affects adolescents' initial expectations (i.e., their priors), adolescents showed higher exploration and discovered the other good option in the current task.

Rosenbaum, G. M., Venkatraman, V., Steinberg, L., and Chein, J. M. (2018). The influences of described and experienced information on adolescent risky decision making. *Dev. Rev.* 47, 23–43. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5841249/pdf/nihms915299.pdf>

Examines the literature on the description-experience gap, and highlights differential decision making when risk information is described versus experienced. Explores the developmental literature comparing adolescent to adult decision making.

Saewyc, Elizabeth M. (2000), Nursing Theories of Caring: A Paradigm for Adolescent Nursing Practice. *Journal of Holistic Nursing*, 18, 2, 114-128.

Smith A. R., Chein J., Steinberg L. (2014). Peers increase adolescent risk taking even when the probabilities of negative outcomes are known. *Developmental Psychology*, 50, 1564–1568. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4305434/pdf/nihms652797.pdf>

The current study investigates how peer observation affects adolescent risk taking when the information necessary to make an informed decision is explicitly provided. The findings expand our understanding of how peers influence adolescent decision making and have important implications regarding the value of educational programs aimed at reducing risky behaviors during adolescence.

Weinberger DR, Elvevag B, Giedd JN. (2005). The adolescent brain: A work in progress. The Campaign to Prevent Teen Pregnancy; Washington, DC. <http://www.kvccdocs.com/KVCC/2013-Spring/PSY215-02/content/L-19/The%20Adolescent%20Brain-A%20Work%20in%20Progress.pdf>

New research suggests that the pre-frontal cortex is one of the last areas of the brain to fully mature. The brain produces a large number of neural connections just before puberty—connections that diminish in number throughout adolescence through a "use-it-or-lose-it" pruning.

Wyatt, Tami H., Novak, Julie C. (2000). Collaborative Partnerships: A Critical Element in School Health Programs. *Family Community Health*, 23, 2, 1-11.

Substance Abuse

Bishop, Darla; Borkowski, Liz; Couillard, Megan; Allina, Amy; Baruch, Susanna; and Wood, Susan. (2017). Bridging the Divide White Paper: Pregnant Women and Substance Use: Overview of Research & Policy in the United States. Jacobs Institute of Women's Health. Paper 5. Retrieved from: https://publichealth.gwu.edu/sites/g/files/zaxdzs4586/files/2023-06/pregnant_women_and_substance_use_updated.pdf

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Trauma and Pregnancy

Aslı Süner Adanir, Arif Önder, Gül Alkan Bülbül, Aysel Uysal & Esin Özatalay (2019) Can gestation be considered as trauma in adolescent girls: post-traumatic stress disorder in teen pregnancy. *Journal of Obstetrics and Gynecology*, DOI: [10.1080/01443615.2019.1673714](https://doi.org/10.1080/01443615.2019.1673714)

This study evaluated PTSD in pregnant adolescents using the Child Post-Traumatic Stress Disorder-Reaction Index. The authors found that PTSD was more frequently seen in adolescents with pregnancy compared with their healthy peers.

Atzl, V. M., Narayan, A. J., Rivera, L. M., & Lieberman, A. F. (2019). Adverse childhood experiences and prenatal mental health: Type of ACEs and age of maltreatment onset. *Journal of Family Psychology*, 33(3), 304–314. <https://doi.org/10.1037/fam0000510>

Authors examined the effects of total adverse childhood experiences (ACEs) on depression and posttraumatic stress disorder (PTSD) symptoms during pregnancy, unpacked effects of total adversity into childhood maltreatment versus family dysfunction experiences, and

assessed age of onset effects of child maltreatment-specific experiences. Findings underscore the importance of differentiating between childhood maltreatment versus family dysfunction ACEs and examining the timing and accumulation of maltreatment experiences during childhood, because these factors affect mental health during pregnancy. Findings also support universal prenatal screening for PTSD symptoms to identify at-risk pregnant women who could benefit from interventions to disrupt the intergenerational transmission of risk and give families the healthiest possible beginning.

Berman H, Mason R, Hall J, Rodger S, Classen CC, Evans MK, et al. Laboring to mother in the context of past trauma: the transition to motherhood *Qual Health Res.* 2014;24(9):1253–64. pmid:24501114. Retrieved from:

<https://journals.sagepub.com/doi/pdf/10.1177/1049732314521902>

The purpose of this feminist grounded theory study was to examine how past trauma shaped the lives of women as they became new mothers. The substantive grounded theory, “laboring to mother in the context of past trauma,” describes the exceedingly difficult emotional and cognitive work undertaken by pregnant women with histories of trauma as they anticipate becoming mothers. Key components of the theory are summarized and recommendations for health and social service providers are provided.

Cohodes, E.M., Gee, D.G., Lieberman, A.F. (2019). Associations between prenatal substance exposure, prenatal violence victimization, unintended pregnancy, and trauma exposure in childhood in a clinical setting. *Infant Mental Health Journal*, 40(6), 786-798.

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Authors examined associations between three known prenatal risk factors that characterize environmental instability in utero—prenatal substance exposure, prenatal violence victimization, and unintended pregnancy—and child exposure to interparental violence and other adverse experiences. The findings expand the understanding of prenatal risk factors for trauma exposure in childhood and, specifically, highlight prenatal substance exposure and violence victimization as risk factors for subsequent exposure to trauma in early childhood. Results suggest that prenatal prevention and intervention programs should target reducing maternal substance use and in-utero exposure to violence.

Gelaye B, Zhong QY, Basu A, Levey EJ, Rondon MB, Sanchez S, et al. (2017). Trauma and traumatic stress in a sample of pregnant women. *Psychiatry research*, 257:506–13. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5626654/pdf/nihms901965.pdf>

Authors examined the construct validity of the 9 item Traumatic Events Questionnaire (TEQ) and to evaluate the extent to which experiences of trauma assessed using the TEQ are associated with symptoms of psychiatric disorders. Findings affirm the utility of TEQ in perinatal settings and underscore the need to screen pregnant women for the occurrence and intensity of traumatic events during perinatal care.

Huth-Bocks AC, Krause K, Ahlfs-Dunn S, Gallagher E, Scott S. (2013). Relational trauma and posttraumatic stress symptoms among pregnant women. *Psychodynamic Psychiatry*, 41:277–301.

Authors examined associations between different forms of relational trauma and post-traumatic stress symptoms in 120 women during the last trimester of pregnancy. Results indicated that severity of childhood maltreatment was significantly related to severity of inter-partner violence during pregnancy, and both types of trauma made unique, significant contributions to posttraumatic stress symptoms. Findings indicate that it is critically important for clinicians working with pregnant women to conduct a thorough assessment of current and past relational trauma, including emotional/psychological trauma, in order to improve the well-being of the mother, the infant, and the mother–infant relationship.

Racine N, Plamondon A, Madigan S, McDonald S, Tough S. (2018). Maternal adverse childhood experiences and infant development. *Pediatrics*, 141(4):e20172495pmid:29559588.

Retrieved from:

<https://pediatrics.aappublications.org/content/pediatrics/141/4/e20172495.full.pdf>

The authors examine the prenatal and postnatal mechanisms by which maternal adverse childhood experiences (ACEs) predict the early development of their offspring, specifically via biological (maternal health risk in pregnancy, infant health risk at birth) and psychosocial risk (maternal stress during and after pregnancy, as well as hostile behavior in early infancy).

Moog NK, Buss C, Entringer S, et al. (2016). Maternal exposure to childhood trauma is associated during pregnancy with placental-fetal stress physiology. *Biological Psychiatry*, 79:831–839. Retrieved from:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4777678/pdf/nihms729088.pdf>

Authors address the hypothesis that intergenerational transmission of childhood trauma may begin during intrauterine life via the effect of maternal childhood trauma childhood trauma exposure on placental-fetal stress physiology, specifically placental corticotrophin-releasing hormone (pCRH).

Domestic Violence / Inter-partner Violence

American College of Obstetricians and Gynecologists. Reproductive and sexual coercion. Committee Opinion No. 554. *Obstet Gynecol* 2013;121:411–5. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion.pdf>

American College of Obstetricians and Gynecologists. Intimate partner violence. Committee Opinion No. 518. *Obstet Gynecol* 2012;119:412–7. https://journals.lww.com/greenjournal/Citation/2012/02000/Committee_Opinion_No_518_In_timate_Partner.51.aspx

Haggerty, Lois A., Kelly, Ursula, Hawkins, Joellen, Pearce, Carole, Kearney, Margaret. (2001). Pregnant Women's Perceptions of Abuse. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 30, 284-290.

Knox, B. (2018). Screening women for intimate partner violence: Creating proper practice habits *The Nurse Practitioner*, (43), 5. <https://nursing.ceconnection.com/ovidfiles/00006205-201805000-00003.pdf>

Reviews current healthcare concerns in heterosexual, bisexual, transgender, and lesbian women, and explores screening guidelines and resources for developing successful screening habits. Additionally, the article discusses how the Transtheoretical Model and Stages of Change offers insight into the behavior of women who experience intimate partner violence and provides safety strategies for these women.

Agency for Healthcare Research and Quality. (n.d.) Healthier pregnancy: Tools and techniques to best provide ACA-covered preventive services. Provider fact sheet. <https://web.archive.org/web/20230528173322/https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/healthier-pregnancy/documents/intimate-partner-violence-provider-fact-sheet.pdf>

Intimate Partner Violence During Pregnancy, A Guide for Clinicians. Retrieved from: <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>

The American College of Obstetricians and Gynecologists (ACOG)/Centers for Disease Control and Prevention (CDC) screen show on intimate partner violence during pregnancy is a training tool for clinicians to increase understanding of the important role they can play in identifying, preventing, and reducing intimate partner violence.

Basile KC, Hertz MF, Back SE. Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007. Retrieved from: <https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf>

Compilation of existing tools for assessing intimate partner violence (IPV) and sexual violence (SV) victimization in clinical/healthcare settings. This document should serve as a guide to aid in the selection of assessment instruments for use in health care settings to identify victims requiring additional services. The identification can help practitioners make appropriate referrals for both victims and perpetrators.

Grief and Loss

March, Karen. (2014). Birth Mother Grief and the Challenge of Adoption Reunion Contact. *The American journal of orthopsychiatry*. 84. 409-419. 10.1037/ort0000013.

A large body of work exists on the grief expressed by birth mothers over the loss of their children to adoption. Less is known about the grief emotions that surface when these women are contacted by adopted adults who seek contact relationships. The themes of mourning, grief, and bereavement that emerged in the qualitative interview data of 33 reunited birth mothers indicate more attention be given to these social psychological processes. Suggestions for future research possibilities and implications for clinical practice are explored.

Krahn, L. and Sullivan, R. (2015). Grief & loss resolution among birth mothers in open adoption. *Canadian Social Work Review* (32) No. 1/2, 27-48.

This descriptive, qualitative study explores birth parents' experiences in current day, open adoptions and seeks to understand their experience of grief and loss and their movement towards grief resolution in the context of an open adoption. Findings of this study confirm that the experience of adoption placement involves grief and loss and that openness in adoption helps to mitigate this painful experience. Most notably, birth parents found meaning, comfort, and peace in knowing of their child's well-being and by having ongoing involvement in the life of the child and adoptive family.

Russell, Marlou. (1996) *Adoption Wisdom: A Guide to the Issues and Feelings of Adoption*. Santa Monica, CA.: Broken Branch Productions.

Williams, Gail B. (2001). Short-term Grief After an Elective Abortion. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 30, 174-183.

STAGES OF BIRTHFATHER GRIEF

There is no “correct” way to grieve or one sudden, shining moment when you are finished grieving. But the following thoughts and feelings are experienced by many birthfathers at some point in the adoption process.

Stage	Description	Questions to Consider	Comments from Birthfathers
Impact	<p>This is commonly referred to as the shock or denial phase. You may question the paternity of the child and your role in the process, especially if you are no longer in a relationship with the birthmother. If there is some doubt about paternity, you may feel tremendous guilt about your doubts and unsure how to respond to your fears. You may also question your potential as a parent. Thoughts of your future (education, job stability and finances) may weigh heavily on your mind.</p>	<p>How do I feel about this pregnancy? What are my thoughts about the role of fathers and the needs of children? Am I equipped to provide a child with security, love and stability? How can I be supportive of the birthmother?</p>	<p>“The first thing to realize is that even if the birthfather wants to play a part in his kid’s life, he’s probably going to go into denial for a period of time. The easiest way to ‘deal’ with a painful situation like this is just to stop looking at it. I would imagine that a lot of birthfathers enter the denial phase early in the pregnancy, and I would bet that a good deal of them never stop denying it.”</p>
Chaos	<p>This phase refers to the first emotional reaction following a placement. The birthfather may feel shocked at how much love and attachment he felt at the birth. He also may feel a lot of responsibility to comfort the birthmother and tend to her needs, rather than to his own. If he is not involved at the birth, he may feel anger about that or it may deeply pain him — or even relieve him. Every person reacts differently.</p>	<p>Do I want to be present at the birth? How would the birthmother feel about me being there? What specific things can I do at the hospital and during the placement? If I cannot be at the hospital, what can I do later to welcome my child into the world?</p>	<p>“It is very rewarding and healing to play a role. Witnessing the birth of my son and seeing the joy of his adoptive parents was the most powerful, exciting, sad, joyful day of my life.”</p>

Stage	Description	Questions to Consider	Comments from Birthfathers
Adaptation	This phase includes the first few weeks following the placement of your child. Guilt and shame often accompany this phase, alternating with feelings of pride and contentment. You may feel confused by the rush of feelings you are having. Intellectually, you may believe the placement was the right decision. But in your heart, you may question it — especially if the birthmother is still deeply grieving. Women are usually comfortable expressing more emotion than men. Some men, though they may want to cry, feel stifled during the adoption process and are unable to express their feelings.	How do I feel now? Why did I (or we) make this decision in the first place? What should my role be now? When should I contact the adoptive family or the birthmother? How should I now refer to my child? Who can I talk to about this decision and my feelings?	“Placing your child for adoption is a major blow to your self-confidence. Especially for us guys — though you’ll meet very few who will admit it. You’ve got to build that up. Being needed by the adoptive parents is the best foundation around. In a way, it still allows the birth dad to provide for the kid. We need that because we’re guys, and we’re supposed to provide for our kids.”
Balance	As you feel more comfortable with the adoptive parents, and as you develop your relationship with them, your role will become clearer to you. You will regain some balance in your life. Adoptive families and birthfathers who have stayed in touch have found their relationships to be extremely fulfilling. Your child will benefit from the love, concern and involvement of both his/her birthparents.	What does it mean to be a birthfather? Is my life going in the direction I want it to? What does this adoption decision mean to me personally? Am I following through on things I said I would do? What do I want my child to know about me?	“The adoptive parents were beyond awesome throughout this entire process. I was very hesitant about meeting them, and I somewhat figured I’d be like a third wheel from the beginning. But they do great at showing me how important I am to them in general.”
Transformation	This phase is the point where everyone who grieves hopes to end up, eventually. Important aspects include developing your self-potential; finding some kind of spirituality or meaning in the adoption experience; developing awareness of how your feelings impact your relationships with your child and the adoptive family; coming to peace with yourself and your decision to place your child for adoption; and lastly, but most importantly, being mindful and appreciative of your child’s presence in your life.	What have I learned from this experience? What do I value about this experience? How can I continue to be a loving force in my child’s life? How can I share this experience with others, so they can learn from my story? Is it possible for me to help others in a similar situation?	“I still keep in contact with the adoptive parents, as they do with me. It’s amazing that I will still be able to know my son, and no one can take that away from me ... I can watch him grow and develop with the confidence that he is well loved and provided for. One of the best characteristics of this adoption is that I didn’t lose a family member. I gained many more.”

MODULE FIVE—ADOPTION BEST PRACTICES: IMPLICATIONS FOR HEALTH CARE SETTINGS

Handouts

Standards for Adoption in a Hospital Setting

<https://napsw.org/docs/adoptions-standards.pdf>

Standards for Adoptions in a Hospital Setting

Standard 1
In hospital settings, social work services shall be provided to individuals involved with the relinquishment of an infant for adoption. Birth parents, adoptive parents, and adoptees are appropriately regarded as clients whose needs and rights shall be respected and considered. The services available to birth and adoptive parents shall include assessment, advocacy, support, ongoing counseling, and/or referral to an appropriate agency for continued intervention.

Standard 2
Hospitals shall maintain a written plan for the provision of specialized social work services pertaining to adoptions. This plan shall be developed by a messenger prepared social worker and it shall clearly define the responsibilities and functions of the social worker's role. The social worker to provide services shall have a Master's degree in Social Work and shall have the opportunity to participate in training related to relevant state and/or interstate adoption laws and procedures.

Standard 3
If a woman presents to the hospital and intends to relinquish her child for adoption but has not yet made arrangements through a State-licensed adoption agency or an attorney, the perinatal social worker shall complete an initial assessment, and, following hospital guidelines, shall provide the birth mother with referrals to State-licensed adoption agencies from which she may choose.

Standard 4
In cases of agency adoption the hospital social worker and the adoption agency social worker shall coordinate services and ensure the required documentation is complete and in the appropriate record(s).

Standard 5
In cases of independent adoption of a hospitalized infant the perinatal social worker shall:

- Have contact with all parties involved, including birth parent(s), adoptive parents, and attorneys. The social worker shall assess birth mother's feelings regarding relinquishment, review her rights and options, discuss her desire to involve adoptive parents, and review her preferences regarding her interaction with the infant during hospitalization or ascertain that these issues have been discussed with her by a qualified person.
- Document in the medical record all information relevant to hospital staff's interaction with birth and adoptive parents.
- Upon learning the adoptive family wishes to be involved during the infant's hospitalization and that the birth mother agrees; meet with the adoptive parents to review hospital policies regarding their involvement during delivery and in the nursery, provide information regarding birth mother's rights during hospitalization and during the adoption process, ascertain the level of involvement they desire, review issues of confidentiality, and provide supportive contact during hospitalization.

Standard 6
In agency or independent adoption the perinatal social worker shall initiate and facilitate communication between birth parents and medical staff and when requested by birth parent(s), between adoptive parents and medical staff. The communication should include ongoing medical information regarding the infant's status and discharge teaching for adoptive parents.

Standard 7
The perinatal social worker shall not be involved in identification or referral of an infant to any specific adoptive family, or the procurement of an infant for adoption for a specific adoptive family.

Standard 8
The perinatal social worker will provide support and teaching to staff regarding psycho-social and legal aspects of adoption.

Standard 9
The perinatal social worker, functioning as an integral part of the health care delivery team, shall be included in every aspect of hospital policy formulation and decision-making when related to the issue of adoption.

Adoption Policy and Procedure Assessment Tool

The following policy areas are suggested as important to protecting the interests of pregnant women considering adoption or making an adoption plan. Review the items below to determine the Policies and Procedures in place at your facility. Indicate for each item whether the policy exists and is sufficient or needs improvement or whether the policy does not exist. Recommendations for each policy area are included to provide additional guidance.

	YES		NO	
	Sufficient	Needs Improvement		
PREGNANCY DECISION MAKING				
Procedures exist to refer a pregnant woman considering adoption as soon as possible to the appropriate hospital staff.				
<i>Recommendations: Consider requiring that a facility representative (e.g., social worker or case manager) be notified immediately when a birth parent(s) indicates an interest in pursuing or discussing adoption. Determine if and/or how other hospital employees or physicians with hospital privileges should discuss adoption with the patient or participate in adoption arrangements. Consider having a designated staff member who is an “expert” in adoption and who can be a point of contact when other staff members are uncertain how to proceed in a situation with a particular parent or family. Consider having this staff member build relationships with adoption and other social services providers, and advise on updating policies as needed to reflect current laws, trends, and best practices in adoption.</i>				
Protocols are in place to prevent undue or inappropriate influence of birthparents considering adoption.				
<i>Recommendations: Consider prohibiting facility personnel and medical staff members from initiating, discussing or imposing their personal beliefs or suggestions to a birth parent(s) in order to avoid any undue influence or a potential conflict of interest.</i>				
Direction is provided with regard to the prohibition of hospital personnel and medical staff members engaging in placing children either for adoption or for temporary foster care.				
<i>Recommendations: Consider prohibiting facility personnel from making referrals or suggestions regarding possible adoption for their personal benefit or the benefit of family members or friends. Be clear that hospital staff are not permitted to mention potential adoptive parents to patients, show profiles of prospective adoptive parents, or to refer a patient to “someone they know” who wishes to adopt.</i>				
A protocol clearly defines the importance of confidentiality of the mother.				
<i>Recommendations: Consider prohibiting disclosure of the mother’s adoption plan with other hospital personnel unless it has a direct connection to care. Outline that information should not be provided to individuals who call or visit the hospital without the express permission of the mother.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
A policy is in place that outlines the referral process that is to be used when additional support outside of the hospital setting is indicated.				
<i>Recommendations: Include procedures to ensure that referrals are made to competent and/or licensed professionals, including adoption agencies and pregnancy counseling agencies. Consider developing a list of providers to which hospital staff can refer.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
LABOR AND CHILDBIRTH				
A policy is in place that guides hospital staff in supporting the expectant mother’s labor and childbirth plan. The policy includes the procedures to be followed when changes to the plan are made.				
<i>Recommendations: Consider who must be familiar with the plan. Ensure the following elements are included:</i>				
<ul style="list-style-type: none"> • Who will be in the room during labor and childbirth? Will the prospective adoptive parent(s) be present? • Are there other spaces for adoptive parents at the facility (e.g., another hospital room) where they may wait during labor and spend time with the infant after birth? • When would the birth mother like to invite the prospective adoptive parents to meet the infant? • Are the birth and adoptive parents in agreement on any routine healthcare procedures that the infant may face soon after birth (e.g., vaccinations, circumcision)? • Do the birth and adoptive parents have a plan for the child’s name? Birth mothers sign the original birth certificate and can name the infant, although adoptive parents have the right to re-name the infant once the adoption is finalized and the adoption birth certificate is issued. • Have the birth and adoptive parents discussed whether the infant will be breastfed following birth? 				

	YES		NO	
	Sufficient	Needs Improvement		
CONTACT WITH THE BABY				
Procedures are in place that support following the mother’s wishes regarding contact with the baby during the hospital stay and protect her parental rights and responsibilities.				
<i>Recommendations: Birth mothers making an adoption plan should be permitted see the baby, hold the baby, feed the baby (either bottle or breast), name the baby, and room-in if desired. Support should be provided to mothers who wish to supply the infant with expressed breast milk, either before or after the adoption, including the provision of counseling about pumping and resources for how to maintain and manage a supply of breast milk.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
BIRTH ANNOUCEMENTS				
A protocol exists for the release of birth data to newspapers, new baby websites affiliated with the hospital, or other similar platforms.				
<i>Recommendations: Birth data should not be made available for publication on babies whose mothers are planning adoption.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
THE ROLE OF PROSPECTIVE ADOPTIVE PARENTS				
Protocols surrounding the prospective adoptive parents' involvement are clear. The policy assures that the birth mother is provided with the opportunities to spend as much time as desired with the infant after birth.				
<i>Recommendations: Prospective adoptive parents should attend the baby's delivery only at the birth mother's request. Visits and participation in the infant's care by the prospective adoptive parents should be in accordance with the birth mother's wishes and be facilitated so that the birth mother does not feel inadvertently pressured in her in making her final plans. Consider whether adoptive parents should receive a wristband, ID, or other designation indicating to staff that the mother has allowed them to be there.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
DISCHARGE				
Discharge guidance is adequate for situations where the infant is being discharged to someone other than the birth mother or birth father. Documentation requirements related to discharge of an infant to anyone other than the mother are sufficient.				
<i>Recommendations: With the birth mother's written permission, permit discharge of the infant to a relative, the birth father, or an adoption agency/attorney. Discharge of an infant to anyone other than the mother should be accompanied by a written release signed by the birth mother authorizing the hospital to discharge the baby to the adoption agency representative and to release all child medical information. A photocopy of the identification card of the designated agency representative who received the baby at the time of discharge is advised.</i>				
Protocols are in place pertaining to the delivery of complimentary gifts for new parents.				

	YES		NO	
	Sufficient	Needs Improvement		
<i>Recommendations: Ensure that complimentary gifts are given separately as needed to both birth parents and prospective adoptive parents.</i>				
Policies are in place that support screening of the birth mother for postpartum depression before discharge, since this screening may not be as available as it would typically be during well-child visits for the infant.				
<i>Recommendations: Consider protocols that inform birth mothers about the range of normal emotional responses, to recognize if they are struggling beyond that threshold, and to know when and where to seek help.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
RELEASE OF INFANT'S MEDICAL INFORMATION				
Protocols around the release of the child's medical information are outlined, including details with regard to what specific types of information is to be released.				
<i>Recommendations: Consider providing this information to the party assuming physical custody of the child at discharge to ensure continuity of medical care.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
INFANTS DELIVERED BY A SURROGATE				
Guidance is provided regarding situations involving the birth of a child delivered by a surrogate, including the discharge of infants in gestational carrier situations.				
<i>Recommendations: Consider state specific laws or other requirements that the hospital must follow. Include specific documentation requirements.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
OTHER				
State-specific legal considerations are incorporated into policies surrounding adoption.				
<i>Recommendations: Include how and when parental rights are ended, who is legally eligible to adopt, and which legal rights all participants will have post-adoption as well as general state policies regarding adoption.</i>				
Procedures are in place for receiving infants surrendered via Safe Haven.				
<i>Recommendations: Safe haven providers are required to accept emergency protective custody of the infant and to provide any immediate medical care that the infant may require. The provider is also required to notify the local child welfare department that an infant has been relinquished.</i>				

	YES		NO	
	Sufficient	Needs Improvement		
ADOPTION EDUCATION				
Expectations regarding training on adoption related issues for hospital staff are clearly defined.				
<i>Recommendations: Consider training for hospital staff who may come into contact with pregnant women or women who have given birth that includes adoption agency professionals. Ensure that training includes being ready to discuss all options—parenting, abortion, and adoption— in a productive, unbiased, non-judgmental way. Ensure that hospital staff are at least somewhat familiar with their state’s policies regarding adoption, to include:</i>				
<ul style="list-style-type: none"> • Are open adoption agreements legally enforceable in their state or are they courtesy agreements? • When is the termination of parental rights document signed? • Does the state have an adoption revocation period during which birth parents can change their minds and regain their parental rights? • What are birth fathers’ rights as far as notification and relinquishment? • What is the status of open records? 				

References:

Model Adoption Protocol For Hospitals: Developed by the Health Care Provider and Social Work Committees of Adoption STAR, Retrieved from: https://www.adoptionstar.com/wp-content/uploads/2013/09/Model_Adoption_Protocol.pdf

The American College of Obstetricians and Gynecologists Committee Opinion on Adoption, Retrieved from: <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2012/06/adoption.pdf>

Best-practice recommendations for adoption planning and placement in the healthcare setting, Retrieved from: <https://www.npwomenshealthcare.com/best-practice-recommendations-adoption-planning-placement-healthcare-setting/>

Infant Safe Haven Laws, <https://www.childwelfare.gov/resources/infant-safe-haven-laws/>

Educating Hospitals About Adoption: How Hospital Staff Can Support Parents Considering an Adoption Plan, <https://web.archive.org/web/20151009161831/http://www.adoptioncouncil.org/files/large/3d58e5a8d79ca22>

Resources

Adoption STAR. (n.d.). Model Adoption Protocol For Hospitals. Retrieved from:
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Additional Reading

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Provides information about health care coverage for newborns, including in situations where an adoption plan is being made by the expectant parent.

Karst, d. & Lindsey, M. (2012). Educating Hospitals About Adoption: How Hospital Staff Can Support Parents Considering an Adoption Plan. Adoption Advocate, Vol. 52. National Council for Adoption. <https://web.archive.org/web/20150910153157/http://adoptioncouncil.org/publications/2012/10/adoption-advocate-no-52>

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MODULE SIX—PULLING IT ALL TOGETHER

Handouts

Assessing Community Resources

At first glance, identifying a community resource that meets an individual’s specific needs may be like looking for a needle in a haystack. There are, however, some helpful techniques that can be used to assess whether a resource is a good match for a particular patient/client.

Asking clarifying questions to help patient/clients hone in on their specific needs as much as possible is the first step in the referral process. This sets the stage for focused, productive communications with community agencies or resources on their behalf.

One key factor is whether the health care provider will make the referral directly to the resource or whether it will be necessary for the patient/client to obtain the information for him/herself. Regardless of what method is used, it is recommended that the individual be “coached” to obtain information and assess its value, a skill that they can use in the future.

Most health care providers are aware of a number of community resources, either through personal networking contacts or through collecting business cards and agency brochures at conferences and meetings. These contacts can be used to narrow the search and identify a small number of resources that may work. Starting with “who you know” is always a good idea. When looking for resources and supports, it is important to trust your feelings about the interactions. Developing a trusting relationship is key to being able to honestly discuss service needs and find a good match. Assessing the following issues can help:

- Were you able to get through to the provider in a timely and easy manner?
- Did you feel comfortable talking to the provider?
- Did he/she treat you respectfully and confidentially?
- Did he/she readily answer your questions about the range of services provided?
- Did he/she respond to your specific needs or just talk generally about the services?
- Would you feel comfortable sending a patient/client to this community resource?

The following questions are a good starting point for patient/clients to ask in deciding whether to make an appointment with a particular resource:

- What services do you provide in pregnancy counseling and adoption?
- What are your eligibility criteria?
- What are your fees? Who pays these fees?
- Do you know about other resources that might meet my needs?
- If you had a loved one needing these services, is there a resource you would recommend?
- Are there any other questions that would be helpful for me to ask?

When evaluating resources and supports you will want to be able to assist your patient/clients in recognizing those aspects of the service or service provider that are important in determining a potential match for their needs and preferences. Some important questions to consider and/or coach your patient/client to consider are:

- Who does the provider consider to be the primary client? The birth parent(s), the unborn child? The adoptive parents?
- Does the provider provide the full range of pregnancy counseling and adoption options that your patient/client is interested in considering?
- What will this provider do to protect the rights and preferences of the patient/client(s)?
- Will this provider be competent and respectful of the age, religion, ethnic and cultural background of the patient(s)/client (s)?
- Will the provider provide a translator if one is needed?

Helping patient/clients find appropriate resources is an important aspect of the services offered by health care providers. Developing the knowledge and skills necessary to assess how services fit with their individual needs and preferences will enable patient/clients to become informed consumers and to advocate for themselves.

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