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Transitions of Adoptive Parents: A Longitudinal Mixed Methods Analysis

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Abstract

As adoptive parents create a new family, they face myriad changes both pre-and post-placement of their child. The aim of this study was to describe parent perceptions and depressive symptoms during this transition via reports collected with an online survey. Using content analysis, we analyzed a total of 110 responses from 64 parents at three time points: 4–6 weeks pre-placement, and 4–6 weeks and 5–6 months post-placement. Five main themes were revealed: Transition from uncertainty to a new normal; unique experiences related to adoption; rest/fatigue: out of balance; life stressors; and faith/spirituality. Two subthemes were also identified: previous losses (pre-placement) and joy and love (post-placement). During the transition from pre-to post-placement, adoptive parents experience a unique passage, with both challenges and strengths exclusive to this group of parents. While acknowledging the commonalities of some parenting experiences, healthcare and adoption professionals should recognize the unique dynamics that adoption brings to families.

Keywords

parenting; depression; content analysis; healthcare screening

Introduction

The transition to parenthood is a time of upheaval physically, psychosocially, emotionally, and financially. Having a new child is an inherent transitional experience for all parents, but there are unique circumstances for adoptive parents (McKay & Ross, 2010). Adoptive parents not only have to adapt to the presence of a new child, but they may also have to travel, endure legal battles, invest significant amounts of money, face the possibility that their child may not be relinquished, and potentially encounter stigma regarding adoption (Levy-Shiff, Goldshmidt, & Har-Even, 1991; Foli, South, Lim, & Hebdon, 2012a; Foli, South, Lim, & Hebdon, 2012b; Vandivere, Malm, & Radel, 2009). Adoptive parents may also have experienced previous infertility issues and grieve the loss of a hoped for biological child (Tasker & Wood, 2016). There is also overlap with the stressors that any parent faces: role changes, increased levels of stress, lack of sleep, and even alterations in their intimate partner relationships (Foli et al., 2012a; Foli et al., 2012b). Hence, it is crucial that informed assessments and interventions occur in this unique parent group; to date, however, there have been few studies that attempt to understand adoptive parents' experiences and perceptions across time. To provide parental perspective throughout the adoption process, the purpose of the current study is to assess the transition of adoptive parents from pre-placement to post-placement, using both qualitative and quantitative longitudinal data.

The current study examines the transition to parenthood for adoptive parents, both mothers and fathers from weeks prior to the child's placement to immediately after, as well as six months following placement. Parents contributed comments in response to a grand tour question soliciting general perceptions of adoptive parenting. These comments were paired with assessments of depressive symptoms at each time point. Approaching the data in a temporal manner–from prior to and after child placement–the transition to adoptive parenthood can be holistically and temporally explored.

Challenges of Adoptive Parenting

The process of adopting a child can be unpredictable. Some adoptive parents have described the experience of having to become parents without major pregnancy or developmental milestones, especially for those parents adopting older children (Fontenot, 2007). In contrast to three trimesters of pregnancy, adoptive parents endure months, sometimes years, working through the adoption process, which may facilitate or inhibit growth into their role as parents. The addition of a possible special needs child, including an older child, to the family causes prospective parents to wonder what the next step will bring (Fontenot, 2007; Vandivere et al., 2009). Adoptive parents may have to navigate school systems with older children and the medical system with children who have significant physical or developmental health issues (Foli, 2017). Adoptive parents may also put greater pressure on themselves to be perfect parents (McKay & Ross, 2010). This pressure can be both internal and external, with adoptive parents describing the expectations from friends and family that they are blessed and lucky to be parents (McKay & Ross, 2010). Fear of having their child taken as well as an internal expectation for perfection due to the long wait for parenthood may be other factors contributing to the pressure to be exceptional parents (Fontenot, 2007; McKay & Ross, 2010).

Adoptive parents may be parenting sibling groups rather than just one child, which results in potential challenges with pre-existing family dynamics (Tasker & Wood, 2016). Families are faced with creating a new family script, reconciling new and old family relationships (Fontenot, 2007; Tasker & Wood, 2016). For those adopting internationally, there may be challenges related to caring for children and adolescents who have been institutionalized (Gunnar, Bruce, & Grotevant, 2000; Loman, Johnson, Quevedo, Lafavor, & Gunnar, 2014; Stellern, Esposito, Mliner, Pears, & Gunnar, 2014; Wiik et al., 2011). Domestic adoptions, such as foster care to adoption cases, may involve children who have experienced neglect and past trauma (Child Welfare Information Gateway, 2013). Adopted children may present with special health care needs that may or may not have been disclosed prior to adoption (Foli, South, & Lim, 2012; McKlindon, Welti, Vandivere, & Malm, 2011), leaving the parents scrambling to cope and care for the child after placement.

The financial ramifications of adoption may be significant for some adoptive parents, depending on the type of adoption. When adopting from a public agency, adoption can cost up to $2,500, while agency, independent, and intercountry adoptions can cost up to $30,000-$40,000 (Child Welfare Information Gateway, 2011). There are universal adoption expenses such as home study and court costs, and there are unexpected expenses related to the care of a child with special needs. The addition of adoption-related expenses to the existing expense of caring for a child can be daunting for some parents (Child Welfare Information Gateway, 2011).

Adoptive parents may experience strain on their marital relationship from the stressors of the peri-adoption period. Relationship quality and risk for dissolution has been studied in both heterosexual and homosexual couples (Goldberg & Garcia, 2015; Goldberg, Smith, & Kashy, 2010; Hock & Mooradian, 2012). Goldberg and Garcia (2015) found no difference in the odds of relationship dissolution between heterosexual and homosexual couples. Predictive factors for relationship dissolution in this study included interpersonal processes such as relationship maintenance activities, adoption related processes, such as adoption preparedness, and child factors, such as child age (older child age increased risk of dissolution) (Goldberg & Garcia, 2015). In another study, Goldberg and colleagues (2010) found similar rates of relationship decline between homosexual and heterosexual couples, with relationship maintenance again being an important factor in relationship quality. Relationship factors have also been implicated in co-parenting quality for adoptive couples (Hock & Mooradian, 2012).

Parental Post-adoption Depression

Researchers have long recognized the impact of the transition point from non-parent to parent for biological parents, and many researchers and organizations, including the American Congress of Obstetricians and Gynecologists, recommend screening for postpartum depression (Smith, Gopalan, Glance, & Azzam, 2016). Measures to support biological parents, especially those experiencing peripartum depression, have been instituted through public and private institutions (e.g., Postpartum Support International, n. d.). However, these parenting support mechanisms may not be relevant to adoptive parents (e.g. breastfeeding classes) (Postpartum Support International, n. d.; Postpartum Progress, n. d.;

Virginia Hospital Center, 2016). In addition, health care providers and school teachers often do not understand the specific issues that adoptive parents and their children face; therefore, adequate support may not be offered to these families (McKay & Ross, 2011). Part of this may be due to the lack of literature addressing parental demands and mechanisms to support parents during the postadoption period (McKay, Ross, & Goldberg, 2010). Adoption professionals, while recognizing this difficult transition, may not be empowered within the adoption system to render social support for families after placement of the child (McKay & Ross, 2011).

Because of the challenges adoptive parents face, they are vulnerable to depression just as biologic parents are vulnerable to depression. Mott and colleagues (2011) found similar levels of anxiety or depressive symptoms in biological (n=147) and adoptive mothers (n=147). As measured by the Edinburgh Postnatal Depression Scale (EPDS), 7.5% of birth mothers compared with 8.8% of adoptive mothers screened positive for depressive symptoms (Mott et al., 2011). Adoptive fathers also experience depression, with one study demonstrating rates of depressive symptoms at 24% as measured by the Centers for Epidemiologic Studies Depression Scale (CES-D) and 11% as measured by the EPDS (Foli et al., 2012a). Both adoptive and biological parents experience issues such as lack of sleep, infant fussiness, and behavioral problems in children that are linked to depression in the literature (McKay et al., 2010). More specifically, research has identified factors associated with depressive symptoms in adoptive parents including: pre-adoption emotional stability, partner relationship, age of the child, social support, history of infertility, how much the parent is bothered by the infertility, sleep deprivation, and parental expectations of the adopted child and themselves (Foli et al., 2012a; Foli et al., 2012b; Levy-Shiff et al., 1991; Mott et al., 2011).

Transition to Adoptive Parenting

Despite the challenges and potential vulnerabilities during the adoption transition period, adoptive parents have inherent strengths. Adoptive parents are generally older, more established in their careers, and have a longer lasting intimate relationship (Levy-Shiff et al., 1991). Additionally, they are often more well educated and in a higher socioeconomic class (Jones, 2009; Vandivere et al., 2009). They may have weathered the obstacles of infertility and the pre-adoption process, possibly developing resiliency that allows them to cope with the adoption process. Adoptive parents have also made the conscious choice to parent, have waited and sacrificed for parenthood, and have possibly experienced infertility, miscarriage, and even failed placements prior to adoption (Levy-Shiff et al., 1991; Vandivere et al., 2009). In a study comparing prospective adoptive parents versus prospective nonadoptive parents, researchers found that the adoptive parent group had more positive perceptions of their own parents, lower anxiety and avoidance regarding relationships, and higher levels of marital adjustment compared to the nonadoptive parent group (Calvo, Palmieri, Codamo, Scampoli, & Bianco, 2015).

Awareness is growing regarding the challenges that adoptive parents face, but there continue to be gaps in research regarding the transition process for adoptive parents from preplacement to post-placement. Fully understanding this transition process is vital in the

appropriate development of resources for parents and their children (McKay & Ross, 2010). For example, in a study addressing relationship quality across the adoption transition, there was evidence suggesting that relationship quality declined over time and was related to avoidant or confrontational relationship coping mechanisms, existing depression, and maintenance of relationship (Goldberg, Smith, & Kashy, 2010). This demonstrates the need for relationship and family support for adoptive families to address depressive symptoms, partner relationships, and coping. Families at risk, whether they are biological or adoptive, deserve and require empathetic support services during times of acute stress.

Method

Study Design and Participant Recruitment

The current study was part of a larger investigation that focused on classes of adoptive parents' trajectories of depressive symptoms across time (see Foli South, Lim, & Hebdon, 2016a; Foli, South, Lim, & Jarnecke, 2016b). The majority of the parents who participated in the current study were clients of the largest adoption agency in the United States. Recruitment methods included electronic and hard copy recruitment flyers, adoption agency advertisements in the client magazine, and a webinar on emotional health provided by one of the content expert investigators. Interested participants contacted study personnel to enroll in the study. After obtaining information about the study, participants were directed to an online survey collection site where informed consent was obtained electronically; without giving their consent, individuals were unable to proceed with the survey.

Inclusion criteria for participants were: access to the internet; be at least 21 years of age; have the ability to speak, read, and understand English; and anticipate placement of the child within approximately 4–6 weeks after completion of pre-adoptive questionnaires. If an anticipated child was not placed, then the survey respondents' returns were not included in the subsequent analyses. For the current analysis, parents needed to provide comments and answer CES-D questions for at least one of the three time points in the study. Data were collected between February 2013 and December 2014 at three time points: 4–6 weeks pre-placement (T1), 4–6 weeks post-placement (T2), and 5–6 months post-placement (T3). As an incentive, each parent received a $20 gift card for survey completion at each time point. This study was approved by the institutional review boards at Purdue University and the University of Hawaii.

Demographics and Single-Item Measures—Demographic items included parent gender (male, female, other [transgendered or intersexual], declined to answer), child gender (male, female), parent (year born) and child age (months), parent and child race/ethnicity (Caucasian or White American; African/Black American, Native American, Hispanic American, Asian American/Pacific Islander, Bi-racial or Multi-racial; and Other), income (Less than $25,000; $25,000 to under $35,00; $35,000 to under $50,000; $50,000 to under $75,000; $75,000 to under $100,000; and More than $100,000), education (Less than or a high school diploma/GED; High school plus vocational/technical training; High school plus some college; Four-year college graduate; and Post-graduate degree), job status (full- or part-time), history of infertility ("I have received infertility treatments; Yes, No, Declined to

answer), how much the participant was bothered by infertility ("It bothers me that I can't have a birth child"; rated 1–5; 1=strongly disagree, 5=strongly agree), religion, level of religiosity (rated 1–7; 1=not at all, 7=very strongly religious), number of adopted children, the type of adoption (public, private, and inter-country), and whether the parent considered the child to have special needs (see Table 1; select categories have been collapsed for presentation of findings). As definitions of special needs vary between states, especially in terms of eligibility for adoption subsidies, we asked parents whether they considered their child to have special needs. If yes, they were then asked whether the special need was physical (including cleft palate), emotional/psychological, developmental/cognitive, or other. A history of mental illness and partner's history of mental illness were also assessed; however, due to item wording being unclear to respondents, these variables were not included in our analysis. Parental demographic items were collected at T1 for the majority of the sample. Child characteristics were collected at T2. Information about heterosexual/homosexual couples was obtained as participants completed the questionnaires. This information was volunteered via email correspondences to the research team as partners were asked to complete surveys. For this study, two participants identified themselves as a same-gender couple.

Open-ended Question—For the original study, we posed a grand tour question to collect qualitative data in order to augment the quantitative longitudinal data: "Please use the space below to include any additional information–any experiences you would like to share with us or anything else that you might not have been asked about that you would like to add." This question was posed at each of the three time points. All responses to this question were included in data analysis, even if a parent provided comments for more than one time point.

Center for Epidemiological Studies Depression Scale (CES–D)—Depressive symptoms were measured by the CES-D, a short, self-report scale designed to measure symptoms of depression in the general population (Radloff, 1977). Twenty items are rated on a 4-point scale (0–3), and scores range from 0 to 60. A cut off of ≥16 was used to determine a positive depressive symptom screen. CES-D scores were collected at each time point. For this sample (n=64), Cronbach's alphas for were 0.90 at T1, 0.92 at T2, and 0.91 at T3.

Analysis

As previously described, data were collected via an online survey; therefore qualitative comments were entered by the participant and ready for analysis. Content analysis of the qualitative comments was performed using the inductive approach (specific to general) described by Elo and Kyngäs (2008) for thematic analysis (DeSantis & Ugarriza, 2000). Using induction, we extrapolated meanings and contexts from parent perspectives of the adoption transition. An inductive approach works well when there is limited or fragmented prior knowledge of a phenomenon (Elo & Kyngas, 2008). Three phases were used in the analysis: preparing, organizing, and reporting (Elo and Kyngäs, 2008). Preparing involves selection of a unit for analysis such as a word or theme, and themes were selected as the unit of analysis for this study. The context of the analysis was parental transitions across time, from the adoption process to integrating a new child or children into the family. Organizing

occurred through open coding, assignment of categories, and data abstraction (Elo & Kyngas, 2008). Embedded within the grand tour question posed was the sub-text of how responses would become distinctive over time, as the individual parent transitioned with the addition of a new family member. The final stage of analysis, reporting, occurred through confirmation of major and minor theme categories (Elo & Kyngas, 2008).

In order to maximize trustworthiness of findings, collection of data across time, multiple coders of the data, and descriptive findings were emphasized (Elo et al., 2014). Two researchers reviewed the data with an initial reading for comprehension and familiarization of the data. A second reading involved coding and interpretation of the data into meaning units, and a third reading allowed for extrapolation of the data into major and minor themes. Both investigators who were involved in the descriptive content analysis had extensive previous knowledge of the dynamics of adoptive parenting (e.g., Foli et al., 2012a; 2012b; Foli, South, Lim, & Hebdon, 2016a). After independent coding was achieved, the investigators met several times to discuss themes/findings. At each level of analysis, if there were discrepancies between researchers regarding themes, the data were reviewed and discussed until concordance was reached.

In addition, to understand the parent and child characteristics for those who filled out the open-ended question for at least one time point, quantitative analyses were conducted using chi-square tests or Fisher's exact tests for categorical variables and two sample t-tests for continuous variables. P-value <0.05 was considered statistically significant.

Results

A total of 64 individuals, out of the primary sample of 129 parents, offered comments (i.e., qualitative data) at either T1, T2, and/or T3. Table 1 displays demographic characteristics of the parents included in the current analyses and their adopted children, as reported by the participants. Of the sample of 64, 41 parents provided data at T1, 37 at T2 and 32 at T3. Most of the sample (92%) were Caucasian or white, approximately 51 (80%) were enrolled through a single large adoption agency and 32% reported incomes of greater than $100,000 per year or 41% had completed education past a four-year degree. Below half, 44%, of the children were categorized by their parents as having special needs and 51% of the children were through inter-country adoptions. The child's characteristics used were, in general, reported by the mother at Time 2. The mean CES-D score was the highest at T1 (mean=8.4).

As not all of the primary study sample responded with comments, we compared demographic variables and CES-D scores between the individuals contributing and not contributing qualitative data (see Table 2). Significant associations were noted in four areas: gender (i.e., proportionately more females supplied responses than did males), job status (more parents who had a part time job responded), infertility (more parents who did not have infertility issues responded) and depressive symptoms at T1. Using CES-D scores as continuous variables, participants in the current analyses were more likely to experience depressive symptoms at each time point. However, when the CES-D was used as a categorical variable (≥ 16), the significant association between contributors and non-contributors was found only at T1.

Themes Across Time

Five overall themes emerged from the adoptive parents' responses that reflect the temporal nature of the transition and demonstrated patterns across time (see Table 3). These qualitative patterns will be augmented with quantitative data such as the parental age, child age, and CES-D scores. With the exception of the theme, "Life Stressors," the patterns appear to be either unique to adoptive parents or characteristic of the experiences of adoptive parents.

Theme 1: Transition from Uncertainty to New Normal—The first theme was the focus on the adoption/placement transition itself: Uncertainty (T1); Happy It's Over/ Transitioning/ Moving Forward with a New Normal (T2); and Life Is Good!/Settling into the New Normal (T3). Many parents reflected upon the uncertainty of the process and the stress of how the process unfolds over time. In certain adoption cases, such as foster care or intercountry adoptions, the prospective parents may meet the child during the adoption process. This was the case with a 47-year-old parent who reflected on the impact of meeting her son, who was approximately 2.5 years old. Prior to placement, this individual, whose CES-D scores at T1, T2, and T3, were: 3, 7, and 2, respectively, wrote:

> The situations which have caused me the most anxiety during the process and currently are: the delays and uncertainty of the process, worrying about being a good parent. I also felt frustrated at certain points. This was especially true after I met my son. It seemed that the process slowed down for me after that and since he had become very real to me during our time together I really wanted the process to speed up! Not slow down!

The process itself is a source of uncertainty, a lack of control about what will happen next during an intense and important time. A 44-year-old adoptive mother of a 13-year-old child, who scored above the depressive screening threshold at two times points (T1=16, T2=4, T3=29), attributed her depression to the adoption process: "Over all I think I am a positive and optimistic person. It is just this adoption process that has me down at times."

In contrast, immediately after placement (T2), parents reported significant relief that the process had been completed. One 29-year-old mother, who did not experience depressive symptoms, (T1=3, T2=4, T3=4), still commented on how difficult the process was (child's age=22 months):

> You should look into pre-adoption depression! The wait for a referral, to travel, to complete the court process, the multiple unknowns were SO SO hard! Now that our daughter is home, I am so happy and relieved this whole process is over!

The beginning of a new normal, which began at the second time point, was described by several parents. Echoed in the comments are subtexts of efforts to ensure their children's transition. One mother, whose CES-D scores escalated across time (T1=0, T2=4, T3=15), stated:

> We have had our children home for one month. We've experienced a lot of challenges, but overall, we feel the children are getting settled in. The girls are happily attending school, the kids are eating well, and bed time is improving. We

> feel our family is finally finding our new normal. :) (parent age=45 years; children's ages=11, 8, and 5 years). Other elements of new adoptive parenting are mentioned immediately after placement (at T2), including a range of emotions such as "We love being new parents" (CES-D=0 at T2; parent age=43 years; child age=1.75 months) to "Things are slowly improving." (CES-D=15 at T2; parent age=40 years; child age=15 months) to "Adoption has been the most challenging thing I've ever done…This is so tough!" (CES-D=24 at T2; parent age=35 years; children's ages=6.5 and 4.5 years).

By 5 to 6 months post-placement (T3), parents describe being energized and relieved to be living in that new normal: "I feel soooooooo much better at this stage in my life than the last time I took this survey. I'm encouraged!" (CES-D=1 at T3). Sacrifice for the children's benefit, including giving up employment and taking vacation to support bonding was noted. One father, who struggled with depressive symptoms at all three time points (CES-D: T1=32, T2=22, T3=25), stated:

> The finalization of the adoption for our boys took place about six months ago. They are doing well, and this is likely due in part to the immense investment we have made in them. My wife quit a very lucrative job to care for them, and we have resisted life directions which would would have improved our short-term prospects at the expense of the boys. (parent age=45 years; children's ages=7.5 and 6 years)

Theme 2: Unique Experiences Related to Adoption—The second theme surrounded the unique experiences as a result of expanding the family through adoption, experiences which slightly changed with time. Prior to placement (T1), adoption preparation and identifying sources of support were noted. After placement, at T2 and T3, parents described the child's integration into the family, including the child's preferences for one parent over the other, and other circumstances uniquely found with adoptive parenting.

Many adoptive parents are required either by their adoption agency or by law for intercountry adoptions, to undergo training so that they may be more prepared to understand and meet their child's needs. Before the child arrived into the home (T1), one father described this preparation, which is unique to adoption:

> I feel like the pre-adoption training has made us aware of the challenges that we may face once we adopt. Furthermore, I feel like my spouse, myself, and our children are capable of meeting those challenges and embrace them out of a sense of devotion and a desire to give an orphan what they otherwise would not have. So I believe that we are prepared to meet the challenges we will face, even though we know it will be hard at times (; CES-D=3 at T1; parent age=42 years; child age=2 years).

After placement, parents describe the singular circumstances that adoption brings, such as adopting an older child or one with special needs. One mother stated:

> Adopting an older child has different challenges. For example, a 2 year old having a temper tantrum in public is acceptable, but a seven year old doing the same is not. I feel more 'eyes' on me with this adoption than with our infant adoption. That said,

> we live in a very polite and liberal part of the country where it would be frowned upon to ask questions about adoption of strangers. So it would be more accurate to say that I feel people's questioning eyes on me. Its burdensome. Sometimes I just say, "special needs adoption" right to them and they nod primly and avert their eyes (CES-D=10 at T2; parent age=48 years; child age=7.4 years).

Other characteristics of parenting through adoption were presented, such as adopting more than one child, dynamics of relinquishment (contested adoption and talking with the birth mother), and child preferences for one parent over the other. Living in the child's country of origin (birth country) for several months was also noted as a unique circumstance related to being an adoptive parent. In intercountry adoption and depending upon processes in that country, prospective parents are at times required to live in a developing country for a period of time. Overall, these circumstances were similar immediately after placement and 5–6 months later (T2 and T3).

Theme 3: Rest/Fatigue: Out of Balance—Parents reported similar experiences with a lack of rest that often accompanies parenting; however, there were also indications that these feelings arose from the adoption process and factors unique to adoption. Prior to placement, one mother commented:

> I feel like I've been running a marathon and am close to the finish line, but am physically exhausted (CES-D=18 at T1; parent age=46 years; child age=3 years).

After placement, the responsibilities of parenting set in and the responsibilities of being an adoptive parent also influence the level of fatigue as one mother described:

> The first two weeks home were the hardest, kind of like the "baby blues", plus with travel and just being physically and emotionally exhausted. I think it's important for adoptive parents to expect these things, even if they are adopting an older child. Give yourself and child grace and treat yourself and your child as if you have just "given birth". Have low expectations, allow people to help, ask for help! (CES-D=3 at T2; parent age=38 years; child age=18 months)

Children who have transitioned to new homes and those who have experienced trauma, often have difficulty falling and staying asleep; and therefore, compromise their parents' sleep. The child's sleep directly impacted this adoptive mother's ability to feel rested in the weeks immediately following placement:

> My son has experienced night terrors since arriving home and this has caused me to lose sleep every night. I think this lack of sleep has caused me to feel down on two separate days since we have been home (CES-D=7 at T2; parent age=47 years; child age=2.5 years).

The child's sleep disturbances may continue for several weeks. A mother described a similar situation after the child had been home for approximately six months:

> Also, my daughter is still not sleeping well at night. The past two weeks she has regressed and will not go to sleep on her own and wakes up often during the night. This has affected my amount of sleep and my overall energy level (CES-D=15 at T2; 10 at T3; parent age=40 years; child age=15 months).

Adoptive parents also described factors similar to what birth parents encounter that are disruptors to restfulness. The individual parent's energy level, sleep patterns, infant adoption (with waking up several times a night to feed), and typical developmental issues (e.g., teething) were also cited as reasons contributing to fatigue by parents.

Theme 4: Life Stressors—The stress of everyday life was described, with comments related and unrelated to the adoption itself. The adoption was seen as an additional stressor to lives that were already busy with unanticipated events occurring along the way. One mother described a life in flux:

> My husband and I have a lot going on in our lives right now. Not only are we adopting a child, we are selling our home, moving to a rented apartment in a new city/town, and my husband is returning to school for his doctorate in a few months. Luckily I have 12 weeks of FMLA that I can take to cover these milestones (CES-D=11 at T1; parent age=34 years; child age=3 months).

Immediately after placement (T2) and five months later (T3), depressive symptoms were shared by some parents who attributed these symptoms to events in their lives that were in addition to or at times, influenced by the placement of the child. One father relates his return to work and the effect this had on bonding with his child. Interestingly, he reports "mild depression," however, his CES-D score of 4 at T2, is well below the threshold of 16:

> As far as I can tell the extent of my mild depression came from when I had to go back to work and my bonding progression started to decline with my child. She stopped letting me feed her a bottle and let me put her to sleep because I was not home as much and my wife was took over most of the care-giving for our daughter. She bonded immediately with my wife so it had always been a struggle for me to bond with her. When this started going down hill, it made me quite sad and frustrated (CES-D=4 at T2; parent age=33 years; child age=15 months).

Work, finances, significant health issues and the stress of raising children continued to be offered as life stressors at T3. Parents describe the ongoing challenges of life and actions they take to survive in the world. Approximately five months post-placement, a mother wrote:

> I am starting a new part time job; my husband is interviewing for another job. My husband's grandmother just died and he was in charge of the funeral, so that was pretty stressful. Our toddler darted out in to the street and narrowly missed being hit by a car. That was the final straw in us looking for a new place to live on a quieter street or in the country. My husband was diagnosed with MS over a year ago and has been having several days where he spends a lot of the day in bed since MS is exacerbated by stress. Hopefully, life will calm down and he will start feeling better (CES-D=9 at T3; parent age=45 years; children's ages=7.5 and 6 years).

The parents described ways of coping and decision making as a result of the stressors of everyday life, including work (returning to work, looking for employment, job changes), health, and child issues.

Theme 5: Faith/Spirituality—At all three time points, parents' responses described an important buffer to their experiences as new adoptive parents and life in general: their faith. Prior to placement (T1), parents' faith was a way to cope with the uncertainty (see Theme 1) of the adoption process. It also provided hope to them that events–the adoption–would work out all right. After placement (at T2 and T3), parents' expressions of faith were tied to gratitude toward God for providing the child, hope for the future, as part of a broader support system (family members' prayers), and a way to cope with unexpected challenges. About five months after placement, a father, who had been diagnosed with multiple sclerosis after the adoption and experienced depressive symptoms across all three time points, wrote:

> We don't regret any of this, and both my wife and I agree that God led us into this phase of life. Two months after taking the boys in I was diagnosed with Multiple Sclerosis. I am doing fairly well, but this development was unexpected and confusing. Many other trials have kneaded their way into the road of the adoptive process, but we are still confident that the road leads to a good place. I have tied to be honest about the emotion and difficulty of the process, and it has been considerable. Still, the difficulty does not alter my bedrock belief that God works in the theater of hard things…(CES-D=32 at T1; 22 at T2; and 25 at T3; parent age=45 years; children's ages=7.5 and 6 years).

Spiritual beliefs in God and having faith also appear to impact expectations. Several parents described how their faith contributed to beliefs that life was not supposed to be easy and that when difficult times were encountered, belief in God would assist them. A mother summarized her thoughts by stating:

> As a Christian, I expect my life to have challenges and difficulties because that is what the Bible says, so that is reflected in some of my answers, My relationship with Christ is what gives me hope, strength, joy and hope for the future (CES-D=2 at T1; 3 at T2; and 7 at T3; parent age=38 years; child age=18 months).

It should be noted that the adoption agency from which the majority of the sample was recruited has a Christian focus to its mission.

Subtheme 1: Previous Losses Surrounding Adoption/Parenting—One sub-theme, which emerged prior to placement, surrounded expressions of previous loss. Several parents described failed adoption situations characterized by birth parents changing their minds about relinquishment, a baby dying, and issues of infertility. A prospective mother described such loss:

> I think overall I am a pretty rational person who does not get too upset about things. I'm pretty laid back, and not overly emotional. I do think that the adoption process really can put you through the ringer when it comes to emotions. We have had man highs and many lows. And unfortunately for us, we have had the ultimate low with having our baby dying when she was born. I do think that the adoption process is not for the 'faint at heart.' But in the end, it will be worth it (CES-D=8 at T1; parent age=37 years; child age=1 month).

This subtheme was not apparent after placement. One rationale for this is that the child(ren)'s presence in the home had negated these issues of loss as the goal of parenting had been achieved (see Subtheme 2 below).

Subtheme 2: Joy and Love!—After placement, several parents remarked about the joy and rewards of parenting their child. Comments such as: "We love being new parents!" and "I can't imagine loving a child any more than our adopted daughter!" There is a sense of completeness, a relief, and yet also a sense of more challenges to come: " …These circumstances add another layer to an already complex adventure, but we're taking it in stride and loving our crazy little family."

Discussion

The longitudinal nature of this study allows for a holistic and temporal perspective of the adoption experience from pre-placement to post-placement for adoptive parents. Parents in this sample reported higher levels of depressive symptoms as compared to the rest of the study participants. One interpretation is that because of their struggles, they may have been more motivated to express their feelings by forwarding comments compared to others in the sample who did not struggle. Post-adoption depression has been addressed in the literature, but peri-adoption depression with changes from pre-adoption to post-adoption is an issue that requires further investigation. This study provides context for this transition over time with the varying challenges and stressors that are experienced pre-adoption, immediately after adoption, and six months after adoption.

We confirm and expand upon findings from other qualitative studies that have examined the transition of adoptive parents (Fontenot, 2007; McKay & Ross, 2010; Tasker & Wood, 2016). Similar to other research findings, adoptive parents described a range of emotions from uncertainty to relief to joy (Fontenot, 2007). Struggling with being rested was a pervasive theme across all time points, which is also consistent with findings from other studies (Foli et al., 2012b; Fontenot, 2007; Levy-Schiff et al., 1991). Adoptive parents reported everyday life stressors consistent with routine challenges any parent might face, yet the unique contexts of adoption circumstances such as previous losses, age of children, and legal issues layered these challenges.

Perhaps the most important message from the current study findings is that the transition for adoptive parents is characterized by adoption specific experiences and resource needs that are not applicable to birth parents. Many parents, birth or adoptive, experience transition, lack of sleep, and life stressors, but adoptive parents have preplacement legal, financial and emotional concerns that lead to vulnerability (McKay & Ross, 2010). The common assumption that adoptive parents do not require support, due to demographic profiles that speak to higher socioeconomic status and the lack of physical labor and delivery of a child, is negated by these findings. Smit (2010) supports this finding through themes from 107 parents who had experienced an intercountry adoption. Two themes derived from the data: "Unique health care needs of international adoptive families: We are different" and "Importance of support from health care providers: Do they know or care?" (p. 254) reflect on the unique experiences of adoptive parents and the important role of healthcare providers.

Uncertainty was a significant theme in the pre-placement period, reflecting the challenges adoptive parents encounter as they wait for placement, navigate the legal processes of adoption, and prepare for the great unknown of a new child. Tasker and Wood (2016) also noted uncertainty, specifically a sense of unsafe uncertainty, where parents have fears about the future, their decision to adopt, and their approach to parenting their adoptive child. While this uncertainty cannot be avoided due to the nature of adoption and parenthood in general, specific measures to support patients such as adoptive parent support groups and couples counseling may help ameliorate some of these fears. While the lack of rest is frequently voiced by all parents, the reasons for fatigue may be different for adoptive parents. For example, traveling to a different country or the child's inability to sleep due to past experiences is not uncommon for adoptive parents. Previous losses stemming from infertility, failed adoptions, and unanticipated barriers in the adoption process are also exclusive to these parents. Training for adoption and mental health professionals regarding the losses specific to adoptive parents may promote a more insightful approach to support and treatment.

Similarly, the strengths of adoptive parents may also be distinctive when compared to birth parents. One strength reported by many parents was that of their faith and spirituality, and their ability to rely on this when encountering obstacles in the adoption process. It should be noted that the sample was largely drawn from an adoption agency with a Christian focus, which may have influenced this finding (see Limitations). Tapping into the strengths of adoptive parents such as spirituality, maturity, education, and life experience may foster resilience (Levy-Schiff et al., 1991; Vandivere et al., 2009). Despite adoptive children having more healthcare needs as compared to the general population of children (39% versus 19%, respectively; Vandivere et al., 2009), adoptive children are also more likely to be provided with healthcare, such as preventative medical care and dental care than biological children (Bramlett, Radel, & Blumberg, 2007). One conclusion may be that adoptive parents are more vigilant and attentive to the healthcare needs of their children. Individuals in the current study also voiced instances of sacrifice to foster child-to-parent bonding and career decisions that were intentional to the betterment of the family. This could be attributed to parental maturity, the purposeful choice and the wait to parent, greater financial security, or the sacrifices already made during the adoption process.

As the new normal sets in post-placement, the child's presence may also signify a new beginning for the family. One clear subtheme, "Joy and Love!" echoed the parents' gratitude toward having their child home, being a parent after long waits and infertility, and the stress of pre-placement uncertainties. It would seem, therefore, that adoptive parents experience the transition to parenthood in unique ways, with both facilitators and challenges (McKay & Ross, 2009). One caveat to these findings is that despite socioeconomic and educational advantages, adoptive parents will need support both pre-and post-placement. Healthcare and adoptive professionals are advised to assess ways to maximize strengths and offer support during periods of uncertainty and adjustment.

Clinical Implications for Psychiatric Nurses

Historically, social work has been considered the most influential profession for adoptive families, from the home study to placement of the child. However, there are multiple opportunities for nurses, in both acute and primary care contexts, to monitor adoptive parents' experiences, including assessment of depressive symptoms, as they transition to parenthood. These opportunities may also arise when the child presents with behavioral issues or in family-centered therapy. Nurses should recognize that although there is no physical labor and delivery involved, parents, both mothers and fathers, will experience the stressors that come with parenthood, as well as general life stressors. In addition to these, this study has described the unique challenges that may surface with a child who is adopted. Recognition of these challenges–and how heterogeneous adoptions are–may allow the parent to feel accepted and be more forthcoming in describing challenges. As reflected in the qualitative data, nurses should also be sensitive to the overall presentations offered by parents. Parents may struggle with stress, and at times, depressive symptoms without meeting the threshold levels as indicated by tools such as the CES-D.

The following list is not inclusive of assessment questions, but the roster serves as a springboard to additional inquiries:

> Pre-placement: "Tell me about the adoption process you're experiencing. Has a child been referred to you? When did you begin the adoption journey? Have you had previous placements that did not materialize? How are you preparing for your child (inquire about physical preparations for the child and psychological preparations such as reading books about adoption and parenting)? Do you feel rested? Describe how you take care of yourself and get renewed energy. What type of childcare arrangements have been made? Will you be traveling abroad to receive your child? What type of adoption arrangement will you have with the birth parents (open, semi-open, or closed)? I know that during this time, there are many unknowns and uncertainties. Do you find yourself feeling anxious or down? If so, do you feel this way often? Who do you look for in your life for support?"
>
> Post-placement: Many of the above questions pertain to after the child is home (i.e., self-care activities, rest, feeling anxious or down, and sources of support). Additional questions include:
>
> > "How do your child's needs compare with what you expected? How is your child integrating into your family? Into the extended family? Do you feel competent in caring for your child's needs? Have you celebrated your child's homecoming? It's important for you to know that some parents don't feel connected to their child right away. Can you describe the bonding experience between you and your child so far? Do you know whether your child has experienced trauma? Do you understand how children may exhibit behaviors that are created from trauma, behaviors that are challenging and even disruptive (continue to probe in terms of family functioning; refer to materials on trauma-informed parenting)."

Limitations

The parents contributing data to this analysis were a subsample of the parents who were recruited for this study. In the current study, the sample reported more depressive symptoms than the larger group of parents, which may affect generalizability of results. On the other hand, these vulnerable parents' data may prove to be more useful as interventions are designed. A large proportion of parents were clients of a Christian adoption agency and their characteristics might not be comparable to the general adoptive parent population. Despite these limitations, we believe these findings contribute to an understanding of the transition of adoptive parents due to the longitudinal design of the study, inclusion of both mothers and fathers, collection of qualitative data from the internet (Beck, 2005), and the mixed method approach to the data. Another limitation is the homogeneous nature of the sample with a mostly heterosexual population. In the current study, only two individuals identified as same-gender parents. Further research addressing transition over time for all adoptive parents would provide a more generalizable view, because homosexual adoptive parents experience specific vulnerabilities related to social stigma (Brown, Smalling, Groza, & Ryan, 2009). In asking one open-ended question, further details about the lived experience of adoptive parents may have been missed. Although, the themes from this study provide a basis for additional investigation regarding adoptive parental transition.

Conclusion

This study expands on previous qualitative research investigating the transition of adoptive parents. During the transition from pre-to post-placement, adoptive parents experience a unique passage, with both challenges and strengths exclusive to this group of parents. While acknowledging that there are commonalities to parenting, regardless of the path (birth or adoption), healthcare and adoption professionals should recognize the unique dynamics that adoption brings to families as children are placed in the home.

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References

Beck CT. Benefits of participating in Internet interviews: Women helping women. Qualitative Health Research. 2005; 15(3):411–422. DOI: 10.1177/1049732304270837 [PubMed: 15761108]

Bramlett MD, Radel LF, Blumberg SJ. The health and well-being of adopted children. Pediatrics. 2007; 119:S54–S60. [PubMed: 17272586]

Brown S, Smalling S, Groza V, Ryan S. The experiences of gay men and lesbians in becoming and being adoptive parents. Adoption Quarterly. 2009; 12(3–4):229–246.

Calvo V, Palmieri A, Codamo A, Scampoli MR, Bianco F. Perceptions of parental bonding, adult attachment, and marital adjustment in prospective adoptive parents. An empirical study in the pre-adoptive period. Sexual and Relationship Therapy. 2015; 30(4):419–432. DOI: 10.1080/14681994.2014.1001355

Child Welfare Information Gateway. Costs of adopting. Washington D. C: Children's Bureau; 2011.

Child Welfare Information Gateway. Parenting a child who has experience abuse or neglect. Washington D. C: Children's Bureau; 2013.

DeSantis L, Ugarriza DN. The concept of theme as used in qualitative nursing research. Western Journal of Nursing Research. 2000; 22:351–372. DOI: 10.1177/019394590002200308 [PubMed: 10804897]

Elo S, Kyngäs H. The qualitative content analysis process. Journal of Advanced Nursing. 2008; 62(1): 107–115. DOI: 10.111/j.1365-2648.2007.04569.x [PubMed: 18352969]

Elo S, Kääriäinen M, Kanste O, Pölkki T, Utriainen K, Kyngäs H. Qualitative content analysis: A focus on trustworthiness. Sage Open. 2014; :1–10. DOI: 10.1177/2158244014522633

Foli KJ. Depression in adoptive parents: A model of understanding through grounded theory. Western Journal of Nursing Research. 2010; 32:379–400. [PubMed: 20040731]

Foli, KJ. Nursing care of adoption and kinship families: A clinical guide for advanced practice nurses. New York: Springer Publishing Co; 2017.

Foli KJ, South SC, Lim E. Rates and predictors of depression in adoptive mothers: Moving toward theory. Advances in Nursing Science. 2012; 35(1):51–63. DOI: 10.1097/ANS.0b013e318244553e [PubMed: 22293610]

Foli KJ, South SC, Lim E. Maternal postadoption depression: Theory refinement through qualitative analysis. Journal of Research in Nursing. 2014; 19(4):303–327. DOI: 10.1177/1744987112452183

Foli KJ, South SC, Lim E, Hebdon M. Depression in adoptive fathers: An exploratory mixed methods study. Psychology of Men & Masculinity. 2012a; doi: 10.1037/a0030482

Foli KJ, South SC, Lim E, Hebdon M. Maternal postadoption depression, unmet expectations, and personality traits. Journal of the American Psychiatric Nurses Association. 2012b; 18(5):267–277. doi:0.1177/1078390312457993. [PubMed: 22956715]

Foli KJ, South SC, Lim E, Hebdon M. Longitudinal course of risk for parental post-adoption depression using the Postpartum Depression Predictors Inventory- Revised. Journal of Obstetric, Gynecologic, and Neonatal Nursing. 2016a; 45(2):210–226. DOI: 10.1016/j.jogn.2015.12.011

Foli KJ, South SC, Lim E, Jarnecke A. Post-adoption depression: Parental classes of depressive symptoms across time. Journal of Affective Disorders. 2016b; 200:293–302. DOI: 10.1016/j.jad.2016.01.049 [PubMed: 27155072]

Foli KJ, Lim E, South SC, Sand LP. "Great expectations" of adoptive parents: Theory extension through structural equation modeling. Nursing Research. 2014; 63(1):14–25. DOI: 10.1097/NNR.0000000000000006 [PubMed: 24335910]

Fontenot HB. Transition and adaptation to adoptive motherhood. Journal of Obstetric, Gynecologic, & Neonatal Nursing. 2007; 36:175–182. DOI: 10.1111/J.1552-6909.2007.00134.x

Goldberg AE, Garcia R. Predictors of relationship dissolution in lesbian, gay, and heterosexual adoptive parents. Journal of Family Psychology. 2015; 23(3):394–404.

Goldberg AE, Smith JZ, Kashy DA. Preadoptive factors predicting lesbian, gay, and heterosexual couples' relationship quality across the transition to adoptive parenthood. Journal of Family Psychology. 2010; 24(3):221–232. DOI: 10.1037/a0019615 [PubMed: 20545395]

Gunnar MR, Bruce J, Grotevant HD. International adoption of institutionally reared children: Research and policy. Development and Psychopathology. 2000; 12:677–693. DOI: 10.1017/S0954579400004077 [PubMed: 11202039]

Hock RM, Mooradian JK. Co-parenting quality among adoptive mothers: Contributions of socioeconomic status, child demands and adult relationship characteristics. Child & Family Social Work. 2012; 17(1):85–95.

Jones, J. NCHS Data Brief, No 12. Hyattsville, MD: National Center for Health Statistics; 2009. Who adopts? Characteristics of women and men who have adopted children.

Levy-Shiff R, Goldshmidt I, Har-Even D. Transition to parenthood in adoptive families. Developmental Psychology. 1991; 27(1):131–140.

Loman MM, Johnson AE, Quevedo K, Lafavor TL, Gunnar MR. Risk-taking and sensation-seeking propensity in postintitutionalized early adolescents. Journal of Child Psychology and Psychiatry. 2014; 55(10):1145–1152. DOI: 10.1111/jcpp.12208 [PubMed: 24552550]

McKay K, Ross LE. The transition to adoptive parenthood: A pilot study of parents adopting in Ontario, Canada. Children and Youth Services Review. 2010; 32:604–610. DOI: 10.1016/j.childyouth.2009.12.007

McKay K, Ross LE. Current practices and barriers to the provision of post-placement support: A pilot study from Toronto, Ontario, Canada. British Journal of Social Work. 2011; 41:57–73. DOI: 10.1093.bjsw/bcq023

McKay K, Ross LE, Goldberg AE. Adaptation to parenthood during the post-adoption period: A review of literature. Adoption Quarterly. 2010; 13(2):125–144. DOI: 10.1080/10926755.2010.481040

McKlindon A, Welti K, Vandivere S, Malm K. Adopted children with special health care needs: National survey findings. Adoption Advocate. 2011:32.

Mott SL, Schiller CE, Richards JG, O'Hara M, Stuart S. Depression andanxiety among postpartum and adoptive mothers. Archives of Women's Mental Health. 2011; 14(4):335–343. DOI: 10.1007/s00737-011-0227-1

Postpartum Progress. Postpartum depression support groups in the US & Canada. n.d. Retrieved from http://www.postpartumprogress.com/ppd-support-groups-in-the-u-s-canada

Postpartum Support International. You are not alone. n.d. Retrieved from http://www.postpartum.net/

Radloff LS. The CES-D scale: A self-report depression scale for research in the general population. Applied Psychological Measurement. 1977; 1(3):385–401.

Smit EM. International adoption families: A unique health care journey. Pediatric Nursing. 2010; 36(5):253–258. [PubMed: 21067077]

Smith EK, Gopalan P, Glance JB, Azzam PN. Postpartum depression screening: A review for psychiatrists. Harvard Review of Psychiatry. 2016; 24(3):173–187. DOI: 10.1097/HRP.0000000000000103 [PubMed: 27148910]

Stellern S, Esposito E, Mliner S, Pears K, Gunnar M. Increased freezing and decreased positive affect in postinstitutionalized children. Journal of Psychology and Psychiatry. 2014; 55(1):88–95. DOI: 10.1111/jcpp.12123

Tasker F, Wood S. The transition to adoptive parenthood: Adoption as a process of continued unsafe uncertainty when family scripts collide. Clinical Child Psychology & Psychiatry. 2016; 21(4):520–535. https://doi.org/10.1177/1359104516638911. [PubMed: 27026662]

Vandivere, S., Malm, K., Radel, L. Adoption USA: A chartbook based on the 2007 National Survey of Adoptive Parents. 2009. Retrieved from https://aspe.hhs.gov/report/adoption-usa-chartbook-based-2007-national-survey-adoptive-parents

Virginia Hospital Center. Medical services: Mother & baby support groups. n.d. Retrieved from http://www.virginiahospitalcenter.com/medical/women/mother_and_baby_support_groups.aspx

Wiik KL, Loman MM, Van Ryzin MJ, Armstrong JM, Essex MJ, Pollak SD, Gunnar MR. Behavioral and emotional symptoms of post-institutionalized children in middle childhood. Journal of Child Psychology and Psychiatry. 2011; 52(1):56–63. DOI: 10.1111/j.1469-7610.2010.02294.x [PubMed: 20649913]

Highlights

- In addition to the stressors experienced in life by individuals and those who transition to a parenting role, adoptive parents encounter unique challenges.
- Psychiatric nurses should be aware of opportunities to therapeutically interact with parents before and after a child is placed in the home, including assessing for depressive symptoms.
- Nurses' awareness of the unique features of adoption, with its uncertainties prior to placement, and post-placement adoption circumstances (e.g., fatigue, traveling, older child adoption, and special needs) is needed to optimize parental functioning.
- Resiliency factors, such as spirituality, may strengthen individuals as they transition to the role of being adoptive parents.

Table 1

Subject Characteristics of the Participants who Contributed Open Ended Responses

Parent Variable	*n* (%)	Child Variable	*n* (%)
Gender		Gender	
Male	18 (28.1%)	Male	30 (50.9%)
Female	46 (71.9%)	Female	29 (49.1%)
Parent Age (yrs.), mean (SD)	37.7 (5.6)	Age (mos.), mean (SD)	29.9 (39.5)
Race/Ethnicity		Child's Race/Ethnicity	
Caucasian or White	59 (92.2%)	White or Caucasian	11 (22.0%)
Other	5 (7.8%)	Black or African American	11 (18.6%)
Income		Asian or Pacific Islander	20 (33.9%)
Under $75,000	25 (40.3%)	Other	15 (25.4%)
$75,000 to under $100,000	17 (27.4%)	Transracial Family	
More than $100,000	20 (32.3%)	No (Same as either of parents)	14 (23.7%)
		Yes (Different from both parents)	45 (76.3%)
Education			
Less than four year college graduate	9 (14.1%)	Special Need	
Four-year college graduate	29 (45.3%)	Yes	26 (44.1%)
Post-graduate	26 (40.6%)	No	33 (55.9%)
Job Status		Type of Adoption	
Full time	36 (56.2%)	Public (domestic)	9 (15.3%)
Part time	12 (18.8%)	Private (domestic)	17 (28.8%)
Other	16 (25.0%)	Inter-country	30 (50.9%)
Infertility		Other	3 (5.1%)
Yes	22 (35.5%)	Length of Waiting Time (mos.), mean (SD)	11.2 (12.1)
No	40 (64.5%)		
Bothered by infertility, mean (SD)[α]	2.4 (1.2)		
Religion			
Protestant	27 (42.2%)		
Roman Catholic	7 (10.9%)		
Non-denominational Christian	23 (35.9%)		
Other	7 (10.9%)		
Level of Religiosity, mean (SD)[β]	6.0 (1.4)		
CES-D at Time 1, mean (SD)	8.4 (7.4)		
CES-D at Time 2, mean (SD)	7.7 (8.5)		

Parent Variable	*n* (%)	Child Variable	*n* (%)
CES-D at Time 3, mean (SD)	7.7 (8.1)		

n=64 parents. SD = Standard Deviation.

[a] Scored from 1 (strongly disagree) to 5 (strongly agree).

[β] Scored from 1 (not at all religious) to 7 (very strongly religious).

Table 2

Comparison between Participants who did not Contribute and Participants who Contributed Open Ended Responses

Variable	Overall (n=129)	Not-contributor (n=65)	Contributor (n=64)	p-value
Parent				
Gender				<0.001
Male	59 (45.7%)	41 (69.5%)	18 (30.5%)	
Female	70 (54.3%)	24 (34.3%)	46 (65.7%)	
Parent Age (yrs.), mean (SD)	38.1 (5.3)	38.4 (5.1)	37.7 (5.5)	0.460
Race/Ethnicity				0.744
Caucasian or White	120 (93.0%)	61 (50.8%)	59 (49.2%)	
Other	9 (7.0%)	4 (44.4%)	5 (55.6%)	
Income				0.288
Under $75,000	42 (33.6%)	17 (40.5%)	25 (59.5%)	
$75,000 to under $100,000	38 (30.4%)	21 (55.3%)	17 (44.7%)	
More than $100,000	45 (36.0%)	25 (55.6%)	20 (44.4%)	
Education				0.540
Less than four year college graduate	23 (17.8%)	14 (60.9%)	9 (39.1%)	
Four-year college graduate	56 (43.4%)	27 (48.2%)	29 (51.8%)	
Post-graduate	50 (38.8%)	24 (48.0%)	26 (52.0%)	
Job Status				0.008
Full time	85 (65.9%)	49 (57.6%)	36 (42.4%)	
Part time	14 (10.9%)	2 (14.3%)	12 (85.7%)	
Other	30 (23.3%)	14 (46.7%)	16 (53.3%)	
Infertility				0.030
Yes	56 (45.2%)	34 (60.7%)	22 (39.3%)	
No	68 (54.8%)	28 (41.2%)	40 (58.8%)	
Bothered by Infertility, mean (SD)[α]	2.5 (1.2)	2.5 (1.2)	2.4 (1.2)	0.578
Religion				0.978
Protestant	56 (43.4%)	29 (51.8%)	27 (48.2%)	
Roman Catholic	15 (11.6%)	8 (53.3%)	7 (46.7%)	
Non-denominational Christian	45 (34.9%)	22 (48.9%)	23 (51.1%)	
Other	13 (10.1%)	6 (46.2%)	7 (53.8%)	
Level of Religiosity, mean (SD)[β]	6.1 (1.2)	6.1 (1.0)	6.0 (1.4)	0.579
CES-D at Time 1, mean (SD)	6.6 (6.2)	4.7 (4.0)	8.4 (7.4)	0.001
CES-D at Time 2, mean (SD)	6.3 (7.5)	4.9 (5.9)	7.7 (8.5)	0.037

Variable	Overall (n=129)	Not-contributor (n=65)	Contributor (n=64)	p-value
CES-D at Time 3, mean (SD)	6.1 (6.9)	4.3 (4.7)	7.7 (8.1)	0.009
CES-D at Time 1				<0.001
<16	105 (90.5%)	58 (55.2%)	47 (44.8%)	
≥16	11 (9.5%)	0 (0%)	11 (100%)	
CES-D at Time 2				0.241
<16	102 (88.7%)	52 (51.0%)	50 (49.0%)	
≥16	13 (11.3%)	4 (30.8%)	9 (69.2%)	
CES-D at Time 3				0.098
<16	94 (90.4%)	47 (50.0%)	47 (50.0%)	
≥16	10 (9.6%)	2 (20.0%)	8 (80.0%)	
Child				
Gender				0.841
Male	59 (51.8%)	29 (49.2%)	30 (50.8%)	
Female	55 (48.2%)	26 (47.3%)	29 (52.7%)	
Age (mos.), mean (SD)	30.1 (39.4)	30.3 (39.7)	29.9 (39.5)	0.961
Child's Race/Ethnicity				0.226
White or Caucasian	32 (28.1%)	19 (59.4%)	13 (40.6%)	
Black or African American	25 (21.9%)	14 (56.0%)	11 (44.0%)	
Asian or Pacific Islander	32 (28.1%)	12 (37.5%)	20 (62.5%)	
Other	25 (21.9%)	10 (40.0%)	15 (60.0%)	
Transracial Family				0.203
No (Same as either of parents)	33 (28.9%)	19 (57.6%)	14 (42.4%)	
Yes (Different from both parents)	81 (71.1%)	36 (44.4%)	45 (55.6%)	
Special Need				0.660
Yes	66 (57.9%)	33 (50.0%)	33 (50.0%)	
No	48 (42.1%)	22 (45.8%)	26 (54.2%)	
Type of Adoption				0.697
Public (domestic)	17 (14.8%)	8 (47.1%)	9 (52.9%)	
Private (domestic)	34 (29.6%)	17 (50.0%)	17 (50.0%)	
Inter-country	55 (47.8%)	25 (45.5%)	30 (54.5%)	
Other	9 (7.8%)	6 (66.7%)	3 (33.3%)	
Length of Waiting Time (mos.), mean (SD)	10.7 (11.6)	10.2 (11.0)	11.2 (12.1)	0.636

Notes: Row percentage. *P*-value was obtained using chi-square test or Fisher's exact test for categorical variable and two sample t-test for continuous variable.

Table 3

Themes Across Time: Pre- to Post-Placement

Theme	T1: 4-6 Weeks Pre-Placement	T2: 4-6 Weeks Post- Placement	T3: 5-6 Months Post- Placement
#1: Transition From Uncertainty to New Normal	Uncertainty (“trying to remain calm”; “hanging in limbo”)	Happy it’s over! / Transitioning/ Moving Forward with a New Normal	Life is good! Settling into the New Normal
#2: Unique Experiences Related to Adoption	Adoption Preparation (sources of support, family friends, adoption agency)	Adoption Circumstances (Child parental preferences; older child adoption harder)	Adoption Circumstances / Unique Contexts (living in birth country, foster parenting, multiple children)
#3: Rest/Fatigue: Out of Balance	Rest/Fatigue (Related to parenting and adoption process)	Rest/Fatigue (Difficult due to child/ infant not sleeping well)	Rest/Fatigue (May or may not be due to child, i.e., lack of parenting skills, winter months)
#4: Life Stressors	Everyday Life Stressors (Diagnosis of illness, finances, family medical leave)	Everyday Life Stressors (Job, going back to school, deceased family member)	Everyday Life Stressors (Personal illness, work-related stress)
#5: Faith/Spirituality	Faith/Spirituality (Anecdote to uncertainty, provides hope)	Faith/Spirituality (God has provided, provides hope for future that all will be okay)	Faith/Spirituality (Part of broader support system, provides way to cope with unexpected)
Subthemes	Previous Losses (Failed adoption, country closed, jaded attitude)		Joy and Love! (Grateful for child, enjoy parenting)