Nursing Care of Adoption and Kinship Families
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For the past 15 years, Dr. Foli’s research program has focused on the transitions and needs of nontraditional social units: adoptive and kinship families. Through her research in the area of parental postadoption depression, Dr. Foli has described and tested a mid-range theory of postadoption depression and articulated the profiles of parents who struggle with depressive symptoms before and after placement; she has published her findings in nursing and interdisciplinary journals. Dr. Foli is a member of the Adoption Quarterly editorial board and has authored or coauthored three additional health-related books, including one specifically about adoption, The Post-Adoption Blues: Overcoming the Unforeseen Challenges of Adoption. Coauthored with John R. Thompson, MD, the book focuses on helping adoptive parents recognize and overcome challenges related to the placement of a child.
Nursing Care of Adoption and Kinship Families

A Clinical Guide for Advanced Practice Nurses

KAREN J. FOLI, PHD, RN, FAAN
To families, no matter what the size, shape, or color, and to my father, Reno Foli, who loved such a family.
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Foreword

This is a landmark book that should have a global readership. For far too long, adoption and kinship families have not received the attention that they so sorely need. Karen Foli has written a text for which clinicians and academics have long been waiting—it will bring visibility to the welfare of adoption and kinship families. The material in this book is well researched, sensitively delivered, and essential for any clinician attending to adoption and kinship families.

The book acknowledges that the typical family—male and female parents with a boy and girl offspring—no longer reflects our society. Nontraditional families, such as adoptive and kinship families, are well entrenched in our society. In this book, Karen Foli draws clinicians’ attention to the unique, heterogeneous families that have experienced relinquishment and acceptance of parenting by persons who have not given birth to the children and have no direct biological ties. With combined expertise and caring, Dr. Foli presents clinicians with much-needed resources. She carefully addresses the unique challenges of advanced practice nurses who are in a position to support adoptive and kinship families.

This well-researched book systematically focuses on each person involved in adoptive and kinship parenting. First, clinicians learn about the historical, cultural, and legal perspectives. Next, advanced practice nurses learn what is needed to deliver excellent nursing care to the birth parents, the adoptive parents, the child who is adopted, kinship parents, birth parents of kinship children, kinship children, and, lastly, special cases of foster care, assisted reproductive technology, commercial surrogacy, and human trafficking.
This book is not just a scholarly text but also a valuable manual and therefore represents a particular pinnacle of achievement within this field. I have little doubt this book will be read by many advanced practice nurses and other clinicians who will find the information in it extremely valuable and its message inspirational. The book will have an incredible impact on the care delivered by advanced practice nurses to make a significant difference in the lives of adoptive and kinship families. Thank you, Karen Foli, for your enduring passion for improving the lives of these long-forgotten families.

Cheryl Tatano Beck, DNSc, CNM, FAAN  
Board of Trustees Distinguished Professor  
School of Nursing  
University of Connecticut  
Storrs, Connecticut
Preface

She was about 9 years old and had been born with spina bifida. The little girl was one of my first patients in my nursing career, and a person whom I will always remember. Thirty-five years ago, I was entering into my community health clinical rotation as a student nurse, and was assigned to a family that also cared for foster children. But Grace, the little girl with long brown hair and glasses that made her eyes seem enormous, was my primary patient and a birth child to the foster mom, Patricia. Patricia and I talked about her other children and foster kids, and her husband, who worked in the local glass factory. Patricia was a petite woman with short, soft brown, curly hair and gentle blue eyes. The etchings of time around her eyes seemed more obvious when she smiled, but it was worth seeing and hearing her laugh. Yet there was a pervasive sadness around her, especially when she looked at Grace and knew that her daughter was vulnerable and always would be.

One day, to complete the family interview that was required, she said we could talk at the local café in a nearby strip mall. She had taken in an infant and knew the baby would be placed soon. The baby went into a stroller, and we walked to the small restaurant, where she ordered a piece of pie and a cup of coffee. The other children were at school, and she explained to me how she often would take about a half hour in the afternoon to come here and think. At the time, I thought how silly that was and what a waste of time. I simply did not have the insight and compassion to understand how resilient this woman was, how wise her behaviors were, and how these habits benefited her family and her ability to be present as a parent.
As a foster parent, she must have seen children come and go. She loved them, and then saw them leave for a new family. Other grief and loss colored her facial expressions. She must have known that her own daughter’s future was uncertain. Grace suffered from frequent urinary tract infections. An additional worry was that the father, Patricia’s husband, had been irritable lately. Stumbling in, by some miracle, I was able to discover during a visit at Grace’s school that unsanitary conditions during her urinary catheterizations were the cause of the chronic infections. The school nurse instituted a new protocol for Grace’s catheterizations to prevent contamination and break in sterile technique. During my rotation, I also discovered that the father suffered from hypertension, for which he was placed on medication by his physician. I counseled him regarding his diet and potassium levels. As the semester was at an end, I hoped that I was leaving the family with a fraction of what they had given to me. At the close of the last visit, Grace’s mother gave me a present: a beautiful crocheted pink and gray blanket. My heart was touched, and I felt that maybe, just maybe, I could be a good nurse one day. I still have that blanket—it is upstairs in my linen closet—and its colors remind me of the myriad emotions that emanate from this world of taking care of children to whom we may not have given birth.

The grayness of seeing a child who has been damaged by cruelty and ignorance; the pewter-colored feeling of a birth mother grieving over relinquishment of her child; the shadow of a grandmother offering a bottle to a baby born with symptoms of drug withdrawal; the iron black color of adoptive parental depression—each certainly is an aspect of nontraditional families. Yet there is also the pink color of unconditional love; the yellow of healing a child who can now feel safe enough to attach to a parent; the rose-shaded knowledge that society is better because of sacrifice and selflessness; and the lavender hue of forgiveness and compassion—these, too, are facets of these families and found in the blanket that this mother gave to me. This book is about these families and the incredible difference that advanced practice nurses (APNs) can make in their lives.

The colors are representative of what I call the “adoption/kinship paradox”—the juxtaposition between loss and grief, renewal and healing. We know more about what we as humans need to attach and connect. We understand issues of identity and belonging. To really grasp these
dynamics, the entire social unit needs to be considered, as well as the lives that are forever changed when a birth child is in the care of others. Although I believe the loss and grief must be recognized, healing and joy should be as well. And last, there is something incredibly human in our imperfections, and it has been my experience that parenting brings our imperfections into focus. When we cease to address these imperfections is when we stop living as moral human beings.

To be a family, and what that means in society today, is undergoing dramatic changes that reflect fluidity in definitions of spouse, children, and kin. The two-parent family with two children, a boy and a girl, no longer reflects our society with its diversity of genders and cross-ethnic members. As one becomes more aware of the presence of nontraditional families—such as adoptive and kinship families—one begins to see them within the fabric of society. It is as if this heightened sensitivity enables one to see through an additional set of lenses, and suddenly, adoptive and kinship families are seemingly everywhere.

Similarly, as nurses we do not often see ourselves as health care providers for adoptive or kinship families. Yet I have encountered many nurses who have cared for these individuals and families with—and without—the knowledge and insights that emanate from the cultural and social structures of adoption and kinship families. Through years of experience and research, I have come to realize that this care is special and specialized, and these are the reasons I decided to write this book. If there were ever populations that needed holistic care, they are nontraditional units such as adoptive and kinship families. And nurses are increasingly in positions to render such care through advanced practice opportunities.

Let us start by defining “adoption” and “kinship families.” Legally, adoption is a process whereby birth parents’ rights are terminated and adoptive parents are given legal permission to care for the child(ren) on a permanent basis. Thus, a triad is created, an adoptive triad composed of the birth parents (also called “first/birth parents”), the individual who is being adopted, and the adoptive parent(s). Statistics of adoptions can be elusive because estimates for annual numbers of adopted children are generated from state court records, the Adoption and Foster Care Analysis and Reporting System (AFCARS), and the U.S. Department of State’s Bureau of Consular Affairs. The 2010 census revealed that 2,072,312 children or 2.3% of all children in the
United States are adopted (U.S. Census, 2010), with approximately 2 million adoptive parents caring for them (Jones, 2009).

Kinship parents differ in several ways. First, kinship parents are close family and friends who have assumed the care of the child on a permanent or temporary basis. There may be several generations of the family living in one home with several identified caregivers. However, some kin caregivers, often grandparents, elect to legally adopt their grandchildren and thus become adoptive parents. Across the country, states are relying on kinship care, rendered by extended family members and close friends, for the 2.7 million children who have been removed from their birth parents’ care (Annie E. Casey Foundation, 2012). This book addresses all three members of these triads or triangles of family, and offers particular insights into their needs through the use of cases and analyses of those family units.

Adding these millions of individuals together, we have, conservatively, 8 to 9 million people (birth, adoptive, and kinship parents, and children/individuals who are adopted or cared for by kinship parents). Therefore, there are a significant number of people living in the United States who need health care providers who understand the contexts of their families, which include a wide scope of issues related to nursing care. Examples include infectious diseases, vitamin deficiencies, attachment and bonding, acute and chronic illnesses, caregivers’ legal right to consent to treatment of a minor, and nonbirth mothers’ decisions to induce lactation for an adopted infant. Complex interfaces with populations, groups, communities, and individuals color these nontraditional families. This text guides APNs through these contexts.

Although adoption and kinship families are found globally, this discussion focuses on the practices within the United States. Stepfamilies and traditional surrogates are also excluded from this text because there is a permanent, primary caregiver who is a birth parent in the home. We concentrate on those unique, heterogeneous families that are characterized by a relinquishment and an acceptance of parenting from individuals who did not give birth to the children and have no direct biological ties.

The readers of this book are APNs who work with adoption and kinship families—certified nurse-midwives, pediatric nurse practitioners, adult-gerontology nurse practitioners, family nurse practitioners, psychiatric mental health nurse practitioners, clinical
nurse specialists, or clinical leaders (note that there is an assumption that APNs hold certification credentials in their areas of expertise). Areas of practice may be in community/public health, mental health, corrections, school nursing, and in acute and primary care areas. Educators of advanced practice courses may integrate this guide with the existing textbooks in courses such as nursing care of the childbearing family, pediatric nursing, psychosocial/mental health nursing, acute and chronic health, health promotion courses, gerontology courses (kinship parents are often older adults), and public/community health nursing.

With this guide, the nursing profession will be able to fully collaborate with other disciplines such as medicine and social work that have discussed and studied adoptive and kinship families for many decades. To strengthen the profession and consolidate this knowledge, two major goals to be accomplished through this book are:

1. **To change nursing’s current thinking about adoption and kinship triads.** The primary purpose of this clinical guide is to inform nurses who care for members of the adoption and kinship triads with current, best clinical practices. The book is also designed to change the current view of adoption and kinship care. I have spoken to nurses and their interest is keen, yet they are apt to defer to other professionals to deliver care to triad members or they feel a sense of discomfort, knowing that there is little information surrounding nontraditional families, and they are unsure where to find such information. Despite hesitations, my research findings support the fact that nurses care for members of these triads in multiple settings. Unfortunately, APNs and graduate student nurses have little clinical guidance that is specific to these populations. I have also found that there is a lack of curricular content in undergraduate and graduate nursing programs to educate new nurses and APNs on best practices related to these populations. With this guide, nurses no longer have to continue to rely on intuition and can feel confident through evidence-based practice when rendering care.

2. **To disseminate knowledge to improve care rendered by nurses.** This book is a fount of knowledge and insight for those APNs who interface with adoptive and kinship triad members (birth parents, adoptive/kinship parents, and individuals who are adopted) across multiple health care settings. Each of the triad members is included
in this needed book that serves practicing nurses who wish to expand their clinical knowledge or as a clinical guide in many nursing courses. As professionals, we are called on to be holistic caregivers. Now more than ever, such humanistic care is needed by so many. This guide approaches these family social units as a whole with consideration of cultural preferences, health disparities, and issues of gender, class, and race. This information will empower APNs to deliver services grounded in evidence and patient-centered care.

Your Narrative

Finally, many of you have firsthand knowledge and may be part of an adoptive or kinship family. You may recognize elements of your situation or a family member’s situation in these pages. Over the years, I have learned of many nurses—perhaps because of the fabric of who we are and what we do—who are members of such triads. Circumstances change, and we may find ourselves in families with a configuration we never anticipated, or we are experiencing feelings of loss that we are still processing. Or some of you may have planned and waited for years to expand your family through adoption. My narrative includes being a member of the adoption triad (adoptive mother), a researcher in the area of adoption and kinship families, and a cofacilitator in a trauma-informed parenting class for rural-dwelling kinship parents. These stories are important, and I hope that our personal narratives will enlighten us and, combined with knowledge, allow us to become providers of quality nursing care to adoption and kinship families.

Karen J. Foli
Acknowledgments

Books are never easy to write—although I love doing so. Writing hundreds of pages seems like a monumental undertaking, and, in some respects, it is. This book, however, was a labor of purpose: to consolidate knowledge surrounding the health care needs and social contexts of adoptive and kinship families so that advanced practice nurses’ patient-centered assessments and interventions are of optimal quality and effectiveness. When you read these pages, I hope you will frequently say, “I didn’t know that!” and provide informed, effective care as a result.

I believe that adoption and kinship nursing is a specialty area that deserves its own scope and standards of practice.

Although writing can be isolating, books are not written in isolation. Many people contributed to this book by offering emotional and instrumental support, and by advising on policies and practices from both an adoption and from an advanced practice nursing perspective. My colleagues and supporters represent a mix of friends, collaborators, and colleagues, many of whom are advanced practice nurses: Jenny Coddington, Melanie Braswell, Patricia Moisan-Thomas, Rhonda Moravec, Janet Thorlton, Jill Lintner, Susan Kersey, Nancy Edwards, Pam Karagory, Kristen Kirby, Becky Walters, Janelle Potetz, and Jan Davis. I would also like to thank Kathy Stagg, MSW, LCSW, The Villages; Sarah Horton-Bobo, MA, director of Post Adoption Support and Education, Bethany Christian Services; and Susan Livingston Smith, LCSW, emerita professor of social work, Illinois State University; all of whom were so helpful in my understanding of the complexities of adoption, the child welfare system, and foster care. Also, my extended family members, who cheered me on, are
to be recognized: Adele Foli, Leanne and Bill Malloy, Margaret and Mark Conway, and Katherine Malloy.

When researching my book on postadoption blues in 2002, I reached out to Cheryl Beck and was grateful for her generosity and willingness to help a fellow nurse, albeit a stranger, who wanted to draw attention to the challenges faced by adoptive parents. Since then, Cheryl has been a mentoring presence, and her consistent kindness has been an important source of support. She graciously introduces the reader to this work (see her Foreword), for which I am grateful.

Elizabeth Nieginski, executive editor, and Rachel Landes, assistant editor, at Springer Publishing deserve so much gratitude. Elizabeth’s vision for this book and her insight into the gap it fills in the nursing profession have been invaluable. Her advocacy to bring it to the nursing profession deserves recognition and respect. I am grateful to Rachel, whose professional communications and hard work helped to secure permissions for use of materials, as well as to shape and refine the chapters.

I thank my family, John, Ben, Peter, and Annie, who give me purpose and help me strive to be a better person. My husband and soulmate, John, gave me tireless encouragement during my moments of doubt and fatigue, and because of his steadfast loyalty, I was able to give this work my very best efforts. I want to specifically acknowledge my children: Ben, my older son, whose bravery and earnestness keep me grounded; Peter, whose honor and faith offer me values to be proud of; and Annie, whose forthrightness and affection warm my heart. They are truly gifts to my soul.

This book would not be possible without the nontraditional families whose sacrifices and joys continue to be sources of inspiration. My goal is to honor each member of the adoption and kinship triads and, through the information on the following pages, enhance and optimize the care they receive from advanced practice nurses in a wide variety of clinical settings.
PURPOSE OF THE CHAPTER

In this chapter, we discuss what it is to be a birth parent who relinquishes a child through the formal adoption process. Singularly unique as members of the adoption triad, birth parents’ legal, gendered, political, financial, and emotional rights have been the theme of books, movies, and, more recently, social media. The struggle to make the decision to create an adoption plan is never an easy one, but it must be one that is made with full informed consent and disclosure. Issues of the rights of minors (when birth parents are under 18 years of age), as well as those of class and race come into focus as we examine birth parents’ decisions to relinquish a child. Some would argue that adoption is merely the commodification of children, with the elite class (adoptive parents) benefiting from those who are less fortunate with fewer resources and opportunities. Indeed, birth mothers are found in high school (and later, having dropped out of high school), the “working poor,” and in developing countries across the globe.

We also briefly explore the experience of those parents who do not voluntarily release parental rights of their children and how relinquishment affected them long after placement. In our case studies, stories are presented of a 65-year-old birth father who has recently discovered that he has a daughter, a teenager faced with an unexpected pregnancy, a couple whose vulnerable economic situation and fragile relationship make parenting a child difficult, and a birth mother experiencing grief and postpartum depression (PPD) after relinquishing a baby. We explore these members of the adoption triad and place the important role of the advanced practice nurse (APN) within social and health care contexts.
Learning Objectives

At the completion of the chapter, the reader will be able to:

1. Identify the various contexts in which parents may voluntarily or involuntarily relinquish parental rights
2. Discuss the heterogeneity of birth parents, which influences their motivations to create an adoption plan
3. Define open/closed adoptions, including implications for the birth parents
4. Examine policies and government initiatives related to birth parents, including Safe Haven Laws and the Infant Adoption Awareness Training Program
5. Analyze methods to assess for substance use in pregnant women with an awareness of state laws that require reporting of substance use
6. Identify the signs and symptoms of disenfranchised grief of a birth mother and father who have relinquished their infant in the peripartum setting

RELINQUISHMENT OF A CHILD

Domestic Adoption

Today, there are fewer infants available for private adoption, with demand outpacing supply. If this sounds like an economic principle, it is. And there are multiple and vocal critiques of domestic private adoption, criticisms that are based on the perception of commodification of human life. Perhaps more than any other triad member, birth parents often come with an emotional component that cascades from experiences of loss, difficult choices, and issues of class and gender. More recently, with the onset of “open adoptions,” such experiences have been mitigated or, at least, addressed at some level. Birth parents have been depicted as victims of forced relinquishment (e.g., The Lost Child of Philomena Lee by journalist Martin Sixsmith), and their own genre of birth parent narratives has been created. Indeed, parental rights may be voluntarily or involuntarily terminated, as described in Chapter 1.
Unintended Pregnancies

In 2008, unintended pregnancies accounted for 51% of all pregnancies; 54 per 1,000 women ages 15 to 44 years of age experienced an unintended pregnancy resulting in 27 per 1,000 births (Finer & Zolna, 2014). What is also of note is that there were large disparities in relationship status, income, and education, disparities that have increased over time (between 2001 and 2008). The number of unintended pregnancies ending in abortion decreased and that of births increased. Racial disparities revealed that Black women had the highest rates of unintended pregnancies, with Hispanic women having the highest rates of births resulting from unintended pregnancies (Finer & Zolna, 2014). Women are choosing to raise their children because the pressure of social mores on single mothers to relinquish their children has greatly diminished.

Termination of Parental Rights

In cases of involuntary termination of parental rights, mental health issues or maltreatment of the child is evident, either as neglect or abuse. A plan will be created for parents to follow in order to “get their kids back” and may include negative drug screens. Adherence to the plan will determine whether the child is ultimately available to be adopted. If the plan is not followed or if other circumstances are present that impair individuals from parenting the child, the court terminates such rights, and allows the child to then be available for placement through the foster care system. The time for this process varies with families and situations.

When rights are terminated, birth parents have little to no voice in who will be the next caregivers of their children. In effect, they have lost that right and often blame the foster parents who step in to care for their children. Feelings of anger and powerlessness are often voiced. Informed foster parents will understand that, when possible, creating a partnership with the birth parent supports acting in the child’s interests.

On the other hand, in private domestic adoption, birth parents have the ability to select adoptive parents from profiles posted online and
through adoption agencies and attorneys. They can view the narratives written by prospective parents, which often describe religious background, professions, other children in the home, and sexual orientation. Birth parents can, on the basis of this information, select those individuals to whom they would like to release their child.

Regardless, many vocal critics of adoption believe that there is little choice for birth parents who relinquish a child. Economic hardship creates a “no-win” scenario for those who decide to create an adoption plan. The word “choice,” some would argue, is not accurate. Others disagree and have made a plan they know is the right path for them. The desire to parent may not be part of their desired life experiences, and they have selected individuals who very much want a child in their lives. For APNs, approaching birth parents in an open, respectful manner is important. Understand that individual narratives will differ and that parents’ emotional paradigms toward relinquishment present in vastly different ways. The APN must allow each birth parent to have a voice.

Expenses During Pregnancy

After private domestic birth parents select prospective adoptive parents, certain expenses are allowable, which cannot be viewed as coercive. As with so many laws overseeing adoption, state statutes show some variation in what is considered allowable, as well as the time the expenses are allowed after placement (30 days to 6 months). Allowable expenses typically include maternity-related health care costs, temporary living expenses of the mother during pregnancy, psychological counseling fees, legal fees, and travel fees related to the adoption (Child Welfare Information Gateway, 2013a). Payment that is in any way construed as “baby selling,” is strictly prohibited. The APN assesses for coercive influencing of a birth parent who plans to place the infant through domestic private adoption through payment of expenses or in other ways.

Labor, Delivery, and Postpartum Issues

Being with a birth parent at the time of delivering a baby who is being relinquished can evoke emotions within the health care professional. The paradox of loss and joy is pronounced. Hospital policies are followed, usually with the social worker taking the lead in the
process. “BUFA” is sometimes used as a term to indicate “baby up for adoption”; however, many hospitals are no longer using this language, which some find offensive—the acronym is confusing, and the baby is a person with a name. However, this acronym symbolizes the transitional period when the child is being released into the care of new parents, who may rename the baby.

Health care organizations’ policies will often stipulate that staff are to remain neutral, not persuading or dissuading a parent’s decision related to the adoption. Often, however, the birth mother’s grief and at times revisiting the decision to relinquish the baby will evoke emotions within the nurse who is caring for the mother. Adoptive parents have described to me how, at times, nurses, although not influencing the birth mother’s decision, have held undeserved negative attitudes toward them. Nurses may believe the birth mother is being taken advantage of, and witnessing the intense emotions of grief, loss, and sadness is difficult. There are a few guiding principles to remember in this scenario. First, separate the birth parents’ decision to relinquish a child from the placement of the child to the adoptive parents. Avoid a “bad guy/good guy” judgment. No birth parent should ever be coerced into placing a child (unless parental rights have been terminated due to maltreatment, which has been decided by the courts). Regardless, such relinquishment should not create negative feelings toward the adoptive parents. Second, a personal inventory of emotions may be helpful. Depending on your personal story, such situations may be a personal trauma reminder. Be aware that the compassion you feel toward the birth mother may interfere with your understanding that the adoptive parent also needs your care.

Social service staff members are often the primary professionals to coordinate the adoption events: the signature of adoption consent papers and the timing of them, and the completion of forms for caring for the infant. Court documents may be separate from the medical record; state law will dictate privacy of the parent and child, sealing of the original birth certificate, and whether medical information is de-identified. The secrecy surrounding adoption has begun.

Despite the social worker orchestrating the events postbirth, the nurse also has significant influence over how these delicate, fragile interactions are remembered and how meaning attributed to this life event commences. What do you say to a weeping birth mother as she hands her child to the adoptive mother? How do you react when no one else is looking and you see the grief covering the birth parent’s
face? How do you interpret contentment from a birth mother who has thoughtfully and carefully created this plan? When the decision to relinquish is rescinded, what do you say to remain neutral?

In my study that surveyed nurses who cared for the adoption triad, three major areas of concern were reported by nurses who cared for birth parents: emotional health (resolving and healing); relinquishment decision making (Was this the right choice?); and adoption issues (What happens after my child is placed?; Foli, 2012). The fear of being judged, concerns about the adoptive parents, and conflict with family members over the decision to place the baby were described (Foli, 2012). In this study, nurses were asked what interventions were most effective for birth parents during this time. Psychosocial support, therapeutic communication, follow-up services and referrals, and advocacy were the major areas described. Nurses need to ensure policy is followed by advocating that the birth parents’ rights are upheld throughout the process, including care of the baby. Ultimately, it is the comfort, health status (postoperative recovery from cesarean section to drug/alcohol withdrawal), and preferences of birth parents that supersede others during the time during which the adoption plan is carried out (see Exhibit 3.1).

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<td>Guilt</td>
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<td>Depression</td>
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<td>Grief/loss</td>
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<td>Trauma/trauma of separation</td>
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<td>Fear of being judged/ “I am not a bad person”</td>
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<td>Stress</td>
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<td>Anger</td>
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<td>Drug/ethanol</td>
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(continued)
EXHIBIT 3.1 (continued)

Relinquishment decision making: Was this the right choice?
- Uncertainty/Is adoption the right choice?
- Influence from family members who disagree with adoption plan
- Changing the adoption decision

Adoption issues: What happens after the child is placed?
- Concern regarding adoptive home
- Society’s judgment
- Inadequate pre-/postadoption counseling/lack of support
- Not knowing about the child or adoptive parents not keeping in contact as they had promised
- Adoptive parents involved in birth experience

Nursing Interventions

Psychosocial support
- Understand conflicted feelings
- Grief counseling
- Reassure decision/choice was appropriate
- Self-esteem: “not a bad person”
- Acceptance/validation/affirmation/respect
- Nurse: Be willing to talk with birth parents

Therapeutic communication
- Active listening
- Nonjudgmental approach

Follow-up services/referrals
- Social worker (when child leaves hospital)
- Counselor

Advocacy
- Understand rights
- Lack of pressure to relinquish
- Involvement with care of child

Source: Foli (2012).
The presence of adoptive parents—often seen as obtrusive and invading privacy—is another factor of which nurses need to be aware. Often, especially when open adoption arrangements have been negotiated, adoptive parents will attend prenatal checkups and be present in the labor and delivery room with the birth mother/father. Many nurses and physicians may not understand such arrangements and think it “unusual” and even “unnatural” for such parties to attend these intimate moments. Yet others view it as the integration of two families with the ultimate goal of supporting both the child’s well-being and the birth parents’ lifelong tie with the child.

**Intercountry Adoption**

Often, relinquishment of an infant or child in developing nations is based on several factors, including economic hardship, stigma of out-of-wedlock pregnancies, and gender bias, with infant girls being relinquished more than boys. In select countries, there is now a lopsided gender distribution and other factors, such as higher rates of abortion for female fetuses that have caused concern in these countries. In 1978, the Chinese government instituted the one-child campaign in response to concerns over population growth. Couples were to stop procreating after one child, regardless of gender. Thus, the rule was “bound to lead to difficulties given the immense symbolic and practical importance of male offspring within Chinese society” (Wasserstrom, 1984, pp. 346–347). As a result of this, female infanticide was found, especially in rural areas, and more female babies were relinquished for intercountry adoption. This gender bias was not isolated to China. Roberts and Montgomery (2016) presented an alarming analysis of the disproportionate gender distribution in a rural mission hospital in India. Using data from the hospital and comparing gender birth rates with state ratios, the authors found hospital female-to-male ratios lower than state gender ratios. Further, qualitative themes derived from 17 interviews with women were social norms and expectations of fertility, preference for male children, and health-related decision making, which may be associated with aborting female...
fetuses. The strong bias toward male offspring, with roots in both culture and finances (dowry costs of females), was attributed to this disproportionate ratio (Roberts & Montgomery, 2016). Besides more females being released for adoption, special needs infants are also relinquished through intercountry adoption. Today, many adoption agencies have rigorous in-country placement programs so that infants and children are adopted within their countries whenever possible.

In intercountry adoptions, accounts of infants being taken from unsuspecting birth parents in developing countries prompted the passing of the Hague Convention (see Chapter 1). Eliminating third parties who have financial interests in arranging for adoptions was one of the goals of this treaty. However, others argue that the Hague Convention needs to enforce stiffer penalties on those who duplicitously take children away from unsuspecting birth parents who are misled into signing away their rights (Manley, 2006).

Although reunions with birth parents from other countries have been uncommon, many parents and their children are seeking to find lost family members. Individuals who were adopted from Korea, China, Haiti, Russia, and Vietnam are seeking—and at times finding—their birth families. The popular press offers descriptions of adult children who have found birth parents in countries outside the United States.

**Safe Haven Laws**

There are instances when no adoption plan—or any plan to care for the child—is made. A significant crisis envelops birth parents, making them feel they have nowhere to turn. Keeping such grave instances in view, the National Safe Haven Laws (see Exhibit 3.2) were designed to protect infants from abandonment and their parents from prosecution, if the baby is left safely at a Safe Haven location. These extreme situations affect APNs working in acute care facilities as well as community-based organizations. The infant who has been left via a Safe Haven Law needs to be assessed immediately and when stable, turned over to child protection services to be placed with a foster family.
The Adoption and Kinship Triads

Safety of the Unborn Child and Mother

The APN is also responsible for assessing for alcohol and substance abuse during the birth mother’s pregnancy. However, ethical questions may cloud decisions in the provision of care. For example, state mandatory screening and reporting guidelines may conflict with values against treating the patient as a criminal. The APN’s care will be guided by whether the patient is viewed as an individual who breaks the law or as an individual with a disease state that is jeopardizing her life and the life of her unborn child, as well as mandatory reporting and referral guidance in the state of practice.

EXHIBIT 3.2

Safe Haven Laws

The Safe Haven Laws, also called “Baby Moses laws,” are instituted in all 50 states, the District of Columbia, and Puerto Rico. These laws are designed to protect infants from unsafe abandonment. However, state laws differ. For example, the age of the infant at the time of relinquishment differs between states. The question of who may relinquish the infant also varies by state (e.g., either custodial parent or someone with legal custody of the child). Finally, the question of what party the infant is relinquished to is determined differently in many states. Safe Haven locations in some states require that the infant be given to a hospital or health care facility; others allow police stations and churches. Parental rights may be terminated immediately or, as in some states, after a waiting period. Regardless, these laws serve to provide birth parents with anonymity and protection from criminal prosecution for abandonment.

The National Safe Haven Alliance (www.nationalsafehavenalliance.org) is a not-for-profit organization that supports Safe Haven laws and seeks to prevent harm to abandoned infants. They have established a Safe Haven Confidential Crisis Hotline: 1-888-510-BABY (2229).
The surge in abuse of opioids has spurred several health care organizations to forward policy statements so that providers are guided in the delivery of compassionate and safe care. The Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN; 2015) has issued a position statement:

[AWHONN] opposes laws and other reporting requirements that result in incarceration or other punitive legal actions against women because of a substance abuse disorder in pregnancy. (p. 155)

The statement goes on to add, however, that nurses should be familiar with state laws on mandatory reporting and referrals, and follow these laws. Further, the organization supports universal screening for substance use in pregnant women. AWHONN views addiction as a disease, not as a criminal act (AWHONN, 2015). Similarly, the American Congress of Obstetricians and Gynecologists (ACOG, n.d., 2011/2014) emphasizes that evidence does not support the threat of or incarceration of pregnant women in deterring substance abuse. Rather, targeted treatment is encouraged and includes safe prescribing authority for opioid-agonist therapy (OAT; ACOG, n.d.). ACOG summarizes major points in “Actions to Support Healthy Outcomes for Mom and Baby” (see Table 3.1).

### APN Screening and Management of Substance Use

Although a detailed explanation of treatment of substance use is beyond the purpose of this guide, the SBIRT approach (Screening, Brief Intervention, Brief Therapy, and Referral to Treatment) is an evidence-based practice supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). In 2003, the federal government established the SBIRT grantee program through SAMHSA; data from grantees support the effectiveness of the program (i.e., reduction in alcohol and drug use; improvement in quality of life measures; and reduction in risky behaviors; Office of National Drug Control Policy & Substance Abuse and Mental Health Services Administration, 2012).

Screening questions will identify those who are using substances in a high-risk or unhealthy way; most patients will screen negative.
The Adoption and Kinship Triads

TABLE 3.1  Actions to Support Healthy Outcomes for Mom and Baby

<table>
<thead>
<tr>
<th>Does Not Support Healthy Outcomes for Mom and Baby</th>
<th>Supports Healthy Outcomes for Mom and Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overtreatment of NAS in NICUs</td>
<td>Appropriate comfort care in low-stimuli environment and pharmacological therapy where indicated</td>
</tr>
<tr>
<td>Criminal penalties for women and doctors</td>
<td>Public health approaches focused on prevention and treatment</td>
</tr>
<tr>
<td>Mandatory urine testing</td>
<td>Screening dialogue/questionnaire with patient consent</td>
</tr>
<tr>
<td>Mandatory reporting to law enforcement or child protective services (CPS)</td>
<td>Statistical reporting to department of health or direct reporting to CPS only for indications of impaired parenting</td>
</tr>
<tr>
<td>Overreliance on fragmented PDMPs</td>
<td>Safe prescribing and initial check of PDMPs</td>
</tr>
<tr>
<td>Punitive drug treatment courts</td>
<td>Family-centered drug treatment programs</td>
</tr>
<tr>
<td>Restrictions on medication access and forced withdrawal</td>
<td>OAT with methadone or buprenorphine for women and protections for treating physicians</td>
</tr>
<tr>
<td>Misleading drug prescribing warnings</td>
<td>Evidence-based labeling of opioid medications</td>
</tr>
<tr>
<td>Antifamily, one-size-fits-all drug treatment programs</td>
<td>Family-centered, community-based, outpatient treatment</td>
</tr>
<tr>
<td>Coercive referrals for fertility control</td>
<td>Counseling on pregnancy, planning, prevention, and contraception</td>
</tr>
<tr>
<td>Losing sight of the real harms of alcohol and cigarette use during pregnancy</td>
<td>Continued focus on the greatest preventable health threats—alcohol and tobacco use during pregnancy</td>
</tr>
</tbody>
</table>

NAS, Neonatal Abstinence Syndrome; NICU, neonatal intensive care unit; OAT, opioid agonist therapy; PDMPs, prescription drug monitoring programs.

Source: American Congress of Obstetricians and Gynecologists (n.d.).

Brief Interventions and Brief Therapy are designed to provide feedback and education and instill insight by use of strategic interviewing techniques. Referral to Treatment is the last step and is used for individuals for whom substance use disorders require further assessment and/or treatment. This approach is used for individuals who present with unhealthy or risky consumption of substances, or who may need to be further evaluated for substance use disorders (Exhibit 3.3). Codes for reimbursable SBIRT services are also of note, including commercial insurance, Medicare, and Medicaid.
The skilled APN will be able to use the principles of SBIRT when assessing pregnant women, beginning with screening for alcohol, tobacco, and drug use.
Another online resource, also sponsored by SAMHSA, is the Providers’ Clinical Support System for Opioid Therapy (PCSS-O): “a national training and mentoring project developed in response to the prescription opioid overdose epidemic” (Providers’ Clinical Support System for Opioid Therapy, n.d.). Developed by physicians and APNs, this online resource contains training modules, webinars, and mentoring support for providers in the treatment of opioid dependence. Informed APNs, combined with early screening and intervention, will contribute to outcomes such as healthier pregnancies and fewer complications from alcohol and drug use.

**ADOPTION PLAN**

In the majority of child relinquishment situations, the birth parents have time to consider their options, despite very often feeling that they are in crisis. Representatives and legislators in Congress appear to be invested in ensuring that birth parents are presented with all options when faced with an unexpected pregnancy: raising the child, terminating the pregnancy, and adoption (see Infant Adoption Awareness Training Program later in this chapter). The 114th Congress has introduced a bill in the House of Representatives, H.R. 3428, called the Adoption Information Act (Congress.gov, 2016):

> [The Act] amends the Public Health Service Act to require family planning service projects or programs, as a condition of receiving certain grants or contracts, to assure the Secretary of Health and Human Services (HHS) that they will provide each person who inquires about their services with a pamphlet containing a comprehensive list of adoption centers in their state.

If passed, this Bill would require funded agencies to give specific information related to adoption as a requirement for continued federal support. Overall, however, little research has been conducted on how women choose adoption as a reproductive choice. In a study conducted by Sisson (2015), 40 women who had placed an infant for adoption between 1962 and 2009 were interviewed. Contrary to popular assumptions, most birth mothers who relinquished a child did not see their choice as being between adoption and abortion; rather it was between adoption and parenting the child. Most of the
mothers who had a positive experience with adoption were in open adoption situations, and whether the adoption was open or closed was the biggest predictor of adoption satisfaction (Sisson, 2015).

When minors become pregnant, the issue of consent for placing the baby becomes even more complex because issues of full disclosure, developmental age, and potential for coercion surface. As with so many aspects of adoption law, states vary widely with regard to the minor birth mother’s legal rights. Twenty-eight states and the District of Columbia allow minors to release their children to adoption independently. In contrast, five states require parental involvement, and five states require legal counsel. Finally, 12 states have no legal guidance or policy when a minor becomes pregnant and chooses to create an adoption plan (Guttmacher Institute, 2016). When presented with a minor who is pregnant and considering an adoption plan, the APN should consult state laws to determine the birth mother’s legal rights.

**Openness in Adoption**

An important component of the adoption plan is how much contact or openness will be arranged between the birth and adoptive parents. As reviewed in the history of adoption and mentioned in the study by Sisson (2015) cited previously, varying levels of openness in adoptions have become normative, depending upon the time period. Postadoption connections between birth and adoptive parents exist on a continuum from closed or confidential, to semi-open or mediated, to open with face-to-face visits between birth and adoptive families (see Figure 3.1). In essence, open adoption allows some form of contact between birth parents and the child. Since the mid- to late 1980s, open adoptions have been increasingly common and viewed as being in the best interest of the child (Siegel & Smith, 2012; Wolfgram, 2008).

Evidence supports positive outcomes with open adoption. Siegel (2012) reported that young adults who had been adopted and were part of an open adoption described the dynamics as opportunities to develop identity, expand family, and process feelings. More studies are needed to verify the empirical evidence collected thus far. As in many instances of evidence-based practices, individual needs and circumstances should be fully evaluated. For example, in the
instances of involuntary termination of parental rights, particularly with parental chronic substance abuse disorders, a history of family violence, or maltreatment of the child, open adoption arrangements need to be carefully considered in light of child safety.

Furthermore, when investigating open adoption agreements, birth parents should be advised that postadoption contact agreements vary in the ability to legally enforce them. Postadoption contact agreement laws between birth and adoptive families differ from state to state (to find specific state laws, see: www.childwelfare.gov/systemwide/laws_policies/state/). Many birth parents request postadoption contact as a condition of adoption; however, some prefer to have a closed adoption. Having contact with birth parents gives adopted persons a link to their past as well as access to genetic and medical information. APNs should be aware that there are factors to open adoption contracts that may be difficult at times for all parties. Social workers admit that, at times, there are more complexities with open agreements, but that the effort is worthwhile. The welfare of the child and the long-term benefits should be weighed on an individual basis (Child Welfare Information Gateway, 2013c).

**Birth Fathers**

Biologically, the woman’s body changes as the pregnancy progresses, and it becomes obvious to society that a child is growing within her. In contrast, the man undergoes no such physical changes and can blend into society without communicating his parentage. The “double standard” in sexual behaviors also contributes to the perceptions that fathers do not experience the same emotional consequences as birth mothers do within the context of adoption. But I am not convinced these assumptions are accurate. I spoke to an adoptive family whose child (while in foster care) needed a medical procedure. The birth
father had been notified about the procedure, but no one expected
him to come. However, he did come and was given the opportunity
to relay just how much the child meant to him and how marginalized
he had felt. Yet historically, birth fathers have been given little to no
voice in the placement of their children. Reflecting these practices,
an historical document published by the Child Welfare League of
America (1960) stated:

Within the United States, the unmarried mother has sole rights
to custody of her child. . . . The unmarried father has no legal
right to the custody of his child. He has only a moral obligation
to support, unless he has formally acknowledged paternity or
legal adjudication of paternity has been made through court
action. In such cases, in many states the father does not ac-
quire the legal status of a parent and his consent to wardship
or adoption is not required. However, if adoption is planned,
an agency should safeguard the child and itself against future
litigation by obtaining consent, waiver or disclaimer whenever
possible, even when there has been only informal admission
of paternity. (p. 17)

This document, more than half a century old, reaches into modern
society, which views the father as a secondary parent, even reflected
in hospitals’ policies and procedures during the relinquishment pro-
cess (where their absence is surely notable). Thus, some individuals
would argue that birth fathers are not given their due voice in the
adoption decision–making process. The media case of “Baby Jessica”
drew feverish attention in 1993 when a child placed with adoptive
parents was ordered by the Michigan Superior Court to be returned
to her biological father, who had not been aware of her existence. The
case created scrutiny of the rights of birth parents, increasingly birth
fathers, and, some would argue, accelerated efforts by prospective
adoptive parents to seek out intercountry adoptions (Collinson, 2007).
Further, some would assert that fathers are stereotyped to be uncaring
individuals who often advocate for terminating the pregnancy.
Unfortunately, evidence is extremely limited, but the evidence we
do have negates these perceptions.

In one of the first studies to examine the birth fathers’ role and
perceptions of relinquishment, researchers found that most fathers
relinquished because of their own unpreparedness to be a father and that the decision was made in the best interests of the child. Still, some fathers reported feeling pressured to relinquish their children (Deykin, Patti, & Ryan, 1988). Interestingly, 67% \((n = 125)\) had engaged in search activities, and this was correlated with thoughts of taking their children back. More recently, Clifton (2012) performed in-depth interviews with 20 birth fathers in England to ascertain themes from the experiences of relinquishment. The most prevalent themes were feelings of humiliation and defeat. The author formulated a theory by dividing the fathers’ social and emotional styles as being either shame-prone (vindicators: low likelihood of a rich relationship with the child; or resigners: future role with the child poorly developed) or guilt-prone (affiliators: engaged in building a distant relationship with the child; Clifton, 2012). Research in this area is much needed to better understand fathers’ experiences throughout the process of child relinquishment, and hence support efforts toward healing.

**Effects of Relinquishment on Birth Mothers and Fathers**

As previously discussed, we understand the least about the effects of placement on birth parents, especially long-term effects. Some evidence, however, is important to reference to enable APNs to provide informed care. In one study, Memarnia and colleagues (2015) performed an interpretive phenomenological analysis by conducting in-depth interviews with seven mothers who had relinquished children 2 to 9 years before the interviews. Four overall themes emerged: The first, “no one in my corner,” conveyed feelings of no support before and after the child was placed. Anger toward professionals and the perception that placement could have been avoided were noted. Powerlessness was also a common emotion. The second theme, “disconnecting from emotion,” is a complex phenomenon that simultaneously describes significant emotions while being disconnected from feelings. Further, mothers reported experiencing tremendous guilt and self-harming through substance abuse to numb the emotions. When emotions were acknowledged, it was only for short periods. The third theme, “renegotiating identity,” described the struggle over whom they were and, as the authors stated, their “internal struggle to reconcile being a mother but not a parent.”
Birth Parents | 115

(p. 308). Some mothers felt a need to improve their lives and in so doing, decrease the sense of shame and guilt. “The children are gone, but still here” was the fourth theme derived from the interviews. Birth mothers in the study had contact with their children, despite the children being placed in foster care or being adopted. Myriad emotions were evoked when visits occurred, from anxiety to guilt and anger directed toward themselves.

An organization, Concerned United Birthparents, provides information and support for those individuals who have relinquished their children (see Exhibit 3.4). They provide support through an online presence and advocacy for parents who have released their children into the care of others. APNs’ awareness of potential maladaptive and complex reactions are helpful to avoid stereotyping birth parents who have had children removed due to maltreatment or who have voluntarily created an adoption plan. For uninformed providers, falling into the trap of judging birth parent behaviors needs to be tempered with a full understanding of context and interpersonal dynamics.

EXHIBIT 3.4

CONCERNED UNITED BIRTHPARENTS

Concerned United Birthparents, Inc. (CUB) (www.cubirthparents.org/index.php) is a nationwide organization, incorporated in 1976, that supports birth parents who have relinquished a child. Saving Our Sisters is a program sponsored by CUB that seeks to provide support for unnecessary adoptions. CUB’s mission is articulated as follows:

Concerned United Birthparents, Inc., provides support for all family members separated by adoption; resources to help prevent unnecessary family separations; education about the life-long impact on all who are affected by adoption; and advocates for fair and ethical adoption laws, policies, and practices.
CASE STUDIES: BIRTH PARENTS

CASE STUDY 1: FRANK

Frank just turned 65 years old and is looking forward to finally being able to retire. His original position was a long distance, over-the-road trucker. However, 10 years ago, Frank transitioned from driver to in-house company foreman due to hypertension, which included some occasional dizzy spells. His hypertension is well controlled on lisinopril 40 mg once a day every morning. In addition, Frank has an 8-year history of type II diabetes, which is managed with metformin 1,000 mg with his evening meal. Two months ago, his HgbA1c was 6.9%. He uses a home glucometer for daily blood sugar readings.

He has two adult children by his second wife, who are independent and live out of state. Married for 10 years to his current wife, Frank is content with this third marriage. His wife has encouraged him to attend church services regularly with her, which has helped him make sense of his spirituality.

He is being seen today for increasing dizziness by his primary care provider, an adult-gerontology nurse practitioner (A-GNP), Carol. During her assessment, Carol notices Frank is diaphoretic and has a rapid heart rate (100 beats/minute), and fast, shallow breathing (26 breaths/minute). His blood pressure reading is 150/90, which is higher than his last previously recorded measurements of 118/67, 124/72, and 120/64. He relates his recurring dizzy spells have started to get a bit worse recently and happen when he is under a lot of pressure at work. Occasionally, he will feel dizzy before going to bed. Frank is usually a “cut up,” making jokes when he is seen in the clinic by Carol. At his previous visit, Frank described how he and his wife were going to take a trip on their motorcycles across the Midwestern states, visiting landmarks. Today, however, Frank is quiet, and when Carol inquires about the trip planning, Frank states it has been postponed. When Carol meets Frank’s eyes, he becomes defensive and blurts out he “doesn’t want to talk about it.”

Carol nods and offers the objective feedback regarding his presentation and how it differs from previous visits. “I sense that you’re preoccupied with something.”
Frank’s shoulders slump, and he apologizes, and then relates how a daughter he had “given up for adoption” 40 years ago, contacted him 2 weeks ago. Frank shares when the baby girl was relinquished, the adoption was closed, and he had no idea what had happened to her. At the time, his first wife and he were not getting along, and the marriage and pregnancy were difficult owing to lack of resources. He was bouncing around between jobs on the road, and neither one had their own place to live. They both agreed the baby would be better off with an adoptive family. Shortly after the birth, he and the baby’s mother split up. After the divorce, he lost contact with his first wife, and although he wondered what had become of his daughter, he had no desire to contact her, saying: “I didn’t want to risk messing up her life.”

His major concerns were that his current wife and his two adult children from his second marriage had no idea he had relinquished a child to adoption in the past and that the adopted daughter would see him as a failure. When this daughter did contact him, they agreed to meet for lunch the following week. Frank’s daughter also told him that in her search for her birth parents, she discovered her birth mother had passed away, which made Frank feel even worse. Now Frank is feeling out of control with fear, guilt, remorse, and, yet, excitement—“I can’t believe this is happening.”

**APN Next Steps**

Carol listens to Frank and implements therapeutic communication techniques: listening, summarizing, reflecting, and nonverbally communicating acceptance (open body language, leaning forward). Carol understands how important it is for her to remain nonjudgmental and supportive. Frank has to make some important decisions: how and when to disclose to his family he had fathered a child who had been placed for adoption 40 years ago.

After a few minutes, Carol has the medical assistant recheck Frank’s vital signs: his breathing is normal (16 breaths/minute), and his pulse is regular (90 beats/minute). She listens to his heart and notes a normal, regular rate and rhythm. All lung fields are clear to auscultation bilaterally. His blood pressure remains slightly elevated (136/80), which, compared with his previous measurements, is still high for him, but lower than his initial blood pressure reading of
When Frank is ready to leave, he begins smiling and tells Carol that he has enjoyed his “therapy session.” Carol decides to hold off on changing his antihypertensive medication or ordering additional tests for now, but schedules a follow-up appointment to reevaluate Frank in 2 weeks.

Two weeks later, Frank arrives for his appointment with Carol and is more somber than usual. He relates his dizzy spells have decreased significantly. His vital signs are within normal limits: blood pressure is 120/74, pulse is normal (88 beats/minute), and respirations are normal (16 breaths/minute). He has been monitoring his blood glucose daily using his home glucometer, and his blood sugar readings have been at 70 to 120 mg/dL. He also describes the emotional reunion he had with his adopted daughter and how he truly understands he and his first wife “did the right thing by giving her up.” Telling his current family has been very difficult. With varying degrees of understanding, particularly from his adult children, Frank is feeling a sense of relief. His two adult children feel betrayed because they have been denied knowing about a half sibling for all of these years. It is going to be a journey, he told Carol, but he is glad his family finally knows about his first child.

Carol knows Frank has some work to do with his family. His developmental stage of ego integrity versus despair has been impacted by the reunion with his adoptive daughter (Erikson, Erikson, & Kivnick, 1986). Frank’s need to make sense of suddenly being a parent to a daughter he had relinquished for adoption 40 years ago and integrating this decision into his current life needs to be processed. By being an adoption-informed caregiver, Carol is able to treat the patient in a holistic manner. She compared Frank’s previous presentations such as his blood pressure, pulse, and respiratory measurements, the recurrence of his dizzy spells, and his change in demeanor with his current signs and symptoms. Carol is able to discern the physical symptoms Frank was experiencing were directly related to his current state of emotional distress.

Applying this process in Frank’s care resulted in the best outcome possible; no changes in Frank’s medications or additional testing were necessary. Taking the time to thoroughly investigate the disconnect between Frank’s previous provider visits and the changes Carol was seeing during this most recent visit, Carol is able to offer support
during a crisis, providing a path to moving forward not only for the patient, but also for his family.

CASE STUDY 2: JASMINE

It is the beginning of the spring semester for Jasmine, a 15-year-old freshman in high school. The school has a high rate of school-subsidized lunches with a student body coming primarily from at-risk households. Jasmine has been complaining of nausea and receives permission to leave class to go to the health office. There, she learns from the school nurse, Mary, she is at the end of her first trimester of pregnancy. Jasmine has suspected that she may be pregnant because she had missed her “periods.”

Mary is a member of the National Association of School Nurses (NASN) and realizes how vulnerable Jasmine is on many levels: physically, emotionally, psychologically, and developmentally. Mary, a family nurse practitioner (FNP), also realizes that Jasmine is at risk for dropping out of school (NASN, 2015), and she intends to provide Jasmine with a multifaceted support plan. After Mary and Jasmine discuss the news of the pregnancy, Jasmine concedes to telling her mother and father about the baby that night. She also discloses to Mary that the father “doesn’t want anything to do with her, now that he knows she’s pregnant.” Mary sets up a time to meet with Jasmine and her parents at the school in 2 days.

Jasmine and her parents arrive; the parents present as both tired and angry. The mother barely looks at Jasmine and announces, “Well, if she thinks I’m raising this child, she has another thing coming. I’m still raising my own kids.” The father is silent and looks downward, nodding. Jasmine is tearful and states, “I don’t want an abortion.” She then relates how two of her friends have had abortions and seem different, sadder after they had terminated the pregnancies. Then, in a deflated way, she adds, “I don’t know what to do. Maybe I’ll raise the baby myself.”

APN Next Steps

Mary attended training in 2012 given by the Infant Adoption Awareness Training Program (Children’s Bureau, 2015; see Exhibit 3.5), and
she presents best practices in communicating that placement of her infant is an option for Jasmine and her parents. Mary discusses all the options Jasmine and her parents are considering. She knows that Jasmine’s mother did not want to have the responsibility for raising another child, and that the family’s faith is prolife. Mary initiates the option of adoption: “Have you considered placing your child for adoption?”

Jasmine discloses that she has not really considered it, but cannot think about never seeing her baby after giving birth. Mary explains that there are many ways contact with adoptive parents and the child is handled. Although open adoption agreements and covenants may not be legally binding between the birth and adoptive parents,
Jasmine can select a family with whom she feels comfortable. She can request they sign a contract that would outline contact between Jasmine and the child. Mary also informs Jasmine that some contact with the birth parent is most frequently in the best interest of the child. Mary refers Jasmine to the crisis pregnancy center and to a counselor there for more discussions about the options she is facing. She also ensures that Jasmine has contact with birth mothers who had made an adoption decision, and those who had not, so that she could make an informed choice. Mary also verifies that in the state of residence, Jasmine, despite being a minor, has the right to place her child for adoption without parental consent.

Throughout the rest of the school year, Mary provides emotional support to Jasmine, who decides to make an adoption plan. Jasmine stops by and talks to Mary about some of the taunts from her peers who do not understand how she can “give her baby up.” Mary listens and is careful not to communicate in a way that could later be viewed as coercive in favor of adoption. She knows that this decision needs to be made freely by Jasmine with input from her parents. She allows Jasmine to talk about her emotions, and how it makes her feel when the baby moves inside her. Mary shares how special that feeling is and emphasizes, “It takes a lot of courage to continue to go to school every day.” Mary assesses Jasmine’s social support structure, and discovers Jasmine has one friend and her maternal grandmother who are offering emotional support to her.

Three months later, Jasmine delivers a healthy baby, who, through an adoption agency, is placed with adoptive parents that she selected. They were present at the baby’s birth with Jasmine and her mother.

At the beginning of her sophomore year, Jasmine stops by to see Mary. Although Jasmine’s face brightens when she describes holding her baby immediately after delivery, she becomes less animated as she comments, “I just don’t feel the same.” She says she feels “so old,” and yet she relates that she is convinced it was the best decision she could have made.

Mary understands the critical need for support and the grief process Jasmine is experiencing. Jasmine discloses, “At times, I just feel so angry and sad. I guess when you’re poor and young, you really pay for your mistakes.”
Mary encourages Jasmine to contact her adoption agency to determine whether they sponsor a postadoption support group for birth parents. She also discusses disenfranchised grief with Jasmine and how she needs to feel her emotions, be mindful of them, and continue to find meaning in the experiences over the past year. They talk about the birth father and how Jasmine had been able to make peace with him, including him on the adoption contract for the open adoption.

Mary makes it a priority to check on Jasmine weekly over the next several months. Jasmine is able to show Mary pictures of her child that the adoptive parents sent her. Seeing how well cared for the baby is, how the adoptive parents have honored the open adoption agreement, and Mary’s support and acknowledgment of her grief enables Jasmine to move forward with her life.

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**Case Study 3: The Millers**

Emily and Bart, a biracial couple, have been together for about 8 months, and each has two children by previous relationships. Barely able to cover their monthly expenses, Emily discovers she is pregnant. She is also midway through the surgical technician program at her local community college and hopes that upon graduation, she can finally make a livable wage. Bart has recently been laid off from his job at an American automobile factory and has been helping a friend do small remodeling jobs. They are 2 months behind in their apartment rent and face possible eviction, and have been fighting more frequently about money and what to do about the baby. Bart reasons that one more mouth to feed “won’t make that much difference,” but Emily is leaning toward terminating the pregnancy. One night after a particularly vicious argument that almost turned violent, with Bart slamming his fist against the wall, Emily orders Bart and his two children out of the apartment. She calls the local crisis pregnancy hotline in desperation, and tells them she is considering all her options, including abortion and making an adoption plan. The crisis center staff meet with her over the following weeks and refer her to a reputable adoption agency for more information.

Two months later, Emily decides to make an adoption plan. She and Bart have broken up, and she has informed him of her decision.
to place the baby with adoptive parents. He wants to meet to discuss the decision, and ultimately agrees this is the best option. With the help of the adoption agency case manager, Emily selects a family she believes will respect an open adoption plan.

Emily has been seen on a regular basis by her certified nurse-midwife, Jenny. Emily begins bringing the prospective adoptive mother, Alexis, to the appointments. Emily is at the clinic for her 37th week check. Jenny measures the fundal height, takes Emily’s weight, and checks for signs of edema in her hands, face, and ankles. A urine sample is checked for any abnormalities that might indicate signs of preeclampsia. Jenny also takes a vaginal swab for group B strep. She listens to the baby’s heartbeat, letting Emily and then Alexis, listen as well. All tests are normal or negative, and the baby and Emily are progressing well. Jenny also educates Emily on the signs of true contractions versus Braxton-Hicks.

APN Next Steps

As Jenny finishes the prenatal check, she notices Emily appears increasingly sad. She turns to Emily and asks, “The delivery is getting closer, and I know this is your third pregnancy. Each one is different. What are your questions and concerns?”

Emily quickly looks at Alexis, and Jenny inquires whether Emily would like Alexis to leave so that they can finish the check-up. Emily declines and then begins to cry. She discloses how fearful she is about being alone after the baby is born. She has grown attached to the baby, singing to it and talking to it. Alexis also begins to cry and states, “I feel so guilty taking this child from you.”

Jenny assures both women that she understands how much courage these disclosures have taken, and that the feelings are real and need to be discussed. She asks about their plans after the baby is born and the arrangements that have been agreed upon. Alexis tells Jenny that an open adoption agreement has been drawn up that she and her husband intend to honor throughout the life of the child. Jenny encourages both women to continue to dialogue and share their feelings with one another. She knows that an open adoption arrangement, although in the best interest of the child, can be more complex for the parents. Careful not to persuade or dissuade Emily from any decision, Jenny emphasizes how important it is for
the women to communicate openly and honestly during this time and the upcoming weeks.

She assesses Emily’s social support network and the current dialogue with Bart, who has begun to refuse Emily’s calls and does not respond to text messages. Jenny notes how vulnerable Emily is without proper emotional support and being a single parent to her two children. However, Emily was able to finish the semester at school and has only one more semester before graduation.

Two months later, Jenny sees Emily after a normal vaginal delivery. After deep reflection and consideration, Emily proceeds with placement. Today, she arrives with a flat affect. Before performing a postpartum check, Jenny assesses Emily’s emotional well-being and the resources she has been able to access. Emily states she has been feeling very sad with the stress of explaining the adoption to her other children. She has not attended any support group meetings that the adoption agency has in place for birth mothers because she feels “so ashamed.” Jenny probes further about these feelings and listens carefully as Emily explains that the adoption plan was really selfish on her part so that she could finish school. She laughs, describing how she got “so drunk” last night so she would not have to “feel anything for at least a little while.”

During the visit, Jenny determines that Emily is at risk for significant depression/grief and is coping in unhealthy ways. She assesses her alcohol intake and uses the SBIRT guidance to facilitate this. Physically, Emily’s postpartum check is normal. Jenny asks if she has visited the baby, a little girl, Sophia. Emily says she has not, adding, “I don’t think I could take it.” However, Alexis has invited her to see the baby, honoring the open adoption agreement. Jenny sits next to Emily, leaning forward and encouraging her to attend a support group meeting. Jenny discusses the grief process and the loss of being able to parent the baby, and acknowledges her pain.

Jenny also asks Emily to reflect on how she reached the decision to create an adoption plan, reviewing the steps Emily had taken. She points out that Emily had considered all of her children’s needs; the ability to finish school would create security and stability for her children under her care. Emily had taken good care of herself during the pregnancy so that the baby would be born healthy. She ensured that the baby girl, Sophia, was going to know her and her
birth father, Bart, if he wanted that. She had created a relationship with Alexis before Sophia’s birth that had allowed Alexis to feel secure enough to invite Emily to visit Sophia. Jenny emphasizes how much Emily had done to protect her child and ensure the welfare of her children at home.

Emily is able to make eye contact and promises Jenny to look into the support group. Jenny encourages Emily to look into the postadoption counseling that the agency offers; she also gives Emily the website of online support groups if that is more comfortable for her. They discuss whether Emily might find an antidepressant helpful. Jenny makes a follow-up appointment with Emily to ensure her well-being and to continue to discuss whether an antidepressant would be beneficial.

CASE STUDY 4: CHELSEA

At 34 years of age, Chelsea has just learned of her promotion as manager of the oncology team, late phase development, at a global pharmaceutical company, and that she is 8 weeks pregnant. When she was in her early 20s, she had terminated a pregnancy and could not shake off the feeling of regret afterward. Despite being raised in the Roman Catholic faith, she does not attend church, or feel close to her faith. Yet she does not want to go through with another abortion.

As one of five siblings growing up, Chelsea watched her mother sacrifice her own education and career as she cared for the children in a traditional marriage. Ultimately, her parents divorced after 28 years together, leaving Chelsea even more disillusioned with marriage and family life. Chelsea has been in several relationships through the years, but she always broke things off when they became too serious. She reconciles this with the feeling that she has not met the person she is supposed to be with for the rest of her life. Her pregnancy is the result of a night with an acquaintance, someone at a pharmaceutical conference whom she knew previously when he worked at the same company where she is currently employed. She felt it was her duty to contact him, and when she did, she told him of her decision to place the child with a couple who desperately wants a child. He agreed and asked that she keep him posted on
what would happen next—that he had heard of “open adoption” agreements, where the birth parents are allowed contact with the adoptive parents and the child.

Chelsea is a tall, thin person, and has successfully hidden her pregnancy into the last trimester. At that time, she arranges for family medical leave, citing an ill relative who needed her to help. The company is happy to provide 4 months of leave, given her stellar performance. Chelsea sees a certified nurse-midwife, Susan, for her prenatal care, whose practice is in a neighboring community.

**APN Next Steps**

Susan has guided Chelsea through her pregnancy; the patient is now in her third trimester, gaining an appropriate amount of weight, normal blood pressure, and no evidence of gestational diabetes or signs/symptoms of preeclampsia. The patient reports lots of activity from the baby and feels “like a cow” with all the weight gain. Susan’s only concern is that Chelsea has a very limited support system: one old high school “best friend,” who will be with her in the delivery room. During her week 36 visit, Chelsea discloses her plans to relinquish the child to a couple from out of state. She is a client of a reputable adoption attorney as she wanted the arrangement kept as confidential as possible. The father is willing to sign relinquishment papers upon birth, and they have entered into an open adoption contract with the prospective adoptive parents, which allows them face-to-face contact with the child.

Susan listens as Chelsea describes the arrangements in a matter-of-fact way and how she will return to work about 4 weeks after birth. Plans are made for her to deliver in the hospital in a city adjacent to where she resides. She does not allow the prospective parents in the labor and delivery room, but her friend is there to help her through her contractions and delivery. Chelsea gives birth to a healthy, 7.5 pound infant girl, and the process unfolds without any complications. She is given a private room at the hospital and, after she holds the baby immediately after delivery, Chelsea declines seeing her daughter again, stating: “She belongs to them now.” She completes a medical history form for the adoptive family so that they have information about their daughter’s health background. The hospital nurse offers Chelsea a follow-up call to check on her, but she declines.
Follow-Up

Chelsea sees Susan for her 6-week postpartum check and has a gynecological exam. Her milk has “dried up,” and she feels great physically. Susan counsels her on PPD and birth control methods she might consider. Chelsea nods, and appears to understand.

Susan pauses, sensing something has not been said. Then Chelsea discloses that she drives 5 hours to see the baby weekly because she has that right given the open adoption agreement. Suddenly, she becomes agitated because during the last visit, the adoptive mother, Charley, had begun to cry, saying that she could not feel like Katherine’s (the baby) “real mom” with Chelsea in the environment. She told Chelsea that she believed Chelsea was grieving and that Chelsea needed to seek a therapist to deal with her grief and loss, and learn to deal with the relinquishment. The adoptive mother emphasized that she would honor the open adoption contract, but was concerned for both of them.

Susan leans forward and sits facing Chelsea who is sitting up also. “Tell me what you’re feeling right now.”

“Oh, my gosh! So many things. I guess sadness, guilt . . . I’m wondering who I am. I’ve never felt this.” She then begins to quietly sob with her head in her hands.

Susan understands that relinquishment of a child is one of the most difficult experiences for many birth parents, even when a birth mother, such as Chelsea, is sure it is the best decision for her and her child. But she also understands that Chelsea has had significant hormonal shifts and, as importantly, lacks a support system that would support her emotions and the experience. She is concerned about PPD, and understands that one of the major constructs in Cheryl Beck’s Theory of Postpartum Depression is “loss of self” (Beck, 2002). Because Susan grasps the complexities of Chelsea’s situation—physical, social, emotional, and psychological—she knows there is a need to refer Chelsea to a therapist who also is adoption informed to offer Chelsea the help she needs.

In that moment, however, Susan understands that she can offer comfort and support. “This must be overwhelming for you. Tell me about Katherine.”

Chelsea looks up, “Oh, she’s wonderful!” She looks down. “I know I made the right decision. I just never expected these feelings.”
“Feelings. . .”
“Yeah, like sadness, happiness, peace, guilt, joy, acceptance, sadness, sadness, sadness. . .”
“So much to process.” Susan waits and then asks, “What about the adoptive parents? What are they like?”

Chelsea swallows, but continues to wipe away tears. “They’re great. They’ve been so patient with me. I just show up, you know? I tell myself not to go there, but I can’t help myself. It’s as much for me as for Katherine. There’s no one I can really talk with, and Charley, the adoptive mom, is so kind to me.”

Susan places her hand on Chelsea’s arm. “You’ve been through a lot. And your body has been through a lot. You’re healing inside and out. But we need others in our lives to help us sometimes. Would you be open to talking with a therapist, someone who can help you make sense of all this?”

Chelsea hesitates. “Do you know someone?”

Susan goes on to explain that she is aware of a very caring and competent therapist who has counseled many individuals whose lives have been touched by adoption. She urges Chelsea to make an appointment, and to “be gentle with yourself.” The advanced practice nurse also describes “entrustment ceremonies,” arranged between the birth and adoptive parents to signify the change in parentage (Child Welfare Information Gateway, 2013b). Susan prescribes an SSRI antidepressant for Chelsea, educating her that it will take 2 to 3 weeks for her to feel relief. She encourages Chelsea to call her if she needs additional information. A follow-up appointment is set for 4 weeks.

Susan knows that signs of PPD and grief may be intertwined. Chelsea’s hypervigilance of Katherine may be both a sign of PPD and the grief process. When Susan sees Chelsea again, she will assess whether the antidepressant is helpful and whether Chelsea has entered into therapy.

APNs’ Care of Birth Parents

These case studies are just a few of the possible narratives that are unique for birth parents. However, these case studies represent common issues that birth parents face who have released a child into the care of adoptive parents. Despite common issues, birth parents’
Birth Parents

What to Look for (Assessment):

☐ In voluntary relinquishment, ensure that there is informed consent related to the decision to place the baby (e.g., no fees paid to the birth mother that would be construed as coercive).
☐ Verify state laws for minors who become pregnant, and consider adoption as a third choice for an unintended pregnancy.
☐ Monitor for signs of postpartum depression as well as grief (disenfranchised) and other mood disorders in birth parents.
☐ Assess social support for both birth mothers and fathers.
☐ Tease out physical complaints that may be related to psychosocial needs.
☐ Use SBIRT (Screening, Brief Intervention, Brief Therapy, and Referral to Treatment) guidelines to screen and intervene for substance use.

What to Do (Management):

☐ Consult organization’s and state’s reporting guidelines for reporting substance abuse and use in pregnant women.
☐ Provide psychosocial support and therapeutic communication during and after decisions to release the child for adoption.
☐ Advocate for birth parents’ rights, and understand that relinquishment of a child is not an occurrence that ends when physical custody is released; rather, it is a lifelong process.
☐ Refer to adoption-informed mental health professionals when needed.

TABLE 3.2  Birth Parents: What to Look for and What to Do

situations are heterogeneous and require the APN to individualize the approach, assessment, and plan of care. Priorities include the safety and well-being of the dyad and newly created families established through open adoptions. Safety issues may include substance use while the birth mother is pregnant, self-harm when depression is severe, and domestic violence. We discuss involuntary termination of parental rights further in Chapter 7. Table 3.2 provides guidance in areas that require APN assessment and management.

CHAPTER HIGHLIGHTS

☐ The number of unintended pregnancies ending in abortion has decreased, and births resulting from unintended pregnancies have increased; however, fewer infants are being released for adoption.
Relinquishment of a child and the subsequent termination of parental rights may be voluntary or involuntary.

Critics argue that termination of parental rights based on inadequate financial and social resources is an invalid reason to relinquish a child, and call this “unnecessary adoptions.”

In certain countries, such as China and India, female infants and children are often abandoned or released for adoption at higher rates than male infants and children. These practices are rooted in cultural practices and the value placed on sons.

Safe Haven laws are designed to protect birth parents from criminal prosecution for abandonment; however, the infant must be left in a safe place designated by law.

AWHONN and ACOG oppose laws that criminalize pregnant women for substance use disorders because evidence shows them to be ineffective deterrents to substance abuse. APNs should check state laws for mandatory reporting.

Screening, Brief Intervention, Brief Therapy, and Referral to Treatment (SBIRT) appears to be an effective and efficient method in primary care in screening for and referral for further evaluation of unhealthy substance use.

The Infant Adoption Awareness Training Program has been adapted by the National Council for Adoption, and this training for health care professionals is available online, free of cost.

The continuum of contact between birth parents and adoptive parents extends from closed to open adoption. Open adoptions are the current norm and are considered to be in the best interest of the child. Legal enforcement of contact agreements varies by state.

The effect of relinquishment of a child on birth fathers has been overlooked in both research and, in some cases, practice.

Health care organizations have specific policies and procedures that are followed when termination of parental rights occurs in postpartum units. BUFA or “baby up for adoption” has been used to signify a baby who is being placed with adoptive parents.

APNs and bedside nurses are influential during this fragile time and should avoid making judgments, swaying parties, or showing bias. Therapeutic communication, advocacy, and
openness to grief reactions in birth parents are important interventions.

Questions for Reflection

Following are a few questions to reflect upon. You can use these to start a journal for yourself or in a classroom discussion with peers and the instructor.

1. How do race, class, and gender influence birth parents’ decisions to relinquish a child?
2. What are your attitudes toward impaired birth mothers who endanger or permanently impact the health of their child? Where do the rights of the birth parents end and those of the child begin?
3. Have you ever been in a situation where it was difficult to remain neutral and still advocate for birth parents’ rights?
4. What therapeutic communication techniques do you use when interacting with a birth parent who is experiencing disenfranchised grief?
5. What are your thoughts on open adoption contracts? Should they all be legally binding documents? What if the child’s safety becomes a factor?
6. Which case study spoke to you the most? Why? What personal and professional feelings were evoked within you?

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Kinship Parents

PURPOSE OF THE CHAPTER

In this chapter, we explore the role and needs of kinship parents, a unique, vulnerable, diverse population with health risk factors compounded by the responsibilities of raising children as older adults. Kinship caregiving is somewhat new to our lexicon, but such parenting is not new in practice. Think of the novel *The Wizard of Oz* (Baum, 1900), in which Dorothy is parented by Aunt Em and Uncle Henry. There appears to be an emotional arc to the connection between Aunt Em and Dorothy as their relationship becomes closer, and ultimately ends with Dorothy wanting to return home to her kinship caregivers, not unlike the kinship relationships we see today.

This chapter introduces four individuals in case studies who have assumed the role of the parent. They span a spectrum of legal arrangements based on the birth parents’ presence in the home and in the family. Each has diverse backgrounds that include various challenges related to being a kinship parent: a 68-year-old grandmother who is recovering from orthopedic surgery; an older, middle-aged man who is caring for his grandchildren while his daughter is on military deployment; a 61-year-old woman who has assumed the care of her stepgrandchildren; and an older adult who is victim to elder abuse at the hands of her kinship children. Cases are described, followed by the identified issues and concerns that are amenable to nursing interventions.
Learning Objectives

At the completion of the chapter, the reader will be able to:

1. Discuss comparisons of demographic factors between kinship parents and general households with at least one parent
2. Compare and contrast the family dynamics of kinship foster care with nonrelative foster care
3. Identify kinship family risk factors that are amenable to advanced practice nurse (APN) management or referral, such as food insecurity
4. Be familiar with caregiver burden, depression, stress, and the health effects for older adults/kinship caregivers
5. Describe the assessment and mandatory actions when elder abuse is suspected/discovered

OVERVIEW OF KINSHIP PARENTS

As a profession, nurses are increasingly called upon to contribute to a culture of health, prevent disease, and promote well-being. Although these are worthy goals, nurses have to address the basic needs of individuals and families first (think Maslow’s Hierarchy of Needs). You cannot consider self-actualization if you do not have enough air to breathe, or enough food to eat. The reality of widespread food insecurity in the United States is startling, with 19.2% of households with children experiencing food insecurity (U.S. Department of Agriculture: Economic Research Service, 2015). As the level of poverty increases, so does the percentage of households that face food insecurity, up to 33.7% (U.S. Department of Agriculture: Economic Research Service, 2015). Many of these are households maintained by kinship parents. In fact, 24% of children are adopted by relatives (Vandivere et al., 2009).

In 2014, foster care provided by a relative jumped to 29% of all foster care placements in the United States (Child Welfare Information Gateway, 2016). This figure does not include kinship parents who are not officially accessing the foster care/child welfare system. Kinship parents represent a vulnerable and quickly growing population, which has seen an 18% increase in the last decade (Annie E. Casey Foundation, 2012). It is also fairly common in society: 9% of children will live with extended family for at least 3 consecutive months before they
turn 18 years of age (Annie E. Casey Foundation, 2012). Economically, these families are disadvantaged. Compared with children living with at least one parent, kinship families are more likely to live below the poverty line (22% and 38%, respectively). But the statistics become even more worrisome when extreme poverty is considered: 43% of children with at least one parent versus 63% of kinship households live below the 200% poverty line. The Annie E. Casey Foundation (2012) reports that: “According to U.S. Census Bureau data, kinship caregivers are more likely to be poor, single, older, less educated, and unemployed than families in which at least one parent is present” (p. 4). In addition, many of these children have experienced trauma and adverse childhood experiences (ACEs). This creates a dynamic picture of the potential for multiple patients within one family unit.

Kinship caregivers, who are often grandparents, feel an acute stigma. As director of a project that delivered trauma-informed parenting classes to kinship parents in rural Indiana counties, I heard narratives, reflections of pain and shame at the events that necessitated the removal of children from their birth parents who were often, the kinship parents’ own children. Drug use, death, incarceration, and immaturity were often cited as reasons why these grandparents were now raising their grandchildren. Blurred lines of who are “mom” and “dad,” and new labels of how to refer to the kinship caregivers are agreed upon within the families. Generations learn new boundaries, young aunts and uncles are now siblings, and power is redistributed and negotiated. Legal issues are considered, and often reconsidered. In some of the parenting classes, nonrelative foster parents sat alongside kinship parents. The differences were significant. Boundaries of the families themselves and the multigenerational dynamics present within the family system differed between relative and nonrelative foster care families. The nonrelative foster parents rendered care, knowing the child’s placement was probably temporary, and during this time, their role was to provide a safe, nurturing environment while the child’s birth parents could not. (Table 6.1 presents the differences between kinship care and traditional foster care.) Kinship parents spoke of feeling uncertainty about whether the arrangement would be permanent or temporary, the drain on their finances, being less knowledgeable about services, and ill-prepared to parent children with significant behavioral issues.
During one of the modules in the parenting class, we discuss compassion fatigue that kinship parents may experience through their empathy toward the children under their care who have been abused and neglected. Sadness, shame, frustration, anger, exhaustion, and fear are among the emotions elicited when caregivers’ empathize on a continual, relentless basis. After having the parents discuss what they listed in response to caring for their children, one

### TABLE 6.1 Kinship Care Versus Traditional Foster Care

<table>
<thead>
<tr>
<th>KINSHIP CARE</th>
<th>TRADITIONAL FOSTER CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preexisting relationship with child</td>
<td>No preexisting relationship with child</td>
</tr>
<tr>
<td>Redefines existing family relationships</td>
<td>Strengthens new family relationships</td>
</tr>
<tr>
<td>Mixed feelings about loss of parent to child</td>
<td>Celebration of a new family</td>
</tr>
<tr>
<td>Mixed feelings about loss of role as grandparent, aunt, uncle, etc.</td>
<td>Excitement about new role as parent</td>
</tr>
<tr>
<td>Knowledge of family dynamics</td>
<td>Limited knowledge of family dynamics</td>
</tr>
<tr>
<td>Decision to become a caregiver is unplanned and in crisis; request from parent, child protection or courts</td>
<td>Decision to become a caregiver is planned and voluntary</td>
</tr>
<tr>
<td>Limited preparation for caregiving</td>
<td>Preparation for caregiving role and support already in place before child is placed in home</td>
</tr>
<tr>
<td>Unanticipated requirements to become a foster or adoptive parent</td>
<td>Requirements to become foster or adoptive parent are anticipated</td>
</tr>
<tr>
<td>Guilt over birth parent problems</td>
<td>No guilt over birth parent problems</td>
</tr>
<tr>
<td>Guilt for taking over parental role for the child</td>
<td>Feelings that they are saving the child</td>
</tr>
<tr>
<td>Perception that they are betraying the birth parent by assuming legal relationships</td>
<td>Feeling they are displaying loyalty and commitment to the child by assuming legal relationship</td>
</tr>
<tr>
<td>In competition with birth parent if the child becomes attached to relative</td>
<td>Motivated to demonstrate attachment that is as strong as previous attachment with birth parent</td>
</tr>
<tr>
<td>Split loyalties and hesitation to legalize relationship</td>
<td>High motivation to legalize relationship</td>
</tr>
</tbody>
</table>

*Source: ChildFocus® and The North American Council on Adoptable Children (2010).*
parent commented: “I don’t see one listed here that’s important: guilt.” She was right. For kinship parents, there is often pronounced guilt from perceived mistakes when parenting the birth parents and an attribution of the current situation to these mistakes.

Resources and support are sometimes scarce, and informal networks may be created as a result. I had asked the class participants where I might be able to distribute information about the classes, because recruitment had been a challenge. I wanted to reach folks who might benefit from the information. One quickly said, “Go to the McDonald’s. There’s a bunch of us there. They have that big indoor playground. You should see all us kinship folks with our kids. They just play and play.” Another volunteer in one rural community had advised me to be sure to distribute the fliers at food pantries around the area.

There are also safety issues, which can take various forms. First, kinship parents report being a buffer, a gatekeeper, and a protector of the children whose care they have assumed from the birth parents who no longer can or will care for them. This is especially important if the parent has a substance use disorder. One kinship parent that I spoke with emphasized that only supervised parental visits were allowed with his two grandchildren. And such visits were no longer occurring in his home. He drove the children to a public space for their safety, as he believed behaviors were often better in public places. Second, the behaviors of the child may place the older kinship parent at risk. Evidence of hitting, biting, punching, and bruising should be thoroughly investigated if assessed upon evaluation by the APN—for the both child and the adult. The children who display aggressive behaviors may be mimicking in play what they have witnessed or experienced in their homes and need to be referred to a mental health professional for evaluation and services.

Additionally, the safety of the child has to be considered with kinship placement. When speaking to a group of youth workers in a rural county, staff from the Department of Child Services (DCS) described how they make every effort to find relatives and strongly desire relative placements. Yet, they added, there were occasions when the kinship parents could not pass a criminal background check. Awareness of and prioritizing safety for both the kinship provider and the child are critical for APNs when evaluating patients, both old and young, who are in kinship arrangements.
TYPOLOGIES OF KINSHIP FAMILIES

There appear to be patterns or typologies of kinship families. Using foster family data from the State of Illinois, Zinn (2010) revealed four classes of kinship parents or typologies employing latent class statistical analysis. The first class, “empty nest grandparents,” the largest group at 41%, is comprised of grandparents or great-grandparents who are more often married with very few non–foster children in the home. These individuals are most likely to experience health problems. The second class, “parenting grandparents,” families are also headed by great- or grandparents and contain at least one non–foster care child. Compared with the other classes, the presence of additional adults in the home is high. The third class, “collateral kin with some children” families, are less likely to be headed by partnered adults, but there are other adults in the home. The reverse was found for the fourth class, or “parenting collateral kin,” families: They are less likely to be headed by partnered adults and have no other adults in the home (p. 331). Two important variables that were statistically significant in supplementary analysis were relatedness of family members and the number of nonfoster care children in the homes; these two items may help further define kinship family typologies (Zinn, 2010). APNs may find such categories helpful when evaluating older adult kinship parents and their social support.

CAREGIVING GRANDMOthers

Grandparents experience a spectrum of emotions and stress in their role as kinship parents. The work of Carol Musil and colleagues should be noted. Another notable nurse leader in this area is Susan Kelley, whose work with African American grandmothers provides evidence to support APN practice. The journal GrandFamilies: The Contemporary Journal of Research, Practice and Policy is a source of information for APNs as they provide care to this unique group of individuals. These contributions to nursing science and practice have significantly increased our understanding of caregiving grandmothers’ overall experiences, caregiver burden, and interventions to support optimal health. Caregiving grandmothers reported stress and depression as emotional health outcomes (Musil et al., 2010; Musil, Warner, Zauszniewski, Wykle, &
Standing, 2009). The burden of caregiving is significant, especially over time: Grandmothers who assumed primary care of a grandchild experienced the most stress, intrafamily strain, and perceived problems in family functioning; worsening health and increased stress were also revealed over a 24-month period (Musil et al., 2010). However, depressive symptoms and interfamily strains were found to be mediated by resourcefulness in caregiving grandmothers who were studied over a 5-year period (Musil, Jeanblanc, Burant, Zauszniewski, & Warner, 2013). Resourcefulness training (RT) of caregiving grandmothers using both written and verbal disclosure (tape recordings) was overall effective in reducing perceived stress, depressive symptoms, and enhancing quality of life (Zauszniewski, Musil, Burant, & Au, 2014). A pilot study of an online RT revealed overall positive results; however, modifications, such as support for participants when the study is initiated, were recommended (Musil, Zauszniewski, Burant, Toly, & Warner, 2015). More research is needed to continue to test what appears to be a promising intervention, RT, to support caregiving grandmothers.

**REASONS WHY KINSHIP CARE EXISTS**

For many kinship parents, parenting responsibilities are taken on suddenly and unexpectedly. For others, there is knowledge that families are unstable and in crisis. The DCS is charged with seeking out relatives in order to place children who have been removed from the home. Relatives are then left with the dilemma of caring for the child or placing them in the child welfare system with nonfamily caregivers. From those kinship parents whom I have interacted with, the latter option is often unpalatable: “I didn’t want a stranger raising him. I couldn’t stand that thought.” Yet the children can present with significant histories of maltreatment with thoughts, emotions, and behaviors that sometimes transform the lives of the kinship provider. For example, grandparents have expressed that their friends and other extended family members rejected them, either because of loyalty to the birth parents or because of the child’s behaviors at social events. The grandparents were left feeling their support systems had been taken from them when they needed their friends and family the most. One grandmother said, “I was so hurt when our friends didn’t want to socialize with us anymore. My husband
The Adoption and Kinship Triads

and I used to be so social. I don’t know that I’m over it and they left us years ago. At the same time, I don’t know that I’d ever want them in my life again.”

As previously discussed, family structures vary: Kinship care may be informal and temporary or ultimately result in permanent placement. Whatever the arrangement, we do know children have better outcomes overall when placed with kinship care than with nonrelative foster care arrangements. There are strengths to care provided by kin: Children progressed better with behavioral and social skills problems (Sakai, Lin, & Flores, 2011). Kinship care offers children the benefits of familiar caregivers, continuity of family and cultural traditions, decreased trauma from separation, reinforced identity and self-esteem, reduction of racial disparities, increased placement stability, less stigma with foster care, and preservation of sibling relationships (Cuddeback, 2004; Geen, 2004). Current best evidence suggests that children in kinship care may do better than children in traditional foster care in terms of their behavior, development, mental health functioning, and placement stability (Winokur, Holtan, & Valentine, 2009).

KINSHIP CAREGIVERS’ HEALTH STATUS

Although there is evidence to support the benefits of kinship care for children, much less has been reported regarding how kinship caregivers fare. To determine how the health status of relative adoptive parents ($n = 469$) compared with that of nonrelative adoptive parents ($n = 1,599$), my colleagues and I analyzed data from the National Survey of Adoptive Parents (NSAP) to examine overall physical and emotional health status (Foli, Lim, & Sands, 2015). Remember, these are kinship parents who legally adopted their children. We found that only nonrelated mothers of children younger than 6 years reported better emotional health than those who were related to their children; with this exception, physical and emotional health status did not differ between these two groups. We also found the family is indeed a social unit, and that the level of perceived happiness in the parent–child relationship was important in terms of parental health status. Despite reporting that the children under their care had experienced more maltreatment (abuse and neglect, and exposure
to drugs and alcohol), relative adoptive parents reported using fewer services than their nonrelative counterparts (Foli et al., 2015). Specific questions regarding caregiver depression, parenting stress, and caregiver burden were not included in the questions contained in the NSAP.

**Elder Abuse**

The statistics surrounding elder abuse, including neglect and exploitation, are striking: 1 in 10 adults, aged 60 or older and who live at home, experience elder abuse (Centers for Disease Control and Prevention, 2015). This is considered an underestimation of the magnitude of the problem. Elder abuse has several forms—from physical harm, to neglect, to financial exploitation (see Exhibit 6.1). Although we know that more often the perpetrators are family members, many APNs would not regard the children of kinship caregivers as potential abusers (Brownell & Berman, 2000; Brownell, Berman, Nelson, & Fofana, 2003).

Preservation of the family takes on new meaning when applied to a kinship family. Ethical and difficult questions arise when evidence of elder abuse surfaces: Should the child/adolescent be removed from the home and placed with a foster family (away from his or her network of extended family)? What is the balance between elder safety and the child/adolescent behaviors that may have been generated through maltreatment and trauma? Brownell and Berman (2000) stated:

> Although kinship care of dependent children is not new, the child welfare system that has evolved to date is structured to place children in traditional foster care settings and to move children who cannot return home to their biological parents as quickly as possible to permanency (usually meaning adoption). The system is traditionally child-centered. Foster parents are considered professional caregivers and are expected to maintain and meet predetermined standards as a condition of placement. Children who act out in care are moved to another foster placement. Adolescents are usually moved to congregate care facilities like group homes or into “independent living” situations. Recognizing and respecting the family preservation goal of kinship care is important in developing new program models and treatment modalities
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EXHIBIT 6.1

Elder Abuse

The Administration on Aging defines elder abuse:

“In general, elder abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult. Legislatures in all 50 states have passed some form of elder abuse prevention laws. Laws and definitions of terms vary considerably from one state to another, but broadly defined, abuse may be:

- **Physical Abuse**—inflicting physical pain or injury on a senior, for example, slapping, bruising, or restraining by physical or chemical means.
- **Sexual Abuse**—non-consensual sexual contact of any kind.
- **Neglect**—the failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.
- **Exploitation**—the illegal taking, misuse, or concealment of funds, property, or assets of a senior for someone else’s benefit.
- **Emotional Abuse**—inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts, e.g., humiliating, intimidating, or threatening.
- **Abandonment**—desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.
- **Self-neglect**—characterized as the failure of a person to perform essential, self-care tasks and that such failure threatens his/her own health or safety.”

Source: Administration on Aging (2016).

that address the problem of grandparent abuse, before it becomes too serious for the adolescent to remain in the family or even the community. (p. 104)

This description of the context of elder maltreatment within the wider scope of foster care practices and trans- and intergenerational trauma is insightful. The APN will be one of the first providers to
assess elder and child abuse, and will need such a context to provide patient- and family-centered care.

**Military Kinship Families**

A special type of kinship care revolves around military deployment. Increasingly, women are called to serve, and now, with the repeal of Title 10 U.S. Code, section 6015, women may be assigned to any combat unit, class of combat vessels, and combat platform. Since this change, women have been increasingly serving in the military, and as a result, kinship parents have been asked to assist during times of deployment.

In a descriptive study of 23 kinship parents from military deployment, Bunch, Eastman, and Moore (2007) reported that the parents experienced changes in partner relationships and social networks, and that only 35% had legal custody of the children. Of note for APNs, the majority cited a change in health status, with only 35% reporting their health status as “good” (Bunch, Eastman, & Moore, 2007). It should be noted that kinship providers in military deployment situations, as with other kinship arrangements, may be siblings, aunts, uncles, and close family friends.

**Trauma-Informed Parenting**

In the chapter that focused on adoptive parents, I introduced the National Child Traumatic Stress Network (NCTSN), the concept of trauma-informed parenting, and the wide range of resources available to health care providers. One resource that I have used is a curriculum specifically designed for kinship, adoptive, and foster care parents. Developed by the NCTSN, “Caring for Children Who Have Experienced Trauma” (Resource Parent Curriculum [RPC]; Grillo, 2010a, 2010b) is specifically designed for resource parents (i.e., kinship, foster, and adoptive parents). Advanced by experts from around the country, the RPC is seen as a vital resource for nonbirth parents who are caring for vulnerable children. This curriculum is free to the public (developed with federal funds), and is being implemented by a number of organizations (see Exhibit 6.2). The goals of this curriculum include educational information about traumatized
children and how to respond to challenging behaviors and emotions, as well as how caregivers can take care of themselves and seek support from others. Preliminary empirical evidence appears to support these impressions. Sullivan et al. (2016) reported that kinship parents

EXHIBIT 6.2

CARING FOR CHILDREN WHO HAVE EXPERIENCED TRAUMA: RESOURCE PARENT CURRICULUM (RPC) MODULES*

- **Module 1/Introductions:** Setting the climate for the workshop, including the stories of children who have experienced trauma.
- **Module 2/Trauma 101:** Describing trauma and what can be done to help children.
- **Module 3/Understanding Trauma’s Effects:** Children’s developmental stages and trauma are considered.
- **Module 4/Building a Safe Place:** The concept of safety—physical and psychological—is discussed and its importance to children who have experienced trauma.
- **Module 5/Dealing With Feelings and Behavior:** How trauma translates into children’s feelings and behaviors so that appropriate strategies can be formulated.
- **Module 6/Connections and Healing:** Children’s connections are critical to emotional well-being, and ways to foster connections are discussed.
- **Module 7/Becoming an Advocate:** Helping RPC parents work with teams of professionals and advocate for their children is emphasized.
- **Module 8/Taking Care of Yourself:** The effects of secondary stress and trauma on the parent are described with strategies for self-care.

*Each of the 8 modules is approximately 90 minutes in length (Grillo, Lott, Foster Care Subcommittee of the Child Welfare Committee, & National Child Traumatic Stress Network, 2010a, 2010b).
demonstrated significantly increased knowledge related to trauma-informed care as well as self-efficacy after the RPC curriculum.

In my project, which was supported through funding from the National Institute of Food and Agriculture, we provided health education in cooperation/partnership between nursing faculty and rural-based Purdue University Extension Educators. Purdue University, as part of its land grant mission, has a network of extension educators who are cross-trained to deliver a variety of content, including human development and health and wellness. As members of the communities they serve, extension educators are in key positions to deliver the RPC to kinship parents. The stigma associated with receiving mental health services cuts across urban and rural areas; however, the familiarity that is characteristic of rural communities exacerbates this stigma and often precludes individuals from seeking much needed services. By engaging extension educators, embedding this health education within the umbrella of Purdue Extension, and partnering with nursing faculty, we strategically attempted to decrease the stigma associated with mental illness.

The RPC is unique in several key areas. First, there is an emphasis on the “why” of the child’s behavior from a resource (i.e., kinship, foster, or adoptive) parent’s perspective. For example, if a child demonstrates externalizing behaviors at bedtime (hiding/hoarding food), rather than thinking of consequences to extinguish the behavior, the kinship parent is encouraged to look beyond overt behaviors and attempt to ascertain what is triggering the child’s need to demonstrate maladaptive coping. The child may be concerned about having adequate food upon wakening, having been traumatized by food insecurity or as a reaction to having been victimized through sexual abuse at bedtime (Reagan-Shaw, Sullivan, Sharda, Foreman, & Badeau, 2012). Second, the curriculum includes a focused application through a “My Child” worksheet that enables the kinship parent to apply the concepts of trauma-informed parenting to their child(ren). Third, there is a module devoted to “Taking Care of Yourself,” during which the kinship parents learn about signs and symptoms of compassion fatigue and secondary trauma (Grillo, Lott, Foster Care Subcommittee of the Child Welfare Committee, & National Child
Traumatic Stress Network, 2010a, 2010b). Based on my professional experience, this curriculum is a powerful tool to support kinship parents’ ability to not only understand trauma, but also begin to heal from its effects.

During these classes, the statistics surrounding kinship parents’ struggles become more than sterile, benign numbers on a page. The parents sit, lean forward, and tell their narratives, heartbreaking stories of adult children who have become addicted to substances and are now individuals who cannot be trusted, cannot be left alone with their children. The kinship parents become protectors of the grandchildren who have come to live with them, fierce gatekeepers to prevent further maltreatment. Some confess to generational abuse they themselves have endured. I listen and wonder whether they have ever disclosed these personal traumas to another human being. I see the tears, the heads lowered in shame.

The children come in from the adjacent room where I have arranged student nurses to provide supervision. They grab snacks, handful after handful, as if they know to grab food when it is available to them. They have made craft projects and offer the completed projects to their grandparents. Later, after the children have left, we discuss what is meant by “mom” and “dad,” and who says these to them. The kinship parents report discomfort at being called these titles. Still, they almost universally report that the children under their care want to call them “mom” and “dad.” They make up other names, offshoots of “grandmother” and “grandfather,” and insist they are not the parents. I offer that children signify who loves them, who meets their needs, and who provides safety to them by these words.

They discuss trauma, violence, neglect, physical and psychological dangers that the children—and sometimes they—have endured. Other times, the kinship caregivers relate that the birth parents simply do not know how to care for children because they are too immature to take on the responsibilities of parenthood. The birth parents are transients in the home, sometimes there and sometimes not. Their role in the child’s life shifts as maturity develops. The kinship parent may find that even after years of parenting a child, they have no rights to a permanent parenting relationship when the birth parent emerges once again to assume a full-time role in the child’s life.
Sally is a 68-year-old woman who has assumed the care of her 4-year-old grandson because his mother, her daughter, has been incarcerated for methamphetamine use and dealing. She is recovering postoperatively from total knee replacement surgery she had 3 days ago, and is in a subacute care rehabilitation facility for 2 weeks for physical therapy and 24-hour nursing care.

Sally has taken care of her 4-year-old grandson, Joshua, “on and off” since he was born. A widow, Sally lives in an old house, badly in need of repairs in a lower socioeconomic neighborhood. The boy’s father has not contacted the family for over 2 years. While at the rehabilitation facility, Sally’s friend has been looking after Joshua, but is getting tired. The caseworker from the DCS is not aware of Sally’s friend caring for Joshua because Sally is worried he will end up in a foster home. She has intentionally kept DCS out of their lives because she feels so vulnerable and worried that, because of the disrepair of her home, they will take Joshua away. Her primary concern is not being able to carry food home from the food pantry once she gets home and Joshua feeling abandoned. Sally knows he starts to regress when she is sick, and this is the longest they have been apart. Her friend has complained about Joshua’s bedwetting, something he had stopped a year ago with Sally.

The physical therapy has been difficult on Sally, especially with her body mass index (BMI) of under 19. But she is trying her hardest to get home. She hopes to be discharged within the next 2 days.

**APN Next Steps**

As Sally stands with the help of the physical therapy aide, Janet, her adult-gerontology nurse practitioner (A-GNP), walks into her room. Janet assesses Sally’s circulation and watches as she ambulates from her room and down the hallway. Janet has already reviewed the medical record and seen that Sally’s recovery has been fairly uneventful. The cefazolin has been effective in preventing infection,
and physical therapy is proceeding smoothly. The continuous passive motion (CPM) machine is also effective, according to the electronic health record (EHR).

Janet notices a little boy entering the hallway and running up to Sally. He is clearly glad to see her and shows her a picture he has drawn. Sally strokes his brown hair and touches his cheek as she pauses from walking. The lady who brought the boy is also an older adult and looks tired and annoyed. Sally looks nervously at Janet, and shakes her head at the woman. Janet approaches a bit closer and hears Sally state, “Not now! We can talk later. You know I appreciate all you’re doing.”

Janet stops beside Sally and asks, “Everything okay?” Sally looks down and then at the other woman, who excuses herself and leaves. Joshua says, “Look, Grandmamma, look what I drew!”

Sally blinks and smiles, and then turns to Janet. Hanging onto the bar on the wall, Sally confides that she is taking care of the boy, her grandson, and has all his life. Her friend is helping with the child until she goes home. They arrive back at Sally’s room, and Janet watches as the boy goes to Sally’s lunch tray and eats the food that Sally has saved for him. Janet begins to stop him, but realizes the boy is very hungry.

Janet nods reassuringly, and knows Sally’s recovery may be jeopardized without support and solid discharge planning. Janet realizes Sally is a kinship parent and extremely vulnerable for several reasons. While Sally finishes her physical therapy, Janet calls social services to discuss Sally’s discharge plans. She informs the case manager of what she has learned and arranges for Sally to have a care conference, which will include taking care of an active child.

Two days later, during the case conference, with Sally present, the team discusses discharge plans. Based on Sally’s income, the case manager feels that Sally is entitled to Temporary Assistance for Needy Families (TANF). In Sally’s state of residence, it is possible for DCS to allow physical and legal custody of Joshua without formal foster parenting; however, additional resources would be available if Sally became Joshua’s foster parent. The facility social worker has corresponded with the DCS caseworker, and they are arranging a meeting to discuss steps for Sally to become Joshua’s guardian and foster mother, which would open up needed resources for the family.
Follow-Up
Janet works under a collaboration agreement with a physician and sees Sally the following week in the outpatient setting. Sally is overwhelmed by the paperwork that is required to become a foster parent, but she is slowly working through it. Janet assesses Sally’s weight and notices that she has gained 2 pounds; lab work is normal with slightly elevated levels of cortisol. Janet is concerned as elevated cortisol is common following surgery, but she also knows that Sally is under significant stress as a result of taking care of an active younger child. Janet knows that the cortisol may be eating away at muscle-building protein and making her rehabilitation/mobility that much more difficult. She also knows the loss of protein means poor wound healing.

Janet discusses this finding with Sally and educates her on how to take care of herself first so that she can better meet Joshua’s needs. She encourages low-resource stress relievers such as going to the library or keeping a journal; she alerts Sally to low-cost activities that she can enjoy with Joshua in the community that will also increase her mobility. Last, Janet assesses whether Sally will need a social service consult to complete the foster care paperwork so that she can obtain the resources she needs for her and Joshua.

CASE STUDY 2: SAMUEL
Samuel, or Sam, is a 56-year-old divorced man who has assumed the role of caring for his oldest daughter’s children. His daughter is a single parent who has been on military deployment for several months. Sam has struggled with obesity his entire life and now feels compelled to change his habits to a healthier lifestyle. The two little boys, ages 4 and 5 years, are often more than he can handle. He has caught himself being winded after playing catch with them in the backyard, but he has been eating more for quick spurts of energy. The laundry, grocery shopping, driving the kids to sports, and being a single parent are overwhelming. He has added stress at work because of feeling pressured to leave in time to pick up the boys from day care before it closes.
Working at a desk job in data management only increases his inactivity. As a result, his blood glucose levels at home range between 212 mg/dL in the morning before breakfast and 335 mg/dL after eating. He is on antihypertensive and cardiac medications for his history of congestive heart failure, but often forgets to take his medicine. He also has a history of hyperlipidemia. He has been taking Lisinopril 10 mg daily, metformin 1,000 mg twice daily, metoprolol XL 50 mg daily, and atorvastatin 20 mg daily. He is being seen for his follow-up appointment with his primary care A-GPN, Elaine.

Samuel arrives at his scheduled appointment and is concerned when his intake weight is 250 pounds, 15 pounds more than 6 months ago. His blood pressure reading is 178/94, heart rate is 78, and his oxygen saturation rate is 94%. He feels stressed and is not sleeping well.

**APN Next Steps**

The A-GPN, Elaine, reviews the labs (hemoglobin A1c, fasting lipids, comprehensive metabolic panel, and microalbumin) she ordered to be drawn before today’s visit. They are normal or only slightly out of the acceptable range with the exception of his hemoglobin A1c level, which is 9.2. Elaine can sense that Sam is very stressed when she enters the room. He looks fatigued, and he is only able to offer a weak smile. Elaine sits down and asks, “Tell me how you’re feeling.”

Sam relates how he is overeating for energy, but then has rebound low energy in the afternoon. Elaine listens and offers congruent nonverbal signals to communicate that she is listening and attentive. “Sam, I noticed your weight was up a bit,” Elaine stated.

“I know! It is just I’m a single parent now, and I was never that great of a cook so we eat fast food—a lot. Now, it’s all I can do to get the boys to after-school stuff and then, there’s homework.” His words spill out, even in tone, but defensive.

Elaine understands that Sam is on overload, needs to breathe and take a moment to compose himself. Because Sam is in the day-to-day grind of being a single parent at the age of 56, and holding down a full-time job, she knows her best strategy is to help him find his own motivation and perspective. She reassures Sam that she is not there to chastise him in any way, and that her role is to support him in achieving health and balance in his life. She then uses motivational interviewing (Miller & Rollnick, 2004) techniques to try to
help Sam find answers for himself. Her goal is to have Sam find his own motivation for change and commit to it. She uses the Socratic method so that Sam can avoid resisting changes that she may want him to make, and instead arrive at those changes through his own discovery and motivation (Miller & Rollnick, 2004).

At the end of the discussion, Sam agrees to preplan meals on Sundays and reduce eating fast foods to twice a week. He smiles as he realizes that the situation will last only until his daughter is finished with her assignment, another 6 months. He admits that there is a group of colleagues who try to walk during their lunch hours, and he has been invited to join them. His boss has offered him a standing desk so that he would not be sitting all day. He also agrees to speak to the clinic dietitian and look for ways to eat healthier alternatives. Elaine interjects that buying a water bottle with measures on the side will allow him to measure his fluid intake.

She discusses the management plan with him: increase Lisinopril to 20 mg daily, continue metformin and other medications as ordered. There will be a new medication, glyburide 2.5 mg, to be taken with breakfast; and last, she discusses the use of a selective serotonin reuptake inhibitor (SSRI) to assist in managing his stress. Elaine also instructs him on taking serial blood pressure readings at home, and emphasizes the need for him to exercise as much as possible, ideally, 20 minutes of exercise five times per week. She would like him to bring the food, exercise, blood pressure, and blood glucose logs to his next visit. Sam seems to take it all in and appears less anxious than when he arrived. Elaine asks him to return in 3 weeks for a follow-up.

Case Study 3: Nancy

Nancy is a 61-year-old African American woman who has “inherited” a kinship arrangement from her second husband. The birth mother, Kandi, is in and out of the household, sometimes sleeping in their spare bedroom, sometimes out all night. Nancy’s husband has been laid off, and she has been working extra hours at the retail store where she works. She takes her 4-year old granddaughter, Maxeene, to a health center clinic that distributes the Women, Infants and Children
(WIC) program cards that she can use at the grocery store. Nancy is also receiving TANF, which has qualified her to receive WIC services. The WIC nurse asks how Nancy has been getting along, and she confides in her that she has been having difficulty sleeping, and during the day, feeling very “panicky.” She has also had a flare-up of her rheumatoid arthritis. The nurse makes a referral to the community mental health center for Nancy to see a psychiatric-mental health nurse practitioner (PMHNP).

Three weeks later, Nancy is evaluated by the PMHNP, Pam, who takes a full history from Nancy. Pam determines that Nancy’s own upbringing was fairly chaotic, with a single parent, whose own extended family was in and out of the home, including several male figures. Nancy’s panic attacks have escalated since she took in her granddaughter. Nancy begins crying as she relates that she is aware that Maxeene has been sexually and physically abused. She was present when the caseworker interviewed Maxeene, who explained her drawings of the abuse. Nancy denies that such trauma is in her history, but shares how difficult it is to know that this “little innocent soul” has experienced so much. She relates how she wishes she could help Maxeene more, but does not know how.

Nancy is hypervigilant about Maxeene, rarely letting her out of her sight. When Kandi is in the house, Nancy ensures that Maxeene is never alone with her or anyone Kandi has brought home. She obsesses about Maxeene while she is at work and makes her husband promise to “watch over her—don’t take your eyes off her for a minute.” The panic attacks have increased in the past few weeks with shortness of breath, agitation, and a feeling of terror.

**APN Next Steps**

Pam diagnoses Nancy with panic disorder (American Psychiatric Association, 2013). She explains to Nancy how caring for Maxeene has triggered some thoughts from her past and, furthermore, created secondary trauma from learning about the abuse that Maxeene has experienced. She supports Nancy as a caring and empathic grandmother who deeply wants a safe environment for Maxeene with no further abuse. Pam and Nancy begin cognitive behavioral therapy (CBT) in a partnership. The goal is to decrease Nancy’s symptoms of panic disorder through challenging her patterns of catastrophizing.
and by practicing grounding behaviors. She is dosed with an SSRI by Pam to assist in decreasing her panic attacks and is also provided with education about its use. They also work on issues such as relationship satisfaction and feeling safe.

Maxeene is referred to a child therapist with training and experience in working with children who have survived sexual abuse. This therapist includes play therapy and provides education to Nancy and her husband at the end of the child’s appointment. She also works with Nancy to set boundaries and obtain legal guardianship.

Three months later, Nancy reports a decrease in her feelings of panic. She now has insight into how her past influenced her ability to parent Maxeene effectively. Her goals are being achieved with the use of therapy and psychopharmacological interventions. Nancy and her husband are able to have “date nights” with a trusted babysitter, Nancy’s friend. Nancy and her friend have a barter system arranged and exchange doing “favors” with one another (e.g., cooking meals, babysitting, rides to appointments). Both Nancy and Maxeene continue with their treatment plans and continue to see gains in their health status.

Case Study 4: Margaret

Margaret is a 70-year-old great-grandmother to her 13-year-old kinship child, Lisa. Margaret is a widow to Ralph, who passed away 2 years ago, about the same time that Lisa came to live with her. Together they live in a rural county and seek health care primarily when a condition has advanced to the point they can no longer manage it. They consider folks who do not live in the county outsiders who will need to earn the trust of people who have resided in the area, often for generations. Margaret has a secret: Lisa punches her with her fists when Lisa becomes agitated, especially in the evenings at bedtime. Margaret is a petite woman who barely reaches 110 pounds, whereas Lisa is a “big-boned” child and already weighs 130 pounds. Lisa also plays soccer at the local middle school and is the team captain. Before coming to live with Margaret, Lisa witnessed significant domestic violence between her parents who are in jail for charges related to
drug use and dealing. Past traumatic events also include seeing her parents handcuffed in front of her when she was only 8 years old.

Lisa loves Margaret and is good to her most of the time. However, Lisa cannot control her anger and has been physically abusive for 2 years. In Lisa’s tirades, she blames Margaret for the loss of her parents, “If you had been a better parent the first time, my parents wouldn’t have turned to drugs.” Margaret tries to defend herself, but has become increasingly depressed, with marked weight loss and neglect of personal appearance and hygiene.

Lisa is careful to only punch Margaret in the back and abdomen, so the bruises do not show. Margaret has withdrawn from church and other social activities as Lisa’s aggression has grown. After one particularly violent exchange, Margaret wakes up one morning unable to move her left arm. Significant swelling above her elbow, where Lisa yanked her the previous evening, is also evident.

After she hears Lisa leave for school, Margaret reluctantly drives herself to the city about 30 miles away to the emergency department. She completes the intake form as best she can, stating that her arm was injured because she fell down the basement stairs and caught herself on the railing, which injured her arm. She is nervous and in significant pain. She has not eaten since last night, and only had a few bites as she is struggling to keep enough food in the house for both her and Lisa. Finally, Margaret is told she will be seen and is escorted to a patient room.

She sits on a bed, not wanting to disrobe for fear that the new and healing bruising on her torso will be revealed. After a few minutes, a medical technician comes in to take her blood pressure, temperature, pulse rate, and oxygen saturation level through a finger pulse oximeter. She also asks Margaret for a brief history of the injury, and she conveys her story about almost falling down the basement stairs.

The technician leaves, and after a few minutes, Margaret sees a woman, about 30 years of age, enter the room. She introduces herself as Jean, an emergency department nurse practitioner (ENP) who will be assessing her.

**APN Next Steps**

Jean notes Margaret’s nervous affect and how she is hugging her torso with her right arm. The left arm has been immobilized with
an old towel. She sees a disheveled older adult whose vital signs are stable with the exception of a lower oxygen saturation of 92%. Jean knows this could be due to shallow breathing resulting from pain, and performs a pain assessment. She asks Margaret to give her a number, between 1 and 10 (the Numeric Rating Scale) of any pain she is currently experiencing. Jean also asks what her normal level of comfort is. Margaret hesitates, but the pain is increasing, and rates her arm pain at 9 out of 10.

Jean gently removes the towel from around the right arm and notes swelling in the proximal area of the humerus near the shoulder. Jean checks for peripheral pulses and sensation of feeling in the affected extremity. In consultation with her collaborating physician, she orders an x-ray of the arm and includes anterior/posterior, transscapular, and axillary views. This will determine whether there is a proximal humeral fracture, fairly common in women, especially those with osteoporosis, and any displacement of the bone. But there is something bothering Jean about Margaret, and her story of catching herself before she fell.

Although Jean does not want to move Margaret unnecessarily, she feels that the assessment is not complete. Wanting to ensure that respiratory status is not compromised, she tells Margaret that she would like to listen to her lungs before they take her to x-ray. Margaret bites her lip and nods. As Jean lifts Margaret’s shirt in the back, she notes significant contusions in various stages of resolution with colors, including yellow-brown, and blue-green bruising of the skin.

Jean listens to Margaret’s lungs and instructs her to take deep breaths, which she is unable to do because of pain. Jean gently replaces Margaret’s shirt and sits beside her. Jean knows that establishing trust and rapport is critical to understanding what the patient has experienced. If she comes on too strong, and begins an “interrogation”-type interview, Margaret is likely to shut down.

Jean states, “I used to live in the country. I really enjoyed the beauty of nature and the seasons.”

“Yes. We really like it.” Margaret does not make eye contact.

“I read on your intake that you have a 13-year-old granddaughter who lives with you.”

“Yes. She’s a good girl.”
Jean uses silence for a few seconds. “Margaret, let’s review how you hurt your arm.” For the next few minutes, Jean collects information about the current injury. She finally states, “I see. But I also noticed there are several areas on your back that have been injured.”

Margaret looks down, but does not respond.

Jean relaxes her posture, but leans slightly forward. “I’m concerned about you and these injuries. This must be hard to hear, but if someone is hurting you, you can tell me. I know this is hard to talk about.”

Margaret finally looks at Jean and in a whisper says, “It’s my granddaughter, Lisa. I’m afraid of her. She hits me with her fists and it hurts. Sometimes, it really hurts. She’s been through so much, though, you know. With her parents. Sometimes, she blames me.” Tears roll down Margaret’s cheeks; she continues to look at Jean for her reactions.

“It must have been hard for you to tell me this. I want you to know that it’s brave to be able to talk about this.” Jean discusses the interactions between Margaret and Lisa and collects more information. She realizes that the family is in crisis in several areas: social, financial, emotional, and physical. She watches Margaret as she leaves for radiology, and discusses what she has uncovered with the collaborating physician. They file a report with Adult Protective Services and offer information pertaining to Margaret’s case. X-rays reveal that Margaret’s fracture will be treated without surgery, and the limb is immobilized. Margaret refuses other services before leaving the emergency department.

Caseworkers investigate the report by sending a social worker to the home within 24 hours to determine Margaret’s safety and

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<th>TABLE 6.2</th>
<th><em>Kinship Parents: What to Look for and What to Do</em></th>
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<td><strong>Kinship Parents</strong></td>
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<tr>
<td><strong>What to Look for (Assessment):</strong></td>
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<tr>
<td>□ Assess for safety issues within the family, including signs and symptoms of both child and elder abuse, and report this information.</td>
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<td>□ Assess for caregiver burden and older adult depressive symptoms using validated screening tools.</td>
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<tr>
<td>□ Monitor for signs of psychological distress, including compassion fatigue, depression, and chronic stress.</td>
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</tr>
<tr>
<td>□ Monitor for signs and symptoms of chronic disease exacerbations, which may be related to mental health issues (e.g., depression, stress, or caregiver burden).</td>
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(continued)
well-being. She then arranges for Margaret to receive much needed services, including TANF, relative caregiver state subsidies, family counseling, and individual counseling for both Margaret and Lisa. Safety follow-up for Margaret will be a priority.

**APNs’ CARE OF KINSHIP PARENTS**

Kinship parents differ in significant ways from traditional foster care parents, and present with both challenges and strengths. Unique to kinship providers are the chronic illnesses that require the APN to monitor and manage. These may be adversely affected by caregiver burden, depressive symptoms, parental stress, and compassion fatigue. APNs will need to be sensitive to those kinship caregivers who remain “off the grid” from government systems, such as child welfare agencies, and will need to refer to much needed resources. Research supports that these parents need services, but often access fewer than traditional foster parents. Thus, the skilled APN will need to persuade, motivate, and negotiate so that the kinship family receives the needed financial and social supports (Table 6.2).

### CHAPTER HIGHLIGHTS

- In general, kinship parents are an at-risk population with their own health care needs, limited financial resources, and preoccupation with caring for children who have often experienced maltreatment.
- Kinship families may be categorized by types, with the largest class, “empty-nest grandparents,” most likely to experience health problems.
Caregiving grandmothers often experience depression, stress, and interfamily strain.

Kinship parents may experience compassion fatigue, acute stress disorder, secondary trauma, or posttraumatic stress disorder associated with caring for their children.

Benefits to the children in kinship care versus traditional foster care are well documented and include: behavior, development, mental health functioning, and placement stability.

Elder abuse is growing and includes both abuse and neglect; kinship caregivers may be at risk for maltreatment from both adult children and the children under their care.

Questions for Reflection

Following are a few questions to reflect upon. You can use these to start a journal for yourself or in a classroom discussion with peers and the instructor.

1. Have you or has someone you know acted as a kinship parent? What were the needs of the kinship caregiver? How could an APN contribute to positive outcomes?

2. What stigma do you associate with kinship parenting? What constitutes a “good parent”? Where does parent culpability lie in offspring who abuse alcohol and illegal substances?

3. What policies/legislation should the United States consider to promote the well-being of kinship parents?

4. How can resources reach kinship providers who prefer to remain “off the grid,” with no contact with the Department of Child Services/Child Welfare?

5. Have you rendered care to an older adult who may have been the victim of elder abuse? How did you handle the situation? To whom did you report the abuse?

6. What case study spoke to you the most? Why? What personal and professional feelings were evoked within you?

References


