

ADOLESCENT BIRTH MOTHERS AFTER UNINTENDED
PREGNANCY AND INFANT OPEN ADOPTION

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DEDICATION

To the courageous birth mothers who have shared their stories and to all the birth mothers I have known and loved through the years. May you go from strength to strength. May your words be messages of hope to others in the midst of an unintended pregnancy or beginning their new life with an open adoption plan. May you be inspired by the words of someone dear to me, “Birth mothers love their children so much that they become willing to live separately from them in order to provide the kind of life that they are not—at that time—able to give.”

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ABSTRACT

Lynn B. Clutter

Adolescent Birth Mothers After Unintended Pregnancy and Infant Open Adoption

Birth mothers of open adoption are not well studied. This inquiry explored birth mothers' experiences surrounding unintended pregnancy and infant open adoption placement. The focused objective was to describe adolescent birth mothers' lives following pregnancy and adoption placement. This qualitative study used naturalistic inquiry, with participants giving 1 to 2 hour tape recorded telephone interviews. Verbatim transcripts were de-identified and systematically analyzed. Birth mother samples were at either 1 to 5 years or 5 to 15 years after infant open adoption placement. Overall both samples chronicled stories from preconception through current life. Birth mothers of both samples were unanimous in their support of open adoption.

The sample of 10 birth mothers who were interviewed 1 to 5 years postplacement shared life descriptions from pre-pregnancy; pregnancy with the decision for open adoption placement and choice of adoptive family; birth in context with the adoptive parents and birth child; postpartum and discharge. Postplacing birth mother findings were presented using the acronym *AFRESH*: A—adoption accomplishments; F—fresh start; R—relationships; E—emotions; S—support; H—healing. Personal, social, and relational benefits of open adoption far outweighed pregnancy, birth, and emotional challenges. Even though the process and outcome were “hard,” and included personal obstacles, the open adoption placement was “best.” Birth children were viewed as thriving, blossoming, and

having a wonderful life. Adoptive families were cherished like those of extended family. Birth mothers thought health care providers should share the option, and then provide adoption friendly care. They also would advise pregnant teens to choose open adoption.

Results from the 5 to 15 years postplacement sample of 5 birth mothers yielded themes of (1) satisfaction about decision for open adoption, choice of adoptive couple, and seeing a thriving birth child; (2) personal milestone accomplishments in education, finances, work, life, and relationships; (3) a sustaining sense of being a better person with an improved life; and (4) the essential need for support during and after the process.

Sharon L. Sims, PhD, RN, Chair

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CHAPTER ONE – INTRODUCTION

Heat of the moment, extended time alone with a partner, impulsivity, substance use that alters judgment, partner pressure, violence, or lack of contraception can be precursors of unintended pregnancy. About half (46%) of teenagers in America have had sex at least once (Alan Guttmacher Institute, 2006a). The fertility rate of teenagers in 2006 rose to 40.5 per 1,000 15–19 year old females (Moore, 2008; Hamilton, Martin, & Ventura, 2007). Of those pregnant, about 14% end in miscarriage, 29% end in induced abortion, and 57% end in birth (Alan Guttmacher Institute, 2006a).

The ability to conceive, however, does not mean an adolescent is ready to become a parent with a large part of the script of her life being written in a new direction. Giving birth and parenting or making an adoption plan changes the teen. Those who become pregnant with an unplanned pregnancy and decide to continue the pregnancy face decision making that can change the rest of their lives. Most who decide to continue the pregnancy do choose to parent the child (Hoffman & Maynard, 2008). Those who make adoption plans become birth mothers. Although statistics are not well documented and vary, the rate of babies born who are placed for adoption remains quite low at about 1% for all and 1.3% for White women under 45 years of age (Jones, 2008). An adoption is open when a birth mother has contact with the adoptive family and birth child but does not parent that child. Some have called birth mothers *life givers* or *first mothers*. Birth mothers make the courageous choice to be willing to live separately from their child in order to provide a life for that child that at that point (or with that partner, or in that situation, or at that age), they are unable to provide. This study demonstrates that becoming a birth mother indeed changes that teen forever.

Aim of the Study

Birth mothers are commonly adolescents or women in their twenties who decided to make adoption plans and then placed their infants with adoptive parents that they have selected. This study identified a birth mother as one who gave birth and made an adoption placement. Little is known about birth mothers after the time of infant placement, particularly about *adolescent* birth mothers. Adoption may be open or closed. Open adoption, the focus of this study, was defined as an adoption plan with the birth mother having had some degree of initial choice in selecting adoptive parents. They had some degree of initial and ongoing contact with the adoptive family. The aim of this study was to understand the influences of unintended adolescent pregnancy and open adoption on birth mothers' lives after infant placement. Very little is known about birth mothers' lives once adoption takes place.

Research Question

Since there is a gap in knowledge about birth mothers after adoption placement, this study was designed to discover birth mothers' own perceptions. The research question was, "What are birth mothers' experiences of unintended pregnancy and open infant adoption placement, and how have these experiences shaped their lives following adoption?" Naturalistic inquiry was the basis of the research design.

Background and Study Justification

In the United States, about half of the pregnancies are unintended and about one-third are unwanted (National Campaign, 2008a). About seventy-six percent of the unintended pregnancies occur to women in their teens and twenties (Finer & Henshaw, 2006; Chandra, Martinez, Mosher, Abma, & Jones, 2005); and about eighty-two percent

of adolescent pregnancies are unintended (Alan Guttmacher, 2006a). The teenage birth rate is the highest in the developed world and about four times that of the European Union average (Innocenti Report Card, 2001; Lawlor, 2004). Some pregnancies end in loss and some end in pregnancy termination through pharmacologic or surgical means (Ventura, Abma, Mosher, & Henshaw, 2008). Some of the mothers experiencing unintended, undesired pregnancies continue gestation and avoid deciding until the decision is made by progressing development. The birth is inevitable. The majority of mothers do not want a pregnancy termination for various reasons (Beckwith, 2007). However, adolescents may not desire or feel equipped to be parents. A pregnant teen may parent the child of an unintended pregnancy or have others do so. Should they make an adoption plan, it may or may not be an open adoption plan. Increasingly, adoptions in the United States are open (Grotevant & McRoy, 1998).

The United States has the highest adolescent pregnancy and birth rate among comparable industrialized nations (Martin et al., 2006; Hoffman & Maynard, 2008; Singh & Darroch, 2000). The influence of adoption placement, and particularly open adoption placement, on the birth mothers' own lives has not been well reported in health care literature. The few studies of open adoption that exist have reported a variety of favorable outcomes (Ge et al., 2008; Grotevant & McRoy, 1998) so it may be an increasingly important option for pregnant adolescents. Increased openness was significantly associated with two important measures in one large recent study (Ge et al., 2008). The degree of satisfaction with the adoption process as well as the birth mothers' postplacement adjustment was significantly improved with greater openness. Few teens have heard of the option of open adoption.

In contrast, it is known that adolescents who have experienced one unintended pregnancy are more likely than age-mates who have not been pregnant to become pregnant again and in a more rapid succession with additional unintended pregnancies. Nearly one fifth of all adolescent births are repeat births (Abma, Martinez, Mosher, & Dawson, 2002; Boardman, Allsworth, Phipps, & Lapane, 2006; Maynard, 1996). Whether those experiencing open adoption have a similar repeat pregnancy rate is unknown. Unintended adolescent parenting of an unplanned child, pregnancy termination, and closed adoption have known sequelae of hardship (Hoffman & Maynard, 2008). Open adoption needs exploration, not only to know statistics about birth mothers, but to hear from them about their own viewpoints and lives. This study reveals birth mother perspectives.

The impact of a study of this nature is that the voice of birth mothers' perspectives can be shared with others facing an unintended pregnancy. Having knowledge about open adoption is useful for the decision making process. Learning about how adolescent birth mothers navigated through their own experiences and hearing how open adoption really works for them can open the receptivity of teens in crisis toward this potential option. Open adoption may well fit with many more teens if they learn about the process in time.

Learning about how an adolescent birth mother perceives her own experiences of unintended pregnancy and of open adoption placement can offer health care providers with awareness of perspectives from a distinct group, birthmothers of open adoption. Health care providers sensitized with this knowledge can relate better with those of

similar circumstance and context. Health care providers can have a stronger basis for intervention in ways that promote health in situations of open adoption.

Adolescent Pregnancy and Birth

The experience of unintended pregnancy is generally found to have negative or even destructive impact upon those experiencing it and upon the children they bear. Adolescent parents especially experience this burden, but the consequences often are not observable for several to many years. Early pregnancy and childbearing is linked to poverty, income disparity, and child well-being, single parenting, and reduced education (National Campaign, n.d.a; Hoffman & Maynard, 2008). Currently, upward of eighty-four percent of teen parenting is nonmarital (Hamilton et al., 2007).

Only about ten percent of teen mothers complete a two or four year college program by middle adulthood. Nearly half of all teen mothers never earn a high school diploma, and thirty percent do not earn a General Education Development (GED) certificate (Maynard & Hoffman, 2008). About one-third of teen income during parenting years comes from public assistance. Additionally teen mothers and particularly those who parent before age eighteen, spend most of the early parenthood years single. When they marry, their spouses have relatively low earnings (Maynard & Hoffman, 2008).

Children born to teen rather than older mothers have poorer health with more chronic illness. They are more likely to be subjected to violence, abuse, and neglect. They more often end up in foster care. They have poorer social and academic outcomes that lower their own long term productivity and increase their likelihood of incarceration. They are more likely to become teen parents themselves, thus perpetuating a cycle of disadvantage (Maynard & Hoffman, 2008). Children born to adolescent mothers scored

significantly worse on the behavior-problem index than those of older mothers (Hofferth & Reid, 2002).

The year 2006 ended a fourteen year decline in the United States teen birth rate with a modest, three percent rise (Martin et al., 2009). The same year, the number of births to teens rose by five percent and the number of first time births rose more than five percent. Birth rates increased among White, Black and Hispanic populations, as well as among 15 to 17 year olds and 18 to 19 year olds (Moore, 2008). This widespread rise may represent either a short term rise or a long term sweeping trend. Sadly, the rate continues to increase. An in-depth analysis summarized that there are an increased number of teenagers who became mothers and also that there is historical precedent for a change in trend direction (as in the time between 1986 and 1991). The data suggested that the small increase represented either a reversal of trend or at the least a plateau (Moore, 2008).

Open Adoption for Teens with Unintended Pregnancy

Parenting decisions may mediate the impact of unintended pregnancy. Two possible parenting decisions are teen parenting of the child borne from the unintended pregnancy or open adoptive parenting of the child borne from the unintended pregnancy. When open adoptive parenting is chosen by the pregnant teenager, she is choosing to become the baby's birth mother. Differences in long-term effects of the parenting decision on teen lives are not well understood. Birth mothers are a rarely isolated and described group. Beginning awareness of this group is valuable because unintended pregnancy and open adoption placement affect the women's own health care and future

quality of life. Experiences at this point in their lives can have long range impact that affect many in their home, family, and community environments.

At a societal level, unintended adolescent pregnancy has an enormous economic impact. At a health care level, those experiencing unintended pregnancy use more health care resources. At a family level, unintended pregnancy can put strain on a variety of relationships. At an individual level, the impact of a child is intense and far reaching. Whether the adolescent decides to become a mother or a birth mother changes the rest of her life.

Open adoption has distinctions from other parenting choices. It involves a decision first to place for adoption. Then it involves the selection of adoptive parents. There is an interface between an agency or attorney, the court system, the adoptive parent(s) and the birth child. Open adoption allows a relationship to unfold between the birth mother and adoptive family without having the demands of full time motherhood rest squarely on the shoulders of the teen. In other words, the teen can resume adolescent development while keeping a fundamental emotional link to the baby. This boundary does not mean an all-pervasive lifestyle change.

Specific Context

The focus of the inquiry was that of birth mothers who had experienced an unintended adolescent pregnancy and an open infant adoption. These birth mothers were selected through one particular crisis pregnancy support group agency in a Midwest city in the United States. At the time of inquiry (one to five years postplacement), birth mothers may have lived anywhere in the United States. The particular agency was a crisis pregnancy support group that had the words “crisis pregnancy” in the name. For the

purposes of the study, one who chose to be a part of a crisis pregnancy support group was assumed to have been experiencing an unintended pregnancy.

The director of the support group initially identified people who during and after the pregnancy had participated in the group. Those who had done so one to five years earlier were selected and initially contacted through the director. Selection was of birth mothers who were willing to participate in a one to two hour telephone interview. Participants were asked to be in a private, comfortable location of their choosing where interviews could take place without interruption. Selection of birth mothers was for typical, critical, and available cases to gain sufficient detail for thick descriptions of transcribed interview data. The researcher was the “human instrument of inquiry,” the instrument of choice in a naturalistic design (Lincoln & Guba, 1985, p. 236).

Assumptions of the Specific Context

Several assumptions relate to the specific context of a particular crisis pregnancy support group. Those who attended a crisis pregnancy support group were assumed to have experienced an unintended pregnancy that was self perceived as a crisis pregnancy. A crisis pregnancy is viewed as having the element of crisis: a condition of instability or danger leading to a decisive change, a turning point, or a dramatic, emotional, circumstantial upheaval in a person’s life. An unintended pregnancy is a pregnancy that is identified by the mother as either unwanted or mistimed (occurring earlier than wanted) at the time of conception.

Another assumption is that birth mothers who chose open infant adoption gave the decision a great deal of thought and attention. Birth mothers who chose openness in adoption made an active decision to complete the pregnancy and choose the adoptive

parents. They also chose to have some degree of initial and ongoing contact with the adoptive family.

A third assumption is that birth mothers who responded favorably to a call from the crisis pregnancy support group leader, consented to a telephone interview, and completed the interview with me were typical birth mothers who had experienced open infant adoption placement through the agency. This assumption may or may not be true of birth mothers in other locations or contexts. Since the study used a naturalistic design with a local application, the burden of proof for transferability lies primarily with the person seeking to make application elsewhere to those with contextual and characteristic similarity (Lincoln & Guba, 1985, p. 298). My goal of inquiring within the given situation was that it would bring awareness of a rarely seen but very present population. My hope was that this sample presented a typical birth mother perspective from one out of a similar support group context.

A fourth assumption was that participant birth mothers would generally have a “sampling bias” toward positive views of open adoption. It is likely that those with negative views of their adoption placement experiences would not give ongoing contact information to the support group director or would decline participation in the study. If this were a quantitative study, sampling bias would be a serious design flaw. In naturalistic inquiry, it is not a flaw but is expected. The application is local so a typical case of the setting would be one that best demonstrates or describes the experience. The sampling is purposive where thick descriptions from key informants are sought. Useful informants are legitimate, committed, accepted members of the local context who are willing to act as members of the inquiry team (Lincoln & Guba, 1985, p. 258). A fifth

assumption is that the director could identify and contact participants who would be typical case and useful informants.

Researcher Experiences, Perspectives, and Perceptions

Unlike many types of research, naturalistic inquiry embraces and uses the tacit (intuitive, felt) knowledge of the knower (researcher) (Lincoln & Guba, 1985, p. 40). This knowledge is viewed as beneficial to the inquiry. Rather than causing “bias,” it fosters greater meaning, new ideas, and new applications. It is viewed as an indispensable part of the research process. The human instrument builds on tacit knowledge, uses qualitative methods to engage in the naturalistic inquiry (Lincoln & Guba, 1985, pp. 195–198). Researchers are expected to make explicit their present orientation to the subject of inquiry (Sandelowski, Davis, & Harris, 1989).

My professional and service experience includes a history of work with four unintended, adolescent, or crisis pregnancy agencies. My work history includes experience with those at all stages of pregnancy and postpartum. I have familiarity with child bearing and child rearing adolescents. I also have experience with adolescents who made open adoption plans from the point of beginning intentions to the point of up to several decades after placement. At one time I participated as one of several facilitators of a support group for birth mothers of open adoption. This participation was weekly for over a decade. At another point I conducted limited first trimester ultra sounds and limited counseling regarding pregnancy decision making. I grew to love working with adolescents in relationship to their pregnancy, parenting or journey as birth mothers. I have known birth mothers by choice professionally as well as personally since some of

our children are adopted. Our family enjoys relationships with our children's birth mothers. I do, however, echo James Gritter's statement,

...it is surely an anxious thing to write about a group that one is not a part of, most especially a collection of people whom I care about deeply. I write with good will, but there is a hazard that I understand too little of their reality to do justice to their cause. I must declare from the outset that I am an outsider to the birthparent experience. I am not a birthparent....
(2000, p. 4)

The background of my professional experience has yielded much specific tacit knowledge. Though not conducting research at the time, my "prolonged engagement" with birth mothers enabled a learning of the "culture," and an ability to be "accepted by the local culture" (Lincoln & Guba, 1985, pp. 301–305). I assumed that the ability to unobtrusively attune to birth mothers would be an asset for telephone interviews.

My perception is that health care providers know little about birth mothers. My intuition tells me that learning from birth mothers will enhance awareness of needs but may also spark awareness of strengths that could be applicable beyond the local setting. My general impression is that if more birth mothers knew about open adoption options, greater numbers may choose the option. Since I have been with birth mothers who have much to share about their unintended pregnancies and open infant adoption placements, my present orientation is a conviction that inquiry into this phenomenon is important and that health care professionals can benefit by learning from birth mothers.

Justification of Naturalistic Inquiry

Naturalistic designs are commonly selected in two situations: when little is known about a phenomenon or when what is known has biases or omissions (Sandelowski et al., 1989). In the case of open adoption placement, very little is known about the postplacement lives of birth mothers. Literature on open vs. closed adoption is limited,

and findings have changed over time because the definitions of open adoption have changed over time. One benefit of a naturalistic inquiry is that unknown phenomena can be explored naively (without a priori theory). Vivid descriptions of the nature of the phenomena can be given along with meaning (Sandelowski et al.).

Naturalistic inquiry is useful for discovery and as a starting point. With an emergent design, the process is inductive and locally applied, and initial aims are tentative (Lincoln & Guba, 1985). This means that only what is derived from the birth mothers and the site of origin is used to gain understanding about the study sample. Meaning is created through the interview and study process with attempt to shed light on the unique, make particulars vivid, and create memorable images (Eisner, 1981). This type of inquiry is especially beneficial to the study of postplacing birth mothers of open adoption.

Potential benefits of naturalistic inquiry center on the vivid, thick descriptions that can emerge from the units and categories of meaning, as well as the patterns of relationship between categories (Lincoln & Guba, 1985, pp. 344–351). Once these are established, the report is less formal and is written in a manner that vibrantly conveys the influences of unintended adolescent pregnancy and open infant adoption on the subsequent lives of birth mothers.

Relevance to the Discipline of Nursing

Nurses interface with adolescent birth mothers at the critical points of pre-, ante-, and postnatal times. Often the nurses' role is strategic at the point of labor and delivery as well as the first few days of postpartum. At other points of time, the birth mother's status usually is unknown to nurses and other health care providers. A primary assumption of

this study is that both unintended pregnancy and open adoption placement have important impact on the lives of birth mothers after delivery. It would follow logically then that health care issues may be influenced by those experiences. As nurses learn about birth mothers' perceptions of this influence, ongoing health care issues will be discovered. Nurses will be better equipped to address the issues in ways that promote, maintain, and restore ongoing health of birthmothers and their future children.

Summary

Chapter One has addressed the aim of the study, to understand the influences of unintended adolescent pregnancy and open adoption on birth mothers' lives after infant placement. Worded as a question, the aim was, "What are birth mother's experiences of unintended pregnancy and open adoption placement, and how have these experiences shaped their lives following adoption?" Importance of the topic to society, health care, family, and teens; as well as value for the discipline of nursing was delineated. The research setting, context, and assumptions were presented. Chapter Two addresses relevant literature.

CHAPTER TWO – REVIEW OF THE LITERATURE

The aim of this study was to understand the influences of unintended adolescent pregnancy and open infant adoption on birth mothers' lives after infant placement. The questions of what these experiences are and how they shaped the birth mothers' lives were the study focus. Exploration of the experiences with the birth mothers themselves was important in this naturalistic design in order to construct an understanding based on their viewpoints rather than develop and define awareness through use of literature derived theories. The literature is reviewed here, yet it was not used in shaping understanding of birth mothers' experiences in this study at the point of inquiry. Instead literature was viewed as a milieu of common understanding among professionals. Literature information was gathered from diverse professions since health care literature is limited on the topic of adoption and birth mothers. The topics addressed include pregnancy trends in the United States, unintended pregnancy, pregnancy planning, adolescent pregnancy, pregnancy outcomes, parenting decisions, adoption, open adoption, and birth mothers. This literature review explores each topic.

Literature searches have included database searches of Academic Search Elite, Child Welfare, CINAHL Plus, Dissertations and Theses, EBSCOHost, ERIC, Expanded Academic ASAP, Expanded Academic Elite, Google Scholar, Health Sources for Consumers, Health Sources for Nurses, JSTOR, MEDLINE, Psyc Info, PubMed, SAGE Journals, Science Direct, and Wiley InterScience. Emphasis was placed on articles between the years of 1995 to the present. Additionally, article reference lists were explored for more dated but pertinent sources. Adoption and adolescent pregnancy websites were widely accessed and examined. Since health care literature is so limited

when it comes to birth mothers, a much wider range of literature from many disciplines was beneficial. Lay sources as well held valuable content.

The literature review is an overview of pregnancy in the United States, unintended pregnancy, pregnancy planning, and adolescent pregnancy. Adoption is extensively described with particular attention given to open infant adoption. The focal point of attention is toward birth mothers who are described as well as possible, given the topic's gap in literature coverage. Literature about birth mothers after infant adoption placement is especially lacking.

Pregnancy in the United States

Pregnancy outcomes with percentages of pregnancy loss, induced abortions, and live births in the United States have remained nearly constant since 1990. Fetal loss rates in 1990 were 15 percent of pregnancies, while in 2004 they were 17 percent. Induced abortions in 1990 were 24 percent, while in 2004 they were 19 percent. Live births in 1990 were 61 percent, and in 2004 they were 64 percent. Translating 2004 percentages to numbers, the 17 percent fetal loss is 1.06 million, the 19 percent induced abortions is 1.22 million and the 64 percent live births is 4.11 million. The total United States pregnancies in 2004 were estimated to be 6.39 million (Ventura et al., 2008). Findings of 2001 statistics are similar (National Campaign, 2008d).

Considering pregnancy outcome by age, women in their twenties have the highest overall pregnancy rates. The 20–24 year old rates, then the 25–29 year old rates, are followed by women aged 30–34; then older teenagers, aged 18–19; then women aged 35–39; then younger teenagers aged 15–17 (Ventura et al., 2008).

Racial disparities exist for rate, age, and pregnancy outcome. The overall rates in 2004 for non-Hispanic (NH) Black (139.3), Hispanic women (145.7) and non-Hispanic (NH) White women (84.3) respectively per 1,000. This reveals that Hispanic and NH Black women rates are similar and are about two-thirds higher than rates for NH White women. Age disparities demonstrate a peak for NH Black and Hispanic women at age 20–24, while NH White women have a peak at age 25–29 (Ventura et al., 2008).

Racial disparities for pregnancy outcome are substantially different, particularly with induced abortions and live births. Fetal loss rates are somewhat higher in NH White (18%) compared with rates in NH Black (15%) and Hispanic (14%). Induced abortion rates in percentages are 12% for NH White, 37% for NH Black, and 19% for Hispanic.

Racial disparities for pregnancy intention exist with African American and Hispanic rates being highest. The meaning of unintended pregnancy may vary across racial and ethnic groups. One study assessed the relationship between pregnancy intention and subsequent preterm birth. Differences existed among Whites, immigrant Latinas, U.S.-born Latinas, and Blacks (Afable-Munsuz & Braveman, 2008).

Pregnancy outcomes greatly differ according to marital status. In 2004 a full seventy-five percent of marital pregnancies resulted in live births with just 6 percent in abortions. Unmarried women, however, had fifty-one percent live births with thirty-five percent abortions. Of the 6.39 million pregnancies in 2004, 3.5 million were to married women while 2.9 were to unmarried women. The majority of babies from an unplanned pregnancy are born to unmarried women (Chandra et al., 2005). In 2001 74% of unplanned pregnancies were to unmarried women (National Campaign, 2008a).

Nonmarital childbearing reduces the likelihood of marriage. In an analysis of data from the 1995 National Survey of Family Growth, the transition to marriage for women who delayed childbearing until marriage and for women who had nonmarital first birth were compared by ethnicity. Of nonmarital childbearing women, 82% of White women verses 89% of their counterparts (White women who avoided nonmarital childbearing) had married by age 40. Of Hispanics, 62% versus 93% had married, and of Black women, 59% versus 76% had married by the age of forty (Graefe & Lichter, 2002).

Cohabitation childbearing rates were also different with race. Hispanic women were 77% more likely and Black women 69% more likely than White women to conceive (Manning, 2001). Remaining in the cohabiting relationship after birth was twice as likely for Hispanic and three times as likely for Black women as for White women. The children born to those relationships were 70% more likely to be intended in Hispanic than White women (Manning, 2001).

In summary, in the United States in 2004, age, race or ethnicity, and marital status affected pregnancy frequency and pregnancy outcome (live birth, induced abortion, or fetal loss). Women in their twenties were most likely to be pregnant. Roughly six in ten pregnancies in 2004 ended in live birth, with two in ten ending in induced abortion and less than one in ten (about 1 in 6) ending in fetal loss (Ventura et al., 2008).

Unintended Pregnancy

One critical measure that impacts pregnancy outcome is that of the intent to be pregnant at the time of conception. Unintended pregnancy has usually been defined as pregnancy that is mistimed or unwanted at conception (O'Brien, n.d.; Oklahoma State Department of Health, Maternal & Child Health Service [OK HMCHS], n.d.). A more

extended definition includes pregnancies that at the time of conception, are either mistimed (the mother wants the pregnancy to occur at a later time) or unwanted (the mother did not want it to occur at that or any other time in the future) (Logan, Holcombe, Manlove, & Ryan, 2007; Santelli et al., 2003). These pregnancies hold higher risks than intended pregnancies (Gipson, Koenig, & Hindin, 2008). Pregnancies that occur at the right time or later; or if women are indifferent about the pregnancy are considered intended pregnancies (Santelli et al., 2003).

Worldwide, the United Nations Global Health Council reported 338 million unwanted pregnancies over a six year time frame. Of those, 251 million ended in abortion resulting in 441 thousand maternal deaths. There were 88 million unwanted pregnancies carried to term resulting in 246 thousand women dying from complications of pregnancy, labor and delivery. Internationally, death rates were much lower in industrialized countries than in developing countries. Conclusions, however, were that there was evidence of a serious health crisis that will deepen as more women move into prime reproductive years (Daulaire, Leidl, Mackin, Murphy, & Stark, 2002). Several studies have attempted to measure long term impacts of unintended pregnancy (Axinn, Barber, & Thornton, 1998; Barber, Axinn, & Thornton, 1999), but further research is needed.

In the United States, approximately half of the 6.4 million pregnancies per year are unplanned (Finer & Henshaw, 2006). And approximately two-thirds of these unplanned pregnancies are unwanted pregnancies (Chandra et al., 2005; Finer & Henshaw, 2006). This means that about one in three pregnancies in the United States is unwanted (National Campaign, 2008a).

About seventy-six percent of the unintended pregnancies occur to women in their teens and twenties (Chandra et al., 2005; Finer & Henshaw, 2006). The majority of adolescent pregnancies are unintended. Statistics about intention have to do with the mother's intention and are of a higher percentage when accounting for father intentions as well (National Campaign, 2008a).

When considering unplanned or unintended pregnancy by age, older adolescents have the highest percentage (81%), followed by the consecutive ages of 20–24 year old rates (60%), 25–29 year old rates (43%), and 30–34 year old rates (32%) (Finer & Henshaw, 2006). One can see that in order to address unplanned pregnancy, specific consideration of age is needed for adequacy of intervention.

The National Campaign to Prevent Teen Pregnancy began in 1996 with a goal of reducing the United States teen pregnancy rate by one-third. In 2006, with the estimation of one in three pregnancies being unwanted, the National Campaign's goal turned to bringing more intentionality and planning into pregnancy no matter what the age (National Campaign, 2007a). In one study (N = 403) depression, stress, and low social support were associated with high risk behaviors and sexually transmitted infections in women aged 14–25 years (Mazzaferro et al., 2006). High risk behaviors lead to unintended pregnancy.

Intentionality accounts for marked differences in pregnancy outcome. These differences have striking effects on the mother, her offspring, the family unit, social, economic, and public health. Women experiencing an unplanned, unintended pregnancy have been shown to be more likely to delay prenatal care (Brown & Eisenberg, 1995; Hulsey, 2001; Joyce, Kaestner, & Korenman, 2000; National Campaign, 2008b; Santelli

et al., 2003). They are more likely to expose the fetus to harmful substances (Brown & Eisenberg, 1995). These same women are more likely to smoke and drink during pregnancy. Also, their infants have been shown to be more at risk of preterm birth and low birth weight (Brown & Eisenberg, 1995; D'Angelo, Gilbert, Rochat, Santelli, & Herold, 2004; Hummer, Scmertmann, Eberstein, & Kelly, 1995). Their infants are less likely to be breast fed (Dye, Wojtowycz, Aubry, Quade, & Kilburn, 1997; Gipson et al., 2008). They are more likely to be involved in violence and be separated or divorced from partners (Brown & Eisenberg, 1995; OK HMCHS, n.d.; Pulley, Klerman, Tang, & Baker, 2002).

Striking disparity exists in frequency of unintended pregnancies and births when considering income. Low-income women are disproportionately more likely to have an unintended pregnancy. A low-income woman (a woman below 250% of the federal poverty level) is four times as likely to have an unintended pregnancy, five times as likely to have an unintended birth, and more than four times as likely to have an abortion as a counterpart of higher-income (Boonstra, Gold, Richards, & Finer, 2006; Finer & Henshaw, 2006; National Family Planning & Reproductive Health Association, 2008). These rates have increased since the mid 1990s. Many poor and low-income women cannot afford to obtain contraceptive services or supplies (National Family Planning & Reproductive Health Association, 2007). Many factors are associated with contraceptive nonuse (Frost, Singh, & Finer, 2007). One study found that 46% of women seeking abortions had not used contraception during the month they conceived (Jones, Darroch, & Henshaw, 2002). Repeated counseling reduces risk (Petersen, Albright, Garrett, & Curtis, 2007).

Children born out of unplanned pregnancy and who are not wanted, but are birthed and parented have been shown to have significantly lower cognitive test scores at age two than those born as a result of unintended but wanted pregnancies. Skills such as listening, vocabulary, exploring, problem solving, memory, communication, and overall mental ability were included in this nationally representative longitudinal study conducted by the National Center for Education Statistics (Child Trends, Inc., 2007). This key distinction (wanted vs. unwanted pregnancy outcomes) is understudied, but is important to the study of adoption.

There is a positive association between unintended pregnancy and mental health issues. Depression, anxiety, and even abuse are more common in those with unintended pregnancy (Gipson et al., 2008). There is a surprising absence of studies, however, designed to assess the mental health of mothers with unintended pregnancy. An even greater absence exists in the assessment of fathers (Gipson et al.).

Intimate partner violence has been increasingly associated with unintended pregnancy (Burke, Lee, & O'Campo, 2008; Pallito, Campbell, & O'Campo, 2005; Pallito & O'Campo, 2004; Quelopana, Champion, & Salazar, 2008). Women with unwanted pregnancies have been reported to have higher levels of abuse prior to conception and during pregnancy, compared with those of intended pregnancy (Goodwin, Gazmararian, Johnson, Gilbert, & Saltzman, 2000; Pallito et al., 2005). Being a victim of prior childhood abuse or having a history of violence has been associated with higher rates of unintended pregnancy (Quelopana et al., 2008). Prior abuse is also associated with violence during the pregnancy (Pallito & O'Campo, 2004; Quelopana et al., 2008).

Partner relationship stability of women (15–44) who experienced an unplanned versus planned pregnancy was shown to be different in the 2002 National Survey of Family Growth conducted by the National Center for Health Statistics. Mothers having one or more cohabitating or married relationship changes were assessed. Those with unintended pregnancies had a higher percentage of relationship changes (46 percent) compared with 21 percent of those with intended pregnancies—a full 25 percent difference (Child Trends, Inc., 2007; National Campaign, 2008b). This difference alone accounts for many of the challenges to the family unit, as well as the social, economic, and public health issues surrounding unintended, undesired pregnancies.

Some have questioned the validity of measures related to unintended pregnancy (Santelli et al., 2003; Trussell, Vaughan, & Stanford, 1999). Mistimed and unwanted pregnancies may have different precursors and outcomes, but they are commonly considered together (D'Angelo et al., 2004; Gipson et al., 2008; Morin, St-Cyr-Tribble, De Wals, & Payette, 2001). Pregnancy intention does not necessarily translate into contraceptive use to avoid pregnancy (Barrett & Wellings, 2000; Zabin, Huggins, Emerson, & Cullins, 2000). Planning with intent to become pregnant (intended vs. unintended) and desire to be pregnant (desired vs. undesired or wanted vs. unwanted) have only recently been separated for distinction. The concept of ambivalence about avoiding pregnancy may be expressed in incomplete contraceptive coverage (Higgins, Hirsch, & Trussell, 2008; Santelli et al., 2003). Another complicating factor of pregnancy intention measure validity is that it is retrospective reporting. Quality of life at the time of interview influences recollection of intentions (Joyce et al., 2000, Santelli et al., 2003). In a thorough literature review, the existing evidence on the impact of unintended pregnancy

was said to be mixed and limited for outcomes on child and parental health. Differences in measurement and classification further complicated findings (Gipson et al., 2008). One study assessing the causality of unintended pregnancy with infant and child development lags also found that past studies did not control adequately for potential confounding effects (Joyce et al., 2000). These questions of validity and measurement point to the reality that pregnancy outcome has many determinants and the study of unintended pregnancy is particularly challenging.

Current measures of intendedness are more distinct than those of the past (before 1993). Intendedness implies pregnancies that are clearly and consciously desired at the time of conception. There is a national effort to more plainly distinguish measures that yield differences. Pregnancy desirability or “wantedness” (intendedness) is a factor that is helpful in standardizing surveillance systems and improving assessment of trends (Campbell & Mosher, 2000; Speizer, Santelli, Afaible-Munsuz, & Kendall, 2004). Also, most recent studies indicate a shift toward more rigorous methodologies and research designs (Gipson et al., 2008).

Primary prevention of unintended pregnancy is an important national goal for this serious and costly social challenge. Stated another way, increasing the proportion of pregnancies that are wanted and welcomed is a valuable objective. Indeed, Healthy People 2010 has as one of the overarching goals, “Improve pregnancy planning and spacing and prevent unintended pregnancy” (United States Department of Health and Human Services [U.S. HHS], n.d.b, p. 9-3).

Unintended pregnancy may influence a woman’s behavior during pregnancy. Studies have demonstrated unintended pregnancy leading to less healthy behaviors and to

greater frequency of preterm birth and low birth weights (Logan et al., 2007; OK HMCHS, n.d.). Outcomes for children have included physical health, mental health, cognitive outcomes, and social outcomes (Logan et al.).

The negative consequences of unwed or undesired motherhood, abortion, premature marriage and parenthood, or undesired adoption placement are important to prevent. Increasing intentionality for one of life's most important decisions is a critical objective for health care providers. This is especially the case for teenagers. Pregnancy prevention measures may include initiatives promoting staying in school and curriculums of sex education (Child Trends, Inc., 2007; Sexuality Information and Education Council of the United States [SIECUS], 2007; Wertheimer, & Moore, 1998), abstinence (SIECUS, 2005), delay of sexual debut, contraception (Gold, 2006; Hoffman & Maynard, 2008; Sonfield, 2003), or emergency contraception (Kavanaugh & Schwartz, 2008; Trussell & Raymond, 2009). When prevention has not happened, thorough decision making helps pregnant women make choices. The assistance by health care workers or support groups has been shown to be beneficial. This decision-making juncture is reviewed in another section.

In summary, unintended pregnancy can have a devastating toll upon individual, offspring, family, and society. Low-income, African American and Hispanic, unmarried, uninsured, and especially young, impoverished women are disproportionately more likely to be at risk for unintended pregnancy. Older adolescents have the highest percentage of unintended pregnancies. Women in their twenties have the highest number of unintended pregnancies. If all pregnancies were intended there would be a reduction in infant mortality, child abuse, abortion, and public cost. Increased opportunities for healthy

pregnancies would exist because care would be received during the preconception and early prenatal weeks, and that is of key importance for healthy outcomes.

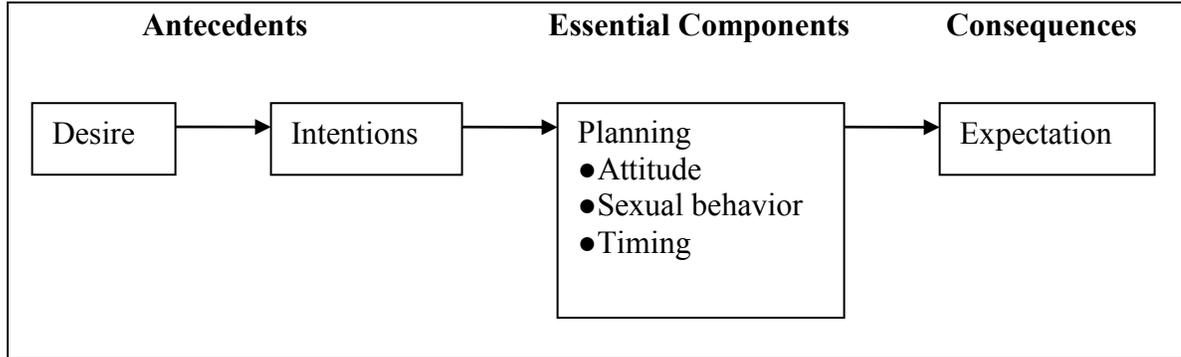
Pregnancy Planning

The concept of pregnancy planning has evolved. At present there is not a scientific consensus of meaning. Further, there is not precise measurement. Family planning has to do with the number of children a single parent or couple desires or expects to have. The timing of these births is included in the planning. Pregnancy planning has to do with intention of pregnancy as well as intention to have and parent a baby. Intention and timing have to do with desire. Contraception has to do with behavior to prevent pregnancy while having intercourse. The most effective methods of contraception generally include those not requiring adherence (Trussell & Wynn, 2008).

Definitions about pregnancy planning include various terms. Planned, unplanned, wanted, mistimed, unintended, and unwanted are all terms that have to do with a pregnancy. Publications over the past several decades have distinguished these terms in different ways (Morin et al., 2001).

In a study using triangulation technique to safeguard validity (Walker & Avant, 1995), Morin et al. (2001, p. 217) developed a Conceptual Model of Pregnancy Planning. The model begins with antecedents of desire leading to intention leading to the essential components. The three essential components of planning include attitude, sexual behavior, and timing. Planning leads to the consequences, or expectation. This conceptual model is pictured in Figure 1.

Figure 1. Conceptual Model of Pregnancy Planning



From “Concept Analysis of Pregnancy Planning Drawn from Women of Childbearing Age,” by P. Morin, D. St-Cyr-Tribble, P. De Wals, and H. Payette, 2001, *Health Promotion Practice*, 2(3), p. 217. Copyright 2001 by Society for Public Health Education. Used with permission.

Three essential components of pregnancy planning include not just the attitude, but the timing, and the sexual behavior. As adolescent pregnancy is considered with this conceptual model, desire of the moment may lead to a sexual behavior that leads to pregnancy. The intentions of pregnancy may not be considered until after the pregnant state is discovered or confirmed.

When considering reproductive decision-making, Kelly and Grant (2007) reviewed various models. Social policies, authors say, tend to be based, explicitly or implicitly on *economic rational choice models*. These may be based on assumptions of preferences, presumptions, and patriarchic biases despite a gender-neutral presentation. Economic-based rationality also has biases. Other theories such as a *value rationality model* may fit better with reproductive decisions of poor and young mothers. Value rationality may better address the complexities of childbearing and child rearing decisions for adolescents. Some have shown that a mixture of decision making rationales is common.

Miller (1994) developed a theoretical framework based on marital childbearing motivations, desires, and intentions. This framework was developed from data about 401 married couples. Psychological constructs such as motivations of intimacy, values, cognitive belief, reasoned actions, and social-normative influences are reviewed. The framework leads from traits or dispositions regarding motivation for childbearing, desires, intentions, and finally behaviors. This progression is assuredly different from that of nonmarital, adolescent pregnancy but includes many of the same elements.

Nonmarital pregnancy decision making is a current and increasing trend. Once pregnant, an unmarried woman now is less likely than in the past to seek an abortion, place the child for adoption, or get married as a result of the pregnancy (Edin & Kefalas, 2005; Kelly & Grant, 2007). Women's decisions to bear and raise children may come before or after discovery of pregnancy. This decision making may occur less before intercourse for adolescents (i.e., as with use of contraception) than with those of other age groups; but also, decision for nonprotected intercourse may be reflective of a value rationality (i.e., as with those having a high cultural value on children).

Adolescent Pregnancy and Birth in the United States

The United States has the highest adolescent pregnancy and birth rate among comparable industrialized nations (Hoffman & Maynard, 2008; Innocenti Report Card, 2001; Martin et al., 2006). In the United States, 22 percent of women had a child before the age of twenty compared with 15 percent in Great Britain, 11 percent in Canada, 6 percent in France, and 4 percent in Sweden. Differences were even greater for births to younger teenagers (Alan Guttmacher Institute, 2006a; Darroch, Singh, Frost, & The Study Team, 2001; Hoffman, 2006; Klein, 2005). Additionally, the age of sexual debut

varied little across countries, but United States teenagers are the most likely to have multiple partners and to resolve unintended pregnancy through abortions (Darroch et al., 2001; Hoffman, 2006). Eighty-two percent of adolescent pregnancies are unplanned (Alan Guttmacher Institute, 2006a). It is estimated that half of the pregnancies among high school students occur among girls who did not use contraception during their last intercourse (Henry J. Kaiser Family Foundation [HJKFF], 2006; Santelli, Morrow, Anderson, & Lindberg, 2006). Sexual content in television was demonstrated to be associated with higher rates of adolescent pregnancy even when controlling other factors (Chandra et al., 2008). Substance use, including alcohol, increases the likelihood of risky sexual behavior, unprotected intercourse, and unintended pregnancy (Brown & Eisenberg, 1995; HJKFF, 2002). The adolescent brain is still developing. This affects behavior, particularly as it relates to priority setting, decision making, reasoning, emotions, and self control. Likewise, hormones, sleep deprivation, and stress impact choices about risky behavior (Herrman, 2005, 2006, 2007). Prevention of risky sexual behavior among teenagers presents many challenges (Ball, 2008; Hollander, 2003, 2008; Jumping-Eagle, Sheeder, Kelly, & Stevens-Simon, 2008; Kalmuss, Davidson, Cohall, Laraque, & Cassell, 2003; Manlove, Logan, Moore, & Ikramullah, 2008; Masters, Beadnell, Morrison, Hoppe, & Gillmore, 2008; Melhado, 2008).

Programs and interventions designed to reduce teen pregnancies have been minimally effective. Primary prevention strategies aimed toward delay of sexual intercourse and improved usage of birth control have been largely ineffectual. This was the conclusion of a systematic review of randomized controlled trials that used 26 studies for analysis (DiCenso, Guyatt, Willan, & Griffity, 2002).

In an international trend analysis of industrialized countries from 1970 through 1999, there was a general, across country trend of having a decreasing adolescent birthrate and pregnancy rate. At the point of the late 1990s the United States pregnancy rate for 1,000 15 to 19 year olds was 83.6 with a birth rate of 54.4, abortion rate of 29.2, and an abortion ratio of 34.9 (Singh & Darroch, 2000). Stated in different measures, in 2002 there were 760,000 pregnancies, and in 2004 there were 420,000 births to adolescents in the United States (Hoffman, 2006). Age at first intercourse averages seventeen for girls and sixteen for boys, yet a fourth of youth report having had intercourse by fifteen (Klein, 2005). In 2007 48 percent of all high school students reported having had sexual intercourse (Holcombe, Carrier, Manlove, & Ryan, 2008). Two-thirds of all teen pregnancies occur among eighteen to nineteen year olds (Alan Guttmacher Institute, 2006a). A younger age at first sexual intercourse is associated with a variety of negative consequences including nonvoluntary sex, multiple partners, and adolescent birth (Child Trends DataBank, 1995). In the 2007 Youth Risk Behavior Surveillance, 7.1% of children younger than thirteen had experienced intercourse in the United States (Eaton et al., 2008). In 2007 fifteen percent of high school students reported already having had four or more sexual partners (National Campaign, 2008e).

The birth rate to unmarried female adolescents, however, has been increasing for the past three decades. This may be reflective of the wider societal trends. In 1977 the “out of wedlock” births to adolescents were 44% (U.S. HHS, n.d.b, 2008). In 2001 78.9% of all births to adolescents were to unmarried teens (Boonstra, 2002; Martin, Park, & Sutton, 2002). Currently, over 84% of teenage childbearing is nonmarital (Hamilton et

al., 2007). More than 96% of Black teen births are nonmarital (Hoffman & Maynard, 2008).

Age at menarche and age at coitarche (first intercourse) explain timing of first pregnancy according to one study (Dunbar, Sheeder, Lezotte, Dabelea, & Stevens-Simon, 2008). For White women, age of coitarche mediated the relationship between age at menarche and the first pregnancy. In Black and Hispanic women, age at menarche explained timing of first pregnancy, suggesting that these two population groups have a higher likelihood of conception. The tendency to become pregnant is more likely with early maturing females than with later maturing females (Sisk & Foster, 2004). Other studies with different samples have had different results (Riley, Weinstein, Ridley, Mormio, & Gorrindo, 2001).

Minority populations are disproportionately affected by teen pregnancy (National Campaign, 2008f). There has been a sharp decline (40%) in the pregnancy rate for African American 15 to 19 year olds between 1990 and 2002 (Alan Guttmacher Institute, 2006b; National Campaign, 2008c). Even with the decline, however, the adolescent pregnancy rate is highest for African Americans, but the birth rate is highest to Latinas (83 births per 1,000 teens). This is compared with 63 births per 1,000 African American teens and 27 per 1,000 Caucasian teens (HJKFF, 2006). A recent finding from the National Campaign to Prevent Teen Pregnancy was that during adolescence, 19% of White, 53% Latina, and 51% of African American girls will become pregnant (Saar, 2008).

Interestingly, in a study about perceived quality of life in predominantly minority pregnant adolescents (N = 42; 92% minority), only the “physical functioning” component

of the eight-component Medical Outcome Survey-Short Form 36, v. 2 demonstrated significantly lower than normative scores (Drescher, Monga, Promecene-Cook, & Schneider, 2003). Perhaps this reveals that these teens may not fully perceive what could change about the quality of life in aspects other than physical. It is unknown how quality of life perceptions change after pregnancy resolution.

There is a growing literature base on association between childhood sexual abuse and its relationship with adolescent pregnancy (Francisco et al., 2008). A significant correlation exists between childhood sexual abuse and teen pregnancy. Victims of sexual abuse are also more likely to be sexually promiscuous (Noil, Trickett, & Putnam, 2003; Saewyc, Magee, & Pettingal, 2004). Intimate partner violence is associated with adolescent pregnancy, pregnancy intention, and pregnancy resolution (Campbell, Pugh, Campbell, & Visscher, 1995; Miller et al., 2007). The causal link between any of these types of sexual abuse or violence and adolescent pregnancy remains unanswered (Blinn-Pike, Berger, Dixon, Kuschel, & Kaplan, 2002).

Negative Outcomes of Adolescent Childbearing

Adolescent pregnancy is a critical social problem contributing to increase health risk for pregnant teens and their children (Franklin & Corcoran, 2000; Kongnyuy et al., 2008). One key goal of The National Campaign is to reduce teen pregnancy rate by one-third between 2006 and 2015 (National Campaign, 2007a). Unfortunately, the teen birth rate has gone up for the second year in a row. Between 2005 and 2007, the teen birth rate in the United States has increased a full five percent (National Campaign, 2009). Several decades of research on teenage pregnancy and childbearing has linked childbearing with numerous negative outcomes. These will be reviewed. Outcomes include medical risks

and complications; reduced completion of years in school; reduced high school graduation; increased likelihood of being a single parent; increased likelihood of having a greater number of subsequent children, nonvoluntary sex, and having multiple partners more than nonteenage mothers; increased likelihood of poverty; increased public cost; and increased difficulties for the offspring of teen parents.

Medical Risks and Complications

Pregnant adolescents younger than 17 years have a higher incidence of medical complications than do other women (Ventura, Abma, Mosher, & Henshaw, 2008; Klein, 2005). Poor maternal weight gain, pregnancy-induced hypertension, anemia, sexually transmitted diseases and other conditions have been more pronounced in adolescent age groups (Kirby, 2001a, 2001b; Klein, 2005).

Reduced Completion of Years in School

In a prospective study in New Zealand (N = 520), teens who were pregnant by the age of 18 demonstrated a greater risk of poor academic achievement, of early school termination, of less tertiary schooling (Fergusson & Woodward, 2000). This finding is consistent with findings in the United States. The education reduction has been observed by others (Dangal, 2005).

In a current study that used the natural experiment of teens who bore children compared with teens who miscarried, teen childbearing and childrearing was shown to be substantially more negative when it came to postsecondary school (Hoffman, 2008). Decreased educational attainment leads to fewer employment opportunities along with reduced income.

Reduced Completion of High School and Beyond

Adolescent mothers complete high school and go to college at much lower rates than their nonpregnant contemporaries (Hofferth, Reid, & Mott, 2001). This was particularly true when it came to college attendance. Women who gave birth in their teens had a 29% rate of college attendance compared with a 70% rate of those who gave birth in their twenties. The trend may be different for teen mothers in the future due to societal changes (Campbell, Hombo, & Mezzeo, 2000). In fact now teen mothers are more likely than in the past to complete high school or to obtain a GED, but they are still less likely than women who delay childbearing (Alan Guttmacher Institute, 2006a).

Increased Likelihood of Being a Single Parent

Adolescent mothers are less likely to get or stay married (Furstenberg, 2003; Graefe & Lichter, 2002; U.S. HHS, n.d.b). Since female-headed households are more likely than two parent households to be in poverty and receive public assistance, marriage may act as an economic security. Women with nonmarital births are less likely to marry but also are more likely to divorce (Graefe & Lichter, 2002). One study demonstrated that only 30% of teen mothers who married after their child's birth remained in those marriages at the age of forty (Lichter, Graefe, & Brown, 2003; National Campaign, 2007b). Not surprisingly, teen parents experience loneliness (Klein, 2001).

Increased Likelihood of a Greater Number of Subsequent Children, Nonvoluntary Sex, and Having Multiple Partners

In one study of adolescent mothers, 42% become pregnant within 24 months of birth of the first child (Raneri & Wiemann, 2007). Once a teenager has had one infant, she is at greater risk of having another. Approximately one fifth of all adolescent births

are repeat births (Abma et al., 2002; Boardman et al., 2006; Kirby, 2001a, 2001b; Klein, 2005; Maynard, 1996). Rapid succession of childbearing has been shown to have adverse health consequences for mothers and their children, especially among teenagers (Gold, 2006).

Adolescents who become sexually active at an early age have a greater likelihood of negative sexual consequences. This includes nonvoluntary and unwanted sex (Moore, Manlove, Gleib, & Morrison, 1998). Also, a greater likelihood exists for having multiple sexual partners (Santelli, Brener, Lowry, Bhatt, & Zabin, 1998; Smith, 1997).

Increased Likelihood of Poverty

Unintended pregnancies are most likely to happen with teens and those in their twenties from low-income and poor families, as compared with those who have abortions or teens in general (Finer & Henshaw, 2006). Teenage mothers are more likely to live in poverty than their peers who are not mothers. Some say as many as 83% of adolescents who give birth and 61% of those who have abortions are from poor or low-income families (Klein, 2005). With the documented education reduction of those experiencing teen pregnancy, there are fewer beneficial employment opportunities and a resultant greater welfare dependency.

Several recent writings have pointed out methodological concerns with some of the estimations of financial costs of teen childrearing. Some have found that teen birth is not a substantial risk factor for various socioeconomic outcomes and may even have some beneficial effects to earnings (Hoffman, 2008). Hotz, McElroy, and Sanders (2008) used a nationally representative sample of teenagers who became pregnant and gave birth in the mid-1970s. They compared this group with the counterpart group who became

pregnant but reported having had a miscarriage. Over *time*, those who had their first child before age eighteen did not work less, earn less, receive less spousal income and have more dependence on forms of public assistance than they would have been with delaying childbearing. Rather, the shorter term negative consequences improved substantially as mother and child(ren) aged. This finding indicates that over time the consequences may not be as dire as once thought. Additionally, it points to a consistently used methodological flaw of comparing those with teen pregnancy and age-mates without teen pregnancy. The two groups commonly have substantial differences in precursors such as family of origin factors (income, single-parent home, education level, etc.) (Hoffman, 2008).

Increased Public Cost

The direct medical costs of unintended pregnancies in 2002 were estimated by one source to be five billion dollars in the United States (Trussell, 2007). The total economic health care burden of unintended pregnancy includes that of births (3.924 billion), induced abortions (797 million), and fetal losses that were unintended (266 million). Use of contraceptives to avert pregnancies was estimated to return a savings of 19.3 billion dollars in direct medical costs (Trussell, 2007). Other sources have found the public cost to United States taxpayers to range between \$7 billion and \$15 billion a year (Maynard, 1996; National Campaign, 2008b; Ventura et al., 2008). In 2004 the federal, state, and local cost to taxpayers was estimated to be 9.1 billion dollars (Hoffman, 2006). Stated another way, it is estimated that every \$1 spent on family planning services saves an estimated \$3 in medical costs (Sonfield, 2003).

Teen pregnancy can go unnoticed until well into the gestation. This means the embryo and fetus can be exposed to teratogens (agents that disrupt development) and result in public and private cost. There is a high rate of elective abortion in teen pregnancy resolution. The births tend to have increased risk of maternal or infant complications. The parenting is of higher risk as well. All of these factors lead to more public cost.

Another measure of public cost is toward employers. While adolescents are not as often employed as other age groups, those who were, took time off to obtain medical care or maternity leave or both. Some quit their jobs. Employers incurred additional costs for training and recruitment (Trussell, 2007).

Increased Difficulties for the Parented Offspring of Teen Parents

Teenagers who are pregnant are by far the most likely to receive late or no prenatal care (Child Trends DataBank, 2007). Teen offspring have higher rates of low birth weight, preterm birth, neonatal death, and sudden infant death syndrome (U.S. HHS, n.d.a). Teen parented offspring may be at greater risk of child abuse or child neglect. They have greater behavioral and educational difficulties at later stages (Hofferth & Reid, 2002; Levine, Pollack, & Comfort, 2001). At kindergarten, the children of teenage mothers have an elevated risk of educational problems and disabilities owing to economic and demographic factors of young mothers (Hollander, 2001).

According to the United States Bureau of Labor statistics, teen pregnancy is a major contributing factor to child poverty rates. A child of a teen mother has a 27 percent chance of growing up in poverty (Shukla, 2008; U.S. HHS, 2008). Children of younger

mothers rely more heavily on publically provided health care than children of older mothers (Hoffman & Maynard, 2008).

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA or welfare reform) cites a variety of negative outcomes of unwed teen births for mothers and their children. The act lists cognitive deficits, poor school achievement, and a greater probability of becoming an unwed parent as negative outcomes for the children of unwed teen mothers. Further, the act states that children born out of wedlock are three times more likely to be on welfare as adults (U.S. HHS, 2002). The act has been criticized for validity of content and rhetoric (Eitzen and Zinn, 2000; Kelly & Grant, 2007). Consequences of adolescent pregnancy may be more related to poverty and other co-occurring factors than to adolescent pregnancy itself (Hoffman & Maynard, 2008; Manlove et al., 2002). Nonetheless, many negative consequences exist for children of teen mothers including being more likely to live in a single-parent, poorer quality home, to spend more time in child care, to be the subject of abuse or neglect, and to spend time incarcerated, than if their mothers had delayed childbearing (Hoffman & Maynard, 2008). These consequences may be changing due to changing cultural norms.

Preventing Adolescent Pregnancy

The United States has health goals of reducing and preventing unintended pregnancy as well as adolescent pregnancy. Healthy People 2010 has significant directed attention and planned outcomes for both of these areas. The Centers for Disease Control and Prevention included family planning in the list of century achievements (Ten Great Public Health Achievements, 1999) so value attention on the topic. Further, the Youth Risk Behavior Surveillance (Grunbaum et al., 2002) has a section directed toward

surveillance of “sexual behaviors that contribute to unintended pregnancy and STDs, including HIV infection.” Studies in other countries have identified risk factors associated with adolescent unintended pregnancy (Woodward, Fergusson, & Horwood, 2001). Congress repeatedly targets unintended pregnancies, as with the unenacted Prevention First Act (National Family Planning & Reproductive Health Association, 2007) and the recently introduced Preventing Unintended Pregnancy Act (2009).

Many agencies, foundations, and organizations have invested vast focus to this area as well. Prevention of unintended adolescent pregnancy, birth spacing, contraceptive use, emergency contraception, male involvement in pregnancy prevention, abstinence and other educational programs have been directly targeted topics (National Campaign, n.d.c, 2007b; U.S. HHS, n.d.b). Programs that demonstrate effectiveness with adolescents tend to include access to clinics and services. Also, family dynamics and attachment, connectedness to caring adults, social support with attention to social norms, community involvement, and similar relationship strategies have been found to be effective in reducing frequency and negative effects of unintended adolescent pregnancy (Kirby, 2001a, 2001b). Many have turned their attention toward developing new sexual ethics that reinforce sexually healthy habits. Public, private, and faith based sectors have drawn attention to the importance of personal responsibility (National Campaign, n.d.b).

The changing trend of teen fertility and birth rates cannot be over emphasized. The 2004 teen fertility rate was 41.9 births per 1,000 women age 15 to 19. The rate for eighteen to nineteen year olds raised the most for adolescent rates (Hamilton et al., 2007). Hispanic adolescents (ages 15–19) have the highest birth rates among their peers, followed by Black then White (National Adolescent Health Information Center, 2007).

For the first time since 1991, the United States has had a rise in adolescent pregnancy and birth. Teen fertility increased 3 percent between 2005 and 2006 (Hamilton et al., 2007; Martin et al., 2008; U.S. HHS, 2008). The 2007 increase brought the total to a 5 percent increase after fourteen years of continuous decline in teen birth rate (National Campaign, 2009). It is still too early to determine if this rise in teen fertility represents a major trend or a minor change (Moore, 2008). Yet, the rates continue to rise.

With the United States having the highest adolescent birth rate of the developed Western nations, it is important to understand the various outcomes of those pregnancies. With nearly half (48%) of women 15 to 44 having experienced an unintended pregnancy (Finer & Henshaw, 2006), attention to what happens beyond the pregnancy is necessary.

Outcomes of Unintended Adolescent Pregnancy and Birth

Recalling that about one in three pregnancies in the United States is unwanted (National Campaign, 2008a); that about seventy-six percent of the unintended pregnancies occur to women in their teens and twenties (Chandra et al., 2005; Finer & Henshaw, 2006); and that about eighty-two percent of adolescent pregnancies are unintended (Alan Guttmacher Institute, 2006a), when adolescents become pregnant, pregnancy and parenting decisions are necessary (Bartel, 2005). These decisions are fundamentally different from those faced with a desired pregnancy. The process and outcome of decision making is important and may extend from the point of pregnancy determination until much later during and even after the pregnancy.

The news of pregnancy is more likely to be a shocking event to an adolescent. This is true for a variety of reasons. First, adolescent understanding of intercourse and its link to sexually transmitted diseases or pregnancy can be limited. Adolescent literacy

levels are varied, and the accurate information related to pregnancy is sporadic at best. Second, the decision to engage in intercourse is commonly spontaneous, “in the moment,” and without planning. Use of contraception can be irregular, minimal, or ineffective. Third, menses may be irregular, so awareness of ovulation is likely to be unknown, yet potential for conception rates may be higher than for those in other age groups.

In a study of the 2002 National Survey of Family Growth (N = 7,643), 39.3% of fifteen to nineteen year olds reported receiving at least one of the sexual or reproductive health care services in the 12 months before the survey (Frost, 2008). This means that nearly forty percent of the adolescents in America were paying attention to sexuality and reproduction enough to obtain services. The importance of this type of information is that teens are involved in sexuality yet are shocked with pregnancy. Typically, the positive pregnancy test is the point at which a teen begins to realize that decisions need to be made about the pregnancy and baby.

Potential outcomes include pregnancy loss, pregnancy termination, parenting the infant borne from the unintended pregnancy, or making an adoption plan. Adoption methods differ and include kinship, closed, or open approaches. Outcomes of the unintended pregnancy will differ with the different approaches.

No matter what the pregnancy choice, unintended pregnancy can bring about some psychosocial issues including grief, mourning, guilt, shame, remorse, anger, dissatisfaction with current life, and the like. There is loss no matter what the decision. The loss may be of the pregnancy or of parenting the child. The loss may be of the adolescent’s own childhood as it had been. The loss may be in terms of time and

emotional energy spent on working out the decisions. The loss may be in terms of relationships that become different at the point of a pregnancy.

The decision making process, combined with psychosocial issues and loss, can bring about decisions that impact people at that point and for their lifetimes. Decisions may be influenced by many people including partners (Evans, 2001; Namerow, Kalmuss, & Cushman, 1993), parents (Low, Moely, & Willis, 1989), peers, or adoption workers (Brett & Brett, 1992; Simmonds & Likis, 2005; Singer, 2004). Further, resolution for one (i.e. the birth mother) may be different from others (i.e. her parents, the birth father, the adoptive parents, the birth child). Various influencing elements such as prior experience with adoption (Namerow et al., 1993) or abuse (Campbell et al., 1995; Lathrop, 1998) can make a difference in the decision making.

In a 1995 survey of adolescents, 51% gave birth, 35% sought abortions, 14% miscarried, and less than 1% chose to place their children for adoption (Child Trends DataBank, 1995). Similarly, in 2006, about 14% ended in miscarriage, but only 29% ended in induced abortion, and 57% ended in birth (Alan Guttmacher Institute, 2006a). Adoption was not addressed in that study. The pregnancy outcomes of loss, termination, parenting, and adoption placement are reviewed.

Pregnancy Loss

In 2004 1.06 million of the 6,390,000 pregnancies resulted in fetal loss (Ventura et al., 2008). As with other age groups, pregnancy loss occurs as a result of many maternal or fetal reasons. One factor in adolescent loss may be that full fecundity does not happen at the point of menarche (Sisk & Foster, 2004). Pregnancy in early adolescence may not be sustained due to hormone levels and other factors. Miscarriage

may take place at various points in the pregnancy and for various reasons. The experiences of miscarriage are diverse for each pregnancy, each person, and each loss.

Pregnancy Termination

About half of United States women who terminate their pregnancies have had a prior abortion (Cohen, 2007). There is a lack of data on abortion rates by income level, yet some research suggests that more poor women desire to have abortions than are able to afford them (Kelly & Grant, 2007). Many states require parental involvement in a minor's decision to terminate a pregnancy (Alan Guttmacher Institute, 2008b). There is a strengthening public and professional view that adolescents should have access to confidential reproductive health services including contraception and abortion (Dailard & Richardson, 2005). Those choosing termination have the decision making process during the pregnancy only. Factors associated with decisions for abortion include being a student, being single, wanting to keep a desired number of children, and poor fit of childbearing with work or relationship situation (Sihvo, Bajos, Ducot, & Kaminski, 2003). Spiritual belief systems impact the decision as well.

In 1972 less than 25% of pregnancies were terminated through abortion. After abortion legalization in 1973, there was a sharp increase, with 45% termination rate in 1979. This rate was stable through most of the 1980s. The rate has declined since 1988 to a low of 34.5% (approximately 215,000 abortions) in 2002 (Hoffman & Maynard, 2008). Between 1973 and 2005, over 45 million legal abortions took place (Jones, Zolna, Henshaw, & Finder, 2008). Teenagers account for 17% of the overall rate. They are more likely than other age groups to wait to have abortions until after 15 weeks gestation when medical risks are significantly higher. Of all abortions, 61.3% are obtained at less than 9

weeks, 17.8% at 9–10 weeks, 9.6% at 11–12 weeks, 6.7% at 13–15 weeks, 3.5% at 16–20 weeks, and 1.1% at 21 or more weeks. Most are surgical abortions, with medication abortions accounting for 13% of all abortion and 22% of those before nine weeks (Alan Guttmacher Institute, 2008a). Medical (vs. surgical) approaches are rising in proportion of abortions. The short term quality of life comparison of those experiencing medical versus surgical approaches were compared in one study, with very similar results in group findings (Westerhoff, Picardo, & Morrow, 2003).

The abortion ratio varies considerably for age and race, with 15–17 year olds having 36%, 18–19 year olds having 32%, Black having 43%, Hispanic 23%, and White, 29% (Hoffman & Maynard, 2008). Reasons people give for abortions include concern for other individuals and not being able to afford the child. Additionally, having a baby would interfere with work, school, or the ability to care for other children. Half say they do not want to be a single parent or are having difficulties with their husband or partner (Finer, Frohworth, Dauphinee, Singh, & Moore, 2005).

In a British sample of 167 pregnant teenagers, pregnancy outcome was strongly associated with whether or not the girl was in a stable relationship (Pearson, Owens, Phillips, Gray, & Marshall, 1995). Only six of the sample had intended pregnancies. Those who decided on pregnancy termination were more likely to be single girls, younger, and to say they had wished to avoid getting pregnant. They were also condom users who more often learned about contraception from school rather than from health care professionals. Long term health consequences of elective pregnancy termination have been poorly investigated (Thorp, Harmann, & Shadiquian, 2003). More

investigation is needed for assessing life outcomes (Fergusson, Boden, & Horwood, 2007; Fergusson, Horwood, & Ridder, 2006).

Induced abortion has aspects of physical health consideration, as well as aspects of ethical, psychological, moral, or spiritual considerations. One review of the evidence used strict inclusion criteria and drew conclusions about findings of associated risks (Thorp et al., 2003). Associations with subsequent sub fertility, spontaneous abortion, or ectopic pregnancy were not found. Associations were found to be present and with increased risk for placenta previa, preterm delivery, and mood disorders substantial enough to provoke attempts at self harm. One conclusion was that informed consent before induced abortion should include information about subsequent risk of preterm delivery and depression.

One study of low-income women (N = 56,741) compared risk of psychiatric admission. Those with no psychiatric admissions or pregnancy events during the year before the target pregnancy were used and compared women who experienced abortions with women who carried their pregnancy to term. Women having had abortions had significantly higher relative risk of psychiatric admission, in both short and long term measurements. Major diagnostic categories including adjustment reactions, single episode or recurrent depressive psychosis, and bipolar disorder were significantly different (Reardon et al., 2003). The study has been criticized for the causal implication.

Another study from New Zealand (Fergusson, Horwood, & Boden, 2008) used a cohort study of 534 women to examine the links between pregnancy outcomes and mental health outcomes. After adjusting for confounding variables, abortion was associated with a small increase in the risk of mental disorders. Women having had

abortions had rates of mental disorders about thirty percent higher than those who had none. “After extensive adjustment for confounding, abortion was the only pregnancy outcome that was associated with consistent increases in risks of mental health problems” (Fergusson et al., 2008, p. 449).

A study comparing miscarriage versus induced abortion had comparison data from interviews at 10 days, 6 months, and 2 years following either miscarriage (N = 40) or induced abortion (N = 80). The short-term (at 10 days) emotional reactions to miscarriage were more powerful than those of abortion. In the long term (at 2 years), there was significantly more avoidance of thoughts and feelings related to the event of the induced abortion rather than that of miscarriage. Assessment used the Impact of Event Scale (Broen, Moum, Bödtker, & Ekeberg, 2004). There have been mixed findings regarding the psychological responses two years postabortion. Another study (Major et al., 2000) found that most women do not experience psychological problems or regret, but some do.

One Canadian retrospective age-matched study (N = 41,039) showed that postabortion health services utilization and hospitalization were higher in patient populations than in an age-matched cohort. Further, hospital day-surgery obtained abortions yielded higher risk for subsequent postabortion infection, surgical events, and psychiatric problems than did community clinic patients (Ostbye, Wenghofer, Woodward, Gold, & Carighead, 2001).

Another Canadian study compared 41,000 women who were three months post-induced-abortion with a similar sized comparison group without abortion. Women who had experienced induced abortions had five times more hospital admissions for

psychiatric problems than those who had not (Ostbye et al., 2001). In another study, a significantly higher risk of psychiatric admissions was found among lower-income women who had undergone induced abortions (Reardon et al., 2003).

Suicide rates after pregnancy was assessed in Finland. The rates associated with birth were significantly lower than rates associated with miscarriage or induced abortions (Gissler, Hemminki, & Lönnqvist, 1996). The suicide incidence of women having had an induced abortion was found to have a six fold increase compared with those having normal pregnancies. The rates tended to be higher among teenagers and those of lower social classes.

Intimate relationship quality and induced abortion were evaluated for associations (Coleman, Rue, & Coyle, 2009). Men and women who experienced an abortion in a previous relationship had negative outcomes in the current relationship. Experience of an abortion within a current relationship was associated with increased risk for various forms of sexual dysfunction, arguments about money, conflict and arguing about partner's relatives, jealousy, and conflict about drugs.

A systematic view of abortion and long-term mental health outcomes told a different story. In a review of twenty-one studies meeting inclusion criteria, studies with quality based methodological factors were systematically reviewed for findings (Charles, Polis, Stridhara, & Blum, 2008). The result was that those with highest quality had findings with mostly neutral differences. This suggested that few, if any, differences existed between those who had abortions and their comparison groups in terms of mental health sequelae. There is inconclusive evidence about whether pregnancy termination affects women's rate of depression.

In the United States, an estimate of repeated induced abortions is 48%, and in Canada, it is 35.5% (Fisher et al., 2005). In a Canadian survey of 1,145 women undergoing abortion (Fisher et al., 2005), 68.2% were seeing a first, 23.1% seeking a second, and 8.7% seeking a third or subsequent abortion. Significant findings included that increased age, history of physical abuse by a male partner, sexual abuse or violence, sexually transmitted disease, and being born outside Canada increased the odds of a repeat induced abortion. Women experiencing repeat induced abortions were considerably more likely to have experienced physical abuse by a male partner, or sexual abuse or coercion.

Because of the awareness of psychological problems associated with the procedure, increasing numbers of postabortion counseling services are becoming available through prolife (Project Rachel, n.d.; Rachel's Vineyard Ministries, n.d.), neutral ("Post Abortion Healing and Help," n.d.), and prochoice sources (Prochoice Postabortion Counseling Programs, n.d.). Induced abortion can "cast a shadow" that leaves a need to "become strong in the broken places." Acknowledgment of the psychological impact is being increasingly heard by authors such as Burke and Reardon (2002), DePuy and Dovitch (1997), and Wilke and Wilke (1997). On the topic of induced abortion, one physician summed up the existing need,

...more research is needed to explore these questions. Because the abortion debate is highly charged and clouded with ideological, political, religious and economic influences, it is sometimes difficult to objectively determine what is factual and credible scientific information and what represents sexual and philosophical ideology. The medical and academic communities are becoming aware that 'researcher neutrality' may well be an oxymoron (Genuis, 2003, p. 102).

Implications specific to nurses about pregnancy termination are limited. One qualitative study suggested that in taking obstetric histories, nurses and midwives are encouraged to give safe, nonjudgmental opportunities for women to reflect about their number of pregnancies and number of living children. This is especially needed when there are discrepancies between the two numbers (Trybulski, 2006).

Parenting the Infant Borne from an Unintended Pregnancy

Infants borne from an unintended pregnancy face greater risk. The risk is due to the circumstances surrounding the pregnancy, the decision making process about the pregnancy, and the possible delay of prenatal care due to indecision. Ongoing risk has not been consistently assessed.

In a United States study, 198 low-income, female-headed families enrolled in child protective services due to abuse or neglect were compared with an equal number of age-matched controls to determine if unplanned childbearing and family size increased the risk of neglect or abuse. Logistic regression analysis suggested that unplanned childbearing increased the risk of child abuse significantly but not risk of child neglect. Additionally, large family size significantly raised risk of both. Unplanned childbearing and subsequent parenting was said to be indirectly related to abuse through its effect in family size. A child from a family with two unplanned births was found to be 2.8 times more likely to have been abused than one from a family with no unplanned births. The likelihood rose to 4.6 in a family with three unplanned births (Zuravin, 1991).

In the past, the consequences of single motherhood were grave, including delayed and truncated education and social activities, unemployment, and role overload due to responsibility of caring for a child without the support of a spouse (Gerrard, McCann, &

Fortini, 1983). Currently, the consequences are less severe, and in some cases positive. Teen pregnancy and parenting remains a complex topic with ongoing need for further study (Spear, & Lock, 2003).

Most states do permit a minor parent to make health decisions on behalf of their children (Alan Guttmacher Institute, 2008a). This is generally in the best interest of their offspring. Minor parents are more likely to receive public assistance.

Adoption Placement of the Infant Borne from an Unintended Pregnancy

Adoption has undergone some fundamental shifting in approach of placement. This is particularly true of United States infant adoption in regard to openness. As one birth mother wrote, “adoption has had a bad history” having stories filled with pain (Dischler, 2006a). Currently there is an emphasis on some degree of openness in the process (Howard, 2005; Reamer & Siegel, 2007). Having openness in adoption affects the outcome (Askren & Bloom, 1999). Statistics and research in the past often do not apply to current adoption due to the openness shift and other societal changes. Since so little research has taken place about birth mothers beyond adoption placement, less is known about the effects of the placement upon the birthmothers. Many believe that openness in choice of adoptive parents and family eases the process for the birth mother (Ge et al., 2008; Grotevant & McRoy, 1998; Larsen, 2008). There can still be a grief or mourning experience (Askren & Bloom, 1999; Gritter, 2000), yet this *can* take place without regret of decision. Great satisfaction is possible with ongoing contact of members in the adoption triad (Siegel, 1993, 2003; Silber, & Dorner, 1989; Silber, & Speedlin, 1983; Waters, 2005; Webber, 2008).

The choice for adoption placement by adolescents has been studied. One dated study of 430 young women found that those who made adoption placements tended to be White, tended to be of more advantaged background, and tended to have a positive attitude toward adoption. They consistently reported that their choice would increase the likelihood of education and financial benefit for themselves; and that the child would likely benefit in emotional development. These young women were encouraged to make adoption placement plans by parents and boyfriend (Kalmuss, Namerow, & Cushman, 1991).

Comparison of Parenting versus Placing Infants Borne from Unintended Pregnancy

Studies have been conducted comparing outcomes of unintended pregnancy. These have had differing and inconclusive results. Since societal values and adoption practices have changed radically, the comparisons are dissimilar over time. Five studies are described here.

In a comparative study between adolescent mothers who placed their children for adoption (N = 146) and those who parented (N = 123), *relinquishers* were more likely to complete vocational training, delay marriage, avoid a rapid subsequent pregnancy, be employed after birth, and live in higher income households. Several measures of self-esteem, satisfaction with life, and satisfaction with the decision resulted in few differences (McLaughlin, Pearce, Manninen, & Winges, 1988).

A second study assessed the short term consequences of parenting versus placing. Logistic regression results revealed that *placers* (N = 216) were less comfortable with their decision, fared better on sociodemographic outcomes, and were indistinguishable

from parenters (N = 311) on social psychological outcomes (Kalmuss, Namerow, & Bauer, 1992).

Another study on the same topic found that over a 24 month period after childbirth, multivariate analyses with control for differences indicated that placers are somewhat more likely to express regret over their parenting decision. They had higher levels of socioeconomic status, engaged in less sexual risk-taking behaviors, and had no significant differences in depression or personal efficacy (Donnelly, & Voydanoff, 1996).

A fourth longitudinal study (Winges, Barnes, Rader, Grady, & Manninen, 1998) found that of the 116 parenters and 76 placers, relinquishers were more likely to remain single, avoid a second childbirth throughout the five years after their first. The groups did not differ in educational attainment, psychological measures of well being, or earnings. Relinquishers were more likely to be employed.

A fifth study assessed placing and parenting nonmarital teenagers for sociodemographic and social psychological outcomes at four years postbirth (Namerow & Kalmuss, 1997). Virtually every outcome demonstrated significantly improved parameters for placers than parenters. The only exception was in feelings about the pregnancy resolution decision. Findings were explained, however, by varying marital, fertility, and welfare experiences since birth of the child.

Summary of Outcomes of Unintended Adolescent Pregnancy and Birth

The outcome decisions of unintended adolescent pregnancy and birth are forged with stress, include loss, and may result in differing levels of resolve or contentment with the plan. Outcomes that have been reviewed include pregnancy loss (not under the adolescent's volition), termination, parenting the child of an unintended pregnancy, and

placing the infant for adoption. Each of the pregnancy or parenting outcomes will yield differences in the lives of those carrying the pregnancy. The topics of crisis pregnancy and adoption are overviewed below.

Crisis Pregnancy

Unintended pregnancy may also be a crisis pregnancy. The difference is the crisis nature to the birth mother. A pregnancy that was not planned holds co-occurring factors that lead the mother to perceive the pregnancy as a crisis. They may state that they were too young, did not want the baby, or had relationship challenges with either the family of origin or birth father. Intimate partner violence can often be a precursor to crisis pregnancy. Date rape drugs may lead to a crisis pregnancy. Impaired judgment due to substance use may lead to a crisis pregnancy. Other reasons a pregnancy may be considered a crisis include fear of family reaction or medical difficulties.

Research in Ireland (none similar found in the United States) explains factors that contribute to this crisis nature and have to do in part by correct and consistent use or misuse of contraception. Contraception use was affected by knowledge level, personal belief systems, lack of self-confidence, and lack of knowledge of fertility or sexual health services. When a pregnancy was unplanned with contraception attempts, it was a crisis pregnancy. Other aspects explaining the crisis nature included relationship status, socioeconomic status, and use of substance that influenced unplanned and crisis pregnancy (Crisis Pregnancy Agency, 2005).

When the pregnancy occurred, the process of resolution is influenced by support of partners, mothers, friends, other family members, and counselors. Women with little or no support found counseling to be a vital source of support and information. In Ireland,

about one fourth of those in crisis pregnancy use a counseling service for coping with the stress, decision making, information on options, and practical help once the decisions were made. Research findings showed that once a woman made the choice to parent or have the baby adopted, they were less likely to attend counseling than those considering abortion (Crisis Pregnancy Agency, 2005).

Adoption

According to a national attitudinal survey of adults (N = 1,554) (Evan B. Donaldson Adoption Institute [EBDAI], 1997), six out of ten people in the United States are directly (own family) or indirectly (friend) affected by adoption. Virtually all Americans believe that adoption serves a useful purpose. Opinions tend to be in three groups: full supporters who have unqualified support of adoption; qualified supporters who have some hesitancy to fully embrace, but have generally supportive views; and marginal supporters who are more supportive than not but less convinced of adoption's merits ("Benchmark Adoption Survey," 1997). Less educated Americans are more skeptical about adoption. Men are more uncertain of its merits. Blacks Americans are more skeptical than Whites. Even with the move toward openness in adoption, most adults in the survey were hesitant about open adoption. Sixteen percent said open adoption is a good idea in most cases. Forty percent think it is a good idea in some cases, 23% said seldom, and 19% never a good idea (EBDAI, 1997, p. 26).

Of birth parents' placement decisions, many Americans are supportive, but not all. A notable minority disapproves, and some view placement as irresponsible or hardhearted. In regard to pregnant teenagers, Americans are divided about what is better

for the child. Slightly more believe the baby is better off adopted than being raised by the birth mother (EBDAI, 1997).

One qualitative study explored why adoption is so rarely considered by unmarried pregnant teens (Custer, 1993). Four phenomena were pivotal to the decision: societal sanctions, low level of knowledge, anticipated psychological discomfort, and lack of support from helping professionals. Though rare, adoption permeates our society. Yet, birth mothers are a relatively unknown group.

Descriptions and Statistics

No one agency is charged with collecting data on adoptions (Child Welfare Information Gateway [CWIG], 2004a). The problem has been known for decades (Stolley, 1993). Adoption statistics have had an interesting mix of findings. On the one hand, books such as Pertman's *Adoption Nation* (2000) report that as many as 100 million people in the United States have adoption within their immediate families, representing a third of the nation (Pertman, 2000; Wolfgram, 2008). On the other hand, formal adoption statistics identify the percentages to be below 3% of the United States population.

Statistics show adoption to remain fairly rare (Jones, 2008). In 2002 1.1% of women and 2.3% of men 18–44 years of age had adopted a child. This was the first time that national estimates of adoption accounted for *all women*, not just *ever-married women*. There were about 1 million women seeking to adopt children in 2002 and a dwindling domestic number of infants relinquished at birth through one month of age (Jones, 2008). Male adoption is primarily increased due to marriage with women who already had children.

The source of adoptions is no longer dominated by private agency or kinship adoptions. Public and intercountry adoptions now account for over half of all adoptions (CWIG, 2004a). The statistics about adoption, however, are not consistently obtained. Intercountry adoptions are well accounted (U.S. HHS, n.d.). Private and kinship adoptions are not clearly gathered or nationally documented.

Adoption appears to be a method of formalizing and solidifying step parenting relationships with stepchildren. More men than women adopted in 2002, reflecting men's adoption of step children. More men who had fathered a child adopted than those who had not been a father before. Three times as many women and men who were in second or later marriages adopted compared with those in first marriages. Women who have not given birth to a child are significantly more likely to adopt than those who have had one or more births. This pattern suggests that for women, adoption is a means of bringing a child into their homes (Jones, 2008).

Census 2000 is the most complete data source on the characteristics of adopted children (Kreider, 2003). In that year, 1.6 million adopted children of the householder were under age 18. This means that 2.5 percent of all children of the householder under 18 years of age were adopted. Adoption takes place in about the same proportion across states (Kreider, 2003).

White adopted children under 18 made up 58% of the adopted children with 16% Black, 14% Hispanic, 7.4% Asian, and 1.6% American Indian and Alaska Native (Kreider, 2003). Of all the states, Alaska had the highest percent of adopted children with 3.9% (United States Census Bureau, 2004). Thirteen percent of adopted children in 2000 were foreign born, with nearly half from Asia, about a third from Latin America, and

about one-sixth were European. Informal adoption is more common among Blacks, Hispanics, and Inupiaq communities in Alaska (Kreider, 2003; Massiah, 2005). Of the adoptive parents, 76% are White, 15% are Black, 9% are Hispanic, 4% are other race, 2% are two or more races, 2% are Asian, and 1% are American Indian and Alaska Native (Kreider, 2003). Among Black teenagers, there are additional barriers to adoption as a pregnancy resolution strategy (Kalmuss, 1992).

Forty states permit minor parents to place a child for adoption. This includes those that explicitly account for minor parents and for those that make no distinction between minor and adult parents. Ten states require an adult to be involved in the adoption process to some degree: 5 states require legal counsel or court appointed counsel, 4 states require parental consent for placement, and 1 state requires parental notification of placement (Alan Guttmacher Institute, 2008a).

All fifty states have legalized infant relinquishment up to specified ages. Safe surrender measures have been included in state laws beginning with Texas in 1999. These preserve anonymity of the relinquishing person and usually involve either authorized emergency services, health care providers, or other organizations such as adoption agencies (Alan Guttmacher Institute, 2008a). Safe Haven laws have provided for over 1,000 adoptions in 36 states and 48 states have these laws (Atwood, 2008).

The study of relinquishment, or of making adoption plans, is hampered by limitations (CWIG, 2005). The relatively small number of adoptions makes generalization difficult. Self-selection may lead to bias in quantitative studies. Also very little literature addresses birth fathers.

Type of Adoption

Many types of adoption exist (Henry & Pollack, 2008; Lyons-Dean, 2003; UMass Medical School Center for Adoption Research [UMMS], n.d.). *Formal adoptions* follow a specific, legally prescribed method in the United States. *Informal adoptions* are less studied because they commonly involve a family member or friend simply taking over the care of a child. *International adoptions* have a more detailed process because they involve state and national laws as well as regulations and laws of the country of origin. *Transracial adoptions* have been singled out in the past, but now are handled in a similar manner as same-race or in some cases as international adoptions. *Foster to adoption* types have their own process whereby potentially adoptive parents become foster parents first and then have options to formalize an adoption. *Adoptions of special needs infants and children* also have unique considerations that affect the process. *Kinship adoptions* have to do with extended family members parenting a child, but arrangements may become *formal* with a legal adoption taking place through the court system or *informal* with no legal process. *Tribal adoptions* of American Indians have their own process and laws.

Formal adoptions may be facilitated through state services, private attorneys who conduct adoptions, or through adoption agencies. Crisis pregnancy service organizations may offer the person experiencing an unintended pregnancy a variety of options for pregnancy outcome. This may include adoption services as part of the organization or may include referral to other organizations that provide adoption services.

Openness in Adoption

Confidential or Closed Adoption

For many years in the United States, confidential adoption was the only option. The method was designed to protect all parties to ensure birth parent's right to privacy, to shield unwed mothers from revealing an "illegitimate" child, to protect adopted children from social ridicule, and to protect adoptive parents from the humiliation of being infertile (Baran & Pannor, 1990; Bussiere, 1998; Ge et al., 2008). A confidential or closed adoption is when minimal or no information is shared between adoptive and birth family members. If any information is transmitted, it is done so through a mediated approach with agency or attorney and stops with the adoptive placement. Records are sealed permanently or until the child reaches adulthood. Contact is not maintained and searching for a birth parent can be nearly impossible.

One qualitative study from Ireland (Kelly, 2009) assessed 18 birth mothers who relinquished in closed adoptions from 1956 to 1979 and who were later reunited with adult birth children. Shame, guilt, embarrassment; fear and upset over the out of wedlock pregnancy; secrecy and coercion with placement were common. It was a "motherhood silenced." While birth mothers were glad for the "friendship-like" relationships now, they were sad for the years lost. There was disempowerment, erratic contact patterns, and unrealistic expectations. This type of closed adoption experience was similar to that in America during that time. Adoption experiences have changed greatly over recent decades.

Those in favor of confidential adoption believed it to be in the best interest of everyone involved and the best method for allowing the child and birth parents a fresh

start without stigma. Several unexpected costs emerged out of research, personal accounts, and case histories regarding the long-term impact of closed adoption. Loss and grief, lack of knowing about ancestors or offspring, and loss of access to vital information were part of the costs. The separation of closed adoption was found to avert resolution of losses (Melina & Roszia, 1993). As one international adoption worker explained, it is not a matter of putting the pieces together, but that pieces are missing.

Mediated Adoption

Mediated adoption is when an agency or other personnel serve as intermediary go-betweens. Typically, shared information is nonidentifying and is shared between parties through agency personnel. Sharing may include some medical history information, exchange of letters, pictures, gifts, or infrequent meetings. Sometimes mediated adoptions are time limited, and sometimes they are ongoing for as long as the agency remains in existence.

Proponents of mediated agency adoption tend to have a philosophy that adoption is a service to the child. The goal is to find parents for a child, not a child for parents (Emery, 1993). This view places the child at the center of the adoption triad. There are other agencies that keep the child as a focus but place emphasis and support toward the birth parent, believing that greater birth parent decision resolution will enhance the child's adoption. Some agencies work to support the postadoption contact plan (Neil, 2002). One study found high levels of compliance and satisfaction with postadoption contact at 4.5 years postplacement (Etter, 1993).

Open Adoption

Open, or fully disclosed adoption is when identifying and ongoing information as well as contact information is shared among members of the adoption triad. Open adoption has been defined differently in different studies and agencies. The level of openness in an open adoption can be viewed as differing points on a continuum (Fratter, 1996) from initial disclosure of identifying information to fully disclosed openness with direct contact and meetings. These meetings may be in public places or homes. Openness may include medical information, phone calls, email, letters, pictures, and face-to-face gatherings. Adoptions may have initial openness and then none, or ongoing openness that builds lasting relationships between triad members. Generally fully disclosed adoptions have the birth and adoptive family in charge of the amount of contact that is comfortable to the triad. The family members interact in ways that feel most comfortable to them (CWIG, 2003). Also, decisions for the amount of contact with the child are determined by the adoption triad. The adoptive agency may have influence into the decisions but not necessarily authority. The degree of openness varies widely (Grotevant & McRoy, 1998; Grotevant, Perry, & McRoy, 2005). Baran and Pannor (1990) describe the historical transitions regarding early openness in adoption practice.

There have been mixed results in research over time having to do with openness. For example, Berry (1991, 1993) found that adoptive parents had high levels of satisfaction with adoption when their initial adoption plan was open and their experience was consistent with that plan. This was in a survey of adoptive parents in California (N = 1,396). In a second study that was prospective (N = 764), openness was not a significant predictor of satisfaction and adjustment among adoptive parents at four years

postplacement (Berry, Dylia, Barth, & Needell, 1998). In the past, this empirical support has been mixed in outcome results. Another example was that Blanton and Deschner (1990) found that birth mothers of open adoption experienced a more intense grief reaction at one to five years postplacement than those of confidential adoption. Caution was given in interpreting findings. It was unclear if the significant differences reflected adaptive healthy or inhibited, unhealthy grieving. The sample size of birth mothers was 18 in open adoptions versus 41 in confidential adoptions.

There is a growing body of empirical research offering benefits of structural and communicative openness in adoption (Jones & Hackett, 2007; Sobol, Daly, & Kelloway, 2000). The research evidence is not conclusive regarding the best level of openness (Brodzinsky, 2006; Grotevant & McRoy, 1998), but openness has demonstrated benefits.

One of the most compelling recent studies is that of Ge and associates (2008). Three hundred and twenty three matched parties of birth mothers and adoptive parents from the Early Growth and Development Study have been assessed for openness in adoption. This sample represented ten states and came from thirty three agencies. Openness was assessed by multiple informants and significantly related to satisfaction with adoption process among both adoptive parents and birth mothers ($p < .01$). Openness was positively associated with birth mother's postplacement adjustment by both self report and interviewer impression ($p < .01$). Additionally in the study, 112 birth fathers were assessed also about openness in adoption. Birth fathers also had a positive association between openness with their adjustment and satisfaction. These significant associations of openness with satisfaction and with postadoption adjustment demonstrate

substantial evidence in support for the practice of open adoption. This longitudinal, multisite study report represents the first wave of findings with more to follow.

The academic and practice literature is clearly supportive of communicative openness. Benefits of openness include increased empathy and understanding between adoptive parents and birth families (Grotevant & McRoy, 1998), improved communication and relationships between adoptive parents and their adopted children (Berge, Mendenhall, Wrobel, Grotevant, & McRoy, 2006; Grotevant & McRoy, 1998), enhanced identity formation for adopted children (Howe & Feast, 2000; Silber & Dorner, 1989), and higher satisfaction with the adoption by the adoptee into adulthood (Howe & Feast, 2000; Raynor, 1980).

One benefit of openness is that it has a “healing effect” on the birth mother to see the child happy (Grotevant & McRoy, 1998, p. 149; Larsen, 2008). Subsequent children of birth mothers indicated a desire for more contact, direct contact, or more information about the child who had been placed for adoption as reported in one study (N = 94 birth mothers about their children) (Henney, Ayers-Lopez, Mack, McRoy, & Grotevant, 2007).

Another benefit is to the adoptive family. In a national study on openness in adoption, adoptive parents and their now adolescent adopted children reported on their contact with birth mothers. Those with contact reported having higher levels of satisfaction about their openness arrangements. They also experienced more positive feelings about the birth mother. They possessed more factual and personal knowledge about the birth mother than did those without contact. Adolescents and adoptive mothers who continued contact had the greatest satisfaction with their arrangement. Less than 1% of the entire sample (177 families) desired less contact (Grotevant et al., 2007). This type

of satisfaction has been evident with international adoptions that have become open (Howard, 2007; Larsen, 2008).

Other studies indicate that adopted children appreciate contact (Hawkins et al., 2007). Open communication between parents and adopted children about birth parents can enhance well-being (Brodzinsky, 2006; Howard, 2007; Lambe, 2006).

Communication between birth and adoptive families can also hold challenges for adoptive families (Jones & Hackett, 2007; Wrobel, Kohler, Grotevant, & McRoy, 1998).

A particular aspect of importance that was identified was face-to-face meetings. One study showed that the level of satisfaction and comfort with contact after placement was higher if there was a preadoptive meeting (Berry, 1993). Other studies also have found increase in satisfaction levels with openness (Gross, 1993). Melina and Roszia (1993) developed an extensive overview of the open adoption experience that covers open adoption from the beginning point, through the adoption process, and through a child's growing years. Caplan (1990) has done the same in story form. Davidson and Wolff (2004) share a probing dialog of the many aspects of open adoption between birth and adoptive mothers, along with a listing of open adoption resources.

Access to Adoptive Services and its Impact on Type of Adoption

Birth mothers' access to care after identification of an unintended pregnancy has several influencing elements. First, their family of origin's viewpoint and reaction to the pregnancy influence the outcome of the pregnancy toward or away from adoption. Second, the pregnant person's access to types of care is influenced by how the access takes place. Third, the type of guidance given influences the choice of outcome. Once

chosen, the influence of experience depends upon the level of openness, the types of support, and the responses of each of the adoption triad.

The pregnant teen's parents, and particularly mothers, have a strongly influential position. Partners and peers, as well as adult and health care support systems, can also influence outcomes (Manlove et al., 2002; Moore et al., 1995). Some birth mothers will seek help by looking in the telephone book. This explains advertisements saying things like, "Pregnant? Worried? Call us." The type of organization can be one that influences toward or away from abortion, parenting, or adoption placement. It may also be a public health service, private agency, or private attorney. Organizations vary widely when it comes to support following the receiving of services. There is no typical scenario for how much support a birth family receives pre- or postadoption placement (McClain, 2008).

One study revealed that an agency's philosophy of adoption, including openness, influences the choice of agency by birth families. In the study, 64 percent of birth mothers and 60 percent of birth fathers selected an agency based on information from a packet, its website, a meeting, or a phone call. Counseling, meeting other birth parents, or a support group were important factors (McClain, 2008).

Some birth mothers wait until they access prenatal care. Adoption or abortion may be decided at the point of care. Care providers may be sought for advice and referral. Referral options may be limited in numbers, depending upon the knowledge of the provider. Health care providers tend to refer more often to public services than to private adoption services.

Some birth mothers wait until the point of labor and delivery to decide about adoption. At this point, hospital social services may be called upon to connect resources.

Depending on the desires of the birth mother, choices may include private adoption through lawyer or agency, or more likely, public assistance through the Department of Human Services. Nurses, physicians, and social workers are instrumental in hospital initiated referral decisions.

Adolescents can be under informed regarding options. Adolescent desires may be unacknowledged by overarching viewpoints of parents or health care providers. Depending upon the timing and type of referral request, unintended pregnancy outcomes vary widely.

In current practice, trends for the level of openness continue to lean toward increasing openness. A study of international history of adoption led to the recommendation that a balanced adoption disclosure system be encouraged as an alternative to formerly sealed adoptions (Carp, 2007). This advocacy for greater openness in adoption records is known as the adoption reform movement.

Barriers to Adoption

Barriers to adoption include low knowledge levels and lack of support from helping professions (Custer, 1993). One study revealed that 60% of pregnancy counselors did not mention adoption. Of those who did mention it, 40% gave inaccurate information (Henman, 2005; Mech, 1984). When accurate adoption information was given, an increase of 19% was seen in the making of adoption plans (Mech, 1984). Many disciplines have been silent about adoption without publication, research, or adoption oriented practitioners (Custer, 1993; Mech, 1984, 1986; Resnick, 1984; Zamostny, Wiley, O'Brien, Lee, & Braden, 2003). Many professionals could improve in the language of adoption, as is suggested by Henman (2005) and exemplified by resources such as one

highlighting adoption friendly language (“Positive Adoption Language,” 1992). Some disciplines have attempted to improve professional information about adoption (Borchers, 2003; Rushton, 2007).

Pregnant teenagers, as well, rarely consider (Custer, 1993) or even know about adoption options. Certain culture groups have a belief that “taking care of your own” does not include making adoption plans. Some have an aversion to the practice (Princeton Survey Research Associates, 1997, p. 26).

Only a very small percentage of birth fathers historically have taken an active part in decisions surrounding adoption (Baumann, 1999). This is changing, with some agencies reporting that a quarter or more of the relinquishments have included active involvement from the birth father (Freundlich, 1998). Community attitudes toward birth father responsibilities are varied and not always supportive (Miall & March, 2005a). Birth father needs and experiences have only recently been considered (Clapton, 2007; Ge et al., 2008; Passmore & Chipuer, 2009).

Societal sanctions played more of a role in previous decades, but they still influence the experience of adoption placement. The functioning and viewpoints of the family of origin, as well as partner and peer views, can bring anticipated psychological discomfort. Sometimes, however, harmony of viewpoint occurs and brings a smooth, supportive transition to the process of adoption placement.

Benefits to Adoption

Adoption holds a valuable option for enhanced quality of life without cutting birth mothers’ own childhood short. Open adoption holds opportunity for ongoing connection so that questions can be answered as they arise, and meaningful relationships can be

developed (Davidson, 2004; Guibault, 2006; Kassof, 2008; Sonogo, 2006). Most recent evidence reveals the advantages of openness (Ge et al., 2008; Sobol et al., 2000). Birth mothers can continue their lives, while knowing that their birth child is receiving love and is being raised in a stable home (as screened by themselves and through agency or state requirements for adoptive parents). Birth mothers can avoid teen parenthood.

Adopted children receive love and provision in a way that birth mothers, at the time of birth, felt they could not provide. Adoptive parents have typically experienced a period of infertility and have completed state required home studies. They are commonly of higher income levels and age when they become parents to an adopted child, and they are fulfilled by becoming parents. Romanchik (2003, p. 29) sums up the benefits of open adoption: “The true gift of open adoption, then, is not only the gift of the adoptive family, but the relationship that the adoptive parents and birth parents create to benefit the child—a relationship where all roles are honored and where the child’s needs come first.”

Compared to long-term foster care of children whose birth parents’ rights have been terminated, adoption costs about half as much as foster care. Additionally, some believe that in the United States, each dollar spent on the adoption of a child from foster care yields between two and three dollars in benefit to society (Hansen, 2007). Adoption also offers adoptees higher levels of emotional security, belonging, and well being (Baran & Pannor, 1993; Hansen, 2007; Triseliotis, 2002). Other favorable measures of psychological adjustment have been identified (Baran & Pannor, 1993; Rushton, 2004). In an analysis of the Multistate Foster Care Data Archive, a projected trend is that the rates of adoption from foster care will continue to rise through 2020 (Wulczyn & Hislop, 2002).

When accurate adoption information was given to those experiencing unintended pregnancy, there was an increase in choice of adoption plans by 19 percent (Mech, 1948). The federal Infant Adoption Awareness Act of 2000 was created to train health care providers to counsel women with unintended pregnancy on an equal basis with other courses of action. There has been a national dispersion of courses to sensitize professionals toward the option (“Project Abstract,” n.d.).

Benefits to the offspring are many and varied. In a meta-analysis of 62 studies (N = 17,767), adopted children scored higher on IQ and better in school performance than children who remained in institutional care or with birth families. When compared with nonadopted environmental peers or siblings, IQ did not differ, but school performance and language abilities did lag with more adoptive children developing learning problems. Even with lags and learning problems compared to environmental peers, taken together, this analysis documents the positive impact of adoption on children’s cognitive development (Van Ijzendoorn, Juffer, & Poelhuis, 2005). Adoption improves an array of health outcomes. Adopted children are less likely to become teen parents, to abuse alcohol or other substances, and to become incarcerated, than those in foster care or with birth families (Hansen, 2007).

The Adoption Triad

The adoption triad is a term that refers to the adopted child, adoptive parents, and birth parents. All three are important for successful adoption placements. Adoption finalization ends any legal rights of the birth parents to the birth child. Relationships of trust are developed and may even be formalized by adoption agencies. These

relationships between birth parents and adoptive families are not legally binding, but there can be a long term impact if trust agreements are not kept (Enborg, 2004).

Adoptees

The majority of research that exists on adoption has to do with the adjustment of adoptees (Brodzinsky, Schechter, & Henig, 1992; Hushion, Sherman, & Siskind, 2006; Passmore & Chipuer, 2009). Adoptees can be the initiators of searches that can cause formerly closed adoptions to become open (Dischler, 2006b). Loss and grief, self-esteem, identity, intimacy, genetic information, and managing issues of adoption are aspects important to adoptees (CWIG, 2004b; Silverstein & Kaplan, n.d.). In one study, clinicians in private and public outpatient and residential treatment settings had a disproportionately high number of children who had been adopted (Grotevant & McRoy, 1998). Yet, in a survey of 156 adult adoptees, only 12% reported seeking professional help during adolescence or adulthood for adoption related issues. They did, however seek help from friends, family, and support groups (Pearson, Curtis, & Chapman, 2007). Adjustment outcomes having to do with confidential adoption have been studied for decades (Peters, Atkins, & McKay, 1990) but that is not the focus of this dissertation. Adoption reunions have varied outcomes (March, 1997), but reunions after confidential or mediated adoption are different from contact in open adoption. In a study of young adoptees (mean age 7.99), openness did not confuse the child about the meaning of adoption or lower their self esteem (Wrobel, Ayers-Lopez, Grotevant, McRoy, & Friedrich, 1996). As one author poignantly shared, “If children can figure it out, so can the rest of us” (Gritter, 2000, p. 8). In a study of children comparing face-to-face contact with letter-only contact

with birth family, children's communicative openness was assessed. It was increased in children who had face-to-face contact (Neil, 2009a).

The importance of adoptive parent empathy toward the birth family of origin has been demonstrated (Brodzinsky, 2005, 2006; Biernat, 2004; Brodzinsky et al., 1992). Outcomes for adoptees of open adoption is emerging more recently, but appears to be generally favorable for the health and development of children. The Minnesota–Texas Adoption Research Project [MTARP] study (n.d.), one of the first multistate studies on adoption, revealed that children's level of curiosity about birth families did not differ by level of openness (Wrobel et al., 1996). One major finding of the MTARP study was that higher degrees of collaboration between adoptive and birth family members were associated with better adjustment during middle childhood (Grotevant, Ross, Marchel, & McRoy, 1999). In childhood, self esteem levels were normal according to a standardized test. In adolescence, the sample was no different from the national norms in levels of adjustment (Grotevant & McRoy, 1998; Grotevant, Perry, & McRoy, 2005), and openness was not a major predictor of adjustment outcome. Adopted children have need for making meaning of their personal story of their birth family, of their adoptive identity, and for creating their own life story. Four patterns of adoptive identity during adolescence were recognized and older adolescents demonstrated more positively resolved patterns than younger adolescents (MTARP, n.d.).

A majority of adolescent adoptees at age 15 seem to want contact with birth relatives, yet they still had difficulties talking about adoption (Hawkins et al., 2007). They were somewhat less likely than at age 11 to want contact. They were more able to discuss adoption than they were at age 11. One author identified life-transforming

choices that are important and specific to adoptees (Eldridge, 2003), and another highlighted issues that are faced (Schooler, 1995). Baden and Wiley (2007) developed an extensive review about counseling adopted persons in adulthood.

Adoptive Parents and Families

Adoptive families have many complex realities (Daniluk & Hurtig-Mitchell, 2003; Lathrop, 1998; Leon, 2002; Pavao, 2005). Adoption continues to be an avenue used by couples, and to a lesser degree singles, for family formation. It is only one facet of nonbiological childrearing. Currently the 35–39 year old age group is highest in taking steps to adopt (Jones, 2008).

In a review of 38 research studies about the adoptive family, several positive and few negative outcomes were shown. Adoptive families were satisfied with the adoption. Family functioning as well as parent-child communication was favorable, and the adoptive families were resilient (O'Brien & Zamostny, 2003).

In regard to openness, adoptive parents tended to be fearful or apprehensive about open adoption, but once experiencing disclosure, became more positive. Results of the study findings on openness were described as “overwhelmingly positive” (Siegel, 1993). The seven year follow up of this longitudinal, qualitative descriptive study revealed lasting positive findings with none of the “dire outcomes” predicted by some. In fact many parents felt more enthusiasm for, and comfort with, open adoption after seven years of successful experience. They felt empowered, without having feelings of intrusion. Further, they wanted more, not less, contact which is consistent with other studies (Gritter, 1997; Silber & Dorner, 1989). Open adoptions were shown to change in frequency and type of contact over time (Dorner, 1998). Open adoption in the study was

viewed by participants as a lifelong process. Public skepticism was pointed out by parents of children in open adoptions, as being something families regularly faced (Siegel, 2003). Adoption continues to be viewed as a lifelong process that changes over time (Melina & Roszia, 1993, 2004).

In a longitudinal study of over 700 adoptions by nonfoster parents, openness over time diminished in contact frequency at the 4 year postplacement time (Berry et al., 1998). Satisfaction levels with the adoption remain high. Other measures of adjustment remain positive. The study is ongoing.

The MTARP study (n.d.) found that those in fully disclosed adoptions reported higher levels of acknowledgment of the adoption, more empathy toward birth parents, and toward their child, a stronger sense of permanence in the relationship, and less fear of the birth mother's trying to reclaim her child (Grotevant, McRoy, Elde, & Fravel, 1994). This is consistent with Sykes findings that contact led to increased empathy and more positive stories about the past (Sykes, 2000).

Additional aspects of the importance of contact to adoptive families in open adoption include issues of contact arrangements, role and boundary clarity, and planning for times of contact (Wolfgram, 2008). Adoptive parents play a pivotal role in communication and adjustment patterns with adopted children (Freeark, Rosenblum, Hus, & Root, 2008). There is an "intricate interplay" of communication. Particularly, adoptive mothers are in a key role and tend to be more involved in contact with the birth mother (Dunbar et al., 2006).

Birth Parents

The majority of birth parents are between 22 and 30 years of age, yet slightly more than one-third are 21 or younger (McClain, 2008). In one study of birth parents, the biggest unifying factor was economic disadvantage. Eighty nine percent of birth mothers and 65 percent of birth fathers had annual gross personal incomes that were less than \$20,000 (McClain, 2008). Low income is the primary reason for adoption placement in the United States and worldwide.

Birth Fathers

Birth fathers have been largely neglected until recently (Clapton, 2007; Freundlich, 1998; Passmore & Chipuer, 2009). Socially they become unknown, because once adoption placement is made, they are not legally sought for child support, as when biological mothers file for support. The adoption process is legally becoming more sensitive to birth fathers, with increasing rights prior to adoption placement. In open adoption, birth fathers are becoming a more present reality (Mason, 1995). Few studies have looked specifically at birth fathers but some are emerging (Baumann, 1999; Clapton, 2007; Passmore & Chipuer, 2009). Birth fathers' report of openness was positively associated with greater satisfaction with the process and better postadoption adjustment (N = 112) (Ge et al., 2008).

Birth Mothers

Long term postrelinquishment findings for birth mothers of closed adoptions can be quite negative for up to a third of birth mothers (Logan, 1996). Areas of concern focus on depression, grief, failure to mourn, suffering, guilt and secrecy related to the adoption. Mental illness and psychiatric treatment have been part of the postplacement experience.

Lack of support from families and agencies has compounded the feelings of isolation and the suppression of feelings and memories. These issues poignantly depict the need for postplacement support of birth mothers. While most birth mothers grieve the loss of their role as primary parents (CWIG, 2006), studies and case examples are beginning to show the experience of grief with birth mothers is different in open adoption compared with closed adoption (Mantell, 2008; Webber, 2008).

Birth mothers in the MTARP study (n.d.) took the Brief Symptom Inventory for mental health. These scores were not related to the level of adoption openness. The MTARP did demonstrate that birth mothers in fully disclosed adoptions had lower adoption-related grief and loss symptoms than those in confidential adoption. Also, as satisfaction with openness increased, birthmothers' current global level of grief decreased. Another finding was that birth mothers in fully disclosed adoptions expressed more satisfaction with the adoption than those in confidential or mediated arrangements.

Though there is no typical profile of a birth mother of open adoption, there is a range of characteristics. One therapist who counseled open adoption birth mothers estimated that the majority of birth mothers over the past 15 years ranged from 15 to 25 years of age and had pregnancies that were the result of sexually active relationships that lasted only a few months (Waters, 2005). Commonly the boyfriends broke up with the birth mother after discovery of pregnancy. Nearly all birth mothers refused abortions due to their own belief system, but they typically had parents, birth fathers, family members or friends who encouraged abortion as the "easiest answer." Their living arrangements may be the home of origin that may be troubled with alcoholism, emotional abuse, or emotional neglect. There may be parental patterns of avoiding or numbing emotional

issues without addressing needs. This is especially true with fathers, thus leaving birth mothers needy of male attention. Yet many birth mothers may be from homes of no significant level of dysfunction. Birth mothers may be living independently, or they may be receiving assistance from others. The majority of birth mothers are looking for love and emotional attachment, but the relationships may not be healthy.

At the time of decision for sex, alcohol is typically involved, that blurs judgment or the ability to hold boundaries. “It just happens!” is another common reason given for sexual contact (Waters, 2005). Commonly, those who have become pregnant, according to Waters, are dealing with several other issues such as “...addiction, codependency, physical, sexual, or emotional abuse, ADD/ADHD, learning disabilities, spiritual bankruptcy, depression, bipolar disorders, anxiety disorders, low self-esteem, unforgiveness, and homelessness to name just a few” (Walters, 2005, p. 7).

Historical Overview

Adoption’s history is important to the current practice, and will now be reviewed. This overview highlights typical patters of the period as well as critical junctures that changed practice. Current practice is reviewed in a separate section. Zamostny, O’Brien, Baden, and Wiley (2003) have written an extensive overview of the historical trends. Their overview draws from many adoption sources and provides trend information. Sokoloff (1993) provides a history dating back to the ancient civilizations. Kahan (2006) presents a detailed history that identifies how the term *put up for adoption* came about during the orphan trains in the 1850s. Sotiropoulos, (2008) presented a review that is especially attentive to African American birth mothers.

This review begins in the 1700s, in the United States, where there was informal child transfer. This transfer was open, without any secrecy. With the industrial revolution and vast immigration influx, *orphan trains* began in the mid 1800s. These trains started in the East and carried orphans from orphanages or the streets on trains out West to be cared for by farm families. Orphan trains ran between 1854 and 1929 (Meiser & Velen, 2003). The children were “put up” on platforms before the farmers who would choose their children (Kahan, 2006). Foundling homes were established in urban areas to care for dependent children. Additionally, older child adoptions were typical (Zamostny, O’Brien, et al., 2003). The first American adoption statute was established in 1851 in Massachusetts (UMMS, 2006).

Early 1900s

Adoption at the turn of the century had many characteristics of openness (Goodman, Emery, & Haugaard, 1998). It was more kinship in nature, where extended family members would take over the care of a child. Children were critical to family livelihood and would work the farms with other family members in rural settings. When illness and death changed a family, informal arrangements were made with next of kin or *kith* (nonrelative but family-like relationship) (Wolfgram, 2008). African American communities have functioned in this manner until present (Dutt & Sanyal, 1991; Gibson, Nelson-Christinedaughter, Grotevant, & Kwon, 2005; Manning, 2001). In 1917 a Minnesota statute began to seal adoption (Zamostny, O’Brien, et al., 2003). In 1926 the New York Court of Appeals ruled that an adoption agency was not compelled to give out contact information of adoptive parents because “secrecy is the foundation underlying all adoptions.” Within twenty years most states were sealing original birth certificates (Reitz,

1999). Record closure and secrecy for “protection” was prominent in the 1930s through the 1950s (Meiser & Velen, 2003).

1940s

Secrecy continued with widespread sealing of adoption records. Intending to improve adoption practices so that adopted children would not be considered second-class citizens, birth mothers would “move on with their lives” after closing the door to any identifying link with that child. The adopted child was thought to do better if there was no knowledge of the adoption (Goodman et al., 1998). The lowest number of adoptive placements (50,000) occurred in 1944 (Zamostny, O’Brien, et al., 2003).

Historically, adolescent birth mothers had little to do with the decision for adoption placement. Also, societal values pressured birth mothers to be married or not have a child. Abortions were hidden and adoptions were secret. Agencies attempted to conceal all identifying information, and commonly birth mothers would be sent out of state to homes for unwed mothers, or to receive adoption services. Confidential adoptions were considered the best option to allow her to be safe from embarrassment of an unplanned child, to put the past behind, and to have freedom to move on with her life without the reminder of a child (Grotevant & McRoy, 1998). The birth mother was “free to grieve the placement” and not have the role strain of parenthood. Adoption was usually a clandestine process shrouded in shame (Pertman, 2000).

1950s

From 1953 to 1971 Jean M. Paton pioneered and led the adoptee search movement in America. It later was referred to as the adoption reform movement, and it denounced sealing of adoption records. She also called for the creation of a national

mutual consent adoption registry for voluntary reuniting of adopted adults with their birth parents. She was the first to advocate for open adoption (Carp, 1998).

Premarital pregnancy was common in the 1950s and 1960s. Women were less likely to resort to “shotgun weddings.” As marriage rates declined, nonmarital pregnancies increased (Furstenberg, 2003).

1960s

Unlocking the Heart of Adoption (Ganz, 2003; see also Demchuk, 2008) is a documentary that directly addresses issues of adoption from the perspective of the adoptive triad (birth parents, adoptees, adoptive parents). It reviews some historical experiences with a range of emotions felt at critical points. Many of the examples, however, have birth mothers from the 1960s and 1970s who did not want to relinquish custody. Their own parents and societal pressures did not allow them to keep the children. Relinquishment was a very negative experience for birth parents. In the late 1960s and 1970s adoptees and birthparents challenged the tradition of secrecy and demanded opening of records. Pediatric consultation was encouraged in the process of adoption (Smith, 1968).

1970s

In the 1970s search and reunions became more common. Many adoptions (about 175,000) took place prior to the legalization of abortion. Before 1973 19.3% of all premarital births of single, White women were relinquished for adoption (Zamostny, O’Brien, et al., 2003). Out of all children born to never-married women under 45 years of age, in 1973, 8.7% were relinquished (Jones, 2008). Abortion legalization did sizably reduce the number of adoption placements, particularly by White women. The rate of

White birth mothers declined by 34 to 37% from the rate in 1961 (Bitler & Zavodny, 2002).

In 1972 the National Association of Black Social Workers said that transracial placement was “cultural genocide” (Zamostny, O’Brien, et al., 2003). The practice of transracial adoption did not become widespread until several decades later (Vidal de Haymes & Simon, 2003). The Indian Child Welfare Act of 1978 had aspects affecting adoption (Meiser & Velen, 2003).

Birth mothers challenged the secrecy of adoptions unsuccessfully in court several times (Haugaard, West, & Moed, 2000). The literature was beginning to include articles about openness (Baran, Pannor, & Sorosky, 1976). Florence Ladden Fisher founded the Adoptees’ Liberty Movement Association (ALMA) to aid adult adoptees of closed adoption in searching for birth relatives. ALMA also sought to abolish the practice of sealed records for adoptees over 18 years of age. ALMA members wanted all adoption records opened, including court, agency, and birth records (Carp, 2007). Focus was extended toward changing state laws and to developing collaborative agreements between birth and adoptive parents (Haugaard et al., 2000). In 1978 the concept of the adoption triangle (now triad) was introduced by Sorosky, Baran, and Pannor (1978).

In the 1970s Lee Campbell, a birth mother who had felt coerced into placement in the 1950s, wrote a letter to the Boston Globe saying, “seeking to correspond with other women who had lost children to adoption” (Sotiropoulos, 2008, p. 182). She and other birth mothers began the first birth mother’s rights organization in 1976, now known as, Concerned United Birthparents, Inc. (Concerned United Birthparents, n.d.). Lee Campbell has been called the mother of the birth parent movement (Gritter, 2000).

1980s

The Adoption Assistance and Child Welfare Act of 1980 began a system of prioritizing outcomes for children served by welfare agencies (Berry, 1998). This meant that there was a quick return of foster children to biological families when possible and adoption placement when not possible. The change made more children available for adoption (Zamostny, O'Brien, et al., 2003).

A second generation of adoption search leaders focused on the therapeutic value and little risk of openness and searching (Baran & Pannor, 1993; Carp, 1998). Social policy and adoption practices were moving away from secrecy and shifting to support for the child (Wolfgram, 2008). Key relationships in the child's life were highlighted as important (Berry, 1998). In 69% of public and private agency adoptions, the birth parents had met the adoptive couple (Berry, 1991). Access to sealed adoption records, however, could only be accessed by court order with a "good cause" or "compelling reason." The American Adoption Congress (founded in 1979) and the Child Welfare League of America [CWLA] found increasingly sympathetic attitudes among social workers and lawmakers. States began to pass ALMA's proposals facilitating searches (Carp, 2007). In 1986 the CWLA passed a resolution endorsing open adoption as long as all triad members agreed (Kahan, 2006).

One concern about openness in adoption was that adoptive parents had concern about how birth parents would react with seeing birth children. Those opposed to open adoption believed that contacts with birth parents would hinder the bonding between adoptive parents and adoptive child, with adoptive parents feeling less secure in their parental role. Birth mother mental health was thought to be hindered as well by not

experiencing the finality of separation and full mourning, causing “intrapsychic” differences (Kraft, Palombo, Woods, Mitchell, & Schmidt, 1985). As Wolfgram stated, “How would the concept of *family preservation* extend to adoption in terms of contact...What about the battles between birth parents and adoptive parents, fears of reclaiming...dangers of open adoption? What about the dangers of not moving toward open adoption?” (2008, p. 134).

Between 1982 and 1988 3.2% of all premarital births to single, White women were relinquished. Black women relinquished at 1.1% and Hispanic at less than 2% in 1988 (Bachrach, Stolley, & London, 1992; Zamostny, O’Brien, et al., 2003). Between 1989 and 1995, out of all children born to never-married women under 45 years of age, 1.7% were relinquished (Jones, 2008).

By the mid to late 1980s critics of open adoption thought adopted children would be confused about who their “real parents” were, and would thus suffer with identity and self-esteem issues. Adoptive parents would fear intrusion, have a poorer relationship with their child, and feel a lack of entitlement as “full parents.” Birth mothers would not be able to put the adoption behind them because of their ever-present grief (Grotevant, 2000). Yet in that same era, one of the early research studies on open adoption began to inform people about what open adoption contact is like (Belbas, 1987). In 1984 Arizona enacted a provision of retaining health and genetic history of the adoptee that would be available upon request after the adoptee became an adult (Meiser & Velen, 2003).

In 1983 the book, *Chosen Children: New Patterns of Adoptive Relationships* was written (Feigelman & Silverman, 1983). It was especially rich in details about transracial adoption. Also that year the book *Dear Birthmother* was written (Silber & Speedlin,

1983). This book debunked four myths of adoption by recognizing that birth mothers care and remember, that secrecy does not allow a child to search for roots, and that the search is not for other parents but to gain identity. Further, it shared about birth mothers writing letters explaining the reasons for making adoption plans and to say “good-bye.” It also encouraged birth parents to remain a part of the birth child’s life. This type of openness was beginning to be accepted in some agencies that were enhancing correspondence. In 1989 *Saying Goodbye to a Baby* was published by the CWLA (Roles, 1989). The perspective toward birth mothers was respectful and informative. Poems such as “Legacy of an Adopted Child,” which described “two different kinds of love,” were included.

Since the 1980s there has been growing diversity in adoptive families. There has been an increase in single person adoption as well as lesbian/gay adoptions. Private or independent adoptions have increased (Zamostny, O’Brien, et al., 2003).

1990s

In the early 1990s self-help adoption publications such as *The Primal Wound: Understanding the Adopted Child* (Verrier, 1993) were profoundly anti-adoption. The viewpoint was that adopted adults were psychologically damaged (Carp, 2007). In 1992 the number of adoptions was 127,000, when 42% were stepparent adoptions, 15.5% were foster care adoptions, 5% were international, and 37.5% were private agency or independent adoptions (Bachrach et al., 1992; Zamostny, O’Brien, et al., 2003). In 1999 the number of international adoptions more than doubled since 1992.

In 1993 a common view in the literature was that adoptees were typically within the normal range of functioning. As a group, however, they were perceived to be more vulnerable to emotional, behavioral, and academic difficulties than non adopted peers of

intact homes with biological parents. Some researchers identified methodological problems with existing adoption research (Brodzinsky, 1993). Adoption had come to be accepted as the most desirable solution for children who were not able to be reunited with parents and who needed permanent homes (Schulman & Behrman, 1993).

In 1995 the demand for adoption was about 500,000 women (including couples). This translated into 5 to 6 adoption seekers for every actual adoption. The most common profile for an unrelated adoptive applicant was White, childless, wealthy, educated, and dealing with infertility (Zamostny, O'Brien, et al., 2003).

In 1996 with the frustration related to lack of progress in securing open records, the Bastard Nation was formed. This adoptee rights organization had as its main goal the “opening of all adoption records, uncensored and unaltered, to an adoptee upon request, at the age of majority” (Carp, 2004, p. 16). They viewed access to birth records as a civil right and not a need. The right of privacy for birth mothers and the “equal rights” of adoptees were in opposition. By 1998 26 states had put into place some form of voluntary mutual consent adoption registry for adoption triad member contact. Sixteen states also had court appointed intermediary procedures in place (Carp, 2007).

Created out of the shared emotional pain experienced on Mother's Day, in 1990, a group of Seattle, Washington, birth mothers began a ceremony called Birth Mother's Day (Wolch-Marsh, 1996). The closed adoption system caused birth mothers to have a sense of shame, prolonged loss with separation, and a denial of motherhood. Birth mothers felt they had a motherhood experience with the act of birth alone being acknowledged to be a profound, life changing experience. Birth Mother's Day, which is celebrated the Saturday before Mother's Day, was designed to acknowledge their experiences. Their unique, birth

motherhood, makes possible the motherhood of others. Birth Mother's day reduces the "invisibility" of a birth mother (Wolch-Marsh, 1996). This type of celebration has spread internationally and in the case of open adoption, it has become for some groups a time of reunion where the adoptive family honors the birth mother for courageous choices. Poetry, songs, words of thanks, gifts, and celebration may be part of the ceremony (Romanchik, n.d.).

In 1997 the Adoption and Safe Families Act mandated shorter timelines for adoptive placement (Zamostny, O'Brien, et al., 2003). This act facilitated rapid adoption, so it was hoped to increase the numbers of adoptions and lead to fewer waiting children.

The 1990s began the more widespread reporting of research on open adoption issues (Martin, 1998). Professionals were reviewing transitions in their own adoption practices (Bauman, 1997). One study of adoption trends in California found that birth mothers were generally seventeen to thirty years old, decided to make an adoption plan with a couple outside of their family, and the majority of birth mothers had some contact with the adoptive family (Barth, Brooks, & Iyer, 1995). The first multistate research on open adoption was established—MTARP (Grotevantt & McRoy, 1997; MTARP, n.d.). This far-reaching, longitudinal study on open adoption began in the mid-1970s and currently has followed participants for over twenty years (N = 720). Pieces of the project are shared through many references and described in other sections. The MTARP study impact really began in the 1990s. One significant aspect was that higher degrees of openness between adoptive and birth families predicted greater socioemotional development (Grotevant et al., 1999).

2000s

Out of all children born to never-married women under 45 years of age between 1996 and 2002, 1.3% were relinquished (Jones, 2008). In 2001 international adoptions rose to 19,000 (Zamostny, Wiley, et al., 2003). In 2004 they were 28,884, and in 2008 numbers declined to 17, 433 (U.S. HHS, 2009) due to difficulty in intercountry process. In 2002 nearly 1 million women were seeking to adopt children.

Oregon was the first state to open records in 2000. Birth parents were given three options once contacted by an intermediary: “I would like to be contacted,” “I would prefer to be contacted only through an intermediary,” and “I prefer not to be contacted at this time (Carp, 2004, p. 127).” By the end of the year, 4,962 records were issued and 325 contact preference forms had been received. Of these, 214 birth mothers wanted direct contact, 21 wanted intermediary assisted contact, and 77 wanted no contact (Carp, 2007). Exploration of openness options has taken place (Carp, 2007; Hayes & Kim, 2007; Roby, Wyatt, & Pettys, 2005; Sobol & Daly, 2007). Also, increased genetic testing began to be encouraged before, during, or immediately after the adoption process for timely treatment as needed (American Society of Human Genetics, 2000).

In summary, many groups have begun to study adoption and levels of openness. One critical review of research overviewed 14 open adoption studies largely in the 1990s (Wolfgram, 2008). The type and amount of contact that is optimal for adoption triad members has been investigated internationally in many countries, and a few, but significant, longitudinal studies related to openness in adoption exist. Infant adoption and various types of adoptive and birth families are being explored (Groze, 2007; Holbrook, 1996; Wrobel, Grotevant, Berge, Mendenhall, & McRoy, 2003). In the United States the

proportion of children adopted from foster care, and thus older children, is dramatically rising (Wolfgram, 2008). Additionally, step parents are adopting more regularly. The formation of the family unit is increasingly complex, with adoption adding to the complexity. Fortunately, along with the variety in family formations, a new tolerance and even appreciation of diversity is emerging.

Adoption in Current Experiences

Though most trends are moving toward open adoption, skepticism continues (Miall, 1998; Princeton Survey Research Associates, 1997; Siegel, 2003). Little consensus exists about the term open adoption (Gross & Sussman, 1997; McRoy, Grotevant, & White, 1988; Siegel, 2003). Quantitative and qualitative studies continue to increase our awareness. These studies are being reported in journals such as *Adoption Quarterly*. Conceptual and theoretical frameworks are also being developed and used (Johnson & Grant, 2005).

Openness in adoption appears to be more of a spectrum that is expressed in different ways and frequencies. As well, triads have different modes of contact that can change over time (McRoy, 1999; Meltz, 2008). For this study the term *open adoption* is used as a flexible spectrum, with the specific adoption triad defining what degree of openness is best for them.

Currently the media tends to be filled with mixed information and myth. Professionals as well, offer knowledge that is mixed in quality. Access to a full range of care options for those experiencing unintended pregnancy is mixed, especially when considering adoption options. The general trend in level of openness is a balanced adoption disclosure system that allows flexibility to the adoptive triad.

Additionally, the process is changing into a multiethnic, multicultural experience. It is redefining our understanding of family (Pertman, 2000; Wolfgram, 2008). Adoption has been principally liberated from the sealing of records, so there are options for much greater communication and interaction. Open adoption with some level of disclosure is appearing to be optimal for most (Dischler, 2006a; Ge et al., 2008). It is becoming increasingly accepted in the adoption world. In most cases, birth and adoptive parents love and want what is best for their birth and adopted children (Gritter, 2000).

Media

Adoption myths continue to fill current media. Novy (2005) has written a book about adoption, with examples from literature and other media that illustrates several such myths. One is that there can only be one set of “real” parents. This is inaccurate to the reality of many adoptive experiences. Experiences of searching for birth parents is individualized (Brown, 2008; Wrobel, Grotevant & McRoy, 2004), and adoptees have unique experiences with open adoption. In reality, searching is overdramatized in the media. The sense of self and the values of birth kinship also can be overdramatized. One author’s own experience with a closed adoption (Callahan, 2007) influences her outlook. The autobiographical portions may not apply as directly to open, kin, or international adoption experiences. Popular media tends to reinforce negative messages about adoption (Waggenspack, 1998). Also, media may present unrealistic viewpoints of adoption. The recent movie *Juno* (Reitman & Cody, 2007) presents a birth mother during her decision making and adoption planning. Several books have been valuable for the study of open adoption (Gritter, 1997, 2000; Mason, 1995; Melina & Roszia, 1993; Rappaport, 1992; Romanchik, 1999; Silber & Dorner, 1989; Silber & Speedlin, 1983; Waters, 2005).

Professionals

Professionals who interface with those experiencing unintended pregnancy face difficulty because of the intense emotions within the teenager at the point of pregnancy realization. Commonly the teenager has many relationship issues that affect her decision making. Most are unfamiliar with adoption options, especially open adoption. Professionals seldom have adequate time, knowledge, or desire to broach the topic of adoption. Once the topic is mentioned, if a teenager chooses to learn about adoption, the management or referral process is another difficult process for professionals who often feel ill equipped for the task. During the process, professional opinions about adoption can affect teenager decisions.

After adoption placement, support is again limited because professionals tend to be least oriented toward birth mothers. This inadequate support was the focus of one study of 112 adoption social workers (Neil, 2006) and another of teachers' and counselors' perceptions (Taymans et al., 2008). In regard to court proceedings, attitudes and assessments of other professionals do influence viewpoints of the adoption experience (Harris & Lindsey, 2002). Attitudes of the adoption workers affect the views of adoptive parents on postadoption contact (Gross, 1997; Silverstein & Demick, 1994; Sobol et al., 2000). Privacy, confidentiality, autonomy, and honesty influence the adoption experience (Harris, & Lindsey, 2002; Reamer & Siegel, 2007).

Counseling related to adoption was shown to have clear differences in a comparison study of adoptees and birth parents depending on the background of the therapist (psychologists, social workers, marriage/family counselors, and psychiatrists). Therapists who inquired about (54%) and addressed adoption (72%) were perceived as

being significantly more prepared and helpful compared to those who did not (Sass & Henderson, 2002).

Birth Mothers

Currently birth mothers have less social pressure to marry, and they have more support when choosing the options of parenting or adoption. Making an adoption plan may include choosing adoptive parents through pictures, written information, and sometimes *life books* of adoptive families. Typically birth mothers can have choices related to type of adoptive family, the location (in-state or out-of-state), and to a varying degree the amount of contact after placement. The general thinking of many birth parents is that children are best served by living in open adoption situations where adults put the child's interests above their own (Romanchik, n.d.).

There have been two landmark longitudinal studies (Ge et al., 2008; MTARP, n.d.) to date that used a national sample and explored the impact of levels of openness on all three parts of the adoption triad. As part of the MTARP study, 169 birth mothers were assessed from 4 to 12 years after placement through tape recorded telephone interviews (Grotevant & McRoy, 1998). Of the birth mother sample, 52 had confidential, 18 had time-limited mediated with no identifying information exchange, 58 had ongoing mediated, and 41 had fully disclosed adoptions with direct sharing and usually face-to-face meetings. Age range at time of delivery was 14 to 36 years of age, but 67% of the sample was adolescents. While all had adjusted relatively well, those in time-limited mediation and confidential adoptions had significantly greater unresolved grief issues than those in the other two groups. Those in fully disclosed adoptions had some concerns about the impact of contact on their spouses, subsequent children, and the birth child's

comparisons of lifestyle between birth and adoptive families. Generally, the 35 agencies that were represented viewed the birth mother as the primary client and the one who had primary decision-making power about the initial level of adoption openness.

The societal shift toward openness practices was very evident in the MTARP. In 1993 only 2 of the 35 agencies preferred confidential adoptions. Adoption came to be viewed as a process, with the level of openness decided on in a case-by-case manner. Openness was found to reduce adoptive parents' fear of the birth mother reclaiming the child, increase empathy within the triad, and help in developing a trusting secure relationship, while being a definite benefit to birth mother adaptation (Grotevant & McRoy, 1998). The study suggested a need for further research into the long-term impact of openness for all parties in the adoptive kinship network. Adoption workers and other professionals continue to be least oriented toward or supportive of birth parents, when considering the three adoptive triad members (Neil, 2007).

Birth Mother Life after Open Adoption Gap and Importance

The quality of life after a birth mother makes an adoption plan and actually makes the placement is important to know, because it affects her future life and relationships. It affects her contentment with life. It affects her education, employment, and living arrangements. Beyond the birth mother and her offspring, her extended family is influenced by her stability level. Ultimately, society and the birth mother's need for public and health services can indirectly be linked back to her quality of life following the resolution of her initial unintended pregnancy.

One thing about birth mothers that has been supported in qualitative and quantitative ways is that postplacement adjustment is improved with greater openness

(Ge et al., 2008; Gritter, 2000). It is also known that they are sometimes socially isolated after placement (DeSimone, 1996; Logan, 1996; Silverstein & Demick, 1994). Typically the empirical work dealing with adoption openness has used small samples. There have been several notable exceptions that will be discussed further (Ge et al., 2008; Grotevant & McRoy, 1998).

The Grotevant and McRoy study (1998) explored many views of birth mothers related to their adoption and level of openness. The intent of the study was to explore variations in levels of openness and to find out effects of that level to the adoption triad members. The birth mothers' lives following the adoption were assessed 4 to 12 years postplacement in confidential, time-limited mediated, ongoing mediated or fully disclosed adoption. Most birth mothers were satisfied with their own adoption choices and with the quality of the adoptive family. The majority of the birth mothers had not heard of open adoption prior to agency contact and those involved in confidential adoption arrangements did not know about it even at the time of placement. Those involved in ongoing mediated and fully disclosed adoption arrangements were significantly more likely to select adoptive parents. The ability to see the child postplacement had a "healing effect." Birth mothers with fully disclosed arrangements viewed their placement realistically and found it to be mutually beneficial (Grotevant & McRoy, 1998, pp. 149–150).

Other important findings related to the birth mother came from the study. First, the frequently used dichotomies of *open* and *closed* adoption is limiting in the study of openness because there are many permutations of openness. Second, birth mothers were found to have substantial indicators of role adjustment overall, but level of openness was

significantly related in a positive way to role adjustment with the ongoing mediated and fully disclosed group. Third, level of openness was significantly related to grief resolution, again with ongoing mediated and fully disclosed groups scoring consistently improved in role adjustment four to twelve years postplacement (Grotevant & McRoy, 1998). Findings related to the MTARP study (n.d.) continue to emerge as the study continues longitudinally.

In the landmark work from the Early Growth and Development Study (EGDS), Ge and associates (2008) report significant findings of satisfaction ($P < .01$) with the adoption process and a positive association with the birth mother's postplacement adjustment ($P < .01$). These findings are especially pertinent to this dissertation study since results are in part about the birth mother's own life after an unintended pregnancy and open adoption placement.

To date, particularly in health care literature, there is a gap in awareness of a birth mother's own life following an unintended adolescent pregnancy. While closed adoption findings such as those in the Logan study (1996) demonstrate grave aftereffects for birth mothers, aftereffects for those of open adoption are less studied and less clear.

A publication from the Evan B. Donaldson Adoption Institute pointed to critical gaps in knowledge about birth parents' needs and preferences. The publication listed four critical points. One point was, "What is the emotional and psychological impact of adoption loss for birth parents, and what practices facilitate grief resolution and healthy long-term adjustment for them?" (EBDAI, 2006; Smith, 2006). This study directly addresses the gap as it relates to open adoption and adolescent birth mothers. A study like this, that focuses directly and solely on birth mothers, tends to help minimize

perspectives of others in the adoption triad in order to elevate the birth mother views. This study amplifies and elucidates some basic qualitative information from birth mother's own perceptions. The insights will assist health care professionals to be aware of unique needs and strengths of adolescent birth mothers after open adoption infant placement.

In the qualitative descriptive pilot study prior to this study, five birth mothers were interviewed by telephone for 1–2 hour interviews. These adolescent birth mothers placed their newborns five to fifteen years prior to the interview (Clutter, 2007). They made adoption placement through one agency in the Midwest United States, and all participated in a birth mothers' support group for some length of time. They could have lived anywhere in the United States at the time of interview. De-identified transcripts were analyzed for themes. Four themes emerged. First there was satisfaction over placement decisions including open adoption choice, couple chosen, and their currently thriving birth child. Second, there were personal milestone accomplishments in education, finances, work, life, or relationships. Third there was a sense of currently being a better person overall with an improved life. Finally, the essential need for support was consistently mentioned.

Summary Statement

Descriptions of birth mothers' postdelivery lives are few and limited. Research is incomplete about what happens to women who have borne children that were conceived in an unintended pregnancy and then placed in an open adoption (Reitz, 1999). Aspects about their own quality of life are only minimally described. Health care literature, as

opposed to that of social sciences, is fairly silent when it comes to birth mother life outcomes, no matter how they choose to manage their unintended pregnancy.

Part of the reason these women are lost to health care is that after the point of the last postpartum visit, birth mothers interface with health care for reasons other than crisis pregnancy. They are known less as birth mothers or as ones who have experienced unintended pregnancies and more as patients for other reasons. While health care professionals may be in contact with these women regularly, their birth mother status may be unknown, unnoticed, or unimportant to the immediate care.

It is difficult to locate and study this population regardless of whether their pregnancy resolution is through loss, abortion, parenting, open or closed adoption. Their quality of life following the crisis pregnancy is of importance because it affects the future well being of these women. It affects the rate of additional crisis pregnancies. It also influences the quality of life of their current and future offspring (Klein, 2005).

CHAPTER THREE – METHODS

Understanding the influences of unintended adolescent pregnancy and open adoption on birth mothers' lives after infant placement was the aim of the study. To address the aim, a qualitative design using naturalistic inquiry (Lincoln & Guba, 1985) was used to gain understanding of birth mothers' lives beyond the birth of a first crisis pregnancy and after open adoption placement. The benefit of understanding the experience of open adoption following infant placement is that health professionals may be sensitized to the strengths and challenges for birth mothers as well as to the meaning of these experiences to them. This chapter includes information about the study design and methodology of naturalistic inquiry, with its benefits for addressing the gap in literature. An account of the assumptions of naturalistic inquiry follows. The chapter continues with sample characteristics, data collection, data analysis, human subjects' issues, and quality criteria.

Study Design

This qualitative research used naturalistic inquiry to investigate, understand more clearly, and describe the influences of unintended adolescent pregnancy and open infant adoption on birth mothers. Qualitative studies of this nature are used in investigation of a specific phenomenon within real-life context. Guba and Lincoln indicate that the purpose of this type of study is “to reveal the properties of the class to which the instance being studied belongs” (1981, p. 371). The object of the study (Stake, 2005) was birth mothers at the time of one to five years after infant placement. The unit of analysis was the postopen adoption placing adolescent birth mother stated perceptions of their own experiences. The design used optimizes understanding of the particular unit of analysis

(Stake, 2005). Yin describes three categories of study: explanatory, descriptive, and exploratory (1989). The exploratory study is commonly used when the phenomenon is very limited or blank in research literature. Given the limitation of birth mothers' lives after infant placement, this naturalistic study was exploratory in nature.

Methodology of Naturalistic Inquiry

Naturalistic inquiry [NI] was uniquely suited to the study. Learning directly from women who have experienced unintended crisis pregnancy and open adoption was an important beginning point to documenting their lives and experiences after delivery of the baby. Naturalistic inquiry was selected to inform this study because it is a means of investigating individuals without making change. The NI investigation occurs through minimizing artificial changes and through listening to descriptions. The investigator seeks to identify authentic speech while attuning to components of meaning to distill essential elements. The research captured units of meaning that were used to communicate experiences and views of the participants, birth mothers after infant placement.

Naturalistic inquiry is useful with this population for several reasons. One notion of NI is that the instrument of choice is the "human instrument," meaning the researcher (Lincoln & Guba, 1985, pp. 39–40). I could gain trust with birth mothers due to extensive familiarity with the population and to attuning to the unique language and needs. Birth mothers are very difficult to access. They tend to relocate frequently. They are rarely gathered in groups. They rarely share this part of their lives. If they are part of a support group, it is unusual that facilitators or leaders of that group (gatekeepers) release access

to members. In this case, access was possible and NI allowed for robust sharing without any intent to intervene or modify the birth mother's past experiences or views.

An additional reason birth mothers are difficult to access is that adolescent birth mothers are a vulnerable population. Underage pregnant children become emancipated minors or those above eighteen are the youngest of adults. Adolescents and young adults have differing literacy and developmental levels with limitations of descriptive capacities. Further, in most contexts personal benefits of communicating this intimate part of their own lives are few, so the motivation to share can be limited. In contrast, however, opportunities to fully share experiences without others' judgments on such an emotionally charged topic are rare. Birth mothers may embrace and enjoy communicating in such a manner.

Naturalistic inquiry facilitates a trusted researcher gaining access to people within a culture group to work with natural informants in a way that allows the dyad (researcher and informant) to construct an understanding. A natural informant is someone who is a legitimate, committed, and accepted member within the local context (support group) but who is willing to act as a member of the inquiry team (Lincoln & Guba, 1985, p. 258).

NI allows the researcher to enter into listening with the intent to draw out thick descriptions of experience and emotion. The experience of any birth is one known to be intense, creating a great need to verbally share. Sharing of birth stories is part of any postpartum experience. This sharing does not necessarily take place with birth mothers. Sometimes the birth is cloaked in silence. Fortunately, birth mothers who have been a part of a support group have had some experience sharing their story. This was true of the study sample. Participants were distinctively suited to being NI informants.

Assumptions of Naturalistic Inquiry

Several assumptions underlie the NI design. There are five primary axioms that distinguish this form of inquiry. These axioms are assumptions of truth. First, it is assumed that the nature of reality (ontology) is such that there are multiple, constructed realities that can only be studied holistically. Second, the researcher and participant are interactive so that the knower and the known are considered as inseparable (epistemology). Third, the aim of the inquiry is to develop an idiographic body of knowledge that is specific to distinctive characteristics of the unique situation rather than to identifying broad, law-like generalizations. The fourth assumption is that all entities are in a state of mutual, simultaneous shaping, so there is not a focus on causation. The fifth assumption is that inquiry itself is value bound, and that truth is best achieved when the inquiry is a natural environment (axiology). This means that naturalistic study does not include prior theorizing (Lincoln & Guba, 1985, pp. 36–38).

Sample Characteristics

A purposive sample for typical cases, as described by Lincoln and Guba (1985) was obtained. Qualitative sampling strategies are fundamentally different from that of quantitative studies (Byrne, 2001; Erlandson, Harris, Skipper, & Allen, 1993). A purposive sample was essential to increase the range of data exposed and the likelihood of uncovering a full array of multiple realities (Lincoln & Guba, 1985, p. 40). The pilot study sample consisted of five birth mothers who had given birth and placed their babies from five to fifteen years prior to the interviews (Clutter, 2007). The dissertation sample consisted of ten birth mothers who had delivered and made newborn open adoption placements one to five years prior to inquiry in spring of 2009. These birth mothers were

recruited from a crisis pregnancy support group in one city in Midwestern United States, though participants currently lived in various places in the United States. The women were considered to have had a “crisis” pregnancy because they had attended group meetings at the support group that had “crisis pregnancy” as part of the group name. The director of one crisis pregnancy support group was asked to identify birth mothers who were typical examples, or those who best represented the experience of unintended adolescent pregnancy and open infant adoption. The director telephoned past group participants who had given birth one to five years prior to spring 2009. The director asked permission to have me call and explain the study. All of those called agreed to receive my call. Possible participants received the study explanation and an opportunity to ask questions. Those deciding to participate (all who heard the consent read did participate) established a 2 hour appointment for a telephone interview. They were asked to have a private location where they could talk freely. The telephone interview in a location of their choice was perceived to be a *natural setting* for birth mothers, necessary for NI.

Specific Support Group Characteristics as Context of the Sample

The particular support group had weekly, two hour meetings in a home setting. The support group meetings occasionally had gatherings in one church building. The group built contact lists of participants and sought to develop a supportive network where those experiencing crisis pregnancies could gather with those who were making or had made decisions to parent their baby or decisions to make adoption plans. People who had just discovered they were pregnant, those who were at any stage of pregnancy, and those who had already given birth came together for mutual care, personal growth, decision making, and support.

The general format of a meeting was to have the director open, then give each person opportunity to verbally share. Sometimes other members would comment on one's sharing. Sometimes people would ask questions. Sometimes other leaders, helpers, or even adoptive mothers would attend. The purpose of the meeting was for the support of adolescent and other-aged women experiencing crisis pregnancy. Parenting decisions were made for adoption or parenting. Choosing of adoptive couple was made privately but shared in the context of the group. After delivery, participants continued in attendance as desired and as available. Typically each mother would be honored after delivery with a special party. A birth mother would have a personal shower at the beginning of a group meeting, and a parenting mother would have a baby shower at the beginning of a group meeting. Some participants moved or stopped regular attendance after delivery but would periodically return for events or when in town. Amount and timing of ongoing contact with the group was by personal choice of the member. Ongoing contact information provided by birth mothers was maintained by the director.

Additionally, once a year near Mother's Day, the agency would hold a Birth Mother's Day ceremony. Birth mothers would be honored for their courageous choice to be willing to live separately from their birth child in order to provide a life for the child that the birth mother could not—at that time—provide. Some birth mothers attended alone and some used the time to have a reunion with their birth child and adoptive family. All ages of birth children attended the occasion. Food and activities after a more formal celebration fostered an atmosphere pleasing to all members of the adoptive triad, but the focus was to honor birth mothers.

Data Collection Methods

Telephone interviews up to two hours in length were conducted that included consent, opportunity for questions, brief demographic information, and the interview. The consent form was read verbatim. Participants were told that there may be one additional phone call if needed, to clarify or expand on sections of the first interview, and that a Wal-Mart gift card for \$20.00 would be sent to participants as thanks for participation. While the tape recorder was on, the participant stated her name, that she had heard the explanation of the study, and that she willingly consented to the interview.

Demographic data related to age at time of delivery, current age, parity, race and ethnicity, education, and marital status before and since that pregnancy was gathered. The birth mothers were asked about their lives during the time surrounding the birth through the first several years after birth. Unstructured, audio taped telephone interviews began with the following prompt, “Tell me about your life during the time just after your birth child was born. Tell me the long version of the story.” These responses were audio-taped, as were prompting questions that were specific to the participant’s discussion, in a manner consistent with naturalistic inquiry methodology.

I proceeded through unstructured or semistructured interviews with the informants (participants). Rich descriptions unfolded naturally and were accompanied with clarification and questions in order to generate consensus of understanding between the birth mother and me (i.e.: “Please amplify on ...” or “Please clarify ...”). Interviews were tape recorded using two devices to protect against technology failure. I transcribed interviews within three days after each interview. The interviews were completed and transcribed verbatim with all identifying information removed to maintain confidentiality.

Data Analysis

Data analysis was begun by assessing individual transcripts. The analysis began concurrently with data collection of additional interviews, according to NI protocol. Each transcript was divided into units of meaning. Constant comparison of interview transcripts for this inductive analysis took place in order to isolate units of meaning as well as categories.

The time frame of actual data collection and analysis was spring of 2009. All telephone interviews were conducted according to the study protocol. The transcripts were completed by the researcher without any technology failures. No further verification process was necessary beyond what happened during the interview.

Data collection and analysis happened simultaneously (Erlandson et al., 1993). The process of data analysis is further described here. Since content analysis interpretations are fluid, they are open to change throughout the study. For this reason, NI is never truly *finished*. The constant comparative methodology used was one where the first transcript was analyzed for *units of meaning*, followed by analysis of subsequent transcripts. A unit of meaning is a word, phrase, or paragraph that is distinct in gist and can stand by itself. Each transcript was printed on colored paper with different colors for each transcript. Units of meaning were cut and put in an accordion file under fluid categories. Once units of meaning were clipped, the transcript of origin for any given clipping was evident by color, but units of meaning could be compiled and categorized from multiple interviews.

The constant comparative method as described by Glaser & Strauss (1967) and used within naturalistic inquiry, has steps beyond unit of meaning isolation starting from

the first interview transcript and subsequent transcript analysis for additional emergent units of meaning. The category themes were identified on the accordion file with file names on Post It® Notes that could be modified. The incidents of new transcripts began to be compared to each category or theme and were included appropriately.

Category themes and their properties were defined and delimited. They were described and refined. Themes can be used to write a grounded theory (Glaser, 2004; Glaser & Strauss, 1967) but in this study remained as themes and descriptions without theory development.

The units of meaning were constructions that were refined or interpreted, then compared and contrasted dialectically to gain understanding. Refining had to do with the art and skill of understanding human actions, utterances, products, and institutions and then interpreting this understanding to the essential meaning (Appleton & King, 1997).

All units were then categorized in sets of meaning. Sets were considered units that fit together. Units were arranged to categories based on “look-alike” or “feel-alike” items (Lincoln & Guba, 1985, p. 347). Rules for inclusion were written on cards that were fluid and tentatively maintained, like the accordion file sections. Cards with units and categories with “look/feel-alike” information were accumulated to a point of being able to give names or titles to theme categories that represent the “essence” of the rule for inclusion.

Analysis of content included searching for anomalies, conflicts or inadequacies (Lincoln & Guba, 1985, p. 348). Each unit was assessed to determine that it “belonged” to each category’s rule for inclusion. There was a miscellaneous pile that was repeatedly assessed for identification of irrelevant information or for inclusion in a category.

The categories were examined for relationships between them. Some were determined to be subsumed under others. Some were further subdivided. Sometimes the examination revealed missing or incomplete information. Follow up phone calls were considered to complete any incomplete or unsatisfactory categories. No follow up phone calls were needed by the end of reviewing all the transcripts. Fullness of description was developed for the categories.

At this point the processes of extension, bridging, and surfacing were used. Extension is where units and categories are used to advance understanding of the researcher. Bridging is the building of relationships between “disconnected” but known information. It is the connection aspect of categories. Surfacing is similar to hypothesis formation, where logic is used to propose new information that ought to be found.

Dialectic logic was also used. It is comparing and contrasting in order to synthesize and gain higher truth. The divergent and convergent thinking from an emic perspective leads to explanations that are constructed (Appleton & King, 1997). The explanations are affirmed by people in the context and are refined so that there is substantial consensus. In this study, the director and other birth mothers served to assist in contextual refinement for consensus.

Exhaustion of transcript information, saturation of categories, and the emergence of regularities were the rules that brought the data collection to a close. Regularities were found to the point that any new information was a redundancy or an overextension to the findings. Overextension means that a unit of meaning was far removed from the primary unit or category information. Strauss and Corbin (1990, 1994) describe saturation as the point where no new insights are obtained, no new themes are identified, and there are no

new categories. The constant comparative method was used and point of redundancy (Lincoln & Guba, 1985) led to saturation. Bowen's discussion of saturation was useful in the process (Bowen, 2008).

At that juncture data reconstruction included the categories with full descriptive identifiers and themes, definitions, and relationships. The data conclusions had to do with the interpretations and inferences. All of the units and categories were derived from the transcript data, and were confirmable within the data. The refined understanding led to the final written product of the investigation (Lincoln & Guba, 1985).

The way this practically occurred was that I took each accordion file section, created definitions and relationships, and then proceeded to a deeper analysis. I created wall murals from extensive spread sheets of meaning units that were divided into the categories. This was a visual means allowing for greater analysis. The meaning units were viewable on my computer, with the color coded pieces, and on the murals so that I could synthesize content.

A descriptive reporting mode was used for presenting study findings. This mode is novel-like, less formal, and expressive. The end result is this dissertation, publication, presentation materials or other scholarly product stemming from the research that gives voice to birth mothers in a way that can give meaning to health professionals, adoption workers, and birth mothers themselves.

Human Subjects Issues with Protection of the Participants

IUPUI/Clarian Institutional Review Board approval and agency assent were obtained. This included physical and emotional protection and safeguards for participants. The crisis pregnancy support group director offered an additional option of

protection for participants. That was the possibility of complementary counseling with a professional therapist should some unanticipated emotional difficulty arise with any one of the participants. The safeguards were verbally given in the consent that was read prior to interviews. The consent was mailed to each participant following interviews and along with the gift card. No difficulties arose. I was pleased to read an article about methodological and ethical issues with sensitive research topics (Hess, 2006). Most of the safeguards of protection mentioned for protection of participants and avoidance of biased viewpoints were in place in the study.

Quality Criteria

Trustworthiness has to do with the study findings being worth the attention of readers because it is true to the stated intent and appropriate in methodology. Scientific rigor is the way integrity and competence is demonstrated in order to show the legitimacy of the research process (Tobin & Begley, 2004). Qualitative studies have distinct means of maintaining scientific rigor (Sandelowski, 1986). Lincoln and Guba (1985) identify four primary approaches to scientific rigor for qualitative studies and NI in particular. Lincoln and Guba's criteria include credibility, transferability, dependability, and confirmability. Lincoln (1995) later described additional criteria for judging quality. These, as well, are depicted.

Credibility

Credibility has to do with techniques that make it more likely that study finding will be plausible or realistic. It has to do with goodness of fit between the respondent's views and how the researcher represents those views (Tobin & Begley, 2004). Use of prolonged engagement, persistent observation, and context awareness enhance credibility

(Lincoln and Guba, 1985). The prolonged engagement used in this study is a one to two hour interview with undivided attention toward one participant. An additional optional phone call was also included. The study did not account for repeat interviews that would strengthen persistent observation. However, the need for gaining insight into the population was reduced due to the strength of my tacit knowledge of the population. I have experienced over a decade of regular contact with birth mothers of open infant adoption from the point of initial awareness of pregnancy through decades after infant placement. This tacit knowledge is a benefit for credibility and minimizes a need for prolonged engagement. Because of the strength of tacit knowledge there was already substantial awareness of the “culture” of the sample.

Tacit knowledge of the population does not give sensitivity to the sample. That sensitivity in this study comes through the persistent “observation” through the interviews, but more importantly through the reading, re-reading, and analysis of the transcripts and contextual margin notes of the study. One of the great strengths of NI is that analysis and result stay very close to the data. Since this study does not go beyond descriptions and identification of theme categories, researcher based extrapolation is minimized and findings are truer to the participants.

Telephone interviews were ideally suited and effective since distortions from inquirer presence was minimized. Also, adolescent and young adults are used to this mode of communication. Trust could be built rapidly. Telephone interviews allowed the needed thick descriptions to unfold easily.

There were three aspects of context awareness and input other than interview transcription. The first was the use of my own margin notes that were taken during and

immediately after each interview. These notes indicated emotional overtone, distractions, pauses, and the like. After each interview I reflected on the experience and recorded diary-like questions or comments.

The second aspect was reference to agency written materials after the completion of analysis. These materials exemplify characteristics and descriptive written stories of those with similar experiences to informants in the sample. These materials strengthen the referential adequacy (Lincoln & Guba, 1985, p. 283). Written materials available were stories of actual birth mother experiences. Of particular benefit was a short DVD with four birth mothers alone or with their birth child and chosen adoptive families. Birth mothers described their open adoptions. The materials were not used for the analysis but for awareness of the wider context of the study. They helped to build descriptive context.

The third aspect was occasional questioning of the agency director. The intent was to verify general context information. Her comments were used primarily to clarify language for more accurate reporting.

Peer debriefing sessions are especially important with naturalistic inquiry due to the intensity of the interpersonal communication. Peer debriefing helps researchers remain focused, without undue emotional “baggage.” It is beneficial for exploring working hypothesis, catharsis, and maintaining good judgment (Lincoln and Guba, 1985). Two types of peer debriefing were maintained. One was for emotional debriefing. This was through biweekly telephone conversations with another PhD candidate in the same program who was at a similar level but with a different type of study. This was not documented except by noting dates of contact. The overall subjective impact of the emotional debriefing session was beneficial.

The second type of peer debriefing was for the purpose of enhancing the emerging analysis. The focus of conversation was to advance the clarity of theme characteristic identification and affirm soundness of process in transcript data unitization, categorization, and theme characteristic names, definitions, and descriptions. Twice-monthly peer debriefing meetings were maintained throughout the data analysis time period. Additional meetings were made during critical analysis times. This peer debriefing was conducted with a nonrelative, non-nursing program PhD candidate in a separate university who was at the same level with a qualitative, focus group study. This was useful for two reasons. First, ideas and perspectives from another discipline caused me to consider different aspects of meaning during the analysis. On several occasions my analysis was modified based on those perspectives. Second, content analysis debriefing provided an opportunity to be accountable for the process of analysis to help ensure that categories and themes were based on transcript information, and not my tacit knowledge. Again, the input was useful and confirming.

Following data collection, analysis, and rough draft writing of findings, both peer debriefers and my research advisor gave input about the influence of my perspectives on the findings. Adjustments were made to maintain authenticity and to attune findings to those of the birth mother transcripts, and thus speak to credibility. The different sources of input to me helped avoid having tacit knowledge or bias override authentic findings from the birth mother transcripts.

Transferability

Transferability, or applicability, is comparable to external validity in quantitative studies. It refers to the generalizability of study findings. While generalizability is crucial in

quantitative studies, in naturalistic inquiry, there is a local application. Description and understanding are more important for the local context. The time, the context, and what the people say are parts of the local application in which the participants are members. Application of findings is tentative and is designed for that specific context.

Transferability means that the reader of the research study sees application in other contexts. In this case it may be application to unintended adolescent pregnancy and open infant adoption in other locations. Transferability refers to the possible range of application by those using the research. The transferability aspects of this study had to do with the potential applications in different contexts. Ideas for this are shared in the discussion and recommendation sections of Chapter Five.

In NI, this transferability is valuable for usefulness in other situations. The thick, rich descriptions used in this study facilitate transferability. The results should read like a novel as descriptions are recounted. I have attempted to provide abundant quotations in Chapter Four that demonstrate credibility. The type of reporting allows the complexities to be clearly elaborated, thus aiding in use by the reader to similar contexts.

Dependability

Dependability, similar to reliability, has to do with consistency or stability of findings if replication of the study were to take place in the same or in similar settings. Credibility is essential to dependability, and aspects such as thick contextual descriptions help establish both concepts. In this study, thorough documentation and strict adherence to data collection and data analysis methods strengthened dependability. The decision making in the data analysis was about data findings, not about researcher extrapolations or theories. Staying close to the data in this way strengthened dependability. One article

that I found was a presentation of an open adoption triad (Webber, 2008). It was so similar to my findings that it seemed like the birth mother could have been in my pilot sample, as she was eight years postbirth and placement at the time of the writing.

Confirmability

Confirmability and completeness have to do with the findings genuinely stemming from characteristics of the participants as opposed to biases, motivations, interests, or perspectives of the inquirer. The concept is also referred to as neutrality. In NI, however, the researcher is so inextricably a part of the process, the researcher cannot remain separate or completely neutral. Nonetheless, it is essential that the driving force of the content originated from the participants. The findings must be derived from the data. As explained earlier, I worked hard to remain true to the data. My advisor had access to all the de-identified transcripts and was able to perceive discrepancies from transcripts to findings.

In this study, although the literature review drew from many disciplines, and many theories or constructs could be used for deductive application, findings were from within the actual data interviews. Data analysis included saturation of transcript sources for identification of units of meaning, development and saturation of theme categories, and emergence of regularities to the point that any new information was a redundancy or an overextension to the findings. Confirmability came through comparison with agency written and audiovisual information, input by agency director, and nonspecific questions and answers by birth mothers who were not a part of the studies.

Accurate accounts were important. The primary means of ensuring accurate accounts was with consistent data management with double recording and rapid follow

up of transcription completion. Accurate accounts facilitated confirmability. The emergent constructions were reported as themes.

Additional Criteria for Judging Quality

As NI has emerged, so have the quality criteria. Yvonna Lincoln (1995) described additional criteria of rigor. In regard to significance, one quality measure has to do with *building the discipline's body of knowledge*. Another criterion is *identification of where the study fits within relevant literature*. A third criterion is that the study is *presented in sufficient depth so that it can be replicated*. This study brings information rarely reported and not in current health care literature. It is significant in shedding light on characteristics of a population served but not understood by those in the profession. It is presented with enough detail to be repeated.

Lincoln (1995) adds *community as arbiter of quality* as a new criterion. This means that the study has a broader purpose beyond the profession or the “knowledge producers and policy makers.” It has a close connection with the community “from which it springs and in which it is intended to be used” (Lincoln, 1995, p. 281). This study applies to the wider community of adoption workers, and principally to those experiencing unintended adolescent pregnancy who have made open infant adoption placements. A primary strength of this study is its applicability directly to this group. It is my sincere plan to have opportunities to use the dissertation findings in ways that benefit birth mothers of open adoption.

Giving voice to the marginalized, the silenced, or minority groups is the focus of another criterion. Lincoln (1995) states that serious qualitative researchers should seek out the perspectives of these underserved voices to give them opportunity to be heard.

This criterion is truly reflected in the study of birth mothers after open infant adoption placements. Their voice has long been silent (EBDAI, 2006; Smith, 2006).

Reflexivity or *critical subjectivity* is a criterion of understanding one's own psychological and emotional state in order to facilitate the research process with the participants. During this study, a diary was kept that was useful for peer debriefing sessions as well as greater self-awareness. This process of peer debriefing, in turn, assisted in enhanced research outcome.

Reciprocity refers to the importance of being person-centered so that the deep sense of trust, caring, and mutuality can develop in the researcher-participant relationship. In this study, every interview was characterized by a felt connection.

Sacredness is another criterion and refers to the notion that science has aspects of sacred or spiritual in relationship to the human inquiry. There is a concern for human dignity, justice, respect, and the appreciation of the human condition (Lincoln, 1995, p. 284). Particularly because the population of this study is lost to health care after the adoption placement, sacredness as a criterion was a strength in this study.

The final criterion shared by Lincoln (1995) is the idea of *sharing the perquisites of privilege with the community served by the study*. Benefits from the study should not be limited to the knowledge producers, but also with the disciplines and research participants. My earnest hope is that beyond the publication of this dissertation and the Wal-Mart gift cards given to participants, benefit from the creation of meaning and vivid descriptions (Eisner, 1981) will extend to members of the nursing discipline, those who work within adoption, but especially to birth mothers. I hope as well to report findings of the study to the birth mother support groups at a later time.

Summary

Chapter Three has addressed the design, naturalistic inquiry methodology, assumptions and benefits of using naturalistic inquiry, sample characteristics, characteristics of the support group, data collection, data analysis, human subjects' issues, and quality criteria. This naturalistic inquiry had a sample of birth mothers who had experienced an unintended adolescent pregnancy and an open infant adoption placement one to five years prior to 2009. They were recruited from one Midwestern United States crisis pregnancy support group where the support group leader identified qualified potential key informants. Key informants were selected as typical cases for those experiencing open infant adoption placement. De-identified transcripts of the telephone interviews between me and the five women of the pilot sample (five to fifteen years postbirth and placement) and ten women of the dissertation sample (one to five years postbirth and placement) provided the basis for the data analysis. Data analysis followed the constant comparative methodology used in NI. Emergent meaning units and theme categories were identified, de-limited, described and category relationships were conveyed. Data analysis continued to the point of meaning unit and category saturation. Trustworthy strategies of prolonged contact and thick descriptions were used. The theme reporting was in a less formal, narrative style.

CHAPTER FOUR – ANALYSIS AND INTERPRETATION

In this chapter, I present my findings. Four sections include demographic findings, the birth mother story timeline, messages to health care providers, and messages to pregnant teenagers. The original study purpose was to understand the influences of unintended adolescent pregnancy and open adoption on birth mothers' lives after infant placement. The actual findings are best portrayed within a wider context than just after placement because birth mothers descriptions of prepregnancy, pregnancy, and birth offer an essential background for understanding life after birth child placement. Birth mothers shared information from prepregnancy through their current stage of between one to five years postbirth and infant adoption placement. Many of the findings are depicted as a narrative of typical birth mother's experiences over time. This *timeline* of sorts opens with the scene of prepregnancy, relationship with the birth father, and the discovery of pregnancy. The story continues through the experience of pregnancy, to decision making about adoption, choice of the adoptive family, to birth. Birth, discharge, and court finalization tend to be significant life events for the birth mother. These are developed in the time line and followed by transitions in her life. In this story presentation, example quotations are used heavily to convey meaning. Postplacement findings of the influences of unintended pregnancy and open adoption experiences on the birth mothers' lives are primary to the study purpose. They are shared through the use of an acronym, *AFRESH* as a literary tool to aid the reader in understanding the findings.

Following the birth mother timeline, I present important messages that birth mothers had that contribute to health care providers. Since content to health care providers is part of what makes this dissertation distinct from that of other disciplines,

unique contributions are seen as important enough to warrant a separate section. Also a section is devoted to some messages birth mothers had for pregnant adolescents. Since birth mothers demonstrated insights valuable to pregnant teenagers, the section is useful as well. It particularly speaks to Lincoln's (1995) quality criteria of "community as arbiter of quality" in the sense that it applies to the wider community of adoption workers and those experiencing unintended adolescent pregnancy (see Chapter Three).

Much of health care has been silent when it comes to birth mother voice. Since birth mothers in the study sample have been through the experience of unintended pregnancy and open infant adoption placement, they were able to succinctly express messages of value. Their contributions are wisdom worthy of note.

Data Sources

The primary study findings were taken from transcripts. Memos or margin notes made by me were a second source of data. These offered several highlights of text emphasis that added depth to several transcript portions. The verbal findings as transcribed were so valuable that many sections in this chapter have quoted materials. In fact the birth mothers were well able to express their views and were often the most apt way to share the content. While I summarized some points, I err on the side of sharing many quotations. There is a richness to their words that, I think, conveys important nuanced meaning.

In addition to transcripts and margin notes, the third source of contextual data was support group agency information through literature, media, and the director. This data was not used as part of the analysis, but as background awareness of the agency and support group context. Written information, agency DVD of birth mother stories, event

information, and website materials offered exemplars that, according to naturalistic inquiry, support and affirm the credibility of transcripts in a way that gives affirmation within the local context. An important source of background was the agency director who provided several refining ideas in discussion with me. These contextually descriptive items, for the most part, assisted me, as the researcher, in seeing priorities within the transcripts. Credibility, dependability, and confirmability were thus strengthened.

A fourth source of data was from the pilot study sample. In the fall of 2007, a pilot sample of five birth mothers was conducted (Clutter, 2007). The sample was of the same population, but at a different point postbirth. The five women were five to fifteen years postbirth and placement. Findings from that sample shed light on several aspects of birth mother life after open infant adoption and will be addressed here, as well as highlighted alongside 2009 findings of the ten.

Demographic Findings

Eleven women were identified by the agency director as ones who might be study participants. One who did not participate was reached by phone, was willing, but was not available by phone again. The study consent had not yet been read to that person. The remaining ten were reached by phone and participated in the study.

Interviews of the ten were conducted in the spring of 2009 from February through April. Analysis occurred concurrently and continued through May, 2009. The participants were emancipated minors and young adults who were sixteen through twenty-two years of age at the time of interview (spring 2009). Ages at time of childbirth were fourteen through nineteen, with one having delivered during her early adolescence (13–15), six

during middle adolescence (16–17), and three during later adolescence (18–19). Table 1 summarizes data.

Table 1. *Participant Characteristics*

#	Pseudonym	Current Age	Age at childbirth	Education completed	Ethnicity
1	Bluebird	21	19	HS	Caucasian
2	Bunting	19	16	12 grade GED	American Indian
3	Cardinal	18	16	HS grad. in 1 month	Biracial: Caucasian American Indian
4	Goldfinch	20	17	11 grade GED	Caucasian
5	Herron	18	17	HS	Biracial: Caucasian African American
6	Hummingbird	18	17	HS+1 semester Community College	Caucasian
7	Robin	22	19	HS+1 sem. College	Biracial: Hispanic Caucasian
8	Sparrow	20	18	HS+1 yr. Community College	Caucasian
9	Swallow	21	17	HS+3 yr. College	Caucasian
10	Wren	16	14	in HS grade 10	Caucasian
	Summary	1-16; 3-18; 1-19; 2-20; 2-21; 1-22	1-14; 2-16; 4-17; 1-18; 2-19	2 in HS; 7 HS graduates; 2 some CC; 2 some College	6-C; 3-Bi: C-AA, H-C, C-AI; 1-AI

Two of the ten were gravida 2 and both had prior induced abortions: one a parental decision and one a self decision. These induced abortions did have impact on the choice of adoption for the second pregnancy. These findings are summarized in Table 2.

Table 2. *Participant Characteristics not linked with Participant Number*

Gravida with birth child	Ethnicity	Current status and activities
Gravida 1 = 8 Gravida 2 = 2	Caucasian = 6 American Indian = 1 Biracial = 3 1 Biracial: Caucasian African American 1 Biracial: Hispanic Caucasian 1 Biracial: Caucasian American Indian	Student-HS = 2 Now pregnant = 2 Starting college = 2 Working = 4 Not working = 2

In educational status, two were currently in high school, seven were high school graduates, two had some community college, and two had some bachelor's level college. Birth mothers reported what they were doing at present. Two were high school students and two were starting college. Two were pregnant again but with different birth fathers. Four were working and two were not currently working or going to school. See Table 2 for educational summary.

Race and ethnicity were varied. Six were Caucasian and three were Biracial. Of the three biracial participants, one was Caucasian-African American, one was Hispanic-Caucasian, and one was Caucasian-American Indian. One participant was full American Indian (see Table 2).

Birth children included four males and six females. Ages of the birth children ranged from one year, one month to four years, five months. There were three, one year olds; four, two year olds; two, three year olds; and one, four year old. These findings are summarized in Table 3.

Table 3. *Birth Child Characteristics*

#	Pseudonym	Age at time of interview	Gender
1	Jill	2 years, 3 months, 10 days	Female
2	Karl	1 year, 4 months, 11 days	Male
3	Kelly	4 years, 5 months, 9 days	Female
4	Mary	3 years, 1 month, 24 days	Female
5	Melanie	2 years, 7 months, 11 days	Female
6	Ned	3 years, 6 months, 6 days	Male
7	Nel	2 years, 5 months, 11 days	Female
8	Sidney	1 year, 1 month, 21 days	Female
9	Tom	1 year, 6 months, 11 days	Male
10	Troy	2 years, 7 months, 21 days	Male
N=10		1 yr-3; 2 yr-4; 3 yr-2; 4 yr-1	4-M;6-F

Table 4 summarizes the adoptive family characteristics. All ten families were two parent homes in single family dwellings. Sibling numbers varied with families consisting of none to four other children in the family. Whether or not these children were adopted was not assessed, but there was a mix of adopted and biological children. At the point of interview, all but one had older siblings and three had younger siblings. Table 4 reveals birth order with one being raised as a first born in the family, five being second born, two being third born, and two being raised as fourth born children.

Table 4. *Adoptive Family Characteristics*

#	# Parents	# Siblings	# Children order (older, younger); gender (F,M)
1	2 Parents	0	Tom-1y 6m no others
2	2 Parents	1	1 older F; Troy-2y 7m
3	2 Parents	3	3 older F; Sidney-1y 1m
4	2 Parents	2	1 older F; 1 older M; Jill-2y 3m
5	2 Parents	2	1 older F; Kelly-4y 5m; 1 younger F
6	2 Parents	3	2 older M; Ned-3y 6m; 1 younger F
7	2 Parents	2	2 older M; Nel-2y 5m
8	2 Parents	3	3 older M; Karl-1y 4m
9	2 Parents	2	1 older M; Melanie-2y 7m
10	2 Parents	4	1 older F; Mary-3y 1m, 2 younger F; 1 younger M
			<i>Note: names are pseudonyms</i>

None of the birth mothers was currently living with or consistently involved with the father of the baby (FOB). Two birth mothers lived with their own mothers; three lived with mother and sibling(s). That means that half of the sample lived with at least part of their family of origin at the point of interview. Two of the birth mothers lived with extended family members. Their own siblings may or may not have lived with the extended family members. One birth mother had a new adopted family of her own. One lived with her boyfriend and another lived with boyfriend and others. The current boyfriends were not the fathers of the babies.

Two of the ten fathers of the babies (FOBs) talk with the birth mothers on occasion. Several FOBs had sexual relations with the birth mothers after birth and before termination of the relationship. Two of the fathers have some degree of relationship with their babies who reside with the adoptive families. Of the birth fathers, only one talked with the birth mother as well as had contact with the birth child. Table 5 summarizes the current living status of birth mother and father of the baby involvement.

Table 5. *Current Living Status of Birth Mother; Father of the Baby Involvement*

Others in birth mother's home	Birth mother involvement with father of baby	Father of the baby involvement with baby or adoptive family
<ul style="list-style-type: none"> ➤ Her mother (2) ➤ Her mother and sibling(s) (3) ➤ Extended family with or without siblings (2) ➤ A new adopted family (1) ➤ Boyfriend not FOB (1) ➤ Boyfriend not FOB and others (1) 	<ul style="list-style-type: none"> ➤ No relationship but occasional talking (2) ➤ No relationship (8) 	<ul style="list-style-type: none"> ➤ Visits or calls to adoptive family (2) ➤ No relationship with baby or adoptive family (8)

The support group agency used for this study had a facility that birth mothers could live in if they came from other states, if they needed a place to live temporarily while pregnant or just after open adoption placement before they were settled in their new lifestyles with income and a place to stay. Three of the birth mothers lived in this facility at some point. Two were from out of state and one needed a place to stay. All three found this place to be very beneficial economically, but also emotionally because they could talk with other birth mothers who had or were going through similar things.

Eight of the ten babies were placed during the time of hospitalization and birth. One baby was in the neonatal intensive care unit for a prolonged time, so discharge of mother was much before discharge of baby. In that case, the birth mother and adoptive parents would see the baby every day in the hospital. Another birth mother parented her child for the first six months and then made an adoption plan.

The ten birth mothers of the dissertation sample provided the candid, telephone interviews. The substance of the interview transcription is the bulk of material used for the dissertation analysis. The birth mother story timeline with postfinalization findings are presented. Messages to health care providers and messages to pregnant teenagers follow.

Birth Mother Story Timeline

Birth mothers shared information from pre-pregnancy and family of origin through their current stage of between one to five years postbirth and infant adoption placement. Some also discussed ideas of their anticipated life expectations in one year and in five years from the point of interview. These findings are presented as the story of typical birth mothers through the stages. Quotations of all ten interviews are included. Table 6 is

a sequential timeline of important aspects of a birth mother’s life that will be detailed in the following sections.

Table 6. Timeline of a Birth Mother’s Life Milestones

Time Period	Timeline Sequenced Aspects of Importance
Prenatal	prepregnancy→discovery of pregnancy→father of the baby→pregnancy→open adoption decision→choosing the adoptive family
Natal	becoming a birth mother→labor and birth→the baby→postpartum→discharge→facing life after open adoption
Life Beyond Hospital Stay	A =adoption accomplishment, adjustments, adventures ahead F =fresh start and direction R =relationships: changes and new E =emotions: processing and settling S =support, spiraling up or sliding down H =healing, health, happiness

Prepregnancy

Most of the ten birth mothers experienced some substantial stressors before pregnancy. This information emerged as the interviews progressed. Analysis of each interview revealed a time of increased stress for the teens. There were different stressors but the time prior to pregnancy was described as one with intensity. For example, several had experienced lengthy relationships with their boyfriend (“my childhood love” or “high school sweetheart”), predisposing them to greater pressure for a sexual relationship.

Some had other issues as in this example,

My mom was just so strict and she never told me anything about sex like birth control or condoms, she just said, like, “Don’t do it.” So I didn’t. But, I just kind of went crazy for a couple months and got pregnant. I had slept with like seven guys so I didn’t know who for sure. I mean, I know who [my birth child] looks like and I think I know, but he doesn’t want anything to do with us.

Some said they had been “a bad kid” or “a trouble maker” at home. One shared she “smoked, drank, snuck out, and rules didn’t apply” to her at the time. There was a lot of

fighting at home (“we clashed and butted heads daily”). One had parents of origin with an intact marriage yet with severe parent/child difficulties, one had currently separated parents, and the rest of the parents were single or re-married. Family violence issues were present. One reported, “I was having trouble since I was a little kid with my brother, abusive and beating me up and stuff, I mean, my life’s never been easy.” Another birth mother point out,

...after that [parent’s divorce] I started drinking a lot when I was 15, smoking weed, just, I guess ‘cause I was mad and my sister and I would still sneak out of the apartment and go walk down to my dad’s house and go visit him. ‘Cause we weren’t allowed to do that.

Some had very close relationships with individual parents, but none had nuclear family with married parents who were in their first marriage. Several participants were currently living with extended family. Two were living with their current boyfriend who was not the father of the baby. Several had substantial school difficulty and change. For example, one shared that she was suspended from school, bored during the time off, and became pregnant.

Several birth mothers had moved from place to place or had lived with a parent with severe parenting deficits (“I had to raise my [younger siblings]...I didn’t have a childhood”). Several had parents with mental or physical illness that influenced both parenting and stability of home. One shared “My mom has bipolar and I know there’s something wrong with my dad too but I don’t think he ever went to a doctor to get diagnosed.”

Impoverished living influenced home of origin stability. Several teenagers worked full time and went to school full time. The issues of money, transportation, and payment of rent for living at home or on their own were critical ones that determined residence.

One shared “I had just dropped out because it was too much for me to go to school and have to work and not have transportation to do either one.”

Parent-child (now birth mother) communication before the pregnancy seemed to be varied among participants. Some parents and teens had open, positive communication (“I would only talk to my mom and my boyfriend...I was just really close to my mom”) while others had terrible fights. Still others stopped talking to one another or met needs but were emotionally hostile or distant.

My general impression was that the family of origin or the prepregnancy time seemed to have quite a bit of stress with a variety of stress sources. Some, but certainly not all, of the stress may have been self induced. Perhaps this degree of stress should not have surprised me, but it did. For most, life in the family of origin and life in general before the pregnancy seemed intense for various reasons.

The families of origin were certainly not all dysfunctional. Some birth mothers reported strong family support that became even stronger through the pregnancy and open adoption. “They stand behind me one hundred percent” is a quote I heard several times. Yet, for the most part, this is the story about an adolescent who has a particularly tough time as a teenager; who through a variety of reasons may not have felt cherished, may not have had social support at that point, or may have made some choices that in hindsight she would have handled differently. She may have had more than most of impulsive, risky behavior or behavior contrary to parental desires. She may have tended to rebel or act out on struggles by having sexual relations. However, she may have been shouldering more responsibility than most. She may have had concerns that are commonly those of adults.

Discovery of Pregnancy

The discovery of pregnancy came from themselves, teachers, best friends, relatives, or others. Sometimes comments triggered the decision to take a pregnancy test. Once the pregnancy was discovered, attempts were made to limit the people who knew about the pregnancy. Sometimes there was denial or an ability to conceal the pregnancy. One shared that she hid the pregnancy until the day after her water broke. Another explained,

Nobody, even, my closest friends did not even know I was pregnant. I was small; I never got really big so it was kind of kept very secret and private. When I actually had him, I only was out of school for a week and then I went right back to school and just picked up my life where it left off.

One shared that she had been a good student so it was noticed and reported by the school counselor to her mother that she “looked kind of funny and was sleeping through class.” Still another said, “I didn’t really know how to tell my parents so I didn’t.”

Teachers confirmed rumors of pregnancy. Relatives, or boyfriends told parents, or the girls themselves told their parents. Once discovered or told, parents had mixed reactions, but most were supportive in actions. They confirmed the pregnancy, sought medical attention or took the laboring ones to the hospital. One revealed how the discovery came about,

[A friend said,] “I’ve never seen you with a pooch.” Others at work were saying, “You look like you’re pregnant.” I was like, “no, no.” [I took a test] and I got home ‘cause I wanted to tell my mom first once I found out and I got in the door and just fell to the floor crying and my mom says, “He got you pregnant.” I go, “Yeah. What are we going to do?” My mom goes, “Alright, alright, what do you need?” I was bawling. “It’s OK. We’re going to take care of this; we’re going to go to the doctor.”

Other mothers and fathers were shocked about not being told. Some parents were disappointed, silent, or rather task oriented. One shared, “My parents freaked out after

they found out but are really supportive. I have a close relationship with my parents so that helped...emotionally I was kind of up and down; didn't know what the hell to do." Another's mother said she would help with everything and revealed that the mother, herself, had given her baby up for adoption at the same age. One described telling her father,

I called my dad after I left the doctor. I was waiting in the car and I just started bawling. I said, "Dad," He's like, "what's going on?" I was like "Promise me a couple of things." He's like, "What?" "Promise me, tell me you are going to be with me and help me through whatever is going on and that you're not going to change your opinion about me." He started laughing and he goes, "OK." And I was like, "I'm pregnant." He was like "Alright, OK." We went to lunch and he said, "I told you this was going to happen." He's like, "Everything I told you that boy was going to do to you he did to you. But it's like OK. We'll do what we've got to do. I'm behind you." And at that time adoption wasn't even in my brain. [Later about considering adoption] he said, "Once you do this, it's for good."

The common choice was to not tell people who didn't absolutely need to know. If the girl stayed small, it was easier to conceal. One father found out when the daughter was well into active labor,

I hid it and the night that my water broke I was at work and I came home at about midnight and I actually set my alarm to get up in the morning, like, "Oh I'll take care of it in the morning." Then finally I got to the point where I couldn't so I went in to my dad's room and I was like, "Dad we need to go to the hospital." And he was like "Why? Are you pregnant?" "Well, I'm having the baby." And he was like "OK." He took it the way I thought my dad would take it. He was like, "Get in the car we'll go to the hospital."

The Father of the Baby (FOB)

Significance of the relationship with the FOB ranged from that of a *sperm donor* after unknown intake of a date rape drug, to not knowing which partner the FOB was, to a short *fling* relationship, to an important longer-termed relationship. These relationships

ended at the point of pregnancy awareness, during the pregnancy, birth, or within the first year after birth.

The FOB—if a boyfriend—was important at the time. One shared how the FOB worked with her at the time after the pregnancy discovery, “He would be like, ‘OK, we need to figure out what we’re going to do. And I’d be like, ‘Yeah I know, I’m going to tell my mom.’ And I would have in my head that I’m going to tell her and then I wouldn’t tell her.” Another said that the FOB was behind any decision she made about the baby. A third said that when she had an acute infection during pregnancy, the FOB was very supportive.

The relationship commonly had or developed challenges. Several indicated substance abuse by the FOB (binge drinker or alcoholic, methamphetamine addict, “heavy pill popper,” and drug dealer), some said that he was “a jerk,” “crazy,” “psycho” and was or became emotionally abusive. The pregnancy precipitated some of the behavioral outbursts.

The pregnancy was a turning point. Some said the FOB denied the whole thing, cheated, changed, was not nice any more, did not do anything for her or the baby, or “wanted nothing to do with me.” The rare birth father was supportive through the pregnancy. The following example was a refreshing distinction, “I had the support of [the birth child’s father] and he was supportive of the whole adoption.... ‘If that’s what you need to do, then let’s do that. It’s whatever you want to do’ and that felt really, really good.”

The discovery of pregnancy was considered a crisis and typically, but not always, negatively impacted the relationship. In this sample two birth fathers said to get an

abortion, but the birth mother would not do so. In two cases the decision for adoption placement may have ended the relationship, as one explained, “He was not in favor of adoption placement but did nothing for the baby.” Some of the fathers later came to a point of agreeing with placement.

Of note was that, upon retrospection, several of the birth mothers berated themselves for staying with the birth father so long. One said she was hoping,

...that I would go back with my baby’s daddy. Because at that point I wanted him back again. How stupid I was. And I just wanted him back. And then I moved, and as soon as I moved back I still dated him even though he had kicked me out. And I dated him up until the point he bold faced me and he told me it wasn’t my decision whether I would place [birth child]. And I’m like, No, it *is* my decision.

Several feared the birth father would try to get custody, and one reported the birth father was bitter about the break up but fine with the open adoption. One said that after jail her boyfriend contacted her because, “He wanted to get back together with me. When I brought up [the baby], he just really didn’t have any interest in the baby at all.” Some boyfriends use the baby as emotional pressure toward the birth mother to remain in the relationship. Two birth fathers had big emotion swings from wanting to “do what’s right and be a part of [the birth child’s life]” to getting angry and “doing crazy things.” Both eventually had noninvolvement. The mixed feelings of an ongoing relationship and paternity are exemplified in this quotation, “He’s still not ready to settle down. When I talk to him he says, ‘I’m ready but then I’m scared too.’” This seemed true even of open adoption, when paternity does not mean garnishment of income or carrying of other responsibilities.

Several described how the birth father would provoke them by using the baby as an emotional trigger to get to the birth mother. One shared,

When we were fighting—the way he would make me the maddest was if he said anything bad about [their birth child], I would like get so mad and he would use that to hurt me sometimes...he was there mostly for me except when we were fighting, he'd just like to trigger me and I would just like tell him, "you know what, that's the best thing for her and me [the open adoption]."

Relatives had opinions about the boyfriends. Some really liked them and their families, and some hated them. One was afraid at first because the family hated her boyfriend. Another related, "My mom said, 'I know you still love him, but you know you're not going to want to live that life.' I was like, 'I know.' 'So don't get back into that mess.' So he's done." Another revealed that a father-figure to her said, "If I ever see him he will be dead."

One birth father had opinions about the open adoption saying that "if we're doing this, I want it to be *open* adoption. If I'm a part of it, I want open adoption." Several did go on to see the birth child after the hospital stay. One birth mother had a gathering of her extended family and the FOB when the adoptive family came for a visit. She described the birth father's reaction to seeing the baby for the first time: "He came over. Everyone was at my house and he came over. He sat down and he would not take his eyes off her. He stared and stared and stared and stared. And fed her. It was a really good moment."

At the time of interview, to my knowledge, no birth mother was still involved with the birth father. Several reported isolated sexual encounters before relationship termination. It was difficult to break up with the birth fathers. Here is an example of the difficulty in ending the relationship, "I'd be one of the girls who would make excuses for him, like 'Oh, whatever,' and making excuses. And then he just kept pushing me and pushing me and like you know, whatever, and I just finally got away."

A couple of birth mothers still had telephone, email, or Facebook contact with the FOB. Adoptive families occasionally had contact with some FOBs and with several of the FOB's relatives. Birth mothers had opinions about how they would like to see their baby's father act, and it was different from how they saw their actual FOBs acting. One hoped,

The father of my *child* is going to be in my child's life whether he likes it or not and he [FOB] wasn't ready to settle down and quit messing around with drugs and stuff to raise a kid. And, come to find out he had two other baby mommas too. And I'm like, oh no. So every day, I'm so glad for what I did [open adoption].

Support during the Decision Making Process

The agency was a primary new support at the point of deciding how to handle the unintended pregnancy. The initial contact with the agency was self initiated, or came through mother, a friend, a relative, or a health care referral. Once contact was made, agency support came through the director or an associate, the weekly support group meetings, the transitional house (three of the study participants), counseling, and the adoptive family. The support may have come in the form of emotional, physical, mental, spiritual, or social dimensions of life. Consistent contact with multiple forms of supports seemed to enhance growth and the ability to make decisions about pregnancy choices.

The director and agency associates listened to initial contact telephone calls and connected women having unintended pregnancies to agency resources, most notably the weekly support group meetings. Sometimes a face-to-face visit with a girl was important.

Weekly support group meetings with those who had or were currently facing unintended pregnancy were especially important to most during the decision making process. As others shared their struggles and decisions about making adoption plans or

parenting, the study participants seemed to integrate what they heard into their own decision making process. The examples tended to facilitate the decision making process. Giving voice to their own plans helped them see they had some control of the situation and helped refine their options. Perhaps for the first time they voiced desires, plans, and outcomes.

Several examples demonstrate the benefits of support. One example shows the benefit of peer support through the agency support group,

It helped me out being pregnant because they had been pregnant before and I hadn't been pregnant so they told me all the stories and told me how it was to have an adopted child that has different parents. They kind of really helped me with the whole idea.

One birth mother from out of state shared the benefit of the agency transitional home support and her changing perspective on other relationships,

But everything we did in the transition house just made me realize that I would get attitudes with my mother and how I was acting. Being in the house made me realize how much I really need her [her mother] and how much she does for me, keeps a roof over my head, clothes on my back and how special she really is. So it helped me, helped me realize how wonderful my mom is. So, moving to [state] helped me more than one way. I think *that* [moving to be at agency] was the best decision I ever made. Yeah, I had to get away from being in trouble, and bad people I was around. I needed to get a clear head and that was the perfect place to do it because I didn't know anybody, I was just there and had to kind of cope with things.

Participants reported that early support during initial decision making came through means other than the agency as well. When family of origin members were involved, birth mothers reported growth in those relationships and genuine help as a result of their support. At the point of pregnancy, however, not all parents were able to be supportive. One reported, "Group and the counseling helped me with that [pregnancy decisions] 'cause my mom really didn't know how to help me at that point."

One shared about her supportive boyfriend who was not the father,

That whole time and my best friend at the time who is now my boyfriend, came over every day, and stayed there every night. It was just, he pretty much took care of me for the next two weeks. He'd bring me movies, he'd bring me grape soda, 'cause that's my favorite soda and finally when I could get out and do stuff he took me to church and I went to the support group My boyfriend helped me a lot through it. If it wasn't for him, I'd probably be a little bit crazy. He helped me out a lot. He talked to me.

Occasionally, the FOB was an important support of the adoption process. When the FOB was truly supportive, he had input that the birth mother carefully considered.

Pregnancy

In learning about these unintended adolescent pregnancies, I was struck by the positive reports about pregnancies. Pregnancy literature emphasizes the tendency for adolescent pregnancy to involve greater risk than pregnancy during other maternal age ranges. There were indeed some reports of infection, bleeding, preeclampsia, preterm labor, and preterm deliveries. Most, however, reported wonderful pregnancies and that they enjoyed being pregnant. They were active, tried to keep their usual schedules, but were very tired. Being tired was a consistent comment.

Parental opinion was a factor during the teen's pregnancy. Parents that knew were disappointed but very supportive. One birth mother shared that hearing the baby's heartbeat changed her mother's viewpoint. Describing the office visit she shared, "...and everything changed. Yeah, she was crying and the doctor was real, she was just happy, and she was there for me ever since that day. She was very, very supportive."

The agency was also helpful during pregnancy via the support group and also with practical help. The agency linked birth mothers with legal, medical, transportation, and financial resources. Mentors were available, labor support doulas, and prepared

childbirth class instructions. These were mentioned as extremely helpful supports during pregnancy.

Open Adoption Decision

Birth mothers came to a point of realization that they wanted to consider choosing to have an open adoption. Some knew right away that open adoption placement was what they wanted, some came to the decision over time, and all considered the baby's future life. They realized their youth, lack of readiness to raise a baby, and believed two-parent families were better suited. Several commented that they made the open adoption decision because of financial concerns. One explained,

So I decided to gather information about how much it would really cost for me to literally live on my own and support this baby that was my child. And I just looked online, and called places to see how much rent was and how much utility would be and ask people things. I came to the conclusion that I couldn't do it.

One said, "And I'm like, 'OK, I don't have a childhood. And I'm about to raise another kid?'" so she chose open adoption.

Others planned to parent but over the course of the pregnancy changed their minds as with this example, "There was also the possibility of me trying to keep the kid so I was working and trying to see if that was a possibility. And, when I realized that wasn't going to happen, I was for the adoption." Some heard of the agency and decided to attend a support group meeting. One explained, "I got the medical care that I needed, went to group, and planned on parenting. At six months I started thinking about if I could really do it myself at [this age]." She decided parenting would not be best and made an adoption plan. Some had extended family members who knew about the agency, some

chose open adoption after they looked at life books about adoptive families and some chose after meeting a particular couple or family.

The following quote is fairly typical of the birth mother perspective at the point of deciding to have an open adoption plan:

I didn't have anywhere to live. I didn't have a car. I barely had a job. I knew that I could do it; I could get on welfare and everything. I was really poor when I was growing up and I didn't want her to have to go through that. Plus, I wasn't sure who her dad was. 'Cause I wanted her to have a dad since I didn't meet mine.

Birth mothers wanted to make sure their baby had a good life. Table 7 summarizes reasons birth mothers gave for choosing open adoption of this child and at this time in their lives.

Table 7. *Reasons Birth Mothers Gave for Choosing Open Adoption*

I wanted the baby to have:	I:	I wanted the baby to avoid:
<ul style="list-style-type: none"> ➤ a loving mother and father ➤ siblings ➤ a stable life and home ➤ provision for needs ➤ provision for desires ➤ stay at home mother ➤ fun ➤ the best life possible ➤ a better life than I could give at that time ➤ spiritually strong family 	<ul style="list-style-type: none"> ➤ was still a kid myself ➤ was not able to provide ➤ did not have support ➤ was not ready to be a parent ➤ still needed school ➤ would have to get a job ➤ would have to have day care 	<ul style="list-style-type: none"> ➤ being around bad influences ➤ day to day lack ➤ a life without a dad ➤ a life of struggle ➤ a life with an unstable parent ➤ being raised by a single mom

Choosing the Adoptive Family

Some birth mothers chose the adoptive family early on in their pregnancy, some later, and some even at the hospital after birth. One chose after parenting for a season.

The choice was made with life books that were photo and written descriptions of couples

or families. These families had finished the full preadoption process including the home studies by social workers and the extensive adoption agency requirements. The life books were shown to birth mothers. Sometimes birth mothers chose the family based primarily on the life book information as with this example,

Then I looked through [the adoptive family's life book] and I was half way through it and I was like, "This is it. This is them. This is who I want it to be." And they were like "Are you sure? Are you sure? You know we can talk about it" and blah, blah, blah. And I was like, "No, I'm sure," I want, I was like, "Look, they do all this fun stuff and I want my baby to be able to have a lot of fun."

Some birth mothers choose the adoptive family based largely on interview meetings with them. The agency encouraged face to face interviews. What triggered the decision to choose an adoptive family is often unique as with this example,

I met them and I *loved* them and just the way that they connected with him [baby]. And the way he looked in their eyes and the way they looked in his eyes. And just, it was meant to be. I knew that these were the parents he was meant to be with. And so I asked them two questions as they were walking out of the room. I asked them if she liked catsup and she said her nickname in high school was *catsup*. Can you believe it? She goes, "I eat catsup on everything." And then the other one was, "Do you let your daughter watch Sponge Bob?" and she said, "No." and he said, "Yes." And I go, "OK, awesome." So they left the room and I told my sister, "OK, that's them. I don't even want to talk to anyone else. That's who I want to be the parents of my child." And she said, "OK, well sleep on it just to make sure." And you know, my mind was set, but I slept on it anyways. So the next morning at seven, I was like, "Alright, OK, it's seven, I slept on it. Call them."

The adoptive family was chosen for various pleasing features. One birth mother liked the fact that a family had a young adopted sibling because, "he'll have someone to talk to about that." Another had a particularly special relationship with the adoptive mother, and still another had a mixed ethnicity family similar to her birth child. Spiritual qualities of the family were also important and several times the phrase, "it was meant to

be” was shared by the birth mother as describing the choice of the particular adoptive family. Proximity was an aspect that affected the choice of adoptive family as well. One described the realization that if she had a closer adoptive family, she would be able to visit her birth child more. As the time of decision drew near, she knew she could not have her birth child living out of state.

The adoptive family became deeply important to the birth mother during and after the adoption process. Particularly the adoptive mother became a consistent caring support and often a role model. Frequently the prospective adoptive mother would take the girl to appointments, to the mall, out to lunch, and other places. Sometimes the girl would be with the family in their home. This would help her enjoy being with them, as well as see “how their family was and how they did with their children.” The participants grew to love and trust the adoptive family. Overwhelmingly, birth mothers felt that their birth child was safe, in a great family, and had advantages that she herself could not provide. Their strength became part of the confirmation that her decision for open adoption was the best option as in this example:

I felt like I needed to do the *best* thing possible for my baby so I looked into open adoption. I reviewed life books which are pictures and stories almost like photo albums of different families who wanted to adopt children. One had a note, “Kelly & Joe are looking for a little brown baby to go with their youngest daughter [who is African American],” and so I looked through it and I kind of felt like, “This is it, this is the family, this could be the family that takes care of my baby and adopts my baby.” I interviewed them with my mom and asked questions about schooling and discipline and just basic stuff. We discussed naming. I had set a name and they didn't agree, then I leaned over and said to my mom, what about the name, “__” and right then, [the adoptive mom] said, what do you think about the name “__” and it was the same. It was kind of like a meant to be thing. So I knew it was supposed to be. I picked them.

Becoming a Birth Mother

In summary, with support the birth mother was able to think of what would be in the baby's best interest. She determined that making an adoption plan would be more suitable than parenting the child herself. She looked through life books about adoptive families. She met one or some and chose one family. The teen decided to make an adoption plan typically some time during the pregnancy. She prepared herself to become a birth mother. She began to build a lasting relationship with the adoptive family. Particularly the adoptive mother became a friend, a confidante, and perhaps a mentor. The birth mother came to esteem the adoptive family highly. This relationship typically deepened during the hospital stay and beyond. The meaningful nature of the relationship with the adoptive family was one of the notable benefits of open adoption placement to birth mothers. The relationships extended beyond that of aspects surrounding the baby.

Labor and Birth

Labor was everything from "a really easy labor," to life threatening for mother and baby. I will describe the onset of labor with one situation to give a sense of how the laboring experience can differ from a usual labor:

But at about 4:00 in the morning I was like, "OK I'm awake." Like I think still then I was just like, "This can't be happening. This is not happening." So I like got up, I tried to get ready for school. My mom came upstairs said good bye to me, (So like yeah, this is like completely crazy), came upstairs, said good bye, I told her I loved her. She had gone to work and I didn't go to school, obviously. At about 11:00 I called her and I was like, "I lied, I am pregnant, and I'm pretty sure I'm in labor." She was home within like in 2 seconds. She came home, we went to the hospital. I got to the hospital and found out I was actually 10 cm. dilated.

The birth was a powerful time with complex interactions. The intensity and wonder of being part of creating a new little baby touched the teens deeply. They often

felt a “perfectness” of the baby. Some had so prepared for the open adoption that they had the perspective that they were carrying and birthing someone else’s baby. Birth mothers genuinely had a desire to make the adoption plan work well. This desire was coupled with an awareness of the process being “so hard.” The difficulty was not that the decision to make an adoption plan was doubted, but that the coming loss was felt deeply. This coming loss loomed at birth, but was especially felt while in postpartum, and most intensely at discharge. It was *hard* during this time that was already filled with hormone changes and postpartum blues.

Childbirth labor or emergency delivery was everything from preterm, typical, fast, late, or atypical with problems. Preterm delivery may have been an emergency such as with this example,

My sister had been checking on me through the night and right when she passed my door, she heard me say, “I’m going into collision.” And that’s the last thing I remember. And I guess, from what I’ve been told, I was convulsing on my bed. I bit half my tongue off. My mom came in there...couldn’t get me to come to. My sister called my grandparents and they called the ambulance. The ambulance came and my mom said, “She’s pregnant and you need to get a hold of the doctor.”

Health issues during pregnancy may have led to an induction of labor.

A typical delivery of one who had attended the agency support group may have included a labor support doula, someone who assisted one-to-one with the birth mother’s labor. This was viewed as extremely helpful. The labor and delivery may have been uneventful, relatively short in time length, and described as “a really easy labor.” Or, it may have been quite challenging.

A typical delivery had the adoptive mother or both adoptive parents present in the room as seen here,

[The agency director] had this thing that we had to sign and fill out to say how much involvement the adoptive parents can have. When I filled mine out, I let them have everything that they wanted to do, come in my room, or be in my room through the delivery and all that stuff. So, they were at the hospital a lot of the time.

Another example is,

I just felt like, really, [the adoptive mother] is never going to get to experience what all happens and stuff like that 'cause she can't have kids. And so I was like, yeah I'll let her be in the room, and let him be in there. I was comfortable about it.

Some birth mothers had nonmedicated deliveries. One shared with pride, “[The adoptive parents] are in there and [the adoptive mother] just looked at me like, ‘I can’t believe she’s doing this without medicine.’” Some had epidural medication that made the delivery “smooth sailing” and “probably the easiest birth ever.” Those who had overdue deliveries sometimes were induced and had very long labors. One birth mother was in the hospital laboring two and a half days. Some had cesarean sections as in this example,

And I guess I had a c-section and she was born 2 pounds and 1 ounce. My mom said when she saw her, she didn't think she was going to make it....I remember seeing her when they took her out of my stomach. Barely, just hanging there in the palm of their hand. And they were like, “We've got to get her to neonatal.”

A catharsis of emotion was typical of the immediate postbirth time. One shared, “Right when he was born, I just burst out in tears. I think it was a release, and it was upsetting and so many emotions just came over me at one time.”

The Baby

The birth mothers had a sense of wonder about the baby and regularly commented about the baby being “exactly like” themselves and “perfect.” If the baby was critical or the birth mother had a cesarean section, she only briefly viewed the baby as with this example,

They were all around the baby and I don't even remember them handing me the baby 'cause it was so fast, 'cause I think she had a problem like when she was coming out, like she couldn't breathe or something.

Birth mothers bonded and noticed things that were, "exactly like me" and warmed to the baby. They tenderly shared memories like, "he looked just like me, he had my eyes, and my face, and just like me." Words such as "perfect," "pretty," and "beautiful" were commonly used. This example sums up the general perception,

But I got very attached to her in the hospital. Well, she looks exactly like I do, exactly. So it was really hard. And she was like, just perfect. Nothing was wrong with her or anything. She was perfect and so pretty and I was just really attached.

Eight of the birthmothers had the adoptive family present at or just after delivery. They worked together with the adoptive family. Some birth mothers held the baby first. Sometimes the adoptive mother held the baby first. In adoption, the point of birth is a change point. Many tender experiences are shared. Here is an example of the transition from birth to adoptive motherhood that is almost like the passing of a baton in a relay,

Toward the beginning, I was still *the mom* on her wrist. And so I had to bring [the adoptive parents] in. And so once we got that figured out, only certain people on the list could go in. So it was like [the adoptive parents], me, and my mom were the ones that were allowed in. So we kind of started having to take turns because the feeding times, when she started drinking out of the bottle. So [the adoptive parents] are going to take these times and then I can go in. And I had to let them take the first. I had to let them take more time to feed her than me because I knew she wasn't coming home with me and me bonding with her like that.

At the point of birth and immediately after delivery, some hospital staff members were awkward with the whole situation as one shared, "A lot of people don't understand it [open adoption]. Oh yeah, because in the end it's all for the baby." The birth and adoptive family of this study seemed to be able to work through and establish a comfortable schedule of who is with the baby. This seemed to happen without any

hospital staff intervention. The mutual joy of birth, the admiration of the birth mother's strength, and a relief of successful delivery seemed to be celebrated by all of the typically exhausted people present at and just after the baby's delivery.

Postpartum

Postpartum was a time of transition and deep emotion. The events of birth and immediate postpartum affected the next several days. There was a wide variety of experiences. Those with complications had memory gaps about their experiences,

Birth mothers who were physically able typically enjoyed time with their babies as is evident in this reflection,

Well they didn't have any room in the hospital for the adoptive parents so for about a week I got to take care of her. Yeah. It was awesome. I mean, it was very hard too. It was harder to give her up, because of that chance to be alone with her for so long. But it was good too. Everything that goes on with it has two sides. But I got to hold her and give her a bottle and change her diaper. And we watched TV together and everything.

Her statement, "Everything that goes on with it has two sides" is consistent with so many aspects of open adoption placement, particularly during postpartum. Birth mothers were aware of postpartum being a different and really unique experience for them. One shared,

I had this little baby boy and he was just the most precious thing I had ever seen. Those three days he was with me during the daytime and at night time he would go to the nursery or with [the adoptive parents]. But if I was awake, he was with me pretty much. I loved it. I loved getting to be in my hospital room alone with him. It was a different little experience that we, I kind of like sat there and I talked to him and told him kind of like what was going on. He was only a couple hours old but he totally understood me. I'd hold him and talk to him, and look at him. Yeah, cherish every minute of that.

Some genuinely enjoyed aspects of postpartum. It had joys and sorrows. Positive experiences sometimes happened with the birth fathers as exemplified here,

My baby's daddy came up and he stayed with me throughout the few days that I was there. It was really good, just the three of us in the hospital. I loved it. It was one of my most prized moments even though we're not together anymore. I'll always remember, until, of course I have more kids and then that will be better moments.

And, sometimes quite negative experiences happened with the birth fathers,

My blood pressure kept shooting up. They finally had to take my phone away from me and not let me have any contact with him [FOB] until I could get my blood pressure under control. . . . When it came down to signing the birth certificate, I asked, at that point I was like, "Do I *have* to put him on there?" Even though you're the only guy I had ever been with and they were like, "You know, that's up to you." I did not put his name on it.

Most wanted time alone with their baby, as in this example, "They [adoptive family] knew that I wanted that time [with the baby]. But I had told them that that was the one thing that I wanted. But they were still up there, you know, and everything." A few, however, guarded how much time they spent with the baby. It was as though they were taking caution to not allow their hearts to get too deeply involved at that point. This quote demonstrates,

[The baby] was staying with the ___ family down the hall. And so I didn't spend much time with [the baby]. I knew if I did I wouldn't go along with the adoption. . . . I really, really hated them at that time. Because I had to leave the hospital without my kid and they got to leave with [baby]. I was really upset about that. And so I really, really did not like them at all at the time. I almost changed my mind several times in the hospital. It was the most depressing time of my life ever, was those three days. It was really bad.

Some had important postpartum health issues. Birth mothers faced complex social issues, high blood pressure, eclampsia resolution, cardiac issues, blood loss, and postpartum mood disorders. Sometimes these were not readily identified by the young, overwhelmed birth mothers, and sometimes they were hidden.

Birth mothers were aware of the coming changes and sometimes these looming realities played into their postpartum blues. Anticipatory grief and perhaps self protection measures were in place. The following quotes typify the mood,

Well, I just kind of, it's hard because I'm adopted myself. And even though it was an open adoption and I knew that I was going to see her, and you know get pictures and all this stuff, it was just kind of hard to just think that I won't see her take her first steps. I won't see her crawling, or any of this stuff because she's not—technically she's not—my daughter well she's my daughter but...she's not. So it was just difficult for me. I cried and I didn't...I let the adoptive mom take care of her afterwards in the hospital, after the birth so that they could kind of be together and stuff. I didn't want to get too attached 'cause I felt like I might have changed my mind or something like that so, it was really, really difficult. It was hard. But, reassured and good because there were a lot of people who cared and loved her and wanted to hold her. I knew she was in a good place.

Replaying the decision-making that had already been done during pregnancy seemed to be important. It seemed to help them to be strong and resolved to complete the open adoption placement, even with the intensity of their postpartum emotions. For example, One relayed, "I want [the baby] back every day but that's what *I want*. But I know what *[the baby] needs* is more important. And [the baby] needs a stable life. So coming to realize that makes it easier."

Then it was kind of like, they put me in another room and I was all relaxed and then I got to spend the first day with the baby. But the second night—'cause [the adoptive parents] told me—they were like, if you want the baby in the hospital, keep the baby with you. This is your time with her. And so I spent a little bit of time with her and I told my parents, I actually was like, "She's so pretty." I wavered on my decision, but decided adoption.

On occasion there is a definite wavering of decision. In this sample, one voiced a definite point of wavering, but had a reassurance after the caring response of the adoptive mother. She continued with her open adoption plan, explaining,

I started hanging out with Brian and Jane (pseudonyms) a lot. I got really close to Jane, and I know, Brian too, but Jane and I went shopping, I hung out with Ann, their little kid a lot. You know she (Jane) just did everything. She took me to my doctor's appointments, she took me to lunch, if I was ever bored I could come hang out and watch TV at their house. So I built like a really good, strong bond with them.... [In the hospital she sent a message to the adoptive family saying,] I was thinking about keeping, and that I was really sorry. And then Jane's response back was, "Do whatever you want to do. We love you. We support you no matter what, you know, like, we love you, you're our family now." 'Cause they spent so much time with me.

Open adoption placement can be a joyful, painful experience. The most difficult time seems to be the days of postpartum and discharge. The joy and pain of postpartum were very individualized and improved when the birth mother had opportunity to gain support and to build a relationship with the adoptive parents. She was also bonding with her birth child in a unique way. The pleasure of that bonding often was marvelous and healthy. One shared satisfaction over knowing her birth child knew her voice.

Discharge

The pinnacle of painful emotion was discharge. Almost universally the time of discharge was a deeply difficult point. Ambivalence and raw emotions are so evident in the following statement on her day of discharge, "And I lost it. I could not stop crying. It was tears of joy but then sadness for me. But I was so happy for [the adoptive mother]. And she was crying."

Discharge can be a point of hospital staff confusion. What happens at the hospital can have lingering effects at the vulnerable postpartum point. Sometimes mistakes are made that are hurtful. This quote exemplifies,

Leaving the hospital was the hardest thing because my sister was putting the baby in the car seat. I was getting into the wheel chair and the gentleman that was pushing me out, he said, "We prefer the mother to hold the baby." We were like, "OK, well, the baby's not going home with

me.” He was like, “Oh, I’m sorry.” And we were like, “It’s OK, you didn’t know.”

It is easy to envision the following situation in this vivid portrayal, “Especially the day I left the hospital and I got in one car and the baby got in another. We went in different ways. That was the hardest.” One readily can picture this depiction as well, “Then, I was standing in the doorway of the hospital and I saw [the baby] and her family get in the car with the baby and drive off. And I just cried the whole day.”

Pleasantly, there were also some “best case” examples of the discharge event. The adoptive mother made a very big difference at this juncture as one birth mother aptly illustrates,

We were leaving the hospital. It was just like a big group thing. [The adoptive mother] does a really good job like with not just trying to be, “Oh I’m the mom, I’m the mom.” She does a really good job about saying “This is your birth mom, I’m your adoptive mom” and stuff like that.

Social support for the birth mother’s family and even the adoptive family also made a difference.

The finality of one phase of open adoption happened at the point of discharge. The birth mother seemed to say good-bye to her birth child and good-bye to parenting this child. She then turned to meet her own life reality. It was life after open adoption placement. It was life as a birth mother. Each birth mother would come face to face with her ongoing emotions as well as her own current life situation. Her plans seemed to take on a greater intentionality.

Posthospital Life as a Birth Mother Through the Time of Adoption Finalization in Court

The birth mother was immediately faced with having her own life without the baby after having been through the major life events of pregnancy and birth. She was still

resolving her own grief. After discharge various problems were faced. Postpartum mood disorders, including depression, anxiety, and initial diagnosis of mental illnesses, were some of these difficulties. Another emotional hurdle for some was the adoption finalization. Adoption finalization in court brought a closure of sorts to the open adoption even though the relationships continued.

Immediate grief and depression came in waves. One explained, “I had a lot of nights where I cried myself to sleep and just being by myself and depressed. Depression set in really, really bad. ‘Cause I had struggled with depression before I even conceived her. I got on antidepressants.” Another shared, “I got put on antidepressants, I’d say for 6 months. I chose not to do counseling.” Still others worked through their own grief through counseling, support group, times with her own family members or times with the adoptive family.

Several birth mothers tried to pick themselves up and function as they had in prepregnancy times. This was not always successful. One shared,

I was a jerk to everyone. I felt like I’d made a great decision and I’d done what was right but I didn’t really care anymore. I had nobody to care for, didn’t really feel like anyone cared for me so I just went on about my life. But when I moved to the transitional home, everything changed. And I was so happy, and I lit up, and it was amazing. When I became a Christian, I started playing with children.... It was amazing. I went from being like a total grouch to being the sweetest person on earth.

She would be hit by the emotion of it all at unexpected times and sometimes in debilitating ways. Acute grief episodes happened. Those who attended the weekly support group definitely benefitted from attendance and from telling their stories. But, some did not attend.

Seeing the baby and the adoptive family unanimously helped birth mothers. Sometimes getting out with the adoptive mother and baby was an inspiration. Sometimes the visits would reaffirm the goodness of the adoption decision. For birth mothers who were at a distance or were not able to see the adoptive family often, visits were very helpful, but the good-bye was bittersweet. Self talk, like the following, helped, "I would kind of talk to myself that this is the right thing. Where would I be if she was with me? Well, I would be struggling and she wouldn't get everything she needed. And then I would be OK again." This self talk was a reminder of her reasons for making an adoption plan. This self talk emerged as an important discovery that seemed to be a regularly used coping method when the emotions were strong. This notion of a self talk litany will be discussed more later.

It remained difficult for birth mothers as they thought about the baby and the open adoption. They had various issues to consider, such as the child's views of the adoption in the future and how they would explain their decision to make an adoption plan.

The day of adoption finalization at the court house was mentioned by several as being stressful. It was an event when the finality was viewed as momentous. Some felt relief and others felt drained, but it gave a degree of closure. Again support made a difference. This example captures the emotion.

I think maybe a few weeks, 2 weeks, 2 ½ weeks, I had to go to the court house and sign that I'm placing [the baby] for adoption, and that was really, really hard for me to actually sign something that says legally I'm not her mother anymore. That was really, really difficult for me. But, I had a lot of support. Well the agency, the agency is supportive. Everyone at the agency is supportive. I was going to the adoption support group. I went before [the baby] was born and I went afterwards. [Another birth mother] came with me [to court]. So, then that was really, really nice.

Some felt hopeful and gathered strength through the realization of positive outcomes. A birth mother explained, “I don’t know, it gets harder, but then I just realize, this is what God wanted. This is, she’s got everything she could ever...She’s got things that I could never give her. She’s got it all.” So, even though birth mothers were recovering from their own loss, they had courage and were encouraged with the open adoption situation. Some felt that the open adoption made them a stronger person.

One can see that birth mothers were faced with grief, depression, and a feeling of this being the hardest thing they would face in life. Along with their difficulties was a gathering strength. Other issues such as boyfriend problems and people not understanding the open adoption were at hand. Future plans were now immediate. One explained, “I had to finish school and start my life and I was still just a kid.” There was a hopeful sense of being a stronger person along with a great need for that strength. We will see in the next section that there is a turning afresh for birth mothers after the open adoption placement is in her history.

Life after Open Adoption: AFRESH

The intent of this inquiry was to get to the self perceptions of birth mothers about their own life after unintended pregnancy and open infant adoption placement. This information was desired in order to see how these experiences shaped their lives. Chapter Four used two primary ways to reveal the perceptions birth mothers had about themselves. The first was in this timeline prior to birth and infant placement. After this crossroads, the birth mother turned to reflect on her own life that was forever different. Within the first months after discharge, she was nearly recovered from the birth. She was still filled with emotion. She was experiencing new relationships and facing changes in

old ones. Decision making was still very necessary. The demands of life that had been on hold began at that point to nag for her attention. The big question was, “What will her life be like?” The second primary way of revealing birth mother perceptions in the chapter after birth and infant placement came about after analyzing transcripts.

One birth mother used the word, “fresh” and “refreshing” several times to describe desirable aspects of her life after becoming a birth mother. The term *afresh* means “from a fresh beginning” (Merriam-Webster Online Dictionary, 2009). To focus reader understanding of the findings for this postplacement time period, the acronym *AFRESH* was used so that the postplacement findings could be easily recalled.

A

A stands for adoption accomplishments, adjustments, and adventures ahead. Birth mothers had accomplished many milestones thus far. These included the choices of giving life to the child, settling aspects of the birth father relationship, gaining contact with an agency, gaining support during the process, choosing an open adoption plan, choosing an adoptive couple, giving birth, and making the open adoption placement. The adoption finalization had also become finality, thus completing the legalities of placement. These many events were done. Much was known to be ahead in life for birth mothers. They turned their focus to what life would now hold. Activities, work, education, and relationships may all have needed adjustments. The postplacing birth mothers were more focused and intentional in personal perspective. They had developed a maturity and were embracing the adventures ahead. Adoption accomplishments, adjustments, and adventures ahead were what were being faced at that juncture.

F

F stands for fresh start. Although some returned to the same setting they were in before, they were different people with greater maturity and a different perspective. Most did experience or create fresh changes in work, school, career, finances, relationships, or even health. Their perspective was directed toward finding what was best for them now as individuals. The presence of a birth child caused them to want to be better people. Birth mothers had a fresh start. It was a new beginning; a maturing. One of the pilot study sample participants said it well,

And now I started growing up and taking a different, getting a different outlook on what to do, and trying to figure out how I needed to be a better employee, a better work ethic, better ownership over what I was doing. So that's what I did. I just started working a lot and putting a lot of time into my job and becoming good at it and still trying to build my relationship with my boyfriend at the time [now husband] and my family. Again, I just continued to grow closer to my family.

Another from the pilot sample shared a different angle of the same idea of a fresh start,

After ___ was born, the four years out, I did a lot of growing up. If I would have had ___, I wouldn't have done that. I'd have been in *freeze mode* and everything would have been about that child. You know, or it would have been the opposite. It would have been all about *me, me, me, me, me* because when you're a teenager, you go through *selfish phase*.

The birth mother liked to stay busy. Staying busy may have helped her overcome getting depressed. Activity may have included school, work, social life, physical activity, relationships, and hobbies.

The birth child was a very present influence on her improved lifestyle choices. She wanted to be a good example to her birth child. As one from the pilot sample said, "I have a responsibility to still act in her best interest...to be an example for her. That's how

I feel. I feel very strongly about that.” Indeed, birth mothers made fresh activity and outlook changes, as seen in the following statements from two different birth mothers,

It’s complicated. I wouldn’t have it [open adoption] any other way even though it’s been really hard. I’d say this past year I’ve been doing great. I got off of drugs. I was clean for over a year. I got my own place. I got really into a new hobby. I was just working and staying out of trouble and stuff and still seeing [the baby] at the same time. I’d stay last summer was the best since the adoption.

And then I started college in August. And right before I started, I went to [different state] for a visit for my birthday. I stayed; I think it was a week. I stayed at the [adoptive parent’s] and took care of [her birth child] and stayed with the family. It was nice. I think each time it gets better when I have to leave or when [the baby] leaves me. It gets easier to kind of get back to doing what I was doing.

Her fresh direction seemed to have substantial improvements to some aspects of her old life. There was great satisfaction over personal decision making with a resultant increase in self esteem. There seemed in some to be an ability to embrace the fresh challenges with a newfound happiness or joy. As one shared, “I was so excited to go to college. That really helped me to have something to look forward to. I had all these fresh things in my life. That kind of helped me transition.” Growth, changes, and staying busy were all a part of birth mother’s fresh start (*F*).

R

R stands for relationships. Birth mothers clearly had changes in old relationships and the beginnings of new ones. Some old relationships were terminated and others had tighter boundaries. The relationship with the birth father, for example, had typically ended by the postpartum time. The birth mother often gained a greater ability to establish appropriate boundaries.

Other relationships had been strengthening with new effort given toward their development. Relationships with family of origin often improved. One related,

And a lot of my support was my family being really proud of me. Like, they were just being like, “We’re really proud of you, that’s amazing.” Just being very positive with me helped me stay calm and just didn’t think of it as an issue or something to be sad about. It’s just always something that I became proud of. So, like I said, when I showed the pictures, it was always something I was proud of. Just because that was kind of instilled from the beginning.

Newfound friendships from the support group, for example, had deepened due to shared and similar life experiences. Birth mothers chose relationships more carefully and may even have valued them more.

Those who maintained the prepregnancy friendships had adjustments related to the open adoption. Friends knew how special the birth child was to the birth mother. The relationship with the birth child, as mentioned before, had a lasting impact. All birth mothers planned to maintain involvement in their birth child’s life. The relationship with the adoptive family had grown to be much more significant, often having life changing impact.

The relationship between the adoptive family and birth mother grew to become like extended family. The distance between living locations influenced frequency of visits but the nature of the relationship was family-like. Birth mothers felt they received friendship, unconditional love, listening, counsel, and care from the adoptive parents. The adoptive family was grateful toward the birth mother and the birth mother felt fortunate to have such a wonderful adoptive family. Having the special connection through the adoption made a difference, as seen in these quotes from two birth mothers:

Open adoption is such a great thing. It gives you a whole new family like I've changed my life because of this. I thought because I placed my son, I would have less reason to care but I have more reason because I have a whole crowd of people who care about me. Her parents, [adoptive mother's] parents, [adoptive dad's] parents, their brothers and sisters, their kids—not [adoptive mother's] kids, but her brother's and sister's children. They all care about me and we're all one big family now. You go from having nobody to having everybody.

When I thought about it I was like, I wouldn't be about to supply things for her, or take her a lot of places, or give her a lot of things. Like I would still have to be going to school and plus the dad was being such a jerk and I wanted the baby to have a mom and a dad. I don't know. And after I met [the adoptive parents], it was like—perfect— 'cause they go on a lot of trips like she's already gotten to go to the ocean and they do like a lot of things. And I wouldn't have been able to do that with her. [The adoptive mother] like stays at home with her, you know, is there for her every second of the day, and I wouldn't be able to do that so I kind of just figured that it was better. And so it's like a good thing too because you *can* give your baby a life, a good life, and still see her and be in her life.

Family of origin, newfound friends, and the adoptive family all seemed to be relationships of meaning. Several birth mothers also had new boyfriends who were not the baby's father. The relationship with the birth child continued to blossom.

The baby's development was a continual wonder. Birth mothers loved knowing their birth child was safe, thriving, and growing. They also loved knowing that birth child was aware that they were the birth mother. One explained, "She knows me, she knows who I am. She kind of already knows where she came from. They grow up knowing that." Another related,

Out of all that, that's happened, it's been really worth it because ___ [birth son] is the happiest kid I've ever seen. He's good, he's well mannered, he's very smart, and he's very happy. So it's definitely worth it. I would not have changed anything if it would have changed the way he is now and how happy he is. That was the way I wanted and that's what happened. So even though I had to go through the things I did, it was worth it.

They savored a relationship where they could be a part of milestones. Often they would visit on important days such as birthdays and holidays. They enjoyed special shared events. For example one birth mother and her birth child rode a camel together for the first time. When not together, pictures and mementos were important. The following quote revealed the growth, change, and development of the child as well as the sense of birthmother satisfaction.

Oh, he looks just like me. It was like a warm feeling to hold him and to know that he was OK and he was safe where he was. 'Cause you always wonder what he's doing, how he's doing. It was just after a month to see how much he had changed was really cool and interesting to see how much he had grown just over a month's time with me seeing him. Especially when you don't see him on a daily basis. Like every time you see him he's so much bigger and so different than the last time.

The changing relationship with the baby over time was aptly revealed in this quote,

After the first 3 years it does kind of fade a little bit, the more I get older, I'm not around home much, so I don't go and see her much, you know what I mean? But it's different because now she's getting older. And now I think, when it was more crucial for me to see her, it was less crucial for her to see me. But now that she's older, and I don't get to see her as much, I think it's more crucial for her to see me, like me to be a part of her life, because she asks about me more. She's like, "Where is my birth mom? When is she going to come see me?" and that kind of stuff.

Birth mothers were adamant about openness in adoption relationships. One shared, "I don't think I could have ever done a closed adoption. I think I would just wonder too much about him." Another explained, "I don't know what I would do if it was closed. I think open adoption is the best, the most amazing thing out there. Because not only will you grow up.... I get pictures and presents and I see her whenever I want." In short, the view about the open adoption relationships was, "I love them, and it's good. It's just like a big, big, huge family like I love." The birth mothers in this sample had

what many would consider very open adoptions and they were avid supporters of openness in these relationships.

E

E stands for emotions that need processing and settling. While the events of the unintended pregnancy and open adoption had taken place, the emotional ramifications lingered longer. Sometimes unresolved issues cropped up. The birth mother had an array of emotions about the events and changes. She may still have been resolving the finality of the adoption. This emotional load required emotional work. How she handled the load, in part, determined her future wellbeing.

Being a birth mother and having made an adoption was still hard. Even those who had a strong sense of the rightness about it, and generally good feelings about having done the best thing, there were still difficult times. They shared about days that were especially hard or sad. Here is how one worked through a swell of emotion with the adoptive mother:

I was having a hard day and I was like, [on the phone with the adoptive mother], “I can’t do it. I don’t want to talk.” And she’s OK with that. “That’s normal. I just think that’s OK to cry because it’s just normal. It’s your firstborn. If you don’t cry you have something wrong with you. Even if it’s your second or third, that’s your baby. It’s OK to cry.”

Birth mothers seemed to figure out ways of coping. Some strategies were common sense and some were unique. Some developed over time as ways that worked. Staying busy, sports, pets, and hobbies helped when emotions loomed. Being with or staying away from the adoptive family and birth child helped at different times. Emotions (*E*) that cropped up were handled in different ways but needed handling. In large part, how they managed these emotions gauged how they did in the next section, *S*.

S

S stands for support, and spiraling up or sliding down. Support made all the difference in facilitating a birth mother spiraling up in quality of life. When a birth mother maintained a consistent support system, she grew and was happy. Sometimes, she slipped into old patterns or made destructive choices due to her difficulties. She slid down instead.

Support group meetings, professional counseling, and talking with newfound friends were viewed as needed and important. Parents and those of the family of origin were a source of help for many at this time. School friends and old friends may not have been in the picture due to changes experienced in the past year. Support from somewhere was needed by all. As one said, “You know, no one can have too much support. It helps a lot.”

Support group meeting attendance continued after the birth. The amount of involvement with weekly and special event meetings varied. As one birth mother shared about its importance to her, “That was a group of people who also placed their babies for open adoption and it was nice to hear them talk about it—what I was going through too.” The length of time after birth that a birth mother participated differed. If the birth mother’s family or adoptive family were primary in the role of support, other venues such as the agency support group were less necessary as with this example,

‘Cause they [family of origin] completely support me one-hundred percent. I’ve been to a couple of [agency] events but I don’t go to the weekly meetings. It was a lot of fun to be around birth mothers who have been through a similar situation as you and have felt the same feelings. It’s nice to have that support system and to know that it’s there if you need it....In all honesty, I think if it [the adoption] would have been more closed I would have felt the need because I would have been upset. But it’s so open, that like, what more could I ask for? I’m happy. I’m very

happy with the way things have turned out. I haven't had any problems, like haven't gone to counseling because I haven't felt like I needed to. So, I mean, it's really good.

Support may also come from group leader, house mother, mentor mom, adoptive mother, birth father, new boyfriend, or members of her family of origin. Mothers were important supports sometimes, "She was very supportive. She was the only person I would talk to and I would always just sleep up in her room because, because....I just...I would...[Interviewer question: 'You needed her comfort?'] Yeah."

Some birth mothers had to negotiate how they would tell others who had not known about the pregnancy or placement because they did not know the level of support they would receive. This process of opening up seemed to happen in time when the birth mother could cope with explaining what happened. Gradual telling is seen in this quote,

And I didn't tell her [boss] about it till afterward, and she was like so mad at me for that. Then she wanted to go meet [the baby and adoptive family]. I didn't tell my cousin, I was really close to my cousin too, and I didn't tell her. I told her on her birthday.

Misconception and nonsupport happened with regularity, and the birth mother had to find ways of managing both. Birth mothers would not like to tell some people because "a lot of people don't understand." They "haven't been put in that situation" and the birth mother did not want them "talking bad about it." Here was an example, "My older brother wasn't so supportive about the open adoption because he thought that would just be really hard on me and stuff like that. But, he's warming up to it."

Counseling was part of the support system and was beneficial when social or emotional health issues emerged. Also, it was valuable for sorting out life values. The following example demonstrates its importance.

And I went to the counselor that [the agency] provided, __. She is a good lady. She helped me realize, really, what I wanted to do with my life. Really, because at that point in time I was at a standstill, I was at a brick wall. I didn't know what I was going to do. I had just had this baby and he's with this wonderful family. This wonderful family loved me. And I didn't know how to take that love. I didn't know how to take it and put it in my life and make it be OK. And she just, I guess she helped me put the love and this new family, she helped me place it in my life to where it all just fit there just perfectly. And that's what she helped me do.

Sliding down, or a backslide, was present with some more than others, but mentioned in both samples. A birth mother's prepregnant time may have included substance abuse, risky behaviors, or lifestyle choices that the postplacement birth mother now did not like or want. She may, however, have slipped back into some previous negative behaviors, or even returned to some less positive relationships. She may have suffered some bad consequences, or she may have been able to catch herself and improve her choices, as seen in the following statements.

Afterwards I had a little spout with taking some pills and drinking. And I drove my car and I shredded the tires. It was not too far after the birth and was from drugs and I have been clean since then. That was a very rude awakening for me 'cause I didn't have a scratch, I didn't get pulled over, I didn't go to jail, I didn't end up in the hospital. And it pretty much showed me that I need to straighten my act up or something bad is going to happen. And, I didn't want [the adoptive mother] to have to tell [my birth child] that your birth mother died because of doing drugs and that broke my heart. So I straightened up big time after that [3 years ago]. I've been a good girl; try to be a good aunt to [own birth child and adoptive parent's other child]. [Interviewer question, "To what do you attribute that change?"] "To having people that truly cherish my being."

When I went to school, I just went to guys. And that helped, but it shouldn't have. But, that's what I did. Which is a bad idea...and so if I had a guy there to hold me to him, with me crying, you know, that helped me.

My sense with these slides downward is that birth mothers perhaps started back into their lifestyle at a pace that was too fast. For example, "I went to school after two weeks which was a bad idea. Because I wasn't ready...It was just too much and too hard

[work and school]...but I'm on my medicine now and am better." Processing the events of an open adoption may require a great deal of emotional work (recall *E*). It seemed that those who slowed their pace, took new but less demanding paces, or guarded against too much stress, fared better than those who went immediately back to school, work, school and work, stressful environments, and the like. Another shared, "I just started my freshman year of college. I was just so overwhelmed. I just needed a break. I just needed time." Those who "anesthetized the pain" by using drugs, marijuana, alcohol, or relationships seemed to take a downward slide that needed to be reversed. Once birth mothers had some self discovery, they turned back toward a spiral up. *S* stands for the importance of support that fosters a spiral up instead of a slide down.

H

H stands for healing, health, and happiness. The unintended pregnancy that became a crisis for the teenager forced the adolescent to address problems. Often the process required emotional healing. Her body was physically healing after the pregnancy resolution. She was gaining greater health. There was a true contentment, a satisfaction, and a joy that characterizes the birth mother after open adoption. With the positive resolution of the pregnancy and with the pleasure she experienced with both the open adoption and seeing her birth child develop, she grew in happiness. Many of the quotations already shared reveal healing, health, and happiness. These may have been evident in emotional, mental, physical, social, spiritual dimensions of life. There was restoration and a greater degree of wholeness.

A strong and growing sense of satisfaction over placement was evident. A positive feeling about the adoptive family and a pride in the birth child was evident. A

growing awareness of improved life for the birth child was also something to which birth mothers gave voice. This improved life seemed to affirm the goodness of the open adoption decision as expressed in the following,

There are times when it's hard for me and I get upset and wonder what life could have been like with him. But, I know that me being an eighteen year old mom was just not in the cards for me. And you know, I wanted a better life for myself but not only that, that he would have so much of a better life being with the [adoptive family] especially because they're an amazing family. And he would have had a good life here too, but not—I probably wouldn't have been able to give him the stuff that they can give him. So, that helps me know I made the right decision. And I *never* regret the decision of giving him up at all because he is in a very good place right now.

Usually it seemed typical at some point to wonder about what it would have been like to have parented the baby. Then, after pondering the notion of parenting, the prevailing view was that the placement decision was good, great, or “the best” decision. The decision to place at all and to place with “this family” was felt to be the best. The following example gives a “word picture” of that perspective.

I always told myself, I was going to give my kid everything they wanted...everything I didn't have. So if my kid came up to me and said, “Mom I want a pair of Nike shoes that are \$150.00.” I'm like OK and give it to them without worrying if they were going to have something to eat on the table that night and stuff like that. So, I was like, “My kid's going to have a better life than I did.” And I knew at the time that I could not provide that for [this baby]. So I knew that the best thing was an adoption. Because I mean, I look at her now and I'm like, OK she has everything she wants from [adoptive parents]. And like, she speaks English, she speaks Spanish, and she does sign language, too. And I was like, I sit there and look, I'm like, “She has a *good* family. And so, it's a good thing. But, it's also very hard sometimes to see her.”

Birth mothers had or gained this happiness or satisfaction, this sense of *rightness* over the open adoption placement decision. As summarized by one who knew it all along,

I know this might be hard to believe, but I knew the whole time that I made the right decision. I knew that this was for the best. And not to

mention, I just think I couldn't have taken him away from them. They were so good with him. And they were so, like I couldn't imagine taking that from him.

Summary of After Placement Birth Mother's Lives

Adolescent birth mothers of open adoption had their own lives, afresh. Adoption milestones were accomplished, adjustments were being made and adventures were ahead for birth mothers (*A*). There was a fresh start at work, school, career, finances, and health (*F*). Relationship transitions were occurring (*R*). Emotions were being processed and settled (*E*). Support was helpful to birthmothers for spiraling upward in quality of life. When support was avoided or lacking, sliding downward was possible (*S*). Healing, health, and happiness were being experienced with their lives and in the open adoption arrangements (*H*). The time following open adoption placement indeed, appeared afresh, that is, with a fresh beginning.

Birth Mothers Anticipations of Life in One Year

Birth mothers were asked about where they see themselves in one year. Some responded about jobs, school, living situation, finances, relationships, and of course, the relationship with their birth child. They thought they would be working or going to school, but those in high school thought they would be finished and be "old, turning into an adult." Vocational technology programs or college were the intended career path pursuits of some. Gaining a "better" or "really good" or "cool" job "in my area" was the hope and plan. A couple thought Social Security Disability or housing assistance may help immediately. They thought they would have a car. A few had very ambitious and probably unrealistically high ideas of the income they would be earning.

They thought they would be in an apartment on their own or sharing expenses. Only a couple anticipated being in a relationship at one year, but would “not *have* to have a boyfriend to have somewhere to live.” One summarized,

I dated an idiot. Things happened. [I want to] just hopefully getting my life going. ‘Cause I want to show [my birth child] what I’ve become as well. Like [making an adoption plan] means I can go on with my life and I need to show [my birth child] what I can do.

They planned to all continue to see and have times with their birth child and adoptive family. Some thought they would return to church and see their family more. They seemed to have positive, hopeful words about the future. Vocal intonations during this portion were upbeat, confirming of their words.

Birth Mothers Anticipations of Life in Five Years

Birth mothers also were asked about where they see themselves in 5 years. Some had ambitious aspirations of profession, home ownership, relationship, marriage, or having a family. Universally, again, each would have their birth child in their life going forward. The following are example comments.

In 5 years I hope to be done with school and to kind of be settling down and starting my job that I’m going to have for awhile. Hopefully I’ll be in a good relationship. I’ll be 23 and probably just having fun and working, and obviously having [my birth child] in my life. He’ll always be in my life.

I hope I’m in school or finished with school and have met somebody I want to spend the rest of my life with. I would really, really like to get married and have kids before I’m too old. I want to have kids when I’m young, but I want to make sure I’m ready too. I don’t want to have the same thing happen. If I end up getting pregnant again I’m not going to do the adoption again. I wouldn’t be able to do it. So, I want to make sure I’m ready completely, and married before I have kids. And I’d like that to happen within the next 5 years but I don’t know if that will happen.

It is interesting and not surprising that the comments by birth mothers about anticipations of life in one and five years are very similar to the reported realities of those in the pilot sample who are five to fifteen years beyond birth and placement.

Pilot Sample Findings Five to Fifteen Years Later

In 2007 a pilot sample assessed five birth mothers of open adoption who had made infant adoption plans five to fifteen years prior to the interviews (Clutter, 2007). Interviews and transcriptions followed the same format and manner as for the study sample group, and the birth mothers were from the same agency. The thematic data analysis of the pilot sample yielded four themes: (a) satisfaction over placement decisions including open adoption choice, couple chosen, and thriving birth child; (b) personal milestone accomplishments in education, finances, work, life, or relationships; (c) a sustaining sense of being a better person with an improved life; (d) support being perceived as essential. The concluding thoughts about that sample were that participants who had experienced a crisis pregnancy and an open adoption plan reported satisfaction with the open adoption, personal growth, and positive crisis resolution.

It has been interesting to review the differences in findings between the comments closer to the event (the dissertation sample of one to five years postbirth) and those more distant (the pilot sample of five to fifteen years since birth). The pilot sample members had all experienced sustained employment. Several had purchased a home, several had gained financial independence from parents, and several were married. Each of the five had ongoing relationships with her birth child and adoptive family. Their satisfaction was easily shared and was done so with a sense of continual pleasure. There was a pride and contentment about the decisions having been right although hard, and with some it was

the “hardest decision but the best” of her life. One voiced it was the “100% most right decision I have ever made.” The hard part included grief that was unexpected in its depth given the satisfaction with decision.

In contemplating the differences in the narrative findings between the pilot and dissertation samples, findings were congruent, compatible, and confirming. Pilot study comments seemed to come from a place of greater resolution and even joy. For example, one reflected over spending the night at the adoptive family’s home at about one month postdelivery, “I saw how they were raising him. I saw how they interacted. They have three other children. I saw how their family was and I felt like I did the right thing. I felt like I made their family wonderful!” They had effusive comments about the growth, development, and character of their birth children. They had notable personal accomplishments that were very much like the “in one year and in five years” comments of this study. Boyfriend selection was an aspect of difference noted between those chosen at the high school stage (with low self esteem) and at their current point. Recognition of their personal lack of readiness to parent at the point of unintended pregnancy was poignantly voiced. The increased awareness of past lack of readiness confirmed birth mother satisfaction with the open adoption. The ongoing positive relationship with birth child and adoptive family provided the same type of positive substantiation.

Narratives of the pilot study group were more contemplative and more integrated, as though perceptions about their own unintended pregnancy and open adoption placement had been thought about, talked about, and settled. In short, they grew up, became more mature, and were more pleased with their own decision making that had been improved due to these very experiences.

Wide and diverse support systems were evident in all five interviews. Agency related supports such as the support group meetings, contact with the director and the counselor played a vital role before, during, and after the pregnancy and placement. The ongoing involvement of the adoptive family and birth child of those in the pilot study seemed to have worked into the “fabric of their lives,” and truly had changed from a “life chapter of crisis” to one having satisfying memories with strengthening growth.

I found one quotation of caution especially meaningful.

Initially you feel really great about yourself, everything is wonderful and you're going to like, you know, live your life a certain way. And it's so easy of a thing to fall back into old habits, if it's men and drinking, or whatever you know, trying to fill that hole again with the wrong things. I think for me just being cognizant of that is very important. 'Cause I didn't expect it. You know, I just thought that everything was going to be all perfect now and there wouldn't be any temptations any more [after the open adoption placement]. I think watching out for that maybe, as a health professional you know that that would be an important thing. I just didn't even realize it [that her behavior was slipping]. You know, it just didn't even occur to me until someone else said something. And then that was a reality check.

In the dissertation sample of ten, several reported these *fall back* experiences (see the *S* in the *AFRESH* section). Health care providers may genuinely be in strategic positions to inquire about or even see behavior changes with a birth mother. It is helpful to be alert to the possibility, recognizing it as a potential vulnerability.

Overwhelmingly however, from findings of both samples, my sense is that the after open adoption placing birth mother is a stronger, more resilient version of her former self. It seems that she is more self confident, has fewer self image issues, is pleased with her personal growth, and has great satisfaction over the adoption situation.

Messages to Health Care Providers

Birth mothers of this inquiry were asked if they had anything to say to health care providers. They had surprisingly a lot to share with health care providers. Some of the sharing was from the standpoint of having been through the experience and some was from seeing how various providers interfaced with them as the recipient. From the point of pregnancy confirmation to well beyond hospital discharge, various members of health care can have negative or positive impact upon birth mothers. These birth mothers were very much in favor of open adoption, of health care providers sharing about, and being supportive of birth mothers choosing open adoption.

At the Point of Decision

One birth mother came to the point of decision toward open adoption through her health care provider. She shared, “I went to the doctor and she had told me just good different things you could do. One of the things was that she gave me a card for the agency.” That girl came to the support group and decided upon open adoption. Sometimes, the health care provider is the first person to know about an unintended pregnancy and so is in a position to identify possible alternatives and resources. All too often, adoption—let alone open adoption—is not offered. Pervasively, birth mothers strongly believed health care providers should explain open adoption as an option. Birth mothers related the following,

Definitely if a woman is in need of any type of thing [at the point of pregnancy awareness] then refer them to even consider open adoption. They should definitely explain open adoption because a lot of people don't understand the word *open* when they hear *adoption*. They just hear the *adoption* and they think, “No, never see you kid again?” It's like, “Nope, I don't want to do it.” ‘Cause that's definitely how I was. But, I can just see how so many women will be reached, and so many children will be just,

be saved through this *ministry* and other *ministries* because open adoption is such a great thing.

I would just tell them if someone is not ready and doesn't want to have an abortion, open adoption is a good thing. 'Cause like, you're not raising the kid...It's hard sometimes but, if you're not selfish and stuff like that. Like there's people who have kids and shouldn't have kids...I would have done the same thing too—struggling to make ends meet and still live my life too. But yet, I stopped to think. And so many people my age are like, "Why did you do that?" And so many people who are older than me are like, "I can't believe you did that; that is a good thing to do." [It is better to wait until] you're ready to raise the kid than bring a kid into this world and not be ready to raise it.

Choosing Adoption

Coming to the point of choosing adoption is a process. Health care providers can be sensitive to the process and supportive while it is taking place. These examples share some of the advantages of open adoption.

"It takes a really courageous person to really think that through at the time you're pregnant. And to realize, 'This is for the baby, it's not for me, it's to better my kid's life.' I was probably about 4 or 5 months, 6 months when I was really thinking about this. I still wondered and wondered. And it came down to the last minute [to pick the adoptive family]...there are so many decisions I've had to make in my life, but I never had to make a *big* decision like that in my life.... And then one day, I thought, 'You know I got to accept that I am pregnant and I got to do what's best for the baby.' It might be hard on me, but yet, I know in the back of my head, that kid has medicine when she's sick; that kid has food on the table when she's hungry; that kid has a whole roomful of toys that her and her sister play with; and she has so many people that love her.

Now, looking back, it makes me feel great knowing that what I did was a good thing for somebody else's life. I just know it was a good thing because I gave somebody a great life. I gave people that might not have...I gave a woman another child that she wanted that she could not have...I gave two parents someone that they love. I mean they love me; they love [their child]. It's just a great thing knowing that you did something good for somebody...I know I did the right thing!"

Sometimes pregnant adolescents come to the hospital and have not made any plans for the baby. This is the point when nurses can interface, listen, or refer. The

following example demonstrates the importance of having a critical moment plan for birth mothers by hospitals, nurses, physicians, social workers, and the referred community agencies.

I think the whole time I was pregnant I knew that I couldn't keep him. But honestly, the ultimate decision was on the way to the hospital I knew that I couldn't keep the baby. I'm just glad they had people at the hospital to help me with that and talk to me about that. I didn't know about open adoption at that point. That's why I had thought, "Oh my God, this is scary. I'm going to have to give him up. I'm not ever going to talk to him or see him." But then they said, "We do open adoption." At the time I was kind of wary about it because I didn't know if I would be able to, like I wanted to see him but at the same time I didn't know if I was going to be able to see him and not have him as my own. And that's why right after I had him I didn't meet them and didn't see him, just so I could kind of feel it out. But once I was home and stuff I knew, "No, I need to see him, I need to be a part of his life."

Valuing Open Adoption

Simply put, birth mothers want health care professionals to value open adoption. The reasons include the many benefits of open adoption and the great need for guidance and support through the process. Birth mothers want encouragement and guidance from health care professionals that supports them during this major life event. They want health care providers to share the option of open adoption.

Nurses are Important in the Process

Nurses do seem often to play a vital role. Sometimes care is beneficial, sometimes uninformed, and sometimes damaging. It is influential no matter how appropriate it is. These are examples of care considered helpful.

Well, the nurse at my hospital, [name of nurse], really, really helped me by giving her personal experience. I thought that was really compassionate and sweet. I don't know, just being understanding and sympathetic is a really good idea. It helped me get through it. She came and sat down. She just told me that she had been through the same thing and that it only gets

easier. That I was doing the right thing. Even though I didn't know her. But, it just meant a lot to me.

Yeah; the only thing that I really noticed was that some of the nurses were really, really cool. And they were awesome, like they'd pull me aside and go, "You know, I know a lot of stress is on you and having all these people here, and a lot of this is expected, but if ever you feel like you want someone out, just let me know, and I'll kick them out." She was like, "this is about you. It's not about them." That reassured me.

Sometimes with open adoption, many visitors can be present. Birth and adoptive family members, agency members, doula, staff members of the hospital, and health care providers can all be present. Being an advocate is especially important. Giving birth mothers the knowledge that they had health care choices helped, such as if they wanted something changed. A special connection and communication was developed with the nurse who acted on her behalf.

Yeah, because the nurses are supposed to listen to you. Establishing the relationship with the nurse would also help too because, like I'm a people pleaser, and I may say yes to like cutting the cord or something when if I had that relationship I could talk to the nurse and say, "Hey, this is what should happen."

A nurse becoming *their* patient advocate was very important to birth mothers. Having preferences established privately, away from others, was the helpful approach, the way that "made me feel more respected." Birth mothers wanted nurses to be aware that it was still very important for them to spend time with the baby. They wanted nurses to view them as "the main character in the play," meaning a primary focus of care for the nurse.

Some Things Can Be Counter Productive or Destructive

Once a birth mother has decided to make an adoption plan, it is not in the interest of the birth mother or the baby to berate or try to change the birth mother or her decision. That is not professional nursing care. While nurses do serve a role in listening,

supporting, and caring, nurses are not replacing the role of a support group, an agency, or a social worker. Nurses are not decision makers on behalf of the birth mother. It is not a nurse's role to dissuade someone from making an adoption plan or to persuade an adoption plan at the point *after* a birth mother has already made a decision. If the person had already come in to the hospital with an established open adoption plan, nursing care should center on support of that plan.

Some birth mothers make their plan and choose adoptive families very early in the gestation. Some had bonded with the adoptive family. When they came to the hospital, it was a very different situation than one who came to the hospital with no plan and no supportive network. A nurse's role is to assess the situation and be patient-centered in focus. Patient centered in this case means birth mother centered. The following are examples of destructive nursing care as related by the experiencing birth mother.

I would tell them that when they encounter a girl that is doing an adoption, don't tell them that they're making a bad choice, 'cause I had a couple nurses do that to me. And they were like, "How could you do that? That's your baby." You know, and I just really didn't appreciate that. I had one nurse that came in there my last day and she was crying, and saying I just want to tell you how wonderful of a person you are. And she was the one who mostly took care of me. But a couple of these other nurses were just *so* rude. They were just, "How could you do that to your baby? That's your baby; I don't care how old you are." Yeah, I did *not* like that. Because as much as I knew that I was in the right and they were in the wrong, it still hurt really bad.

Some of nurses were a little bit rude or they just didn't know how to handle the situation—who wanted to hold [the baby] or what, because when I'd ask for something, or I'd ask to see the baby, they got kind of like weird or, if I wanted the baby to be held by [the adoptive mother] they'd get kind of confused like what was going on or, what was OK and what wasn't, you know? So I just think like even if the nurses felt more comfortable asking more questions it would even help us. Because if they kind of knew more of what's going on, it would help. Just ask. I think if

there's an adoption going on, if they know what's OK and what's not OK, that's good. Because I know a few times the nurse had come in and said, OK, are you sure you want [the adoptive parents] to do this and do that? So repeatedly we had to ask the nurse to do this or do that and it just seemed like the nurse was being rude or ignoring us, sometimes. Maybe it was because they were confused or didn't know how to handle it.

I would add that the nurse may be uncomfortable with open adoption because historically, closed adoption has been very boundary distinct, without any identifying information being exchanged. The nurse's role was to make sure that the birth mother had no contact with the adoptive family, and often with her own birth child. Now it is different and these birth mothers were saying that if the nurse had a question about how things were to be between the adoption triad members, privately asking was the way to find out. This would make them feel more respected.

Another troublesome sense was demonstrated in this statement, "And another thing too about the nurses, you know maybe they don't think that we care about the babies, but we do." It is sad to hear that nurses may be projecting their own feelings, and because a birth mother makes an adoption plan nurses perceive her as uncaring. The opposite is most often true, particularly in open adoption. Birth mothers care so much that they put a plan in motion that will ensure love and care for the baby.

Finally, birth mothers *do* experience ambivalent feelings. This should be expected and can be eased by the nurse. Again, when other people are not around, ask, "Hey, can I ask you something?" or say "In a little bit, may I talk with you, alone?" Then, assess anew. One birth mother pointed out, "People really do say things differently when people are around. A nurse could say, 'I want you to think about [a topic] and in a little bit we can talk about it,' because on the spot can be hard for birth mothers. There are so many things going on. One minute you feel fine and the next you don't."

Some Things Can Be Especially Helpful

When the nursing staff is sensitized to care of birth mothers, their care can make a big difference in the early hospital experiences of open adoption placement. Perinatal nursing care is remembered for years to come by families. Nurses have a marvelous opportunity to be remembered positively as ones who facilitated the life transitions of open adoption. The following describes several such circumstances.

In my situation, everybody was *great* with me. I think the best part was that the nurses who knew I was placing for adoption, were just very, very nice to me and you know, one lady came up to me and said, “You’re doing a wonderful thing.” And people who are placing their baby for adoption kind of need that, that kind of... [Interviewer question, “Affirmation?”] Yeah right. It’s hard enough when you’re kind of almost, giving your baby up, you need someone to be like, “You know, you’re doing a really good thing. I just want you to know that.” And that helped. That helped out *so much*.

I know I bonded with the nurses up there even though it was a fast deal. Everyone up there thought open adoption was an awesome deal because I’m still in the baby’s life. I’m still growing up with the baby and still letting the baby know I still loved her and I was doing this for her not me [for the baby’s benefit and not her own].

But one nurse made me feel really, really good about that [her decision to make an open adoption plan]. And I think that that was really important. That like the nurses understood the girls [adolescent birth mothers] and reassured the girls of that [supported them in their open adoption plan].

Another aspect of helpful care had to do with hospital policies on the care of birth and adoptive families. One very positive example was, “And they gave us options: I could have my own room and [the adoptive couple] could have their own room, but I just said that I would rather them be in the room.” Adoption specific care where everyone is supportive and comfortable with birth mother, adoptive parents, and care of the baby by either party makes a big difference. One shared,

My doctor was really good about it all. My doctor was really supportive of it all because like [the adoptive mother] was always with me and then the nurses—everyone was really supportive so I didn't have any really negative outcome at all. The doctor was really nice and then, yeah, I don't know, it helps when the [nurses and staff] are really nice to you and supportive.

Small care differences yielded important emotional benefits for all those involved.

One example was when the doctor had the sensitivity to print two ultra sound pictures, one for the birth mother and one for the adoptive mother. Another factor had to do with ease of care. One shared, "It wasn't awkward. I guess he'd interacted with a lot of people that were doing adoption so he just kind of already knew about it and he thought it was a good thing." Birth mothers quickly sensed when there was an uncomfortable feeling. Birth mothers, as one might imagine, did not like feeling that they were being judged, or that their situation was being perceived as unusual or even abnormal. Even if professionals are less exposed to birth mothers of open adoption, they do not have to act awkwardly or pass judgment. Birth mothers preferred them to simply ask questions. Asking questions was helpful. Nurses are good at asking questions, since that is how assessment is done, so adoption specific questions can easily be integrated into care.

Preventive Care for Birth Mothers after Open Adoption

Finally, after discharge and within the follow up care at six weeks and beyond, birth mothers are vulnerable.

Be aware that just about everybody who goes through adoption is going to go through a depressful time and they need to be watched to make sure they don't turn to drugs or other things. I could see about 90% of them doing that. I think it's the best decision in the world to make, but it's going to be hard. It's not going to be easy. They need to be aware of that. They're going to be depressed whether they are going to be attached to the baby or not. They should watch them whether they kept the baby or not. Either way, I can see somebody being depressed having a baby and not being able to take care of it. You know, I couldn't have dealt with that. I

couldn't have dealt with having [the baby] and then not being able to give him anything, you know, whatever the case may have been.

While many birth mothers do well because of early and extended preparation for and resolve about their decision, this birth mother's words hold a caution that can be heard by health care providers. Perhaps as the birth mothers move away from the situation of intensive support, health care may need to be alert for symptoms of depression, substance use, or other behavioral changes that may indicate a need for greater health care. More of this topic will be described in Chapter Five.

Messages to Pregnant Teenagers

Birth mothers had messages to pregnant teenagers on a variety of topics. They shared their views that could be words of peer counseling. As one shared about unintended teen pregnancy,

I would say, "Didn't plan on being pregnant? I know how you feel, I was there too not knowing that I was pregnant and kept telling everybody that I wasn't. But, you know what, you're just going to have to do what's good for you and your kid....When I was pregnant, I was still partying because I didn't know I was pregnant. And when I found out, I think that's part of why I started crying because I knew that I partied. I could not have something wrong. And I was *so* thankful that when my daughter came out there was nothing wrong with her."

Another shared about an abusive father of the baby, stating,

Don't worry about the baby's father, if he don't want to be in your life. And if he wants to be abusive to you, get away from it because he's not going to change. How many times he's told you, 'Oh, I'm going to change this time, I'm going to change this time.' No, they tell you that so that you'll stay with them so they can beat you some more.

The above quotations directed to a pregnant teenager, sum up the importance of getting past denial of the pregnancy, making changes if the boyfriend relationship has problems, and avoiding substance or other lifestyle issues that would affect the pregnancy.

Additionally, birth mothers thought the pregnant teenager should make decisions based on the future for herself and her baby.

Some birth mothers had comments about adoption compared with abortion. One identified five aspects where the teenager may question parenthood as an option for resolving an unintended pregnancy: being too young, already having difficult situations, having a lack of preparedness to parent, being concern about parental reaction to pregnancy, or simply, fear. She shared,

My first pregnancy, I did have an abortion. And then on top of that I have a [child] who was placed for adoption....I kind of just tell them that it's hard right now, and, mainly that you're too young, or you're going through things and you're not ready for this, your parents will kill you or something that you are scared of. And I tell them that there are other ways. I definitely tell them about open adoption. Because, that's the best solution if you're *stuck with something*, if you feel like you're going to be *trapped*, and you can't go to school, or you can't live your life the way you planned it....I try to tell them it's going to be OK, there's a better life, and just tell them to look into adoption. I tell them my story.

Another birth mother discussed adoption compared with abortion. Her main point was one of personal responsibility to the baby after having made the choice of having unprotected intercourse. She also described the benefits of adoption. She stated,

I don't think abortion is right because it's not the child's fault and it's only nine months out of your life. You know, it's only such a short time out of your life to be pregnant and then for this child to live and be happy....You made the decision to have sex. You made the decision to let yourself get pregnant. I mean, why should a child pay for it? You can't do this one thing for this baby that you created? It was your mistake. Nine months out of your life so this kid can be happy and have a life? I mean nine months of your life and just get it done.... It's a great gift to give a child, a life of happiness and health. You know, to be able to live....It's a baby, a human, a living being. You don't want to give it a chance?

A consistent message was that open adoption is a good choice. If a teenager experiencing a crisis pregnancy can consider the life she could give her birth child through open

adoption, it would be a good thing. Adoptive parents could give her birth child a good life.

When teenagers were experiencing an unintended pregnancy and were considering parenting the child, birth mothers wanted them to truly count the cost. One explained,

Just make sure that you really know what's in store for you. Like I tell all my friends when they find out they're pregnant. "Are you ready to be a mom? Do you know what's about to happen?" And, "Are you prepared to raise a baby? Are you prepared for day and night, night and day? Are you ready to give them what they need? Can you afford it? Can you provide them with what they need?" And if not, don't ever think of abortion. And all my friends have seen it. Open adoption. They've all seen [the adoptive family with her birth child]. And they all think it's an amazing thing. And, it was hard on me....in the long run it was best.

One young birth mother pointed out,

Anybody can go out and get a job and support them and their kid. I mean welfare is there, DHS is there, but do you really want to be on food stamps for 20, 30 years? Do you really want to be? I mean Taniff, do you really want to be on that for 18 years. And yeah, child support and stuff like that, yeah, you can court order it but is the father going to pay? Is the mother going to pay? I don't know. Most situations, the father and the mother don't pay. So you're sitting here waiting every first through the 15th of the month waiting for food stamps when you can be out there bettering yourself for you and your child. And if you knew you couldn't raise your child, you should like, [have someone who] is ready for a kid and knows stuff....'Cause no child deserves a rough life.

Considering financial provision, parental oversight and stability, and especially the quality of life the child would be facing were important points birth mothers wanted pregnant teenagers to face before making their parenting decision. Thinking for two people and for the future were valuable preparations for making parenting decisions.

Reading about or looking into open adoption was felt to be important. A primary benefit

of open adoption was that of gaining a family. As one said, “You’ve gained more people to love and support you. You can never get enough of that.”

The benefit of ongoing contact with the baby was a great joy. One described, “You *can* give your baby a life, a good life, and still see her and be in her life.” Pregnant teenagers who felt *trapped* needed to hear that making a difference in the lives of the adoptive family and baby turned the birth mother’s own crisis pregnancy into something good. Birth mothers spoke with passion about the importance of pregnant teenagers being aware of the good things about open adoption to consider before making their own parenting decision.

Chapter Summary

This chapter has included four sections. Demographic findings were described. An extensive birth mother story timeline gave the picture of what it is like to experience an unintended pregnancy, make an open adoption plan, give birth, and go on with life after the placement, becoming a birth mother. Messages to health care providers and to pregnant teenagers gave important insight into the experience of open adoption one to five years after infant placement. I was fortunate to hear these stories first hand. One birth mother summed up her experience with open adoption and I think it captures the experience, “It’s been hard some days, but most of the days have just brought hope for a better future for my baby and me.” Chapter Five will include discussion points that emerged from the findings, strengths and limitations of the study, implications, and recommendations for practice, education and research.

CHAPTER FIVE – DISCUSSION, IMPLICATIONS, RECOMMENDATIONS

This naturalistic inquiry has been the story of teenage birth mothers who have faced unintended pregnancy, have come to the point of making open adoption plans, and then have lived life as birth mothers for one to five years after delivery (dissertation sample) and five to fifteen years after delivery (pilot sample), (Clutter, 2007). This is a relatively unexplored experience. The transcript information from telephone interviews with ten birth mothers in the dissertation sample and five in the pilot sample has offered volumes in the way of revealing what adolescent birth mothers of open adoption experience. Chapter Five is a presentation of discussion that includes relevant literature, strengths and limitations, implications, recommendations, and conclusions. The primary findings have been related to the birth mothers of open adoption story, with special attention to their lives after birth and placement. The findings are now placed within the context of health care and adoption literature.

Discussion

Discussions about Open Adoption

Open adoption is rarely in the literature, let alone a focus on the lives of birth mothers after the adoption placement. This inquiry gives support to the view that open adoption is perceived by birth mothers as a hard but good process (Webber, 2008). Birth mothers see it as a way to give a great life to their baby. Favorable outcomes were voiced about open adoption placement being beneficial to the birth mother as a positive resolution of her unintended pregnancy. The support network developed as a result of association with the agency and adoptive family favorably affects the birth mother's own life.

During the process of open adoption, the known negatives of closed adoption, such as a birth mother always wondering about the well being of their birth child, are reduced in impact. The inability to know about the child and the lack of capacity to go on with life are not present as they are with closed adoption. In the past it has been argued that adoption leads to a “pathological mourning” (Carr, 2007; Millen & Roll, 1985). Some have been concerned that open adoption would not allow a birth mother to “mourn the loss” because the child is still alive. There is concern that birth mothers cannot “get on with their lives” (Grotevant, 2000; Wolfgram, 2008) or have a more profound grief (Blanton & Deschner, 1990). This study provides different evidence showing that birth mothers felt that the open adoption was the best option. While they may have mourned the fact that they are not *parenting* the child, they grieve the loss of parenting, and not the loss of the actual child who is now adopted. They do not lose the child from their lives. In reality, they do not actually *lose* parenting, but they choose to entrust that role to others, given their own situation at the point of birth. They gain the joy of having the baby in their life without the demands of the parenting role. They see the child thriving and happy, and they relish the satisfaction of having made a good plan. The unique nature of the grief of birth mothers has been identified by a few (Leon, 2002; Gritter, 2000). Some have found that birth mothers of fully disclosed adoptions have less grief than those of confidential adoptions (Christian, McRoy, Grotevant, & Bryant, 1997; Henney, Ayers-Lopez, McRoy, & Grotevant, 2007). Postplacement grief could be studied more fully.

“Hard but good” is how these birth mothers described their experience. It is good for the baby, and good for themselves. This “hard but good” notion has been seen in open adoption literature (Gritter, 2000; Webber, 2008). Several authors have also found

favorable birth mother outcomes after placement (Ge et al., 2008; Gritter, 2000).

Cushman, Kalmuss, and Namerow (1997) found that features of open adoption such as visiting or phoning the adoptive family have strong associations with long-term, positive outcomes for birth mothers. Having a role in choosing the adoptive couple was also strongly associated with positive outcomes. Clearly, however, more research is needed into this potentially life changing positive option for those facing unintended pregnancy.

Differences in birth child age at placement have been studied. In the current inquiry, all but two birth children were placed for adoption at birth. One was hospitalized for over two months and placed after discharge, and another was parented until six months and then placed for adoption. Adoptee age at placement has been studied for frequency of later contact with birth mothers (Howe, 2001). Howe found that younger placed babies grew up and tended to have increased contact as adults with birth and adoptive mothers when compared with older placed children. Increased, long-term contact between birth children and birth mothers is an aspect that impacts the birth mother's life in a long term sense and is worthy of further study. The contact between birth and adoptive families in this study was primarily initiated by adoptive parents and birth mothers. There were a few birth children who initiated phone calls, but the children were all less than five years old, so contact by children to birth mothers was only beginning to happen. In the pilot study where children were older, contact was regularly initiated by birth children. Birth mothers commented about wanting to set a good example because of the child's initiation of contact, for example, "she knows how to get in touch with me, she knows me" (Clutter, 2007).

The process of open adoption is unique. It is different from what a parenting adolescent or a birth mother of closed adoption may experience (Concerned United Birthparents, n.d.). The open adoption process typically beginning before birth, continues during delivery and hospitalization, and extends long after discharge. It can continue throughout life. The process needs vast further study. This inquiry adds examples of experiences from one agency in one local setting. It adds examples of those who maintained ongoing open contact. It may or may not represent the wider experience of birth mothers of open adoption.

A prevailing view of those studying open adoption is that neither confidential nor open adoption is best for everyone (Grotevant and McRoy, 1998; McRoy, Grotevant, & White, 1988; Silverstein & Demick, 1994). However, practices over the past several decades have yielded favorable results of adoptions with greater openness (Lee & Twaite, 1997; Wolfgram, 2008). Recently American adoptions have been characterized mostly by some degree of openness (Howard, 2005; Reamer & Siegel, 2007). Even birth parents of older children who face termination of parental rights have had open adoption options in “permanency mediation” (Maynard, 2005). Even in that difficult situation, one “permanent parent” stated, “We came away from there with so much more than a card, or a letter, or a picture. I mean, we came away with a relationship” (Maynard, 2005, p. 518).

A relationship is the essence of what open adoption gives. This is acknowledged in one study where some called the relationship “like a *friendship*, or like *family* or *extended family* and one adoptive parent said, “It is not just a cold contract any more” (Neil, 2009b, p. 279). Still, public view of greater levels of openness in America is mixed and sometimes inaccurate due to a lack of understanding in how open adoptions work

(Miall & March, 2005b). One Canadian nation-wide random sample study revealed advantages and disadvantages of varying levels of openness versus confidential adoptions in adoption triangle (triad) members (Miall, 1998; Miall & March, 2005b). These results were said to be very similar to the Grotevant and McRoy (1998) results. In regard to openness, mixed viewpoints and mixed study findings indicate a continued need for exploration of the complexities of this multifaceted topic (Gross, 1993; Wolfgram, 2008).

In a report of findings of eleven kinship networks (adoptive parents, children, and birth parents of the same network) who experienced face-to-face contact, researchers were impressed by the way those with nothing in common but the shared interest in the children, could work together to facilitate contact (Logan & Smith, 2005). The majority of the sample felt contact was working well. Mutual respect, liking, and high levels of reciprocal “permission” enabled satisfying, amicable relationships. Open and direct communication emerged as a central feature in facilitating contact. Members faced issues such as complex and changing feelings, preparation that did not equip them for the feelings, and expectations of ongoing contact. The contact arrangements required personal rather than agency responsibility for ongoing management.

Open Adoption May Not Be Optimal At All Times or For All People

In a qualitative study of matched adoptive and birth relatives, Neil (2009b) reported findings from interviews at seven years postplacement (child was four years or younger at placement between 1996 and 1997). In this study sample, twenty one of the thirty adoption placements came from *public care*. This means that the parental rights removal had previously been mandated. Thus, the *decision* for adoption with the majority of the sample was not made by the birth mothers. The remaining nine cases consisted of

children who had been placed for adoption due to the request of birth parents. At the 7 year postplacement time, birth relatives (15 birth mothers, 6 birth fathers, 2 birth grand fathers, and 7 birth grandmothers) fell into two groups. One group positively accepted the adoption (N = 14). These had generally positive feelings about the adoptive parents and the new life their child was enjoying. They were realistic about their own current and future role in the child's life and that however hard, things had worked out for the best. The other groups were "resigned" (10) or "angry" (N = 6). The resigned ones were sad, guilty, or very unhappy but resigned to the loss. The angry group had feelings like, "I'm the real parent."

Interestingly, in a supplemental analysis, there were those who were described as "mutual supporters" in adoptive to birth and birth to adoptive family members. These "mutual supporters" were said to have positive spirals of interaction, be collaborative and flexible over contact arrangement, and be tolerant in managing difficulties. They were able to manage their own feelings and have mutual trust. They liked and respected boundaries, had active involvement with the children in the contact, and felt that contact was a benefit to all (Neil, 2009b). These supplemental findings were more consistent with the findings from this dissertation study. Neil's "mutual supporter" group emerged out of a most challenging sample with diverse placement conditions. Even though only nine of the cases consisted of children who were placed for adoption due to birth parent request, and the others were mandated, some of the adoption triad members were able to find their way to a positive, interactive relationship that had contact that was perceived to "benefit all triad members." This is important because it reveals open adoption from a different context. Perhaps a birth mother coming to a point of decision to make an adoption plan

(voluntary birth mother choice versus involuntary removal or other chosen adoption placement) has a pervasive influence on level of satisfaction and contact arrangements in open adoption. Perhaps also support through the process makes substantial difference.

Neil's sample is vastly different from that of the dissertation or pilot samples. The diversity of results between the two studies points to the complexities involved in open adoption and the need for further investigation. One type of adoption may not be a right fit for everyone. Also, the "right amount" of openness is probably specific to the triad. Degree of openness is likely changes over time and with a person's life stage or situation (Henney, Ayers-Lopez, McRoy, et al., 2007). The study of open adoption in various settings with a wide array of samples and sampling methods will give insight. Social support, stress, coping, and adolescent development have been some of the topics recommended for further study (Brodzinsky, 1990). I agree with Grotevant, Perry, and McRoy (2005, pp. 184-185) that much of the existing research on adoption kinship is problem focused. Now, research needs to widen to address developmental strengths and healthy relationship networks for all triad members.

Postpartum Mood Disorder, Emotional and Behavioral Aspects

There was ample evidence in the dissertation samples of emotion and mood disorders. Postpartum depression was voiced by several. Depression that existed prior to pregnancy returned after birth with greater intensity. Other mental health issues were initially diagnosed or intensified. This is consistent with what is known about the significant topic of perinatal mood and anxiety disorders.

It is known that perinatal mood and anxiety disorders (PMAD) represent some of the most important complications with potentially severe or tragic outcomes of

childbearing (Postpartum Support International, n.d.b). Depression is estimated to affect one in eight new mothers (Postpartum Support International, n.d.a). It is estimated to be significantly under diagnosed and under treated (Marcus, 2009; Postpartum Support International, 2009). The consequences of PMAD are far reaching and include substance abuse, functional impairment, increased postnatal depression, and less optimal pregnancy outcome. These consequences raise clinical, social, and economic burden (Bennett, Einarson, Taddio, Koren, & Einarson, 2004). PMAD includes issues of depression, anxiety or panic disorders, obsessive-compulsive disorder, posttraumatic stress, psychosis, and bipolar disorders (Postpartum Support International, 2009). Depression alone has a lifetime occurrence for women of from ten to twenty-five percent. The time of highest risk is during the childbearing years (Organization of Teratology Information Specialists, 2006). With PMAD being so prevalent in general, those with unplanned and unwanted pregnancy experience a greater prevalence of depressive disorder (Bunevicius et al., 2009).

One study found that even after controlling for many sociological and demographic factors, unwanted and mistimed pregnancies were associated with unhealthy perinatal behaviors (Cheng, Schwarz, Douglas, & Horon, 2009). Teenagers as well have demonstrated a higher likelihood of having symptoms of postpartum depression (Lincoln et al., 2008). No current studies were found assessing open adoption and PMAD, but this would be valuable. One dated study of placing, predominantly teenaged birth mothers (N = 64 relinquishing birth mothers of 7,668 screened mothers of live birth, singletons) was conducted in 1990. It did reveal a somewhat greater likelihood of manifesting anxiety and depression symptoms both prior, and subsequent to, the

adoption (Najman, Morrison, Keeping, Andersen, & Williams, 1990). Perinatal mood and anxiety disorders are a significant issue in the study population.

It is possible that open adoption may reduce the risk of mood disorders. Since birth mothers gain a degree of resolution of the unintended pregnancy, and since they develop a happiness with the result of open adoption, there might be indication that risk would be reduced for PMAD morbidity and mortality for birth mothers and infants. The level of happiness about being pregnant was the focus of one study of high risk Black women (N = 1,044) who were enrolled at prenatal care clinics in the District of Columbia. They were assessed for pregnancy intention. Pregnancy intention and happiness were strongly associated, but happiness was a better predictor of risk. Unhappy women had higher odds of risky behavior, depression, and violence. Researcher conclusions indicated that psychosocial screening for happiness could prevent adverse outcomes (Blake, Kiely, Gard, El-Mohandes, & El-Khorazaty, 2007). Perhaps psychosocial screening for happiness could shed insight into the study of birth mothers of open adoption.

There were emotional and social risks with open adoption. These birth mothers faced new relationships, new roles, new life direction, and new emotions with the social changes. Navigating through the emotional and social risk of being able to *do* an open adoption was a risk indeed. Trusting that the adoptive family would provide a welcoming situation when not legally required to do so was a risk each one took with the choice of open adoption. It was an ongoing risk depending on the degree of trust and relationships established within the specific adoptive triad.

Some “numbed” their emotional pain in ways that in hindsight they felt were destructive. Substance use and “going to guys” seemed to bring relief in the short term and to be detrimental in the long term. Birth mothers of this inquiry stopped these behaviors over time and after negative consequences. The influence of the birth child and adoptive family was significant in overcoming the destructive patterns.

One interesting aspect of this inquiry was that there was a transition of focus regarding the future plans of birth mothers after the completion of the unintended pregnancy. Some used the phrase “I just couldn’t do it anymore” in regard to going to college, working a job while doing school, or “trying to get income and study.” Perhaps these birth mothers had been over extending themselves before the birth, or perhaps with the intensity of perinatal and placement emotions, birth mothers needed a break. It would be worth further exploration to see if an “activity pause” is a common event following adoption placement. It seems that there is an emotional and perhaps relational sorting out period. There may be an increased clarity of her direction in life for a birth mother who actually takes time postplacement to pause and reflect. This might be a good recommendation for birth mothers.

Even with the difficulty of these emotions, the birth mothers seemed to universally say that the challenges were not just because of the adoption placement. For example, one with a family history of bipolar disease emerged with a bipolar diagnosis after postpartum discharge. She reported that she knew something was wrong when she was in the hospital, but that it really emerged afterwards. Yet when she considered how her birth child was doing now, she strongly stated that the open adoption was best and that she wanted her birth child to have a stable home with two parents.

Birth Mothers Make Sacrifices

The decision to make an adoption plan costs a birth mother the raising and parenting of her birth child. It is a chosen sacrifice made on behalf of the baby, but it is still a cost. Kriedler (1994) quotes one birth mother who put it well, “I grieved like she was gone forever, forever and ever. I had—she had died from me. But, then she came back, and that’s what’s incredible. It really is.” She went on to say that her relationship with her birth child is a lot like being with one of her nieces. This inquiry found birth mothers who described their relationships like that of an aunt and as an extended family member. Open adoption does provide an alternative type of relationship, but at the chosen sacrifice of not being the one to parent the child. There is a transition process to being a nonparenting birth mother. Some in this sample really knew they were too young to parent. Some became aware of this as they spent time with the child during infancy or toddlerhood. Others knew they could have parented, but chose adoptive parents for the baby’s sake at their own emotional impact.

There may be a social sacrifice. Adoption is controversial and there can be social consequences. There are social transitions as a result of the open adoption. Family of origin members may change their relationship with the birth mother. While most birth mothers enjoyed increasing closeness with most relatives, several in this study shared about extended family members who did not like the adoption placement. One example was,

When he [birth mother’s uncle] told me that [her birth child] wasn’t his niece, I broke down and cried to him and I’m just like, “How can you do this to me? You don’t know how bad you’re hurting me.” He was like, “That’s just in my eyes.” and da da da da da. I was like, “She has the same blood that’s running through you and through her so that *is* your niece.” I guess he came around because now he’ll say he loves his niece.

He and relatives of other birth mothers were said to have “come around” over time. Some saw the example of open adoption and how different family members enjoyed contact with the birth child and adoptive family and then later accepted contact as well.

Being subjected to prejudice is another sacrifice. Certain groups may have a predisposition against adoption. As one birth mother shared,

Sometimes I can't tell some people—especially African American people—can't tell them that I placed her for adoption because they would yell. They would just be so judgmental about everything. Because most African Americans parent their children. They don't even think about open adoption. It's like the worst thing to them. But you know, I've just got to say, I tell people I've got a daughter and sometimes I've just got to say, I tell some people, “she's adopted” and some people I just say, “she's home” ‘cause I feel like, it's not really any of their business anyway.

Fewer African American families apply to adoption agencies. There may be less awareness of the notion of birth mothers. Further, within African American families, there tends to be a strong value toward “taking care of your own.” This may mean keeping offspring within the extended family even if the biological mother is not the parent. This value system means that there could be negative social consequences for the African American birth mother who places her child for adoption. There may also be social consequences for those of other ethnicities who adopt African American children. While “taking care of your own” is a valuable quality, and families often do step up to the task of raising the child of an unintended pregnancy, open adoption could increase as an acceptable alternative to resolving an unintended pregnancy. It may be an option just like options of parenting, kinship adoption, or family parenting. Currently change is occurring in African American cultural acceptance of open adoption (Caldwell, 2009).

Another group in society that may have a predisposition against adoption is the generation of those who became adults prior to the 1970s when adoption began to be more open. The secrecy of closed adoption led to a very negative perspective on adoption. Religious views against premarital sexual intercourse led to a negative outlook on birth mothers and sometimes even birth children. Older generations felt family shame with the presence of an unintended pregnancy. This study revealed some initial difficulties with some of older generations, but over time and experience with a family member in an open adoption, favorable transitions prevailed.

There may also be a group consisting of the younger generation—the birth mother peers—who may have a predisposition against adoption. There may be a condemnation of the birth mother having sex, or of “letting” herself get pregnant, or of not taking care of her baby. Even if high school peers do not have a predisposition against adoption, the open adoption still means changes in relationships. Sacrifices are made by birth mothers in regard to former relationships with peers.

Regrettably, we saw from this study that some of the health care staff members also had a predisposition against adoption, enough to want to privately confront a birth mother at the most vulnerable of times. In the hospital, health care professionals and staff members need to support birth mothers in the choices they have made, even during the difficult points. This inquiry demonstrated that the possibility of having negative views was a true reality. Relationship adjustments occurred because of those views.

The anticipation of negative views can help a birth mother prepare herself with ready answers in the event of negative questions or comments. Birth mothers can guard against allowing the negative views having a big emotional effect on them through

careful choice of disclosure points. Unfortunately, the prejudice can be revealed, like landmines, in ways that are “surprise attacks” that leave emotional damage.

Benefits of Self-Selected Open Adoption Placement

This inquiry has revealed abundant, clear, compelling examples of the joys of open adoption. Voiced benefits included that the baby had a great family and had two parents, that birth mothers could grow up with the baby, and that birth mothers could see and be in the life of the baby without having the responsibility of parenting too young. Birth mothers could also go to school or work without the burdens of parenting, and could have a chance to build a future, stable relationship that could, in time, be conducive to parenting. Family relationship improvements happened as a result of seeing the adolescent birth mother make difficult decisions that were commonly viewed as responsible. Having supportive networks was seen as a benefit of being involved with the agency and adoptive family.

Self image improvements came from knowing a very difficult but good decision had been made. It came from knowing she was able to give her baby a great life. Seeing the child happy and seeing the likenesses to her seemed to strengthen her satisfaction with the open adoption placement decision.

The open adoption allowed support of the birth mother by the adoptive family. This had lasting effects. Having people who “truly cherished my being” was a deeply meaningful boost to the birth mother’s personhood. With open adoption “you gain a family.” The widening of the extended family network to include the adoptive family was a tremendous gain to the birth mother.

Open adoption seemed to build character, responsibility, maturity, love, connection, family peace, and self satisfaction in the lives of birth mothers. The birth and experience were etched in their lives forever. As one experienced birth mother, Romanchik, explained in her powerful poem, “Bittersweet” (Wolch-Marsh, 1996):

I have mourned him
The baby reaching out his pudgy arms
The toddler whispering “Mama” in my ear.
The child....
The teen-ager.....
The adult.....
he would have grown to become
Had I been the one
he called MOM

Yet I have rejoiced
In his smile,
in his love,
in being a part of his life.
I have reveled in watching him grow
into the man he is becoming.

And in hearing him call me,
proudly,
his birthmother.

Being proud of her own choices on behalf of the birth child, seeing the baby grow “so big” and gain developmental milestones were things birth mothers of the study held dear. Pictures, videos, phone calls, letters, notes, and special joint activities with adoptive families made major, positive differences in birth mothers’ ongoing well being.

While they pondered “what would it have been like if I had parented,” they seemed to settle the question based on the wellbeing of the baby. Many had an established thought process for the reasons why open adoption was chosen, the reasons why it was best, and the benefits to her own child (for example, “She has her own room, a mom and a dad who adore her, siblings, a million toys...”). Many also had reasoning

such as, “I could never have given him _____. Plus, now I can finish school, get a job, hopefully get married sometime, and go on with my life while still having him in my life.”

These types of mental reasoning processes helped on good and bad days. Bad days usually meant that the sadness of missing their birth child was at the forefront. Birth mothers of this study seemed to have developed a “mental litany” such as the above example quotes and the following example, “But then I would kind of talk to myself that this is the right thing. Where would I be if she was with me? Well, I would be struggling and she wouldn’t get everything she needed. And then I would be OK again.” This mental litany may be an aspect of further inquiry. It seemed that birth mothers did well in the hard times if they had a ready mental litany that reviewed the reasons they chose open adoption. They seemed to be able to cognitively restructure their outlook and mood with the review of their own, well pondered rationale.

Another coping strategy was having a consistent social support method. One shared that she would call her mother and would say, “Mom, I’m having one of my sad spells.” Her mother would remind her of things that would change her perspective in ways that helped. Others would attend the support group to gain grounding and perspective. Some would go see the adoptive family and connect with the adoptive mother, other family members or her birth child. Still others sought counsel. The support group leader seemed to be an important role model. Having role models fosters resilience (Brown, 2006). It seemed to do so in this study. Having a strategy or method that they could use to gain support at a time of need was valuable and seemed to be helpful, especially during the early postpartum days.

Staying busy, having hobbies, and participating in physical activities were three especially helpful activities after the birth that were mentioned by most birth mothers of this inquiry. While times of reflection and introspection were needed during the decision making process, afterwards their attention needed to be focused in other directions. Staying active and not *over thinking* was beneficial.

Open adoption was seen as being supportive of all in the adoption triad. The adoptive parents had the benefits of historical and physical knowledge about the birth mother as well as a relationship with her. Further, they were able to know and learn about the birth mother in ways that benefitted the child. The child was able to enjoy a stable, two-parent family, usually with siblings, and enjoy ample provision. The child was able to have an ongoing relationship with the birth mother. The extended birth and adoptive families were able to have ongoing contact. A birth mother grew up with her baby and gave that baby a great, happy life. As shared by one birth mother, “It’s just like a big, big, huge family like I love.”

Strengths and Limitations

This study had notable strengths. Birth mothers are *uncharted territory*. These birth mothers had so much authentic information to share and were skilled in the sharing, once given the opportunity. The excellent birth mother candor highlighted areas of clear focus. Because so little is known, this information is needed for maternal-child nurses and generally for health care providers who interface with pregnant adolescents or birth mothers. This information is valuable for those who work in adoption arenas.

Adolescent open adoption placement is a tiny fraction of the outcomes for the massive issue of unintended pregnancy. This study with purposive samples of five (pilot

study of those five to fifteen years beyond the birth) and ten (dissertation sample of those one to five years beyond the birth) from one agency is not going to change national percentages of those choosing open adoption. It simply adds to the awareness of birth mothers, especially their lives after the time of placement.

The methodology of having the “naturalistic setting” of phone use was ideal for young women who amply shared their experiences. The use of recording devices worked well. Private interviews allow a person the ability to give voice to thoughts and not be preoccupied with outward appearance or reactions of others. Telephone interviews, however, are limited in that they reduce researcher awareness of visual and nonverbal cues.

Having the agency director identify typical birth mothers facilitated finding an adequate sample size. This methodology was a notable strength, as access to the population is one of the greatest difficulties in studying birth mothers (Mander, 1992). The choice of agency limited the sample to those tending toward very open adoption. The openness was ongoing. Also, it makes sense that those who had been regular participants in the support group would be known by the director and more likely to be selected. It is acknowledged that those selected and willing to speak would be more likely to be favorable about their adoption situation and birth mother status. This was the population desired, but is limited in its applicability to all of open adoption. Many agencies define open adoption as having identifying information available at the point of placement, but that is the extent of openness. Certainly there should also be studies of open adoptions with negative outcomes. Studies of that nature would require a different context and

method of sample selection. The difficulties of access to birth mothers after adoption placement (Mander, 1992) remain an issue in the study of open adoption.

The samples of the dissertation were at the far side of openness and this is viewed as both a strength as well as a limitation of the study. Commonly, adoption workers describe open adoption as *fully disclosed adoption*. In this study, birth mothers were spending regular time with the adoptive family. This included, for some, birth mother babysitting of the adoptee (birth child) or even weekend or vacation stays at adoptive family homes. Most triads would visit home to home, have extended family gatherings together (on both sides), and even call themselves by commonly understood family terms such as *aunt*. The strength of having a study of this nature is that it draws the focus to what adoption can be like at the high end of openness. The limitation is in applicability to all of open adoption. Open adoptions with less openness would have different experiences. Open adoptions with less or no initial agency support structure would have different experiences. Others have found birth mothers with low or no support structure to have less favorable outcomes, and they have concluded that support should be a significant mediator of postplacement adjustment (Brodzinsky, 1990).

Implications

My general perspective is that open adoption should be considered more widely. A greater percentage of people should embrace it as an option for resolution of unintended pregnancy. There was ample affirmation of open adoption under the local circumstances to support open adoption as a more significant option than the current state, that being less than three percent resolution choice for unintended pregnancy (Jones, 2008). Open adoption is appropriate for many young, pregnant girls who perceive

themselves to be ill equipped to begin parenting or to provide suitably for a baby. I would hope that more research about open adoption would increase general awareness and thus foster a higher percentage of teenagers exploring open adoption as an option. One study suggests that myths prevail about open adoption and so it is a less considered option (Brown, Ryan, & Pushkal, 2007). The satisfaction of birth mothers in this study affirms postplacement benefits of self-chosen open adoption placement as a resolution choice for an unintended pregnancy.

Recommendations

Recommendations for Research

It would be wise for health care providers to study birth mothers of open adoption more extensively. It appears to be a *win-win-win* for birth mothers, adoptees, and adoptive families. This study demonstrates favorable outcomes for birth mothers in one setting. Studies have also demonstrated favorable outcomes for birth mothers of open adoption in many other settings (Ge et al., 2008; Grotevant & McRoy, 1998). Yet, the percentage of adolescents choosing open adoption remains quite low. Research in other settings, with distinct birth mother culture and ethnic groups (i.e. African American birth mothers), and diverse agencies would be valuable. One study, for example, found that French speaking Canadians were significantly less likely to support all levels of open adoption compared to English speakers ($P < .001$). Another study dealt with Aboriginal children (Snow & Covell, 2006). Also, scant research has been done with birth fathers (Gritter, 2000; Miall & March, 2005a; Witney, 2005). Birth fathers may have much influence in the decision, process, and outcome of adoption, as well as their own quality of life issues, so they would be a beneficial focus of research.

This was a study at an agency that kept birth mother needs at the forefront. It was an agency that valued a philosophy of “adoptive families for babies, not babies for adoptive families.” What was best for the baby and birth mother was emphasized over needs or desires of the adoptive family. This type of philosophy, focus, or mission is not routinely the case with support groups or adoption agency organizations. Yet many organizations have turned toward much greater openness in recent decades. Exploring open adoption where other philosophies prevail may reveal different aspects of open adoption.

This study clearly affirmed openness in adoption. All of the birth mothers anticipated ongoing openness and were pleased with their adoptions. They also strongly encouraged open adoption for others. They favorably compared open adoption to closed adoption, having great preference for openness. It is recommended that research about open adoption center around exploring different degrees of openness in adoption. Other studies may focus on determining factors that hinder or strengthen open adoption. Still other studies could explore agency level facilitators for open adoption. Supportive measures that enhance postplacement quality of life for birth mothers could be the focus of study. Postplacement quality of life of birth mothers could be compared with others.

Birth mothers at any point in the adoption experience are the most under studied part of the adoption triad. Postbirth adolescent birth mothers are very different from adolescent parents of children borne from unintended pregnancy. These differences can be assessed for health promotion and prevention of additional unintended pregnancies. Postdelivery resilience of birth mothers after open adoption placement is another topic.

The birth mothers of this study demonstrated resilience. They gained resilience through the social support (Nettles, Mucherah, & Jones, 2000). More studies should focus on the notion of resilience with this high risk population (Fergus & Zimmerman, 2005; Krovetz, 1999). Resilience has been defined as the process or outcome of, capacity for, successful adaptation despite challenging circumstances (Howard, Dryden, & Johnson, 1999; Masten, Best, & Garmezy, 1990). Birthmothers of this study may or may not have had family of origin resilience (Hawley, 2000), but gained resilience through the process of open adoption. This example of positive outcome should be explored for greater use in unintended pregnancy resolution. If positive life adaptations can be made (Glantz & Johnson, 1999), adolescent quality of life can improve (Lawford & Eiser, 2001).

This research used a naturalistic inquiry approach because little is known of birth mothers. As more is known, additional types of qualitative inquiry will be beneficial. A grounded theory study, for example, may lead nicely to midrange theory development for postplacing birth mothers.

Quantitative studies of correlation or difference could demonstrate parameters of distinction for birth mothers of open adoption compared with those parenting, those never pregnant, and those choosing pregnancy termination. Similar study designs could compare those with open, closed, or semi-open adoption. Open adoption and kinship adoption could be assessed for impact on the birth mother. Quantitative studies comparing rates of postpartum depression would be valuable. Quality of life and resilience measures could enhance further awareness of the impact of open adoption on adolescent and other age birth mothers. Additionally many studies of excellent quality

have been reported (Brodzinsky & Palacios, 2005; Ge et al., 2008; Grotevant & McRoy, 1998; Pannor & Baran, 1984; Wolfgram, 2008; Wrobel & Neil, 2009).

Theory use and application to adoption has been fairly widely described. An array of theoretical models has been used in studies (Brodzinsky & Schechter, 1990).

Brodzinsky and Palacios (2005, pp. 259-260) have detailed studies highlighting each adoption triad member. They urge investigators to broaden theory use for more complete understanding of adoption dynamics.

Recommendations for Developing the Literature Base

There was ample affirmation of open adoption under the local circumstances to embrace open adoption as a significant option. Writings about open adoption by health care professionals, adoption workers, or birth mothers should increase. My hope is that birth mothers especially will gain a greater voice in American society. Open adoption is a family constellation type that can be known and valued (Howard, 2005). With additional, positive literature and other media about open adoption, a higher percentage of those facing unintended pregnancy may look into and choose open adoption.

I think it is safe to say that birth mothers of this study felt open adoption to be a noble choice. I would like to see health care, adoption, and lay literature describing it as such. Adoption is something that tends to have media hype with skewed misinformation. I would like to see literature and media correction of misinformation. I truly believe that the silent majority of birth mothers are very pleased with their open adoptions. I believe adoptees and adoptive families of open adoptions are pleased with their situations. Health care and other data bases need to have more content on open adoption, birth mothers, and birth parents in general.

Recommendations for Nursing

Offering Open Adoption as an Option

The nurse or practitioner in a family planning setting is in an ideal situation to offer open adoption as an option. The Infant Adoption Awareness Act was signed into law in the United States in 2000 (Dailard, 2004). It was designed to provide grants to teach pregnancy counselors of family planning programs to provide neutral, factual information and nondirective counseling and referral. Compliance and implementation issues continue with regard to presentation of adoption, and especially open adoption.

Many do not know about open adoption as an option, so presenting this option is crucial. At the point of awareness about an unplanned pregnancy, and especially when parenting is unwanted by the patient, open adoption should be presented as one of the options. Nurses and other family planning professionals need to educate themselves about open adoption in order to adequately present this option at the point of need. Even giving a card or brochure about an agency may open the door for exploration of the possibility of making an open adoption plan. Health care professionals can also become aware of resources such as on-line or local support groups for birth mothers. They could also begin or facilitate a support group (Roby, 2008). Knowledge of agencies that practice open adoption and ready resource materials can greatly facilitate timely support during the decision making process of an unintended pregnancy. Resolution of an unplanned pregnancy can become a greater or lesser crisis depending on the types of support received. Nurses can reduce trauma with therapeutic listening, option presentation, and referral information.

Interfacing with Birth Mothers of Open Adoption through Pregnancy

Nurses in prenatal practices can do the same types of offering of open adoption, but they also have the chance for ongoing nurse-client relationships with birth mothers. Nurses can assess birth mother comfort with her adoption plan. Nurses can affirm the birth mother's courage, and discuss the benefits of open adoption. Birth mothers in this study indicated that encounters with nurses can be either detrimental or beneficial. When nurses inject personal prejudices to birth mothers at vulnerable points, the result can be destructive toward the extensive emotional work done by birth mothers. In turn, affirmation of a birth mother's own choices and plans—particularly when she has chosen to be a part of pregnancy counseling or support group—can strengthen her confidence. Birth mothers truly appreciated encouraging words and did not like being treated as *weird* or *abnormal*. They gratefully received opportunities to be heard and encouraged in their own choices.

Interfacing with Birth Mothers of Open Adoption through Labor and Delivery

Nurses in a labor and delivery setting have a particularly sensitive role with birth mothers. Initial admission can explore the type of adoption and the degree of openness. The relationship with the adoptive family can be assessed. The parameters of who will or will not be in the room can be voiced. Since the birth mother is the decision maker, nurses can open a line of communication availability to act as advocate for her. She is the laboring mother, so she is the patient of focus for the labor room nurse. It should go without saying that the nurse in the labor room should not inject her contrasting views or prejudices. Unfortunately, this study indicates that nurses are all too free with inappropriate, nontherapeutic words to birth mothers. If labor and delivery nurses have

prejudices about birth mothers or adoption, they should work through these apart from a patient or family situation. Months of support group, counseling, and intensive decision making on behalf of the birth child and herself can be shattered by one nurse's poorly chosen words at the point of labor, delivery, or postpartum.

Nurses working in the nursery should, as well, know the type of arrangements for the baby. If the birth mother chooses the postpartum time to be "her time with the baby," this study has demonstrated that can be a powerfully supportive aspect of open adoption. Nurses sometimes may be concerned that time with the baby will make relinquishment worse. The birth mothers' words indicated that it may be harder but not worse. In fact it often seems to make it better because of the shared memories. Nurses can respect the wishes of the birth mother at the point of postpartum and adapt a schedule that allows needs to be met. If the birth mother asks that the baby go to the adoptive couple or to herself, it should not automatically be linked to her decision to place or parent the child. Nurses may overreact and fear she is *changing her mind* when actually the time after birth is an expected time of integrating the experiences of birth, of seeing the actual baby in her midst, and of *processing* the process of making an open adoption.

Postpartum blues and depression are known aspects affecting postpartum. Adoption may hold a greater risk for more intense postpartum mood disorders. Open adoption as well may hold challenges, and referral for counseling may be necessary if support is not present from agency, adoptive family, family of origin, or significant others. The intensity may not reflect on whether or not the open adoption is chosen. It may be a developmental issue of transition. It is the nurse's role to offer community, medical, or counseling options as needed at the point of hospital discharge.

During the postpartum care, it is useful to keep care normal and comfortable. Birth mothers do not want people to *tiptoe around them* or act uncomfortable with the situation. They do want nurses to know what is going on with the open adoption.

A word of caution is given to hospital nurses working with birth mothers. If the birth mother is associated and involved with a reputable support group, or if Social Services is already involved, the nurse should not feel a need to be overly involved or take on a new role. The nurse's role is to work with that client in the facility of employment in the present experience and not as an ongoing contact. Over involvement can present problems when the nurse extends the role beyond that described in standards of nursing practice.

A second word of caution is given to hospital nurses working with women who mention that they have made an adoption plan in the past. Birth mothers of open and closed adoptions have very different experiences. Those with closed adoptions may well have unresolved grief that brings about their mention of the past adoption placement. Nurses or midwives are in prime positions to listen with care and bring some healing to the past unresolved issues as is well described by Fraser (1996).

Interfacing with Birth Mothers of Open Adoption beyond the Hospital Stay

The six week postpartum check is another touch point of opportunity for health care providers in their work with birth mothers. A clear assessment of birth mother wellbeing in regard to the open adoption would be beneficial. Again, if postpartum mood disorder is present, medical referral, additional follow up appointments, or medication may be beneficial. If unresolved issues are present, counseling may be useful. Birth mothers of this study found that being around other birth mothers of open adoption was

advantageous on many levels. Support group involvement for most seemed to help in ways that family of origin could not.

Nurses can know that staying busy, hobbies, and physical activities were three important self-care helps voiced by birth mothers. Visiting and being close with the birth child and adoptive family was important—even vital—in the early postpartum. But actively *not thinking about* the birth child was also important at points in the process of *moving on*. Nurses may offer encouraging words to strengthen a birth mother's self-care. Nurses can offer strategies for preventing and limiting postpartum mood disorders (Battle & Zlotnick, 2005).

Recommendations for Others in Health Care

As with all women experiencing childbirth, health care providers should be familiar with client birth plans and desires. The degree of adoption openness and intended plan of involvement should be charted and communicated among staff members. The involvement with agency, and agency general policies on the degree of openness during the hospital stay, are helpful to communicate.

After birth, assessment of the birth mother's emotional well being can easily accompany the postpartum check. Simple questions such as the following can be useful, "How are things going with your open adoption plan?" or, "Are you comfortable with how things are progressing in your open adoption?" or, "Are there things you would like to see take place before discharge?" Facilitating smooth transitions, and offering times of reprieve from too much activity when needed, can be beneficial forms of birth mother care during the hospital stay.

Health care providers who interface with birth mothers well after the delivery can be alert to changes in behavior or mood. Referral back to the support group or to counseling may help. If positive reports come from the open adoption or birth child, the birth mother can be encouraged by a health care provider who acknowledges her positive pregnancy outcome and personal life choices.

Siegel (2003) addresses the notion that open adoption is not easily defined. The kind and amount of contact in any given open adoption will change over time. Siegel identifies four dimensions of contact in open adoption including type, frequency, timing, and participants. She offers wording that makes sense for a *mediated* open adoption,

Every adoption is unique. Let's talk about what you feel you need now, and may need in the future, in terms of contact with each other, and make a plan that everyone feels works for them. Let's include in the plan a procedure for renegotiating things as people's feelings change over time (Siegel, 2003, p. 416).

An open adoption that is not mediated, as with the participants in this inquiry, seems to manage the changes in contact without difficulty between the adoptive family and the birth mother. Many researchers agree, as this study upholds, that the degree of openness is best decided by the participants themselves (Grotevant & McRoy, 1998; McRoy, Grotevant, & White, 1988; Silverstein, & Demick, 1994). Some have studied the processes linked to contact changes (Dunbar et al., 2006). In this study, the openness was so complete that negotiation of contact happened naturally and without much need of formal mediation. Adoption workers may be involved at needed points (Smith & Logan, 2004). Some may also choose to include the support group or the agency director in issues of contact. Health care providers can learn about the way a particular birth mother manages her adoption and be involved or not, depending on the need. It is interesting to

note that decades ago Kirk (1964) suggested that open adoption forges a new form of relationship. The relationship of birth and adoptive parents that results in them having a *shared fate* is beneficial to all parties.

Recommendations for Society

Adoption is misunderstood. Historical views impact the present and still reveal very negative pictures for birth mothers. One has only to search the internet to find tortured stories about unhappy birth mothers. Closed adoption led to unfinished business on the part of birth mothers and adoptees. This led to a need for opening records, then having search and reunions. These reunions were by no means always favorable. Open adoption has great benefits, resulting in a settled peace with the past events for birth mothers. Society needs work with acceptance of open adoption as a family constellation and as a pregnancy termination alternative. Organizations such as the American Adoption Congress may have impact on public policy and adoption reform (American Adoption Congress, n.d.). There is notably a need for certain generational and ethnic groups to have adoption acceptance. Open adoption, in general, needs to be understood and appreciated for its place in unintended pregnancy resolution (National Council for Adoption, 2003).

People uninformed about open adoption genuinely fear face to face contact between adoption triad members. They think birth mothers will have a greater desire to take a child back than those with a closed or initially disclosed adoption. They fear the adoptive parents will feel threatened. Another concern that has been voiced is that birth mothers will want to have some form of coparenting, will desire to reclaim the child, will interfere with parenting, or will create conflict (Grotevant and McRoy, 1998; Miall & March, 2005b; Reamer & Siegel, 2007; Wolfram, 2008). This study has revealed a

distinct role within open adoption, that of birth mother. This study has shown that adoption triad members can adjust to a level of relationship and contact that is comfortable for all. Birth mothers are aware that the adoptive mothers are *moms* and that they are *birth moms*. They like having some role in the life of the child, and they like that role being valued. They are not trying to blur parenthood. While different triads used different names, such as *aunt* or *birthday mommy* or even *mom* __ (name of birth mother), there was clear evidence that birthmothers knew their own role, that of an esteemed nonparental birth mother who had a special position with the adoptive family. It has been noted by researchers that increased contact reduces fear of things like the birthmother reclaiming, due to the building of trusting relationships (Grotevant et al., 1994; Wolfgram, 2008).

A third misconception that people uninformed about open adoption hold is the fear that the children of open adoption will be harmed, that they will undervalue their adoptive parents as something less than parents, or they will be confused by the role of birth mother (Miall & March, 2005b). This study did not address birth children directly, but some information emerged in the interviews. The birth children seemed to embrace their relationships with their birth mothers without confusion of their parents' roles. This study seemed to reveal a measure of strength in adoptive families and children who are able to relate well with their birth mothers. This is consistent with other sources (Silber & Dorner, 1989).

Society can benefit from greater awareness of different relationships within the adoptive triad. Excellent reviews of literature, such as Wolfgram's review about openness in adoption (2008), and new research, such as that of Ge and colleagues (2008), advance

the knowledge base nicely. Definitional, ethical, and theoretical development on the topic of open adoption is important (Gritter, 1995; Reamer & Siegel, 2007). Greater study with adoptive families and adoptees would be beneficial as well (Berge et al., 2006). Lay publications with accurate information about open adoption and birth mothers advance public acceptance (Duxbury, 2007; Foge & Mosconi, 2003; Howard, 2005; Jones, 2000; Kriedler, 1994; Lindsay, 1987, 1997; “Positive Adoption Language,” 1992; Roszia & Melina, 1993; Silber & Dorner, 1983, 1989; Webber, 2008). Of greatest importance is learning much more about birth mothers themselves. Several birth mothers have written about being birth mothers (Lemieux, 2006; Romanchik, n.d., 1999, 2003) or have been the subjects of articles (Webber, 2008). We need to continue to give birth mothers a voice. Social support of birth mothers is so important (Christianson, 2007), and societal acceptance of open adoption will improve support. Postplacing birth mothers benefit from social support (Theron & Dunn, 2006). Open adoptions need to be hospitable to birth mothers (Gritter, 2009). Birth mothers need to have equal importance in the adoption triad (Gritter, 1997, 2000).

Conclusions and Summary

Birth mothers in this sample and setting were unanimous in their support of open adoption. Even with the process and outcome being “hard,” and even with some having very difficult personal obstacles, birth mothers viewed open adoption as something that, if given the same situation, they would choose again. It was “best for them.” Additionally, they viewed their birth children as thriving, blossoming, and as having a wonderful life. This was voiced as being a better life than they could have provided.

Some knew that the birth child would always be a wonderful part of their life, and the relationship with the adoptive family was something that they cherished.

These birth mothers wanted adoption workers and health care providers to be sensitive to share the option of open adoption at the point of the woman's initial appointment regarding the unintended pregnancy. Further, the birth mother needs initial and ongoing support through the process. Much more is needed in the health care and nursing literature about birth mother experiences. A higher percentage of those with unintended pregnancy should consider choosing open adoption.

This study has revealed an ability on the part of birth mothers to embrace a role other than *mother* to their biological children. They appeared to be enjoying their role as birth mother. This role seemed to be having ongoing importance in their own and in their birth child's life. They took this role seriously, as one where they wanted to be a good example, to extend love, and to have meaningful, ongoing importance to their birth child, and the adoptive family members. In short, everyone in the adoption triad seemed to *get it* about the roles of birth mother and birth child. One summary example encapsulates the findings of the study,

It's hard. I'm not going to say it was the easiest thing. Because it was the hardest thing I'll ever have to go through in my life. But I know it was for the best. I know she's going to have whatever she wants. She's got an amazing mom and dad. And that was one of my big things. I wanted her to have a mother and a father figure. And she knows me, she knows who I am. She kind of already knows where she came from. They grow up knowing that. The oldest [adoptive family sibling] knows exactly who I am, "Oh, there's mom ___." They know exactly who I am. I just. I don't even know how to explain. They're just amazing. And I know that this is what God has planned for me and for [my birth child].

APPENDIX – IRB REVIEW AND APPROVAL

IUPUI AND CLARIAN INSTITUTIONAL REVIEW BOARDS & SUBCOMMITTEES REVIEWS
DOCUMENTATION OF REVIEW AND APPROVAL

IRB STUDY NUMBER: **0707-62B**
(IRB Office will assign)

SECTION I: INVESTIGATOR INFORMATION

Principal Investigator: Sharon Sims, PhD, RN Department: Nursing
(Last, First, Middle Initial-----must have faculty/staff status or faculty sponsor must sign)

Building/Room No.: NU 318 Phone: () - E-Mail: _____

Contact Information:

Name: Sharon Sims, PhD, RN Address: 1111 Middle Drive, Indianapolis, IN 46202
Phone: _____

Fax: _____ E-Mail: _____

If this is a Student Protocol, List Name of the Student: Lynn B. Clutter, MSN, RN, BC, CNS Phone: _____

Protocol Title: **Descriptions of Birth Mothers after Crisis Pregnancy and Open Adoption**

Sponsor/Funding Agency: N/A PI on Grant: _____

Sponsor Protocol #/Grant #: _____ Period: From: _____ to _____

Sponsor Type: Federal; State; Industry*; Not-for-Profit; Unfunded; Internally Funded

Grant Title (if different from project title): _____

*NOTE: Information on the fee for IRB review of new, for-profit-sponsored projects is available at the following link:
<http://www.iupui.edu/~resgrad/spon/irbfee.htm>

SECTION II: TYPE OF REVIEW

- Expedited Review
- Full Board Review (Choose One) → Behavioral or Social Sciences (IRB-01)
- Biomedical (Choose One) → IRB-02 IRB-03 IRB-04 IRB-05

SECTION III: SPECIAL SUBJECT POPULATIONS

- Research to Include:
- Minors Pregnant Women Cognitively Impaired Prisoners
 - Economically or Educationally Disadvantaged Fetuses (or Fetal Tissue)

SECTION IV: RESEARCH SUBMISSION

- Included with Research Submission:
- Informed Consent, dated*:
 - Summary Safeguard Statement, dated**:
 - Drug Brochure, dated**:
 - Other: Description: _____, dated**:
 - Authorization, dated**:
 - Protocol, dated**:
 - Advertisement, dated**:

* version dates are required on the informed consent statements.
** dates are optional and only necessary if required by the investigator or sponsor.

SECTION V: INVESTIGATOR STATEMENT OF COMPLIANCE

I assure the Board that all procedures performed under the project will be conducted in strict accordance with those federal regulations, University and Clarian Health Partners policies that govern research involving human subjects. I agree to submit any deviation from the project (e.g. change in principal investigator, research methodology, subject recruitment procedures, etc.) to the Board in the form of an amendment for IRB approval prior to implementation. By signing this form, I am certifying that all co-investigators listed on the study are aware of the research and are agreeing to participate.

Note: This form and any additional material requested by the Board will not be processed unless they are neatly typed and legible, properly prepared, and signed personally by the principal investigator.

Signature of Investigator: _____ Date: _____

E-MAILED JUL 10 2007

SECTION VI: IRB APPROVAL

This protocol, informed consent statement, authorization, and/or waiver of authorization for use of human subjects in research has been reviewed and approved by the Indiana University-Purdue University Indianapolis Institutional Review Board or the Clarian Institutional Review Board for a maximum of a one year period beyond the final approval date unless otherwise indicated as follows:

Authorized IRB Signature: _____

IRB Approval Date: 8/24/07

AUG 24 2007

Recorded in the Minutes of: _____

Rev. 10/04

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CURRICULUM VITAE

Lynn B. Clutter

EDUCATION

Year	Degree	Institution
1978	Bachelor of Science in Nursing	Oral Roberts University
1984	Master of Science in Nursing Role Specialization Nursing Education Clinical Nurse Specialist Clinical Specialization Nursing of Children and Families: Child Bearing, Rearing, and Development	Oral Roberts University
2009	Doctor of Philosophy in Nursing Major: Nursing Science Minor: Nursing Informatics	Indiana University

LICENSURE

Advanced Practice RN in Oklahoma; RN in Missouri

CERTIFICATIONS

Certified Nurse Educator, National League for Nursing
International Board Certified Lactation Consultant
Labor Support Doula, Doulas of North America
Prepared Childbirth Educator, Prepared Childbirth Educators, Inc.
Clinical Nurse Specialist, State of Oklahoma
Perinatal Nurse, American Nurses Credentialing Center
Fetal Heart Monitoring
Denver II, Developmental Screening
Brazelton Neonatal Behavioral Assessment Scale

EXPERIENCE

Date	Title	Institution
1/2005– present	Assistant Professor (2009) Nursing Instructor (2005–2008)	Langston University–Tulsa

Position Responsibilities:

Nursing Care of Childbearing Family
Course Coordinator
Sole course lecturer, 5 credit hour course
Level II Coordinator (2006–present)

Committees:

Faculty-Student Welfare Committee (2005–present)
Student–Faculty Forum (2006–present)
NLNAC Preparation Committee (2008–present)
NLNAC Criterion 1 Committee Chair (2009–present)
University Accreditation Criterion 3 Committee (2007)
Desire to Learn Online Course Management (2007)
University Service-Learning Committee (2006)
Special Investigation Committee (2006)

1/2007– present	Lactation Consultant (PT) International Board Certified	Saint Francis Hospital Tulsa, Oklahoma
5/2006– 7/2006	Consultant, Co-Developer Childbearing & Childrearing Syllabi	Oklahoma Wesleyan University Bartlesville, Oklahoma
7/2005	Camp Nurse	Kanakuk Youth Camp Branson, Missouri
10/2004– 5/2006	Nurse (PT) Limited 1 st –2 nd trimester ultrasounds	Mend Crisis Pregnancy Tulsa, Oklahoma
1/2004– 1/2007	Childbirth Support Doula (PT)	Hillcrest Medical Center Tulsa, Oklahoma
1/1995– present	Childbirth Support Doula (PT) Group & Event Facilitator	Crisis Pregnancy Outreach Jenks, Oklahoma
5/1988– present	Informal Parish Nurse (PT)	Tulsa Christian Fellowship Tulsa, Oklahoma
7/1997	Camp Nurse	Shepherds' Fold Camp Avant, Oklahoma
1/1997– 5/1997	Adjunct Instructor Advanced Research Class for Honors Students	Oral Roberts University Tulsa, Oklahoma
1/1993– 12/1998	Adjunct Instructor Pediatrics, L&D, PP, NBN Clinical; Skills Lab, Occasional Full-Class Instruction	Tulsa Community College Tulsa, Oklahoma
1/1994– 5/1994	Adjunct Instructor Pediatrics Clinical Group NBN, Clinical; Skills Lab	University of Tulsa Tulsa, Oklahoma

12/1993–	Adjunct Instructor	Oral Roberts University
12/1992	Nursing of Families in Childbearing Phase, Thirteen lectures, Substitute clinical	Tulsa, Oklahoma
9/1988–	Unit Editor and Skills Author (PT)	Tulsa, Oklahoma
3/1991	<i>Comprehensive Child and Family Nursing Skills</i>	
1/1985–	Clinical Nurse Specialist, Educator	City of Faith Medical and
5/1988	Department of Pediatrics	Research Center, Tulsa, OK
5/1983–	Staff Nurse with Hospital Teaching	Pediatric & Adolescent Care
7/1983	Privileges, Saint John Medical Center	Tulsa, Oklahoma
6/1982–	Graduate Nursing Recruiter	Oral Roberts University
12/1992	Graduate Admissions	Tulsa, Oklahoma
9/1979–	Staff Nurse with Hospital Teaching	Tulsa Pediatric Clinic
2/1982	Privileges, Saint John Medical Center	Tulsa, Oklahoma
6/1979–	Staff Nurse	Nursefinders
12/1992		Tulsa, Oklahoma
12/1978–	Staff Nurse, Emergency Room	Saint John Medical Center
5/1979		Tulsa, Oklahoma
5/1978–	Staff Nurse, Intensive Care	Saint Francis Hospital
12/1978		Tulsa, Oklahoma
9/1976–	Student Nurse Extern, Emergency Room	Saint Francis Hospital
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RESEARCH

2008– Adolescent Birth Mothers After Unintended Pregnancy and Infant Open
2009 Adoption, Dissertation, Presentation Research Session accepted for Sigma Theta
Tau International Biennial Convention, November, 2009

2006– Birth Mothers’ Lives After Crisis Pregnancy and Open Adoption Placement
2007 Dissertation Pilot Study

2006– Adolescent Mothers’ Infant Feeding Choices, Clutter, L.; Presentation break out
2007 session at the Statewide Nursing Research Day, Oklahoma City University,
Kramer School of Nursing, 3/23/07, in association with junior student nurses
of Langston University & Debi Bocar PhD, RN, IBCLC, Chiron Mentor

- 2007 Poster presentation and Panel presentation session at Sigma Theta Tau International Biennial Convention, November 2007
- 1997 Young Children's Pain Rating Using the FACES Pain Rating Scale with Abbreviated vs. Original Instructions in Measuring Pain Intensity, (Baker-Lefkowitz, A., Keller, V., Wong, D., & Clutter, L.) *
- 1995 The Influence of Abbreviated vs. Original Instructions in Measuring Pain Intensity in Young Children Using the FACES Pain Rating Scale. (Clutter, L., Nix, K. & Wong, D.)
Available: <http://www3.us.elsevierhealth.com/WOW/faces32.html>, *
- 1994 Young Children's Pain Rating Using the FACES Pain Rating Scale with Original vs. Abbreviated Instructions, (Nix, K., Clutter, L., & Wong, D.) *
- 1993 The Influence of Type of Instructions in Measuring Pain in Young Children Using the FACES Pain Rating Scale, (Nix, K., Clutter, L. & Wong, D.)
Available: <http://www3.us.elsevierhealth.com/WOW/faces19Nix.html> *
- * (Published in: Wong, D.L., & Baker, C.M. (2000). *Wong-Baker FACES pain rating scale reference manual*. Duarte, CA: Pain Resource Center, City of Hope National Medical Center. Available from <http://www1.us.elsevierhealth.com/FACES/faces42reproductions.html>)
- 1984 Pain in Children: Comparison of Assessment Tools, Data Collection. Study publication: Wong, D., & Baker, C. (1988). Pain in children: comparison of assessment scales. *Pediatric Nursing*, 14(1), 9–17.
- 1984 Bonding Characteristics of Three Selected Family Dyads, Master's Thesis
- 1977 The Relationship Between Perceptions of Spiritual Needs and Degree of Illness, Senior Research Paper

PROFESSIONAL ACTIVITIES

- 2009 Wong-Baker FACES Foundation, Board Member, 2009; Secretary, 2009
- 2009 Ladewig, P. W., London, M. L., & Davidson, M. R. (2010). *Contemporary Maternal-Newborn Nursing Care* (7th ed.). Upper Saddle River, NJ: Pearson Prentice Hall. Chapter Reviewer
- 2008 Nurses for the Cure, Susan G. Komen Race for the Cure, Tulsa OK, Co-Chair
- 2008 Website Creation with a Virtual Chartering Ceremony for Upsilon Pi Chapter of Sigma Theta Tau International at Langston University School of Nursing. Developer and designer

- 2007 Olds, S. B., London, M. L., Ladewig, P. W., & Davidson, M. R. (2008). *Maternal-newborn nursing and women's health across the lifespan*. (8th ed.), Upper Saddle River, NJ: Pearson Prentice Hall. Nutrition Chapter Reviewer
- 2006 American Red Cross Blood Drive volunteer, OSU/Langston Tulsa
- 2006 Consultation for an infant and children crisis shelter regarding procedures, policies, volunteer training for infant-toddler age care
- 1997 Wong, D. L., (1997) *Essentials of Pediatric Nursing* 5th Ed. St. Louis: Mosby. My roles: Content contributor. Hospital site liaison. Developer of chapter heading. Obtainer of photos, children's drawings, and quotes; consents from hospital, parents, and child assents
- 1996 Pediatric Nursing Video Series, Mosby, Inc. 6-video series with Donna Wong and others. My roles: Hospital and community site liaison. Pediatric nurse in videos. Coordinator of children and family member participants in videos
- 1985–1988 Tulsa Coalition for Parenting Education, obtained provider membership for City of Faith Pediatric Department (1986)
- 1986–1988 Tulsa Community Collaboration Project (Coordination of services for special needs children ages 0–5). Steering Committee (1986). Parent-professional Partnership Committee (1986)

PROFESSIONAL MEMBERSHIPS

American Association of University Professors

American Nurses Association/Oklahoma Nurses Association

Member. District #2, Recording Secretary. District #2 (1985–86), ONA Convention Delegate (1984). Program Committee, District #2 (1983–84)

Association of Women's Health Obstetric and Neonatal Nurses (AWHONN)

Statewide Conference Planning Committee, (2008)
National Nurse to Nurse Award recipient, (2008)

Midwest Nursing Research Society

National League for Nursing/Oklahoma League for Nursing

Ambassador for Langston University (2007–present)

Sigma Theta Tau International

- 1) *Alpha Chapter* (2007–present)
- 2) *Mu Iota Chapter* (1990–present)
President (1994–95)

Chapter Delegate (2007–2009, 1995)

Directed proposal process and received Sigma Theta Tau International's Chapter Award for Innovative Community Involvement for work with The Greater Tulsa Area Pain Conference 1995

3) *Upsilon Pi Chapter*, (2008–present)

Founding President

Program presenter

Newsletter writer and editor

Directed application process for Regional Chapter Award (award received 2008)

Website developer

HONORS/AWARDS

7/2009 Grant Writing Institute, Accepted Participant, Oklahoma State Regents for Higher Education

1/2009 Graduate Nursing Scholarship, Academic Scholarship, Indiana University Purdue University at Indianapolis

1/2009 Grace Florence Nightingale Nursing Scholarship, Academic Scholarship, Indiana University Purdue University at Indianapolis

6/2008 AWHONN 6th Annual, National, AWHONN / Johnson and Johnson's Childbirth Nurse to Nurse Award, Los Angeles, CA 2008. Annual Convention General Session Presentation

5/2008 Outstanding Scholarship in Nursing and Contribution to Nursing Education, Registered Nurse Community Volunteers, Tulsa, Oklahoma

4/2008 Oklahoma Nurses Association, Award for Contributions to ONA Region 2 and Nursing Excellence

1/2008 Grace Florence Nightingale Nursing Scholarship, Academic Scholarship, Indiana University

1/2008 Andrew S. Cebula Academic Scholarship, Indiana University

4/2007 AWHONN Oklahoma Chapter Award for Outstanding Academic Achievement and Contribution to the Health of Women and Infants

1/2007 National League for Nursing, Appointed as Ambassador for Langston University

1/2007 Andrew S. Cebula Academic Scholarship, Indiana University

9/2006 Andrew S. Cebula Academic Scholarship, Indiana University

- 6/2006 Chiron Mentoring Program, Leadership Institute, Sigma Theta Tau International, 2006–2007 Participant & Foundation for Nursing Leadership Education Grant Recipient; 2007–2008 Selection Committee
- 5/2006 Outstanding Service Award: President’s Outstanding Faculty Service Award, Langston University
- 3/2006 Editors Choice Book Review: Ivey, J. (2006). [Review of the book *Meeting Children's Psychosocial Needs Across the Health-Care Continuum. Pediatric Nursing*, 32(2) 154. Chapter author (see Publications section below)
- 11/2005 Sigma Theta Tau Chapter Mu Iota, Scholarship and Zeta Delta Chapter-At-Large, Wong Atraumatic Care Award for “First Breath,” poster presentation for Creative and Expressive Arts in Nursing sessions at Sigma Theta Tau International 38th Biennial Convention
- 9/2005 Sigma Theta Tau Chapter Zeta Delta-At-Large Research Grant for “The influence of abbreviated vs. original instructions in measuring pain intensity in young children using the FACES Pain Rating Scale”; Researchers: Clutter, L., Nix, K., & Wong, D.
- 4/1993 The University of Tulsa Faculty Research Grant for “The influence of abbreviated vs. original instructions in measuring pain intensity in young children using the FACES Pain Rating Scale,” Researchers: Clutter, L., Nix, K., & Wong, D.
- 11/1992 Book of the Year Awards from American Journal of Nursing and Pediatric Nursing for *Comprehensive Child and Family Nursing Skills*. Unit Editor and Skills Author (see Publications section below)
- 1/1992 Pediatric Nursing 1991 Writer's Award for the group written article, "Diapering Choices: A Critical Review of the Issues." (see Publications section below)
- 4/1991 Oklahoma Nurses Foundation Small Grant Awards for “The influence of the type of instruction in measuring pain intensity in young children using the FACES Pain Rating Scale,” Researchers: Nix, K., Clutter, L., & Wong, D.
- 2/1991 National Association of Pediatric Nurse Associates and Practitioners Foundation Research Grant for “The influence of the type of instruction in measuring pain intensity in young children using the FACES Pain Rating Scale,” Researchers: Nix, K., Clutter, L., & Wong, D.
- 12/1990 Sigma Theta Tau Chapter Zeta Delta-At-Large Research Grant Award for “The influence of the type of instruction in measuring pain intensity in young children using the FACES Pain Rating Scale,” by Nix, K., Clutter, L., & Wong, D.

6/1987 Described in: Ballman, C. (1987). Profiles in excellence. *American Journal of Nursing*, 87(6), 782–787.

10/1986 Achievement in Nursing Practice Award, Oklahoma Nurses Association.

PUBLICATIONS

Clutter, L. B. (2009). It's never too late for education. *The Oklahoma Nurse*, 54(2), 20.

Clutter, L. B. (2008). Praise for CNE on newborn assessment. *Nursing for Women's Health*, 12(1), 13–14.

Pappas, I., Clutter, L., & Maggi, E. (2007). Current legal changes: Innovative legal seminar for nursing students. *Journal of Nursing Law*, 11(4), 197–209.

Clutter, L. (2007). Chiron mentoring benefits all. *Reflections on Nursing Leadership*, 33(1). Retrieved January 30, 2007, from http://www.nursingsociety.org/RNL/Current/in_touch/chiron.html

Clutter, L. (2006). [Review of the book *When parents say no: Religious and cultural influences on pediatric healthcare treatment*]. *Reflections on Nursing Leadership*, 32(3). Retrieved September 30, 2006, from www.nursingsociety.org/RNL/3Q_2006/columns/book_review.html

Clutter, L. (2006). Foreward. In L. Linnard-Palmer, *When parents say no: Religious and cultural influences on pediatric healthcare treatment* (p. xi). Indianapolis: Sigma Theta Tau International.

Clutter, L. (2005). Spiritual issues in children's health-care settings. In J. A. Rollins, R. Bolig, & C. C. Mahan, *Meeting children's psychosocial needs across the health-care continuum* (pp. 351–420). Austin: Pro-Ed, Inc.

Wong, D. L., Brantly, D., Clutter, L. B., DeSimone, D., Lammert, D., Nix, K., et al. (1992). Diapering Choices: A Critical Review of the Issues. *Pediatric Nursing*, 18(1), 41–54.

Clutter, L. (Unit Ed.). (1991). The family, environment, and culture. In D. Smith (Ed.), *Comprehensive Child and Family Nursing Skills* (pp. 243–272). St. Louis: Mosby-Year Book.

Clutter, L. (1991). Fostering healthy sleep patterns in children. In D. Smith (Ed.), *Comprehensive Child and Family Nursing Skills* (pp. 290–294). St. Louis: Mosby-Year Book.

Clutter, L. (1991). Fostering spiritual care for the child and family. In D. Smith (Ed.), *Comprehensive Child and Family Nursing Skills* (pp. 263–272). St. Louis: Mosby-Year Book.

- Clutter, L. (1991). Promoting bonding between parents and children. In D. Smith (Ed.), *Comprehensive Child and Family Nursing Skills* (pp. 254–260). St. Louis: Mosby-Year Book.
- Clutter, L. (1988). Helping Parents Prepare for Travel and Vacations. *Pediatric Nursing*, 14(3), 211–215.
- Clutter, L., Hess, C., Nix, K., Smith, D., Stevens, N., & Wong, D. (1988). Communicating Effectively with Older Children and Adolescents. *Children's Nurse*, 6(1), 2–4.
- Clutter, L., Hess, C., Nix, K., Smith, D., Stevens, N., & Wong, D. (1987). Communicating Effectively with Young Children. *Children's Nurse*, 5(4), 1–3.

PRESENTATIONS

- 5/2009 Pinning Ceremony, Awards Presentation, Langston University, Tulsa
- 12/2008 Pinning Ceremony, Honors Presentation, Langston University, Tulsa
- 10/2008 Tribute to Donna L. Wong, PhD, RN, FAAN, PNP, CPN at the 14th Annual Greater Tulsa Area Pain Conference, co-presenter with Kristie S. Nix, EdD, RN
- 5/2008 Eulogy Sharing, Funeral of Donna L. Wong, PhD, RN, FAAN, PNP, CPN [see: Rollins, J. (2008). Donna Lee Wong 1968–2008. *Pediatric Nursing*. 34(3), 211(2).]
- 1/2008 Faculty and Student Research: Methods and Benefits, Professional Nursing Education Series, Upsilon Pi Chapter, Sigma Theta Tau, International
- 1/2008 Safety & Poison Prevention, Zarrow International School, 2nd grade, Risk Watch
- 11/2007 Breastfeeding Positions & Proper Latch, Lactation Seminar, Saint Francis Hospital
- 11/2007 Leadership Opportunities Within Sigma Theta Tau International, Panel Discussion break out session of 39th Biennial Sigma Theta Tau International Convention, Baltimore, MD
- 11/2007 Poster Presentation: Adolescent Mothers' Infant Feeding Choices at 39th Biennial Sigma Theta Tau International Convention, Baltimore, MD
- 4/2007 Preparing for NCLEX Childbearing Component, Langston University 4th Level Students

2004– 2006 PREP Relationship Skills Training Facilitator, Endorsed by Oklahoma Marriage Initiative, Tulsa, OK. Course for marital and premarital couple education

2/2006 Presidential Induction Speech, Langston University Honor Society

11/2005 Poster Presentation: "First Breath" in Creative and Expressive Arts in Nursing, 38th Biennial Convention, Sigma Theta Tau International, Indianapolis, IN

10/2005 Weekend Women's Retreat Speaker, Tulsa Christian Fellowship

1982– 1999 American Red Cross: Volunteer R.N.: Disaster Nursing; Health Instructor for Preparation for Parenting & Home Nursing

SELECTED CONTINUING EDUCATION

8/27/09 FLU.GOV Webcast to Discuss H1N1 Preparedness for Pregnant Women and New Mothers

8/1–2/09 Adoptive Couples Retreat with ENRICH assessment, Oklahoma Marriage Initiative, Tulsa, OK

7/25/09 From an Ocean of Tears to an Ocean of Love: A Birth Mothers Workshop, Dillon International, Inc., Tulsa, OK

7/20– 2009 Grant Writing Institute, Oklahoma State Regents for Higher Education, 27
24/09 individuals accepted statewide, Oklahoma City, OK

7/16– 2nd Annual Informatics & e-learning in Nursing and Health Sciences Education
17/09 Conference, 7 Contact Hrs., Tulsa, OK

6/8/09 Creating Online Courses, 3 credit hours, The Eighth Floor Technology and Learning Center For Educators, Tulsa, OK

6/28/09 Elsevier/Mosby Lesson: Lactation and Breastfeeding, 1.1 Contact Hrs., online

6/10/09 Sigma Theta Tau International Officer Orientation Webcast, online

6/8/09 Overcoming Barriers to Writing for Publication, Margaret Kearney, PhD, RN, FAAN, Indiana University Webcast

6/5/09 Oklahoma WIC 9th Annual Breastfeeding Symposium for Healthcare Providers, 6.75 Contact Hrs.; 6.3 LCERPS, Oklahoma City, OK

6/3/09 Collaborating to Integrate Clinical Simulation in Education & Patient Care Settings, Oklahoma Nurses Association & OK Health Care Workforce, A Best Practices Workshop, 5.0 Contact Hrs.

- 5/22/09 Bloodborne Pathogens Training, 2009, (OSHA 29 CFR 1910.130) IUPUI, online
- 5/14/09 Simulation Learning System Webinar, Evolve Learning Systems, online
- 2/27/09 Osteoporosis Update, Hillcrest Medical Center, Tulsa, OK
- 1/30/09 Screening Patients for Domestic Violence, Hillcrest Medical Center, Tulsa, OK
- 12/4/08 Cultural Diversity Day, Cultures of Faith Traditions, Langston University, Tulsa, OK
- 11/3/08 PowerPoint: More Animations & Hyperlinks, Eighth Floor, Tulsa, OK, 2 Hrs.
- 10/31/08 Embryo Adoption, R. Finger, MD, MPH, National Embryo Donation Center, Grand Rounds, Hillcrest Health Care System
- 10/23/08 Grant Writing Workshop, Eighth Floor, Tulsa, OK
- 10/27–
29/08 PowerPoint: An Intro, New Features, Eighth Floor, Tulsa, OK, 6 Hrs.
- 10/7/08 Podcasting: Hype or Help, Eighth Floor, Tulsa, OK, 3 Hrs.
- 10/3/08 Greater Tulsa Area Pain Conference “Improving Patient Outcomes with Effective Pain Management,” 3 contact Hrs.
- 10/9–
10/08 Tulsa TECHFEST 2008, over 70 world renowned speakers, OSU-Tulsa
- 8/20/08 Health Informatics at The University of Oklahoma’s School of Community Medicine, Medical Informatics, Research & Education
- 8/6/08 Web 2.0: The Lightning Round Introduction, Eighth Floor, Tulsa, OK
- 7/30/08 Dreamweaver CS3: Level 1, The Eighth Floor, A technology & learning center for educators, 6 Hrs.
- 7/21/08 Publisher: Newsletters, The Eighth Floor, A technology & learning center for educators, 2 Hrs.
- 6/21/08 AWHONN Pre-Conference: Breastfeeding Challenges: Evidence Based and Best Practice Solutions, Los Angeles, CA
- 6/22/08 AWHONN Pre-Conference: Lab Interpretations in Women’s Health and Pregnancy, Los Angeles, CA

- 6/21– 25/08 AWHONN Convention: Many Voices, One Mission, Los Angeles, CA
- 5/18/08 Drugstore Pharmacology, Mary C. Brucker, CNM
- 5/2/08 Registered Nurse Community Volunteers Day, Emergency Preparedness and Smallpox Vaccinator Training, Tulsa, OK
- 4/25/08 Newborn Screening Update, Craig Anderson, DO, NICU Hillcrest, Tulsa, OK
- 4/17– 18/08 AWHONN Statewide Conference: The Culture of Poverty, Tulsa, OK
- 4/11/08 Medical Ethics, Grand Rounds, Hillcrest Health Care System, Tulsa, OK
- 4/4/08 Epidemic Obesity: Impact on our Children, Walt Larimore, MD, Hillcrest, Tulsa, OK
- 3/14/08 Performance Intelligence, Hillcrest Health Care System, Tulsa, OK
- 3/8/08 Latching on to Breastfeeding: An Initiator Course, Saint Francis Hospital, Tulsa, OK
- 3/7/08 Fever in the Newborn, Hillcrest, Tulsa, OK
- 12/6/07 Cultural Diversity Day, Cultures of Disability, Langston University, Tulsa, OK
- 11/30/07 Pregnancy Loss, Post-abortion Trauma, and Unresolved Grief. Teresa Burke, PhD, Saint Francis Hospital, Tulsa, OK
- 11/2– 7/07 39th Biennial Sigma Theta Tau International Convention, Baltimore, MD
- 10/12/07 Greater Tulsa Area Pain Conference with Marilyn J. Hockenberry, PhD, RN-CS, PNP, FAAN, Terri L. Brown, RN, MSN, CNS, and Joy Hesselgrave, RN, MSN, CPON
- 10/19– 20/07 Tulsa TECHFEST 2007, over 50 world renowned speakers, OSU, Tulsa
- 10/11/07 Overview of Guardisil Use, Catherine Gardner, ARNP, Tulsa, OK
- 9/25/07 Don't Stress Me Out, Preventing Student Stress, LUSON Day of Caring, Tulsa, OK, Theresa Valento, RN, MSN
- 9/21/07 Influenza Update, David Scheck, MD

- 9/12/07 Innovations in Hormonal Birth Control. Catherine Gardner, ARNP
- 9/11– Enhancing Early Experiences for At Risk Children. Attachment Disturbances of
12/07 Young Children, Charles H. Zeanah, PhD, Marcia Lee Ledbetter MD, Tulsa
- 9/1/07 Fetal Heart Monitoring Course, Karen Winfield, Saint John Medical Center
- 5/23/07 NLN. Preparation Course for Nurse Educator Certification, Kramer School of
Nursing, Oklahoma City, OK
- 5/21– Statewide Simulation Conference: How to use SimMan with Pam Jeffries,
22/07 DNS, RN, FAAN, Tulsa Community College, Tulsa, OK
- 4/20/07 Mu Iota Chapter Sigma Theta Tau International, Spring Induction Ceremony,
Oral Roberts University, Tulsa, OK
- 4/19/07 Minority Health Forum, Langston University, Langston, OK
- 3/16/07 Snoring & Sleep Apnea, Hillcrest HealthCare System, Tulsa, OK
- 3/9/07 Focus Diabetes 07-New (and Old) Approaches to Therapy, Hillcrest HealthCare
System, Tulsa, OK
- 2/2/07 Male Breast Cancer, Brad Hoyt, M.D., Hillcrest HealthCare System, Tulsa, OK
- 1/26/07 Focus on Glucose Control in Patients with Type 2 Diabetes, Hillcrest
HealthCare System, Tulsa, OK
- 11/9– Oklahoma Nurses Association Annual Convention, Tulsa, OK
10/06
- 10/27/06 Teen Pregnancy Prevention & Parenting Conference with Bill Albert, Dep.
Director, National Campaign to Prevent Teen Pregnancy, Tulsa, OK
- 10/20/06 New Advances in Spinal Surgery, Hillcrest HealthCare System, Tulsa, OK
- 10/6/06 12th Greater Tulsa Area Pain Conference, Tulsa, OK
- 7/26– Chiron Mentoring Program Leadership Institute, Sigma Theta Tau International,
28/06 Indianapolis, IN
- 7/17/06 Understanding Infant Adoption, Infant Adoption Training Initiative, Spaulding
for Children, Saint John Medical Center, Tulsa, OK
- 5/9/06 Nurse Educators' Update: minority students, legal strategies, technology, critical
thinking, Langston University, Tulsa, OK

- 4/20/06 Minority Health Forum on Women's Health Issues, Langston University, Oklahoma City
- 4/14/06 Excel & Power Point Courses 4 Hrs. Langston University, Tulsa, OK
- 2/25/06 Consortium: Current and Future Trends in Educating International Students, Dr. Frances R. Eason, Oklahoma League of Nursing, Tulsa, OK
- 1/26/06 Embracing the Vision, Faculty/Staff Institute, Langston University, Langston, OK
- 11/12– 38th Biennial Convention, Sigma Theta Tau International, Indianapolis, IN
16/05
- 11/8– Oklahoma Nurses Association State Conference Nurses at the Heart of it All:
10/05 Compassion, Commitment, Strength.
- 11/1– Breast Feeding Educator Program, Debi Bocar, RN, PhD, IBCLC
3/05 Lactation Consultant Services™, Hillcrest Hospital, Tulsa, OK
- 10/27/05 Teen Pregnancy Prevention & Parenting Conference, Community Service Council of Greater Tulsa with Bill Albert of The National Campaign To Prevent Teen Pregnancy
- 10/7/05 11th Greater Tulsa Area Pain Conference, Tulsa, OK
- 9/23/05 Online and Blended Courses for Nursing, Dr. Diane Billings, Indiana University School of Nursing
- 6/10/05 5th Annual Oklahoma WIC Breastfeeding Symposium for Healthcare Providers, Tieraona Low Dog, MD and Judi Lauwers, BA, IBCLC, Oklahoma City, OK
- 5/31– Marie Biancuzzo's Lactation Exam Review 2005, Breastfeeding Outlook,
6/1/05 Dallas, TX
- 5/25/05 Course 631: Management of Breastfeeding, Breastfeeding Support Consultants, Center for Lactation Education, Self-Study Course
- 5/8/05 Course 853: Inverted or Flat Nipples, Breastfeeding Support Consultants, Center for Lactation Education, Self-Study Course
- 4/27/05 Breastfeeding Education Workshop, Carol Monlux, BSN, RN, IBCLC; Alisa Erickson BSN, RN, IBCLC; Deena Licht, RN, IBCLC; Mona Keeline, RN, IBCLC; St. John Medical Center, Tulsa, OK

- 4/21– 22/05 AWHONN Oklahoma Section Conference Association of Women’s Health, Obstetric and Neonatal Nurses, Hillcrest Medical Center, Tulsa, OK
- 4/5/05 Medications and Breastfeeding; High Risk Babies and Breastfeeding, Tina Smith, RN, IBCLC Saint Francis Ed. Center, Doulas of North Eastern Oklahoma (DONEOK)
- 4/2/05 Fostering the Spirit of Inquiry: State-Wide Research Day, Langston University, Tulsa, OK
- 3/4/05 Caring for Caregivers-A Grassroots USA-Japan Initiative, Content about art therapy in healthcare, Judy Rollins, RN, PhD, Kaiser Medical Center and Hillcrest Medical Center, Tulsa, OK
- 2/14/05 Cultural Diversity Day: Dance around the world, Langston University, Tulsa, OK
- 12/20/04 Obstetric Ultrasound Module, National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties, Self study module
- 11/9/04 PREP Relationship Skills Refresher Training, Oklahoma Marriage Initiative
- 10/13, 19–22/04 Basic Ultrasound Technology for Pregnancy Assessment through Sonography, Now, MEND Crisis Pregnancy Center, HOPE Pregnancy Center, and National Institute of Family & Life Advocates, Tulsa, OK
- 10/8/04 10th Greater Tulsa Area Pain Conference, Tulsa, OK
- 8/5–6/04 Prepared Childbirth Educators, Inc, Certification Course, Arlington, TX