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Exploring Adoption Options

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Abstract

All across the world, there are thousands of children in need of adoptive parents to provide them with a loving and stable home. These children include newborns placed for adoption, children living overseas, and children within the state's child welfare system.

"Exploring Adoption Options" is written to provide a general guide to someone who is interested in adoption. Adoption is a very complex process and a life-changing experience. It involves many professionals, such as adoption agencies, attorneys, social workers, facilitators, and state operated child welfare services. Children available for adoption can be found domestically or internationally, some of which are explored in this paper.

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What is adoption?

Adoption involves the legal termination of the birth parent's rights, willingly or unwillingly, and recognizes the adoptive parents as the sole persons legally responsible for the adopted child. This legal process transfers all rights and responsibilities of the child to the adoptive parents (National Council on Disability, 2012).

When a child is adopted, that child moves permanently from one family to another family. In the process, all parental rights are legally transferred to the new parents. This means adoptive parents have the same rights and responsibilities as parents whose children were born to them. It also means adopted children have all the emotional, social, legal, and familial benefits of biological children (Dave Thomas Foundation, 2014, p. 8).

The adoption process is a long and complicated journey, regulated by the state and federal or possibly international laws if pursuing an adoption out of the country adoption (Hollinger, 1993). It is a continuous progression of gathering knowledge and education about the choices available. These hurdles take much time to pursue and a lifelong commitment. Overall, adoption is an extremely complex procedure, in which well educated, licensed professionals should be consulted for their services as a guide throughout the process. These professionals can include adoption attorneys, social services, and adoption agencies (Emery, 1993).

Adoption History

During the 1800's, there were many tragedies that plagued America, including war and incurable diseases, that took the lives of many parents (Herman, 2012.). Children with relatives were technically unofficially adopted. Meanwhile, an estimated 30,000 children living in New York City, with no other relatives to care for them, became orphans and homeless (The

Children's Aid Society, 2012). Laws to regulate the adoption process and protect the child were obviously needed. Historical records involving adoption date back to 1851 when Massachusetts passed the first law regarding adoption, the Adoption of Children Act (Herman, 2012). As Herman cited in her report, the passage of this law gave judges the authority to determine if the adoptive parents were suitable to take care of the life of a child. The law also focused on adoption as being a legal process with the child's welfare as the main priority (The Editors of Encyclopedia Britannica, 2016).

Types of Domestic Adoption

Domestic adoption refers to the adoption of a child from within the U.S. in a variety of possible ways, all of which must be approved by a judge (National Council on Disability, 2012). In domestic adoptions, adoptive parents must decide what type of professional to use and the level of openness they would like to establish with the birth parents. Such professionals could include a licensed adoption agency, an independent adoption attorney, a facilitator, foster care adoption, and egg or embryo adoption. Below is a list of considerations for a domestic adoption (Mills, 2011).

Licensed Adoption Agency

Adoption agencies are licensed by the state to process adoptions either domestically or internationally (Dave Thomas Foundation, 2014). Domestic adoption agencies can also be classified as national or local. National agencies are larger and work according to the laws of multiple states. Local agencies are often only licensed and regulated by one state government. Agencies, such as American Adoptions, state that national agencies can offer advantages, such as shorter wait times, larger networking, and marketing outreach (2017). As stated on their website, larger agencies like American Adoptions complete approximately 300 adoptions per year; and

adoptive couples typically experience wait times of one to nine months for a match with a birthmother (American Adoptions, 2017).

Since national agencies work in multiple states, agencies may match the birth parents that reside in one state with the potential adoptive parents that reside in another. In these situations, the agency must abide by the laws of both states (Association of Administrators of the Interstate Compact on the Placement of Children [AAICPC], 2015). Once the child is born, the adoptive parents will travel to the state where the birthmother delivers. Prior to leaving that state with the child and entering the state where the adoptive parents reside, all adoption laws must be followed and approval by the state departments of both states (Libow, 1992). These types of adoptions are known as interstate adoptions and governed by a process known as the Interstate Compact on the Placement of Children, also referred to as the ICPC process. In 1974, the AAICPC was established to create and govern the laws regarding the ICPC process. The ICPC is a statutory law governed by its members, which includes all fifty U.S. states, the District of Columbia, and the U.S. Virgin Islands (AAICPC, 2015).

There are a number of benefits of working with licensed agencies for both birth and adoptive parents. Through these agencies, birth parents get superb services. They work closely with the birth parents, offering counseling services and financial assistance with rent, utilities, food, and medical cost (Beauvais-Godwin & Godwin, 2005). However, these costs are passed then to the selected adoptive parents. As agencies review all the options with birth parents, they really get to know them and often offer to assist with other issues. They may guide them to other resources, such as medical care coverage by the state, GED or educational guidance, and support groups for drug and alcohol addiction. The agency documents social, medical, and family history that will be shared with the adoptive parents as valuable knowledge to have as they raise

the child (Emery, 1993). Medical history suggests what health problems may run in the family and will be important to share with the child's health care provider. The information regarding the family will help inform the child as they grow of where they came from and what their birth family was like. This information helps fill a void in many adoptive children, since they do not have to wonder or guess about their birth connections. When the birthparent moves toward adoption, they can make their own choice in choosing the adoptive parents (National Council on Disability, 2012). Some birth parents establish a bond with the adoptive parents. Thus, some birth parents will then request the adoptive parents be a part of their routine health visits, ultrasounds, and even at the baby's delivery at the hospital. Following the birth of the child, licensed agencies continue to assist the birth parents with post adoption counseling as they cope with the loss of their child (Emery, 1993).

Independent Adoption

Many adoptive parents are searching for more affordable ways to adopt. Private adoption is where the birth and adoptive parents connect through some private means and then hire an attorney for the legal process (Daly & Sobel, 1994). With today's technology, adoptive parents are networking through the internet using social media, advertisements, and personal websites to blog their interest in adoption. They also share their interest with their friends, relatives, co-workers, church, and neighbors trying to make connections with someone interested in placing their child for adoption (Beauvais-Godwin et al., 2005). Some also talk with their obstetricians and other office staff in hopes of finding a pregnant woman interested in pursuing adoption plans for her child. In essence, the adoptive parents are doing a great deal of the work, allowing them to save a considerable amount of money (FurrCohen, 2016). Because the agency and their services are eliminated in this process, then the adoptive parents save on the advertising fees and

counseling services offered to the birth parents. Although this may lessen the financial aspects of adoption, it also removes the services to the birth parents during and after the adoption. The adoption attorney is there for legal counsel and to adhere to the state laws to ensure that the adoption process is binding. Most attorneys do not offer the additional services to birth parents that agencies can offer (Emery, 1993).

Facilitator or Unlicensed Agency

Facilitators are unlicensed individuals or agencies that engage in matching birth parents with adoptive parents. Whereas public agencies are required and often examined for compliance to meet state standards, unlicensed agencies and facilitators are not monitored for their adherence to the laws and ethical practices (National Council on Disability, 2012). Their primary goal is to provide an adoption match, and they do not offer any other types of services. Following a match, all parties involved must then be referred to or find an adoption agency or attorney to move forward in the process. Because of their practices, many states regulate or prohibit the use of facilitators or unlicensed agencies (Child Welfare Information Gateway, 2006). According to Hicks (2007), facilitators do not operate with social workers who can provide skilled evaluations, education, and guidance to birthmothers as they go through the adoption process. As a result, the match often fails because birthmothers lack commitment, emotional preparedness, or misunderstand the adoption process (Law & McDonough, 2014). Approximately thirty-four states and the District of Columbia have laws that regulate the use of facilitators in an effort to ensure that no person, either the intermediary or a member of the birth family, profits from the placement of a child (Child Welfare Information Gateway, 2006). See the table below that distinguishes these states and their regulations of facilitators.

Table 1

States that Prohibit, Restrict, or Regulate Adoption Facilitators

States that Prohibit or Restrict Facilitators	States
States that strictly prohibit the use of facilitators	Delaware and Kansas
States that prohibit the use by restricting the placement of children to licensed agencies	Georgia, Montana, Nevada, New Mexico, and Oregon
States that restrict the placement of children to either agency or a member of the child’s birth family	Kentucky, Massachusetts, Minnesota, Nebraska, New York, and the District of Columbia
State that limit placements to an agency, family member or attorney	Ohio and Oklahoma

States that regulate the activities of Facilitators	States
Twelve States regulate the activities of intermediaries by limiting the compensation that they can receive. It is illegal for these persons or agencies to receive any payment for the placement of the child; reimbursement for actual medical or legal services is the only payment that they can receive	Alabama, Colorado, Louisiana, Maryland, Missouri, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and West Virginia
Eight States allow the use of adoption facilitators, but detail in statute the activities they are permitted or the services they are required to offer	California, Florida, Michigan, Washington, Pennsylvania, New Jersey, North Carolina, Vermont

Note. Adapted from “Use of Advertising and Facilitators in Adoptive Placements: Summary of State Laws,” by the Child Welfare Information Gateway, 2006. Retrieved from <https://www.childwelfare.gov/pubPDFs/advertisingall.pdf>

Foster Care Adoption

Children are brought into foster care when there is a problem with the birth parents' ability to provide or care for their children adequately. Based upon statistics found in the Adoption and Foster Care Analysis and Reporting System (AFCARS), most often children are removed from their homes due to neglect, drug abuse, inability to cope, or physical abuse to the child (U.S. Department of Health and Family Services, 2016). Foster care services are governed by each state's Department for Child Based Services. Children may be placed in kinship care; foster or group homes; independent living facilities; or other types of living arrangement, where they can receive the appropriate support, proper care, and ability to thrive. Foster care is intended to be a temporary solution for the child with the primary goal as reunification with their birth parents (Barbell & Freundlich, 2001).

A series of actions take place during and after a child is removed from their parents. In order for a child to be removed, a judge has to agree to an emergency custody order (ECO), which grants temporary custody of the child to the state (Kentucky Cabinet for Health and Family Services, n.d.). When a child enters foster care, the agency calls the foster parents for placement. At this time, known details of the child's health and well-being will be shared. They will also provide as much detail as possible of the child's case, behavior history, and the circumstances which caused the removal. At this time, foster parents will have the right to accept or decline the placement (Kentucky Cabinet for Health and Family Services, 2015a). Because the ECO is only valid for seventy-two hours, or three business days, a court hearing must be conducted in that timeframe to determine if the child was at risk for abuse and will remain in the care of the state (Kentucky Cabinet for Health and Family Services, n.d.). Usually, it is unknown how long a child will remain in foster care. The child may be able to return to

their parents, if the parents have completed the goals of their case plan, the factors that resulted in the removal of the child become resolved; the child's best interest is to return to their parents, or the judge grants custody back to the parents (Kentucky Cabinet for Health and Family Services, n.d.).

At times there are cases where the birth parents fail to improve their ability to care for their children. When this happens, the child's worker files a petition with the court for a goal change. A goal change hearing is set forth and the judge may change the child's goal from reunification with the birth parents to adoption. At times, infants may become available for adoption from foster care, but most children available for adoption are generally toddlers to age twenty-one with the median age of a child being eight (AdoptUSKids, n.d.). Foster parents will not be able to proceed with the adoption until the court has terminated the legal rights of the birth parents, and all options for relative placement or adoption have been explored (Kentucky Cabinet for Health and Family Services, 2017). The AFCARS Report cited that in 2015, there were 427,910 children reported in foster care and of those 53,549 were adopted with the assistance of the child welfare agency (U.S. Department of Health and Family Services, 2016).

In an effort to assist older children and sibling groups find permanent homes, many states have developed state, regional, and national website listings that includes photographs and a small biography of the child(ren) available (Hicks, 2007). It also provides contact information to inquire about the child(ren). Those listed on these websites have already been in the foster system and are usually legally free for adoption (Gilmore, Oppenheim, & Pollack, 2004). For example, AdoptUsKids can be found at <https://adoptuskids.org/> and maintains the nation's largest database of available children to find loving, adoptable homes (Hicks, 2007).

Many children are eligible for adoption through foster care. According to AdoptUsKids, there are more than 100,000 children in need of permanent, adoptive homes (n.d.). Because children in foster care have experienced some sort of trauma, they are identified as having special needs. According to the North American Council on Adoptable Children (NACAC), this term refers to older children; minority races; sibling groups; medically fragile; or physical, mental or an emotional disability (2007).

Egg and Embryo Adoption

Due to medical science, a growing trend in adoption is through egg and embryo donations. These adoptions allow a frozen egg or embryo donated by a woman or couple, who have been through in vitro fertilization (IVF), to be transferred to an adoptive mother. She can then carry the child, though not genetically related, and experience pregnancy and delivery for herself (Kirkman, 2003). Often times, IVF treatment creates more eggs or embryos than needed for the donating person. This results in unused eggs or embryos left in frozen storage. In 2011, there was an estimated 600,000 embryos in frozen storage, but experts believe an estimated 1,000,000 are now being stored (The Fundamentals of Embryo Donation and Adoption, n.d.). Statistics show that donor eggs result in a 50% chance of a successful birth, whereas donor embryos achieve a 37% successful birth rate (Society for Assisted Reproductive Technology, 2013).

IVF patients who have achieved successful pregnancies and are content with their family must decide what to do with the remainder of their frozen embryos. Their choices are to maintain their embryos in frozen storage, destroy them, surrender them to scientific research, or donate them for adoption purposes (The Fundamentals of Embryo Donation and Adoption, n.d.).

Since the 1990's it is estimated that over 7,000 babies have been born from donated frozen embryos alone (The Fundamentals of Embryo Donation and Adoption, n.d.).

Just like all other types of adoption, there is much to learn about egg or embryo adoption. For instance, donors are allowed to privately choose the recipient of the eggs or embryos from potential adopters or through a donation program. To qualify for this type of adoption, the female recipient must be reasonably healthy and have the ability to carry the egg or embryo (Kirkman, 2003).

Embryos are not considered as babies but as property, which is governed by property laws, resulting in less cost than other types of adoptions. Prior to the transfer of the embryos, the donor's rights are willingly relinquished and transferred legally to the recipient. At birth, as governed by law, the adopting parents are legally considered the child's parents (The Fundamentals of Embryo Donation and Adoption, n.d.). Upon review of the Embryo Adoption Wellness Center (n.d.), they indicate that embryo adoption is a lesser expensive option than compared to domestic or international adoption. The process entails matching fees, counseling, embryo transfer cost, medical testing, and legal fees. A breakdown of these fees is specified in the table below, supplied the by Embryo Adoption Wellness Center (n.d.).

Table 2

Cost of Embryo Adoption

Agency Fee* *Additional travel expenses may be incurred for centralized programs.	\$2,500 – 10,000	May or may not include legal fees, embryo shipping, matching services, counseling, additional medical screening
Home Study/Family Evaluation	\$1,500 - \$3,500	Cost vary by state
Clinic Frozen Embryo Transfer (FET)	\$3,500 - \$6,000	Cost vary by clinic
TOTAL:	\$7,500 – \$19,500	Generally less expensive than domestic or international adoption

Note. Adaption from “Cost of Embryo Adoption,” by Embryo Adoption Wellness Center, n.d., Retrieved from <http://www.embryoadooption.org/embryo-adoption/cost-of-embryo-adoption/>

Open, Closed, or Semi-Open Adoption

Maintaining an open, closed, or semi-open adoption relationship with the birth parents is a matter of personal preference. It is important to understand the differences and controversy in these various adoption options. Adoption professionals will use each participant’s preference as one of the criteria to establish a connection between the birth and adoptive parents (Curtis, 1986).

Open Adoption. Open adoption focuses on the importance of maintaining a committed, ongoing relationship with the birth parents and exchange identifying information (Pannar &

Baran, 1984). This could be by such means as sharing pictures, letters, phone calls, or even visitation with the child. It can also mean the birth parents are involved in the adoptive parent's family functions, such as the child's birthday celebrations, holidays, or school functions routinely. Societal norms tend to favor open adoption, feeling that it is important for an adoptive child to know about their birth parent connections and history in order to have a clear understanding of their own identity and know why their birth parents chose adoption (Curtis, 1986). As statistics show, open adoption has become the most popular practice of adoption within the U.S. as more agencies are stemming away from closed adoption. Statistics identified in one study shows 90% of U.S. infant adoptions have some degree of openness, whereas less than 10% of adoptions are closed, without sharing any identifiable information by (Caldwell, 2005).

Throughout life, it is normal for many adoptees to express concerns, curiosity, or questions relating to their birth parent connections (Hollinger, 1993). This is one reason many today are considering the open adoption concept. Open adoptions provide many beneficial advantages to the well-being of an adoptive child. From the adoptive child's perspective, these benefits could include being better adjusted because they are satisfied with having contact with their birth families, provides them with a better sense of identity, and allows them to question the reasons they were placed for adoption (Curtis, 1986.).

Semi-Open Adoption. When some of those boundaries are restricted, but some form of contact is ongoing, it is usually termed as semi-open adoption. Open or semi-open adoption can have many varying degrees of commitment and is mutually agreed upon by all parties involved. Degrees of openness for semi-open adoptions can include lesser involvement, such as sending

the birth parents letters or pictures of the child periodically without any exchange of personal contact information, such as phone numbers or addresses (Sorich & Siebert, 1982.)

Closed Adoption. A closed adoption means that the adoptive parents and birth parents refrain from having any contact during or after the adoption process (Hicks, 2007). In this case, the adoption process is handled by the third party like an agency, attorney, or social services. In closed adoptions, none of the parties involved speak directly to one another, meet, or share any personal contact information. The birth parents will not receive updated information or letters regarding the child's growth and progress (National Adoption Center, n.d.).

International Adoption

International adoption, also commonly known as intercountry or foreign adoption, is the adoption of a child from outside the U.S. International adoptions are more complex in that they also involve immigration procedures, dossier paperwork, and citizenship completion. Each of these components consists of many forms, procedures, and approval proceedings (Children's Bureau of Consumer Affairs, 2017).

There are many aspects to consider in international adoption versus domestic adoption, such as racial, cultural, and national differences (Bartholet, 1993). Some children eligible for international adoptions are cared for in orphanages, resulting from the loss of their birth parents due to death or abandonment (National Council on Disability, 2012). This may also cause limited or non-existent availability to medical or personal records. It is also important to note that most children are toddlers or older by the time they are brought into the U.S., as it takes time to process all the foreign documentation and approval required (Bledsoe & Johnson, 2004).

U.S. Citizenship & Immigration Services. In addition to the home study, international adoptions must also adhere to the standards provided by the U.S. Citizenship and Immigration

services (USCIS). USCIS examines the eligibility and suitability of the individuals looking to adopt (2016). They also decide if a child is eligible to immigrate to the United States (USCIS, 2016).

Dossier. International adoptions also must submit a dossier to the foreign country in which the adoption is expected to take place. The dossier consists of numerous legal documents, which includes the family's home study and USCIS approved documents. The dossier is sent to the government officials of the foreign country, where it will be reviewed to determine if the family meets their country's eligibility requirements to adopt from their country (Tenenbaum, 1999).

Eligibility Requirements. To complete a successful adoption internationally, certain requirements must be met within the United States federal immigration laws, the country from which the child resides, and the state in which the adopters reside (U.S. Department of State, n.d.). International adoptions work in a similar fashion as domestic adoptions in that every country has their own laws and regulations. Careful research should be conducted to determine if those qualifications are met before starting the process. Many countries have requirements or restrictions pertaining to age, health, income, and marital status (Davenport, 2006). The table below identifies such requirements on behalf of China and Korea's adoption programs.

Table 3

International Programs At a Glance

	<u>China</u>	<u>Korea</u>
<i>Age of Applicant</i>	30 to 55 , for <u>Single female</u> : 30 to 50. No more than 45 years between the parent and the child.	25 to 44 , with waiver to 49 for applicants that meet at least one of the following: one adoptive parent is of Korean Heritage; a Korean adoptee, or previously adopted from Korea.
<i>Marital Status</i>	2 years, if previous divorce, 5 years, limit of two divorces. <u>Single female</u> living with a male partner, must meet the requirements of a married couple.	3 years, no more than one divorce per spouse.
<i>Age at placement</i>	15 months and older	18 to 30 months
<i>Gender Preference</i>	Permitted, but boys are easier to match than girls.	None, more boys than girls. Possibly for Korean heritage, but a much longer process.
<i>Family Composition</i>	No more than 5 children is preferred. <u>Single female</u> , no more than 2 children, youngest at least 6 years old.	No more than 4 children
<i>Income</i>	Net worth of \$80,000, minimum income of \$30,000, or \$10,000 per person living in the home. <u>Single female</u> , net worth of \$100,000, minimum income of \$20,000, or \$10,000 per person living in the home.	Combined income of \$35,000 with financial security.
<i>Health</i>	Should not have significant medical conditions, chronic or infections illness. Some conditions controlled with medication are acceptable.	Excellent health without major medical concerns, Body Mass Index (BMI) under 30%.
<i>Length of Time</i>	9 to 18 months	15 to 24 months

Note. Adapted from “Programs at a Glance,” by New Beginnings Family and Children’s

Services, Inc., n.d., Retrieved from <https://www.new-beginnings.org/programs-at-a-glance/>

Statistics. A tremendous growth began in international adoptions in the late 1990's with the peak being in 2004 with 22,989 adoptions (Children's Bureau of Consumer Affairs, n.d.). Advertisements for international adoptions attracted desperate adoptive parents willing to pay premium wages for the quick adoption of a healthy infant (Tenenbaum, 1999). This spiked an increase in abductions of children to be sold on the black market. The government became aware of this crisis and began to establish the *Hague Convention on the Protection of Children*. This regulated adoptions between the United States and approximately eighty-five other countries effective on April 1, 2008 (National Council on Disability, 2012). While this convention helped alleviate the corruptness, it also created barriers, such as more paperwork and longer timeframes. These circumstances caused a huge decline in international adoptions. In fact, the table below from the Bureau of Consumer Affairs (2017) shows a steep decline in international adoptions between 2004 and 2015.

Table 4

International Adoptions by Year

<u>Year</u>	<u>Total International Adoptions</u>
1999	15,717
2000	18,856
2001	19,644
2002	21,459
2003	21,647
2004	22,989
2005	22,726
2006	20,675
2007	19,601
2008	17,449
2009	12,744
2010	11,058
2011	9,319
2012	8,667
2013	7,092
2014	6,438
2015	5,647

Note. “Intercountry Adoption” by Children’s Bureau of Consumer Affairs, U.S. Department of the State, n.d. Retrieved from <https://travel.state.gov/content/adoptionsabroad/en/about-us/statistics.html>

Child Referral and Assignment. Unlike the domestic adoption process, international adoption consists of matching a child to the prospective adoptive parents. This referral process, as identified by (Tenenbaum, 1999) may or may not provide the adoptive parents with a picture of the child. This information may include age, gender, family history, medical records, or special needs. The adoptive family will then have to make the decision as to whether to proceed or decline the child referred. If the family proceeds, the child will officially be “assigned” to the adoptive parents (Bledsoe et al., 2004).

Travel, Court Hearing, and Finalization. International adoption requires extensive travel to a foreign country. That could mean a prolonged stay and possibly multiple visits to that country (Bledsoe et al., 2004). Following the referral and child assignment, preparation will be made to adopt the child. Forms, such as the I-600 or I-800, must be completed for all international adoptions to formally document and petition the court to classify the orphan as an immediate relative of the adoptive parents (Bartholet, 1993). Form I-864 must also be completed to attest that the adoptive parents have sufficient financial support for the child. Once all forms are completed, they are sent to USCIS for approval. Then, prior to leaving the country, the child must be approved by the U.S. Embassy for a passport and an immigrant visa to enter the U.S. As dictated by the I-604, Orphan Investigation Form, the child must undergo a physical examination by a foreign physician approved through the U.S. validating the child is an orphan and free of any medical conditions unknown to the adoptive parents (Bledsoe et al., 2004). Because the laws vary in all foreign countries, the finalization may occur in the child’s birth country or the U.S. Once the child enters the U.S., the child must apply to obtain a Certificate of U.S. Citizenship, which is a non-expiring, indisputable certificate that validates the child to be a U.S. citizen (Bartholet, 1993).

Adoption Directories

Directory listings for adoption agencies and attorneys can be found periodically through Internet search engines. Websites, such as, Adoption Agencies Directories, can be found at <http://adoption-agencies.regionaldirectory.us/> and feature a list of many adoption organizations categorized by state (2017). Detailed information in the directory provides names, physical and website addresses, and phone numbers. Information is also included that details the list of services offered. Other websites, such as Academy of Adoption and Assisted Reproduction Attorneys (AAAA), can be found at <http://www.adoptionattorneys.org/aaaa/directories-page/aaaa-directories> (2017). AAAA features adoption agencies and attorneys located by state as well. Agencies that complete international adoptions can also be found in these directories (Beauvais-Godwin et al., 2005).

Biological Factors

Many children living in America live in unprecedented circumstances, including unstable family structures, unhealthy environmental factors, and poor economic conditions (Child Welfare Information Gateway, 2013). Homelessness, hunger, violence, and insufficient care or attention can be very influential in a child's demeanor and overall well-being (Barbell et al., 2001). Most children that live in such conditions are not able to receive proper care, support, or sufficient educational experiences, thus resulting in many issues for the child. "Being a child in a low-income or poor family does not happen by chance; parental education and employment, race/ethnicity, and other factors are associated with children's experience of economic insecurity" (Jiang, Granja, & Koball, 2017, p. 1). According to National Institute on Drug Abuse (NIDA), a child can be exposed to a number of factors prior to birth, such as drugs and alcohol

that can significantly affect its health and development that can cause long term implications to the child (2016).

Alcohol and Drug Abuse

In 2005-2006, the National Center on Substance Abuse and Child Welfare (NCSACW) completed a comprehensive review of prenatal substance exposure (2014). The purpose of the study was to measure “prevention, intervention, identification, and treatment of prenatal substance exposure, including immediate and ongoing services for the infant, the mother and the family in order to help local, state and Tribal governments” (Young et al., 2009, p. 1). More specifically, the study focused on such objectives as preventive actions, testing at birth, and the involvement of Child Protection Services (CPS) for infants that tested positive at birth. An examination of state laws was also part of the review in regards to infants exposed to drugs. As found within the report, an estimated 400,000-440,000 infants each year have been prenatally exposed to alcohol or illegal drugs (Young et al., 2009).

There can be numerous detrimental health effects on a fetus, as a result of prenatal substance abuse. Thorough research concludes that tobacco, alcohol, illegal drugs, or abused prescribed medication ingested by a pregnant women can cause significant health issues for infants (NIDA, 2016). Because many drugs cross the placenta, the child is affected to some extent by the drug. These factors could result in the infant being born prematurely or stillborn, among many short-term or long term effects on the fetus (Beauvais-Godwin et al., 2005). Though, it is also known that some children can be born perfectly healthy. So many factors influence the baby’s health, making it impossible to determine the specific outcome for each child until they are born and assessed. When adopting a child possibly exposed to alcohol or drugs, it is best to research all the effects that these substances may have on the fetus and what to

expect once the baby is born. There are many drugs available, such as alcohol, marijuana, cocaine, heroin, and methamphetamines that can be abused causing harmful consequences to the fetus or infant. In the table below, research findings evaluated the use of alcohol, tobacco, and illicit drugs among women ages fifteen to forty-four years old (American Academy of Pediatrics, 2013).

Table 5

Comparison of Drug Use Among Women 15 to 44 Years of Age

Pregnancy Status: 2009–2010

	Pregnant Woman %	Non Pregnant Woman %
Illicit drug use	4.4	10.9
Alcohol use	10.8	54.7
Binge drinking	3.7	24.6
Cigarette use	16.3	26.7

Note. “Prenatal Substance Abuse: Short and Long Term Effects on Exposed Fetus,” by Behnke, M. and Smith, V., 2013, February 25, *American Academy of Pediatrics Journal*. DOI: 10.1542/peds.2012-3931. Retrieved from <http://pediatrics.aappublications.org/content/pediatrics/131/3/e1009.full.pdf>

Because many of the drugs and alcohol can cause dependency issues with the birthmother, it is also possible that the baby will be born addicted to the same substance (Beauvais-Godwin et al., 2005). The addiction to these drugs may result in the child having numerous withdrawal symptoms, including sweating, trembling, irritability, excessive crying, feeding problems, and difficulty sleeping (NIDA, 2016). Unfortunately, some infants can have severe consequences from prenatal exposure, leading to long term and fatal effects including, birth defects, physical malformations, premature birth, learning disabilities, behavioral problems, and sudden infant death syndrome (Beauvais-Godwin et al, 2005).

In the work presented by the Institute of Medicine and National Research Council, substance abuse by parents is a correlating factor for child abuse and social services involvement (Barbell et al., 2001). Research studies conclude that parental alcohol or drug abusers are more likely to abuse or neglect their children (Dube et al., 2001). Problems resulting from the use or abuse of drugs and alcohol can cause a chaotic effect in the home. Because illicit drugs and alcohol can impair the brain's ability to function clearly, it is also likely that it will affect the parent's ability to maintain the safety and health of their child. Parents can exhibit a wide variety of side effects from substance abuse, including inattentiveness, sleepiness, irritability, delusions, and non-coherence resulting in a diminished ability to care for a child (Child Welfare Information Gateway, 2013). Dependency problems on drugs or alcohol can also lead to unemployment issues and financial hardships when addicted parents use their only income to supply their habits instead of using their money for the family's basic needs. As a result, parental substance abusers are likely to struggle with social isolation, poverty, unstable housing, and marital abuse. Furthermore, the co-existence of multiple problems may influence substance use and child abuse (Dube et al., 2001).

The goal of the State and CPS may simply be to provide the family with the appropriate resources needed to recover from addictions and assist the children with recovering from the trauma (NCSACW, 2014). However, it certainly is not an easy undertaking and can be a very complex process. Proper services and resources for these families might include a comprehensive list of professionals, including specialized doctors, social workers, family court judges, special educators, speech therapist, counselors, psychologist, and substance abuse treatment facilities (NCSACW, 2014). Getting access to some of these resources can take time. Parents also need to provide their own transportation to their appointments, which for low-income families, can be a struggle. It is also important that the parents have the willingness to accept the help and take advantage of these services to overcome their substance abuse problems. Treatment may also take months to years to complete and can seem like a long, daunting commitment (Child Welfare Information Gateway, 2014)

Once CPS can substantiate a case of parental substance abuse, the child will most likely be entered into the welfare system as a foster child unless an appropriate relative is available. If relatives are not available, the child will be placed with foster parents. Likewise, a parent may elect to place her child for adoption based upon some of these same conditions. In many instances, it is not clearly known the types or frequency of drugs the mother did while pregnant. Therefore, it is important in all cases to immediately have the child evaluated by a physician (Kentucky Cabinet for Health and Family Services, 2012).

Cost & Financial Assistance

Depending on the type of adoption pursued, affording the high cost of adoption seems to be one of the major obstacles when considering adoption. There are several costs involved throughout the adoption process causing most domestic, excluding foster care adoptions, and

international adoptions to very expensive (Davenport, 2006). These cost factors can be a heavy burden or inhibit many hoping to adopt. All adoption agencies and attorneys have different fee structures. Adoptive parents are normally provided with an estimated expense sheet before anyone commits to the adoption. It is important to note that cost may vary due to the home study and licensing fees, birthmother's living expenses (such as food, rent, and utilities), medical coverage for both the birthmother and the child, counseling and support services, legal fees, and marketing/agency fees. Every year, *Adoptive Families* magazine creates polls for families who have finalized their adoptions. Based upon the totals for the 2015-2016 polls, foster care adoptions cost is relatively little, if anything at all. U.S. adoptions of newborns averaged \$37,000 and international adoptions averaged \$42,000 (Editorial Team, *Adoptive Families*, 2017). See their table below for the breakdown of the average cost for an infant, domestic adoption.

Table 6

U.S. Newborn (Agency) – Average Cost Breakdown

<u>Expenses and Other Fees</u>	<u>Cost</u>
Home study fee	\$2,397
Document preparation & authentication	\$955
Adoption agency application & program fees	\$16,442
Adoption consultant fees	\$1,999
Attorney fees	\$4,337
Advertising/networking	\$1,880
Birth family counseling	\$1,069
Birthmother expenses	\$3,919
Foster care	\$71
Travel expenses	\$2,117
Post-placement expenses	\$2,063
All other expenses	\$5,088
AVERAGE TOTAL*	\$42,377

* Average represents total costs before claiming the Adoption Tax Credit.

Note. Adapted from “Adoption cost and timing in 2015-2016,” by Editorial Team, 2017, April 29. Retrieved from <https://www.adoptivefamilies.com/resources/adoption-news/adoption-cost-and-timing-2015-2016/>

Many families interested in adoption are discouraged because of the huge financial obligation. Over the years as adoption has become more publicized, new resources are available to financially assist the adopters in the process (Child Welfare Information Gateway, 2016). The list below includes a few of the resources available to assist with adoption expenses.

Employee Benefits

Some employers are very supportive of adoption and want to offer assistance as part of the employee's benefit package (Davenport, 2006). Employers may offer to assist with a specific financial contribution, or offer paid leave once the child has been placed in the home. Many well-known companies; AT&T, Bank One Corporation, Sprint, Target, United Airlines, and Wendy's, are supportive of adoption and offer some sort of benefits to their employees (Resources4adoption, 2013).

Adoption Subsidy

Although the risks involved are uncertain in adopting from foster care, it is the most affordable option for adoption. In addition to the adoption being free to little cost, these children may be eligible for an adoption subsidy (Beauvais-Godwin, et al., 2005). These benefits, which are negotiated in special meetings, can vary by state; but all states typically provide monthly payments for expenses, medical assistance coverage, social services, and a one-time-only reimbursement of non-recurring adoption expenses (Dave Thomas Foundation for Adoption, 2014). Another element usually involved in adoption from foster care is that often children will have siblings. The state will attempt to keep all foster and adoptive siblings together in the same home. The financial assistance provided offsets some of the expenses of adopting sibling groups. AFCARS cites that in 2015, 92% of adoptive parents received financial subsidies following the adoption of their foster child (U.S. Department of Health and Family Services, 2016).

If financial barriers are impossible to overcome to adopt, the best option may be to consider adoption from foster care. There is little to no expense to adopt from foster care as the training and home study fees are paid for by the state (Beauvais-Godwin, et al., 2005) For

example, Kentucky foster parents receive a monthly subsidy that covers expenses associated with caring for a child such as food, clothing, and athletic activities. Foster children in Kentucky also qualify for a college tuition waiver to attend any public or technical college and are covered by the state's Medicaid program; which covers all medical, dental, vision, and psychiatric costs for the well-being of the child (Kentucky Cabinet for Health and Family Services, 2012).

Federal Adoption Tax Credit

Because adoption can be a huge financial expense, the federal government approved and implemented a tax credit in 1996 (Annest, n.d.). The credit permitted families to deduct up to \$5,000 (\$6,000 for a special-needs adoption) in qualified adoption expenses from their total tax liability, which provided a tremendous tax relief to adoptive parents who had spent thousands on their adoption (Hollingsworth, 2000). Such qualified expenses included home study expenditures, court costs, legal services, agency fees, and traveling expenses. The adoption tax credit for adoptive families has continued to be periodically reviewed and changed. In 2012, the credit changed, making it nonrefundable, meaning that it can only be claimed by families with a tax liability. It again changed in January 2013 when it became a permanent tax credit. After several years of revisions, the maximum amount available for 2016 was for \$13,460 (Internal Revenue Service, 2017). According to IRS guidelines, this credit is also allowed towards foster care adoptions regardless of the calculated expenditures.

Home Study

Once the adoption method has been chosen, the next step is to complete the home study process. A licensed social worker works with each family to provide information regarding available training activities, the interview process, paperwork, and home review (National Adoption Information Clearinghouse [NAIC], 2004). The social worker's responsibility is to

collect or review family history, home evaluation for safety, educational background, financial information, and other pertinent information to determine if the home is suitable to raise a child. The agencies, along with state laws, determine how long a home study remains valid (Dave Thomas Foundation for Adoption, 2014). If the home study expires before an adoption occurs, the process has to be repeated. On average, the process takes up to six months to finalize; and consists of the following components as stated by the Child Welfare Information Gateway (2015).

Orientation

The orientation consists of a short informational meeting with the agency, attorney, or professional chosen. This usually takes a few hours and can be done in a group setting with other prospective adoptive parents. The orientation provides the opportunity to gather more information about the agency, process, and cost or fees specific to the agency (Child Welfare Information Gateway, 2015). This provides an opportunity to examine any pre-adoptive concerns and gather with other couples wishing to learn about adoption. It is important to understand and evaluate the agency's program and ask questions related to the process, such as child placement procedures, preferential characteristics of an adopted child, and legal obligations (Farber, Timberlake, Mudd, & Cullen, 2003).

Training

Each agency or professional will provide important, customized training information regarding parenting an adoptive child, and potential issues related to adoptive children. If pursuing a domestic adoption, the training may lean towards teaching the adoptive parents about parenting needs of a newborn, childhood development phases, and perhaps the possible side effects of alcohol or drug exposure (Gilmore et al., 2004). However, if choosing to proceed with

foster care adoption, the training may involve an overview of recognizing abuse and neglect issues in children and learning strategies of coping with these issues. Such training may also involve how these issues traumatically impact the child. Classes might also include basic first-aid, discipline techniques, behavioral management skills, and medication administration (Kentucky Cabinet for Health and Family Services, 2015b).

Interviews & Home Inspection

The assigned social worker will request a home visit to complete an interview process and home inspection to check for numerous safety issues (Gilmore et al., 2004). If married, the social worker will want to meet with each spouse. During this meeting, the social worker will discuss information regarding each spouse's family history, including parents and siblings, pets living in the home, marital or divorce history, and other children or adults living in the home (Davenport, 2006). The social worker may ask about factors that influenced the decision to adopt, and also discuss what is being looked for in a child, including age, gender and race. During the home inspection, the social worker will complete a walk through the home. The worker is assessing the home for the number of bedrooms, bathrooms, smoke and carbon monoxide detectors, fire extinguishers, evacuation plans, first aid kits, cleaning supplies stored out of reach, and weapons securely locked away, among other things as stated by the (NAIC, 2004). A telephone is also required, whether it be a landline or cell phone, for emergency situations and access to those phone numbers must be written and displayed. Safety provisions will be enforced for swimming pools or hot tubs which need to be fenced, gated, and locked. All family members living within the home are required to have a physical examination, which usually can be with the family's primary care physician. Upon completion of the physical, the physician must complete an assessment form

detailing any impairments, medical history, and a list of prescribed medications (Child Welfare Information Gateway, 2015).

Records, Verification, and Adoption Profile

Several records are required for the home study to be completed (Davenport, 2006). A record of immunizations is required for all children living in the home. Other documents needed include certified copies of marriage certificates, divorce decrees, birth certificates, employment verification, and copies of paystubs. Additionally, a personal income statement and income tax forms which identifies the adoptive parents financial stability to provide for a child (NAIC, 2004).

All adoptive parents wishing to adopt must provide personal references, as well as pass a number of background checks. Usually three personal references are requested by friends, coworkers, or relatives and one or two references providing a credit history are requested. The adoptive parents must also be fingerprinted and checked for any federal, state, and child abuse records (Davenport, 2006).

Adoption agencies and other adoption professionals usually request an adoption profile of the prospective adoptive families. The profiles may consist of a “dear birthmother” letter, the family’s biography, and photos. It also serves as an introduction to the birthmother; providing her with a sense of the family’s dynamics, home, children, pets, travel or vacation interest, and hobbies or sports interest. An adoption profile is usually requested by many adoption agencies (NAIC, 2004).

Child Placement, Post Placement Visits & Adoption Finalization

Child Placement

Multiple scenarios can occur at the hospital for the birth of the child, depending on the type of adoption all parties wish to establish (Hick, 2007). Being present for the child’s birth

usually only occurs during domestic adoptions. Prior to this point, expectations should have been discussed and agreed upon between the birthmother and adoptive parents in regards to caring for the baby during their hospital stay. If the birth parents and adoptive parents have developed a strong relationship throughout the match process, then it's common to hear of the adoptive mother or parents being requested to be at the hospital, even in the delivery room for the birth (Beauvais-Godwin et al., 2005). This will definitely depend on the comfort and security level of the birthmother as labor is intense and her privacy should be respected. Nonetheless, many birthmothers do request the adoptive parents at least be present at the hospital at the time of delivery, if possible. Many birthmothers also understand the importance of the child bonding with the adoptive parents by frequently visiting, bathing, dressing, and feeding the newborn during the hospitalization. This helps the birthmother observe interactions between the adoptive parents and baby, which can help the birthmother feel more confident in her adoption plan. Attending the birth will also allow the adoptive parents to have access to the doctors and nurses about the child's newborn health screenings (Wiernicki, 2014).

Standard hospital procedures include many medical screenings for a newborn that might include test to screen for health factors and certain disorders or diseases (Beauvais-Godwin et al., 2005). Results of all these tests can be communicated to the adoptive parents if the birthmother signs consent to allow the adoptive parents to have access to the baby's medical records and/or hers. Without this authorization, the hospital staff will not be allowed to disclose any information to the adoptive parents (Young et al., 2009).

While many states have standardized testing procedure for infants regarding diseases, adequate laws are not available that mandate testing for substance exposure. For example, most states require that hospitals screen infants for numerous diseases, such as human

immunodeficiency virus (HIV) and phenylketonuria (PKU) (Beauvais-Godwin et al., 2005). In relation to these problems, the NCSACW also found in their 2005-2006 study that testing of infants for substance exposure to be a very complex and a controversial issue. Results indicated that most hospitals do not maintain the same policies or procedures for testing newborns nor do the hospitals contact CPS with the data or results collected. In fact, they could not identify any state to have mandatory testing of newborns. Furthermore, they estimated that 90-95% of infants that are born exposed are not detected due to the lack of required procedures (Young et al., 2009).

When drug use is suspected, laboratory testing can include a urinalysis sample from the newborn or meconium testing to determine the presence of substance exposure (Young et al., 2009). As noted in the table, urine screens from a newborn will most likely only detect the presence of recent exposure, while meconium drug testing can be conclusive of several months (ChildAbuseMD, n.d.).

Table 7

Positive Urine Toxicology Screens

Positive Urine Toxicology Screens	
Alcohol (Ethanol) <ul style="list-style-type: none"> • 3 to 10 hours 	Hydromorphone (Dilaudid) <ul style="list-style-type: none"> • 1 to 2 days
Amphetamine Or Methamphetamine <ul style="list-style-type: none"> • 1 to 2 days • May also detect MDMA 	Methaqualone (Quaalud) <ul style="list-style-type: none"> • 2 weeks
Barbiturates <ul style="list-style-type: none"> • 2 to 6 weeks 	Methadone (Dolophine) <ul style="list-style-type: none"> • 2 to 3 days
Benzodiazepines <ul style="list-style-type: none"> • Moderate use: 3 to 5 days • Heavy abuse: 3 to 6 weeks 	Morphine <ul style="list-style-type: none"> • 1 to 2 days
Cocaine <ul style="list-style-type: none"> • Direct: 5 hours • Metabolite (Benzoylecgonine): 2 to 4 days 	PCP (Phencyclidine) <ul style="list-style-type: none"> • 2 to 8 days • False positive with Ketamine
Codeine <ul style="list-style-type: none"> • 1 to 2 days 	Propoxyphene (Darvon) <ul style="list-style-type: none"> • Direct: 6 hours • Metabolites: 6 to 48 hours
Heroin (detected as Morphine) <ul style="list-style-type: none"> • 1 to 2 days 	Marijuana (THC metabolite) <ul style="list-style-type: none"> • Urine: Use of one joint: 2 days • Use three times per week: 2 weeks • Use daily: 3 to 6 weeks

Note. “Toxicology Screening in Newborns,” by ChildAbuseMD.com, n.d.. Retrieved from

<http://www.childabusemd.com/laboratory/toxicology.shtml>

Based upon the laws governed by each state, a birthmother may not be allowed to sign her consent to the termination of parental rights until a few days following the birth (Caldwell, 2005). After giving birth, birthmothers are physically drained, mentally exhausted, and hormonally imbalanced. This gives a period of time for the birthmother to recover and reflect carefully upon her decision. Many states do allow consent to be signed twenty-four to seventy-two hours following the birth of the child. In fact, forty-eight states require birthmothers to wait until after the birth to sign the consent, which terminates her parental rights (Hicks, 2007). Once signed, some states allow the birthmother to revoke her decision for a certain time frame, such as 30 days. Other states do not have laws allowing a revocation period. Once the birthmother or parents have signed the legal paperwork to terminate all their parental rights, the child will be free to be placed with the adoptive parents (National Council on Disability, 2012). If the parents reside in the same state in which the child was born, they will be able to immediately take the child home while waiting for the lawyers to proceed with the termination of the parental rights and the adoption. Parents who reside out of the child's birth state will have to wait through the ICPC process, which is typically a ten to fourteen day process (Caldwell, 2005).

Post Placement Visits

Before the adoption can be finalized, the social worker will complete at least one home visit to ensure the placement is going as expected. This opportunity provides the adoptive parents the chance to ask any questions about problems or concerns, parental skills, or about the child's behaviors. The social worker will also want to ensure the safety of the child and that all the child's needs are being met. Following this visit, the social worker will complete her paperwork and make a referral to the court for the adoption to be finalized (NAIC, 2004).

Finalization

The final step in the adoption process consists of a court hearing before a judge. The court hearing can either take place in the state the child was born or in the state for which they will reside. This decision is largely determined by the state's laws and which are more favorable to the adoptive parents (Annest, 2017). The judge will examine all the paperwork provided by the attorney, ensuring that all state laws and proper procedures have been met. The judge will also review the social worker's report of the post-placement home visit and recommendation for adoption. This hearing is usually rather short, with the judge issuing the final decree of adoption (Caldwell, 2005). Historically, the only participants in the court proceedings of an adoption were the judge, child, adoptive parents, their attorney, and social worker. However, a growing trend is to invite friends and family to celebrate and witness the finalization hearing. Upon completion of this court hearing, the child is legally considered that of the adoptive parents, entitling the child to the same rights as that of a biological child (David Thomas Foundation for Adoption, 2014).

Adopting a Child of Abuse or Neglect

As discussed, prenatal factors can cause numerous health care issues. A child who has experienced in-utero substance abuse may experience lifelong consequences (NIDA, 2016). Likewise, children may also endure severe effects from mental, emotional, or physical abuse as well as neglect. Unfortunately, there is no way of predicting the health of a child or how certain exposures to the child throughout its life will affect them. However, specialists and services can assist in improving or resolving many issues that have impacted a child (Child Welfare Information Gateway, 2013).

Maltreatment factors, such as abuse and neglect, can substantially interfere in a child's growth and development (Lazenbatt, 2010). Children's brains simply are not stimulated to develop and grow to its fullest potential when they have been subject to maltreatment (Putnam, 2006). In fact, research studies show that critical brain growth develops during the first three years of life, making it imperative that the infant gets the proper care and attention needed for healthy growth and development (Putnam, 2006). As a child grows and enters the school age years, other signs of the abuse and neglect may appear, including struggling academically or socially in school or among other peers. Children may also show signs of abuse and neglect socially, psychologically, or behaviorally. This might include a variety of issues, such as mental or emotional disorders related to depression or anxiety and attachment issues associated with affectionate related behaviors with strangers or demonstrating unacceptable adult behaviors (Lazenbatt, 2010).

Abuse and neglect can have a number of negative effects on a child. These factors can lead to child development concerns, health care issues, social inabilities, mental disorders, and behavioral issues, among others (Lazenbatt, 2010). Many researchers have examined these areas in studies trying to understand how the child's brain functions, develops, or reacts to the effects of abuse and neglect. Research shows that these altercations in a child's life at an early age can result in a diminished ability of the brain to perform than was potentially possible if such abuse or neglect had not occurred (Putman, 2006).

Physical Abuse

Physical abuse can be described as the intentional physical injury to the child through such ways as intentional hitting, kicking, or burning (Slep, & Heyman, 2006). As the adoptive parent or primary caregiver, it is important to recognize the signs of physical abuse. Children

who have endured physical abuse often have lacerations, bite marks, burns, bruises, or broken bones, or numerous other physical injuries (Lazenbatt, 2010).

Neglect

The primary focus of every parent should be to provide for the child's basic needs. Failure to provide for these basic needs, such as food, suitable housing, supervision, medical care, and emotional well-being can be construed as being neglectful to the child (National Scientific Council on the Developing Child, 2012). Signs of neglect can sometimes be evident in the child's appearance. Failure to provide medical attention, such as routine health care for immunizations or dental checks, can lead to medical neglect, resulting in health concerns, dental issues, CPS referral's, and intervention (Child Welfare Information Gateway, 2013).

Sexual Abuse

Encouraging or forcing a child to engage in a sexual activity, including exposing them to pornography, is sexual abuse. In 2009, sexual abuse claims were confirmed in 9.5% of children (U. S. Department of Health and Human Services, 2010). Sexual abuse is a form of child maltreatment, which requires CPS to remove the child from their home. It is possible for sexual abuse to be a relative factor in foster care adoptions. Indicative factors can be nightmares, bedwetting, advanced sexual knowledge, exhibiting sexual behaviors, or attaches easily to strangers (Child Welfare Information Gateway, 2013). Sexual abuse of a child is reported approximately 80,000 times per year, but the number is even greater for unreported cases (American Academy of Child and Adolescent Psychiatry, 2011). A child who experiences sexual abuse can retain many feelings. Ongoing child sexual abuse can lead to low self-esteem, feelings of being worthless, and an inappropriate view of sex (Lazenbatt, 2010).

Emotional Abuse

Emotionally abused children are usually characterized by behaviors that damage the child's emotional growth through means of continuous criticism, frightening threats or neglecting the child's need to be loved (Child Welfare Information Gateway, 2013). Signs of emotional abuse can include being depressed, inattentive, or detached. Because emotional abuse is difficult to prove, it is crucial for a case to provide a collective documentation by witnesses of the abuse (American Academy of Child and Adolescent Psychiatry, 2011).

Parenting Techniques

Positive influential factors with children adopted from foster care or internationally can help the child tremendously heal. According to the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), parenting techniques that include developing and promoting strong attachments, model and teach acceptable behaviors, and choose effective discipline methods have provided encouraging results (2001). Because of the negative effect of the abuse and neglect, it will take time for the child to adjust to the new lifestyle changes. Strong, emotional bonds between a child and their parents is critical for a child's overall health which encourages trusting relationships, positive behaviors, and healing from previous traumas (Child Welfare Information Gateway, 2013). Spending quality time with the child, meeting their needs, and providing safety and comfort will start making the child be more comforted and soothed (NICHD, 2001).

Although many of these techniques described will assist in helping a child heal, it is still normal for all children to go through behavioral issues for which age appropriate discipline measures need utilized (Trumbull, 2007). Appropriate discipline for neglected or traumatized children should never include physical punishment, such as spanking or hitting. Aggressive

punishments for children, who have experienced abuse or neglect, often remind them of their past trauma and can inflict even more harm to the child (Child Welfare Information Gateway, 2013). Appropriate discipline should include teaching the child about the fundamentals of appropriate or inappropriate behavior. This can be effectively accomplished by using the child's behaviors to discuss what is appropriate or not. Other factors that than change negative behaviors can include positive encouragement, realistic limits, and consistency (NICHD, 2001).

Therapy, Counseling or Support Groups

Although many joys can result from parenting, some challenges will always exist. However, children who have experienced severe abuse or neglect can sometimes be more demanding or difficult to parent. Sometimes, parents alone are not able to provide all the needed support for these children and professional services can assist (NACAC, 2007) Through therapy, counseling, and support groups, necessary skills can be learned to build nourishing relationships, overcome past abuse, and avoid further trauma (Lazenbatt, 2010). Professional therapist should be able to assess the child's behaviors, provide effective treatment strategies, and assist in helping the parents cope with the issues. Support groups can also provide some very beneficial factors for parents. It provides a sense of comfort to know that others share the same difficulties while parenting. Other parents can also share their personal experiences of strategies that helped their family cope (NACAC, 2007).

My Personal Adoption Experiences

I know all too well the difficulties and challenges faced when exploring adoption options. After several years of experiencing infertility myself, my husband and I began our adoption journey. The decision to adopt was just the beginning step in what I found to be a very long,

complex, and complicated journey. My personal experiences are the primary reason for choosing this discussion topic for my thesis paper.

Three years into our infertility struggles, we made the decision to forgo invasive procedures, such as Invitro-Fertilization, and decided adoption was our route of choice to grow our family. We began extensive research using the internet and were overwhelmed at the adoption possibilities. After evaluating all our pros and cons of the various adoption methods, we decided that domestic adoption was the most suitable route for us.

Although the internet assisted in guiding us, we were still very uneducated about the process. We contacted an agency to complete our first homes study process. The agency was very well staffed with courteous and helpful social workers, but the wait became long and frustrating. After three years with this agency, we still did not have a child placement. I therefore started asking more questions about the agency, understanding they were a small agency that only completed 20-25 adoptions per year.

My frustration with the adoption process made me more determined to find out how I could become a parent quicker. I continued with more research, looking into state laws, and found that we did not have to stay in the state of Kentucky to adopt. My research showed me that there were actually other states in which successful adoption statistics were much higher than Kentucky. I also discovered that a larger, more expensive agency produced quicker results. At this point in our lives, we were willing to take that extra step of faith. We then joined an agency that provided adoptive services in all fifty states and performed approximately 300 adoptions per year. After we completed our necessary paperwork and were active with the agency, we were matched in nine months.

On March 17, 2007, the birth of our daughter occurred two weeks after our match. Although drugs and alcohol can be factors to which infants are exposed to prenatally, our birthmother did not have a history of substance use. Our daughter was born perfectly healthy. We quickly established a relationship with the birth family and agreed to maintain contain in a semi-open adoption process.

Although we resided in Kentucky, our daughter was born at a hospital in Kansas. Within moments of meeting her, we were immediately bonded and attached to her. Because of the birthmother's consent, we were informed of all medical screenings and completely involved in our daughter's care while hospitalized. Once she was discharged from the hospital, we waited approximately two weeks for the ICPC process to be completed. Then, we were able to return home as a family of three to enjoy all the pleasures of having our own child.

When Abby was three, we pursued a more affordable adoption option. We became foster/adoptive parents. Through this process, we have dealt with many children traumatized by abuse or neglect. We have been educated and supported by the state's social services department and worked with many parents, school personnel, social workers, and therapists to meet the needs of the child. We have loved and helped many of these children return home or to a relative placement. Sadly, we felt incapable of offering some children the depth of support they truly needed to recover from their abuse and neglect.

After seven years of fostering, we are in the process of adopting from Kentucky's foster care system. We were initially placed with our two boys about eighteen months ago, when they were six months old and five years old. Upon acceptance of this placement, we noticed the infant was not very responsive to adult interactions. He did not laugh when playing such games as peek-a-boo, nor did he like to be held or cuddled. The older boy had very poor hygiene skills with

speech difficulties. These children showed some of the classic signs of severe neglect and possibility drug exposure. We began working with these children, providing love, attention, and resources to help them thrive.

Over the past eighteen months, these boys have made tremendous growth physically, mentally, and emotionally through intervention services and support. They appear to be recovering from their trauma and are happy, healthy children. They have been able to thrive and achieve numerous milestones appropriate for their development and overcome many issues. Our toddler is now a very active little boy that enjoys playing, laughing, being held and cuddled. Our older boy has been involved in speech therapy at school and progressed tremendously. Each boy has also grown to love our family and be relaxed in our home by feeling safe and well cared for.

Although the primary goal of foster care is reunification, there are times when that may simply not be possible for one reason or another. In our situation, the birth parents failed to make progress towards reunification, and they voluntarily signed legal paperwork to terminate their parental rights. Once this procedure has been finalized before a judge, we will proceed with filing an adoption petition for both boys to become permanently and legally ours.

Throughout my life, there have been several hardships, especially when it came to my infertility journey and adoption. But, I can honestly say that I thank God that He did not allow me to have a biological child. I could not imagine where my children would be if I would have been able to conceive children. Each of my children comes with a very unique history. The hardships were just part of the downside of the journey, but we are now moving toward a family of five and look forward to all the joys that parenthood will bring us.

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