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Infertility, Reproductive Loss and the Adoption Home Study Process

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Infertility, Reproductive Loss and the Adoption Home Study Process

by

Emily Jacobsma, BSW

MSW Clinical Research Paper

Presented to the Faculty of
The School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this research was to explore how a history of infertility and reproductive loss impacts an individual's experience of the adoption home study process. Many individuals use adoption to expand their family after losing the ability to have a child biologically. This study examined the prevalence of grief in individuals with infertility and reproductive loss as well as how that grief is currently addressed by social work professionals in the adoption home study assessment. Participants were gathered through social media groups online as well as various adoption support organizations. Participants were asked to fill out a confidential survey with both qualitative and quantitative aspects. Findings show that the experiences of these individuals are diverse, and while some felt that their adoption social worker professionally addressed their grief in the home study, others felt that their social worker was not empathetic and provided too little resources for their needs in preparation for parenting a child through adoption. Equally diverse were the respondents' experiences with grief and loss related to their infertility. While some felt that the loss of a biological child was profound, ambiguous and sad, others stated they felt little grief due to their interest in and commitment to building their family through adoption. It is important for the profession of social work to understand the losses related to infertility in order to properly assess families and prepare them for the task of parenting a child through adoption.

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Infertility, Reproductive Loss and the Adoption Home Study Process

This research study examines the experience and special needs of families in the home study adoption process that have a history of infertility or other medical issues that cause a loss of the ability to carry a pregnancy. In the field of adoption social work there are currently no best practices established to address the needs of these families in the home study process. The family assessment done by the social worker determines the individual's preparedness for an adoptive child. However, there is currently no universal assessment done on infertility grief and loss. With infertility and reproductive loss cited as the main reason families pursue adoption (Van Laningham, Scheuble, & Johnson, 2012), it is important that social workers uphold their obligation to the adoptive children to assure that families receiving them are emotionally strong and resolved in regards to their grief.

Language surrounding infertility is not agreed upon in the medical field and definitions of the problem vary depending on the source of the information. The American College of Obstetricians and Gynecologists defines infertility as the inability to conceive a pregnancy after one year of regular intercourse without the use of birth control (2013). This definition does not include the diverse arenas in which a couple or individual would have the medical inability to conceive biologically and the definition also assumes the couple would be a heterosexual pairing of gender normative bodies. This paper will define and use infertility as the World Health Organization defines it. The World Health Organization (or WHO) states that it as "1. the inability to become pregnant, 2. an inability to maintain pregnancy and 3. an inability to carry a pregnancy to live birth" (World Health Organization, 2014).

In addition to infertility, some people are unable to carry a biological child due to other medical reasons. The experience of these couples and individuals is better defined by the term "reproductive loss." L. Serene Jones defines this as women or individuals who "desire to have biological children, who are biologically unable to do so, and who experience this bodily inability as failure, a desire thwarted, a loss of a potential child they hoped for and expected" (p. 229, 2001). Various medical and personal problems could lead an individual to find pregnancy either impossible or extremely risky for the woman and child. These problems, per my own experience working in the field of adoption social work, can include but are not limited to epilepsy, dwarfism, heart conditions, cancer and genetic problems.

The intersection of adoption and infertility is apparent in the 2007 National Survey of Adoptive Parents done by the United States' Department of Health and Human Services which states that infertility is cited as a reason for 39% of foster care adoptions, 52% of domestic infant adoptions and 72% of international adoptions. The type of infertility is not designated in the Department of Health's survey. However, according to the Centers for Disease Control (2013) roughly 11% of American women of childbearing age cannot carry a biological child because of health limitations (2013). The prevalence of infertility or pregnancy incompatibility calls for family service professionals to be prepared and competent to address the needs of those affected by infertility or pregnancy incompatibility.

Infertility and the loss of pregnancy capabilities involve a grieving process not strongly recognized in western culture (Bell, 2013). The issue of pregnancy is attached to the social concepts of womanhood, sexuality, identity, family and parenthood (Bell,

2013). The grief associated with the loss of the ability to carry a biological child is often expressed through anger, frustration, hopelessness and a loss of confidence by those unable to parent. There may also be a trauma experience of having a critical, life threatening health issue that expands the emotions of grief associated with the loss of pregnancy capabilities (Burns, 1990). These feelings are in conflict with the emotional demands put upon an individual or family pursuing adoption yet, depending on the social worker and adoption agency, these emotional symptoms may not be considered in the home study process.

While the 2007 National Survey of Adoptive Parents done by the United States' Department of Health and Human Services did explore the satisfaction of adoptive parents with their attorney or agency, the capacity in which the adoptive parents are satisfied was not researched by this agency. No articles on the satisfaction of adoptive parents with their social work services was found in this exploration of research literature. The NASW Code of Ethics states that professionals have a commitment to the wellbeing of clients and in the circumstances of adoption the children as well as the adoptive parents are equal stakeholders in the adoption process (National Association of Social Workers, 2008).

The grief associated with infertility and involuntary childlessness presents challenges to the adoptive family as well as the social worker. The family and social worker work together with limited contact and resources in the context of a primarily legal process. This research examines the experience of the adoption home study for families that have experienced infertility in order to help prepare family and child social

workers for the special needs of families who pursue an adoption after the loss of parenthood through pregnancy.

Literature Review

This review of literature will explore the impact of infertility on a person's mental health, the topics of grief and loss, and the process of adoption and its challenges. Many general research articles were found on these topics but few could be found on the specific population of adults discussed in this paper. This paper researches individuals who have a self identified history of infertility and reproductive loss, and who have also completed an adoption home study with a social worker.

Psychological Impact of Infertility and Reproductive Loss

There are numerous articles written on the impact of reproductive loss and infertility on a person's mental wellbeing. Some are written from evidenced based research and some are personal narratives of an individual's experience. Some research was found linking reproductive loss and infertility to higher rates of distress, and these articles are referenced in this literature review. Due to constraints on time and resources, the entire archive of research done on infertility and its impact on mental health was not able to be reviewed. Relevant studies and findings are explored in this paper.

A study was done by Brennan E. Peterson and Georg H. Eifert in 2011 on a single case of a couple enduring infertility treatment and in vitro fertilization procedures after discovering reproductive loss. The authors document that the woman reported experiencing the inability to cope with holding her sister in law's new child and was also unable to be in the presence of friends who were either pregnant or new parents. The authors report that often the stress of accepting the inability to carry a child is amplified

by a person's inability to accept the feelings and reactions they are having during fertility treatment. The couple studied by Peterson and Eifert (2011) had to come to the realization that they needed flexibility and space in their lives and this was done through acceptance of the pain and loss they were feeling.

L. Serene Jones wrote in 2001 in her paper on theological perspectives of infertility that for women, the grief associated with infertility is complex. A feminist, pro choice woman finds grieving a miscarriage to be complicated due to the ambiguousness of the loss. The woman may not view the loss as a tangible child, but the potential for a child, or the embodiment of a child. L. Serene Jones also asserts that grief and fertility are concepts defined and experienced within the context of culture, so it is important to note that this study specifically focuses on the individuals and couples with reproductive loss in westernized American culture. Because pregnancy and biology are so intimately connected to the human body, the loss of the ability to get pregnant, or the loss of a pregnancy, can feel like a loss of a part of an individual's personhood (Jaffe & Diamond, 2010). L. Serene Jones (2001) articulates the connection between womanhood and fertility in American culture:

> *"To grow up "woman" in this culture is to grow up formed by a thickly gendered identity script wherein one's body is assessed in terms of its treasured capacity to give life and thereby to make one "a mother." To be a full woman is thus to bear children and then to lovingly raise them"* (p. 230).

This quote speaks to the external pressure that a woman can feel regarding their body and its capacity to bear children.

While infertility can cause someone to grieve the loss of their sense of self and person hood (Jaffe & Diamond, 2010), an additional study explored the presence of psychological distress in people with infertility, and related that distress to the adverse emotions of individuals with life threatening disease (Domar, Zuttermeister, & Friedman, 1993). An additional research endeavor studied the presence of grief and depression in patients receiving in vitro fertilization treatments and saw that all subjects reported the symptoms of distress or depression before, during, and after their IVF treatment (Lukse & Vacc, 1999).

One study found that the length of a person's infertility contributed to the severity of their depression (Ramezanzadeh et al., 2004). In the span of one to three years of experiencing infertility the women in the study experienced their lowest levels of depression and anxiety (Ramezanzadeh et al., 2004). The experience of distress skyrocketed in the fourth through ninth years of infertility. However, the authors note that these findings could be related to unique cultural aspects of the Iranian population that was studied (Ramezanzadeh et al., 2004). Additionally, researchers Domar, Zuttermeister, and Friedman, who studied individuals with infertility in the United States concluded through their study that "…the chronicity of a disorder affects the level of distress, rather than the diagnosis per se" (p. 50, 1993). They add that infertility is a chronic illness because most patients are not even given the diagnosis until they have been proven to be unable to produce children biologically for one year (Domar, Zuttermeister, & Friedman, 1993). Additionally, another study found that the symptoms of depression were reported at increasingly higher rates the longer they received fertility treatments and failed to become pregnant Lukse, M., & Vacc, N. (1999).

Grief and the Emotion of Profound Loss

Edith Buglass states in her research: "Grief, mourning, and bereavement may be affected by personality, culture, religion, the nature of the relationship with the deceased person, and the way in which he or she died" (p. 44, 2010). Grief is also defined by Edith Buglass as "a natural human response to separation, bereavement, or loss" (p. 44, 2010). The Merriam Webster dictionary defines it as "deep sadness caused especially by someone's death" or simply "a cause of deep sadness." Other terms commonly used to describe grief include descriptive words like guilt, despair, yearning, preoccupation, hostility, denial, acceptance, and sadness (Buglass, 2010). Grief and profound feelings of loss have the potential to be exacerbated by the stigma of shame and secrecy (Seifter Abrams, 2001). For example, one person may utilize avoidance to process their loss and thus requests of their partner to hold their experiences in secret from friends and family. This request for privacy by one partner could be experienced as isolation for the other. Lastly, the experience of loss and the coping mechanisms of one partner can negatively or positively impact the success and health of the couple or family if there is a discrepancy in styles (Peterson, et al., 2006). The woman whose body is impacted by the loss of fertility or reproduction is the one that typically experiences more distress and psychological anguish, so it can be normal for partners to experience the loss differently (Ramezanzadeh et al., 2004).

Adoption and Challenges

The adoption home study process can involve lengthy assessments, trainings and home visits for the family (Crea, 2009). There have also been instances recorded where home studies consisted of brief telephone meetings and few requirements for adoptive

parents (Crea, 2009). After much debate and conversation, the 1993 Hague Convention on Protection of Children and Co-Operation was formed to streamline the adoption approval process and implement safeguards to protect children and birth parents (Crea 2009; Hayes, 2011). The Hague Convention also ensures that children being adopted are truly in need of permanency. Peter Hayes writes in his article:

> *"The Hague Convention is meant to help to ensure that a child has been correctly classified as in need of adoption, has had the opportunity to be adopted nationally, and then gains the opportunity to be placed internationally"* (p. 310, 2011).

A family that completes their home study assessment through an agency that is no Hague accredited can then adopt a child through another country, orphanage, or program that is not Hague accredited, thus the legitimacy of that child's need for adoption is in question (Hayes, 2011).

Home studies are conducted in varying ways depending on the country, state, agency and social worker completing the study (Hayes, 2011). The state of Minnesota requires that background checks be completed, a summary of their local resources, the clients' strengths and weaknesses, their demonstrated commitment to permanency, detailed financial and health information, and personal history narratives on all adults living in the home (Minnesota Department of Human Services, n.d.). Although Minnesota's home study requirements for domestic and international adoptions are fairly comprehensive, this is just an example of one state's expectations.

The issues of infertility and adoption are separate in nature but are intrinsically connected. Infertility is the most common life experience that leads couples and

individuals to pursue adoption as a means to build their family (Van Laningham, Scheuble, & Johnson, 2012). Adoption is often seen as a backup if having a biological child through fertility treatments fails (Van Laningham, Scheuble, & Johnson, 2012). Participants in one study on infertility and adoption pursuit stated that they felt an urgent need to proceed with adoption due to their advancing age and challenges in becoming parents (Daniluk & Hurtig-Mitchell, 2003). It is important to note that parents in a study published in 2011 by Malm, Vandivere, and McKlindon for the United States Department of Health, when asked to rank their reasons for adopting a child from the American foster care system, cited "to help a child in need" as the most common factor in adopting, even if they had experienced infertility.

Peterson and Eifert (2011) found that the infertile couple they studied experienced more adverse emotions as they pursued IVF with failing results. They identified that this pursuit of a family was the greatest source of anxiety and stress in regards to their infertility experience. Although research was found by Peterson and Eifert (2011) explicitly linking an increase in adverse emotions with the experience of IVF failure, no research was found linking adverse emotions with delays or struggles in the adoption process. It is possible that the process of adopting could produce similar anxiety and stress surrounding infertility, much like the pursuit of IVF; however research needs to be done to examine this. There is currently a shortage in research exploring how people with infertility and reproductive loss process their grief while preparing themselves for adoptive parenting (Van Laningham, Scheuble, & Johnson, 2012).

The pursuit of an adoption introduces a new step in the life of an individual or couple that has experienced reproductive loss (Jaffe & Diamond, 2010). Bereavement is

a term that defines the period of time after a loss occurs (Buglass, 2010. The concept of continuing bonds can be a way of addressing the mourning of fertility and a biological child (Jaffe & Diamond, 2010). Continuing bonds means that the loss can be grieved through a transition to keeping the deceased alive with memories and narrative (Jaffe & Diamond, 2010). This is not possible for a person grieving infertility so authors Jaffe and Diamond recommend that therapists explore the hopes and dreams of the couple to maintain a sense of self. This also includes incorporating their future child into conversations and stories (2010). Accepting the transition and then changing the narrative to one of hope simultaneously gives optimism and control to the person who thus far has had no control. This also introduces the reality of the loss of a child from their imagination (Peterson & Eifert, 2011). The child that has the woman's eyes, her grandmother's hair color or her father's laugh is no longer a possibility. This means that adoption is not a solution to infertility because it does not resolve the desire for the genetically linked child. The continued bonds method can help to resolve this grief outside of the adoption process.

A study done by Foli and Gibson showed that some parents experience post adoption depression and that the male partner specifically tends to identify stress factors of lingering grief over infertility or loss of a birth child, delayed or lack of bonding, and depression after adoption finalization (2011). When men experienced these symptoms they were more likely to become disengaged from family, display anger, and experience melancholy or sadness (Foli & Gibson, 2011). Couples in a study done by Daniluk and Hurtig-Mitchell in 2003 indicated that they felt deserted by their social worker after their child was placed in their home. Others in the study shared their complicated feelings

around domestic infant adoption and being able to meet the birth mother. One woman stated that she felt she was depriving another woman of the experience that she grieved due to her reproductive loss and infertility (Daniluk & Hurtig-Mitchell, 2003).

While adoptive parents have been shown in many previously referenced studies to experience profound grief surrounding their infertility, research has also been conducted on the grief and loss experienced by adoptees. Researchers Robert Lee and Jason Whiting (2007) state “Foster care is rife with circumstances wherein the losses are not clear-cut and final” (pg. 417). Children try to adapt into an adoptive family post foster care and experience feelings of confusion, hopelessness, ambivalence, and denial (Lee & Whiting, 2007). Like the therapy with couples experiencing infertility, psychoeducational approaches have been found to be helpful for foster and adoptive children to understand their unresolved grief and how this leads to their behaviors of disobedience and anger (Lee & Whiting, 2007). The shared experience of ambiguous loss is something that children and parents can use as a strength to their attachment and understanding of each other.

Research shows that after adoption finalization, parents still needed to work to conquer negative messages they received and continue to hear in regards to their family and infertility. Some adoptive families hear the message that adoption is less important or second to building a family through biological pregnancy (Daniluk & Hurtig-Mitchell, 2003). Others receive questions from individuals and society in general about the significance of the bonds that they share with their children (Daniluk & Hurtig-Mitchell, 2003). Finally, other families struggle with their own internal beliefs and stereotypes about adopted children and adoptive families (Daniluk & Hurtig-Mitchell, 2003).

Helping the Family Grieve

In the process of this research there was no literature found on best practices for adoption home studies and no research was uncovered in regards to how social workers practice home studies across the United States. However, it is my experience in the profession of adoption social work that it is important for workers to be knowledgeable of effective interventions and resources to refer their clients to. Infertility and reproductive loss can be associated with profound grief (Wilkins, Warnock, & Serrano, 2010), and profound grief can have repercussions in the form of depression, anxiety and other adverse distresses (Domar, Zuttermeister, & Friedman, 1993), (Ramezanzadeh et al., 2004).

The study by Peterson and Eifert (2011) showed that at a one year check in with a couple post infertility treatment, both individuals indicated decreased stress through the use of Acceptance and Commitment Therapy (ACT). A research review done in 2010 indicates that certain characteristics can be attributed to couples that adjust to an infertility diagnosis better than others (Wilkins, Warnock & Serrano). Wilkins, et al., state in their study of current literature that themes emerging in depression and infertility show that personality traits like perception of control, extroversion and optimism led to higher adaptability (2010). The researchers found that personality traits in an individual like neuroticism, avoidance, and feelings of helplessness contribute to depression during and after infertility (2010). Given this information, the profession of social work can use a strengths based perspective to find the specific characteristics in couples that have experienced reproductive loss or infertility, and then using the knowledge of these traits, allow for a smoother adoption process that addresses the client's unique experience.

A study done in 2006 focused on the coping skills of both partners in relation to stress, marital adjustment and depression. A pattern found in the results showed that men tended to cope with infertility through distancing themselves from the problem through humor and making light of the situation (Peterson, et al., 2006). Bets and Thorngren distinguish in their study the fact that partners will experience an onslaught of conflicting emotions and guilt in the face of grief and loss. Each partner will experience the problem differently, often in an "unpredictable and uncertain nature" (2006). A clinician or social worker helping clients who are grieving reproductive loss should pay special attention to the coping mechanisms of the individuals because this directly impacts the success of the family as a whole (Peterson, et al., 2006). Encouraging the use of established bereavement therapy will assist clients struggling with even the most ambiguous of loss. The use of narrative and telling of stories, the stages of grief, and Freud's "hypercathect and decathect" (acknowledgement of the loss and the severing from the loss) can be effective for people grieving their reproductive loss (Jaffe & Diamond, 2010).

Researchers Brennan Peterson, Christopher Newton, Karen Rosen and Robert Schulman (2006) identify in their study of the coping processes in couples with infertility, the need for further research of more diverse families as well as the need for qualitative research exploring the coping processes of couples. They suggest that diversity could include understudied populations like racial minorities as well as couples opting out of fertility treatment. The authors of this study state that this would serve the purpose to "reveal the complex processes of coping with infertility and could shed additional light on positive outcomes as well as negative outcomes" (Peterson, et al., pg. 238, 2006). They state a need for clinical professions to further understand "the

relationship between coping and infertility stress, marital adjustment, and depression across the various stages of the infertility experience" (Peterson, et al., 2006, p. 238,).

One study takes into account this need for research on the diverse experiences of individuals with reproductive loss and infertility. A study done in Iran concluded that there is a significant link between a woman's experience of infertility and an occurrence of depression or anxiety (Ramezanzadeh et al., 2004). Certain protective factors were also found in women who experienced less depression surrounding their infertility (Ramezanzadeh et al., 2004). The experience of having a job and/or a higher education caused the women to experience lower rates of depression in relation to their infertility (Ramezanzadeh et al., 2004). The authors note the importance of culture in this study, as Iran experiences marriage, womanhood, and motherhood in a much more conservative manner than westernized societies (Ramezanzadeh et al., 2004).

It is important for social workers to address infertility and reproductive loss, even if time has passed since the loss was experienced. If a couple had their last miscarriage a year prior to receiving services, addressing the loss in a therapeutic way is still important as parents may feel disenfranchised due to their community failing to acknowledge the loss (Jaffe & Diamond, 2010). This conclusion is further supported by research done in Iran which found that the most profound depression and anxiety related to infertility occurred in patients after struggling from four to nine years (Ramezanzadeh et al., 2004). Researchers Levin and Goldman Sher found evidence that couples grieving infertility generally do not experience extreme marital distress or severe psychological symptoms; thus, any indicator in the couple or individual that they are at risk for severe mental health problems should be taken very seriously by the clinician (2000). An indicator of

the severity of a person's symptoms could be explored by measuring the presence of the depression or mental health symptoms prior to infertility and reproductive loss (Levin & Goldman Sher, 2000).

Because distress, depression, and anxiety can be found in patients with infertility, the same way that they are found in patients with other life threatening conditions, it is possible that psychosocial interventions currently used with the chronically ill could be effective on patients with infertility and reproductive loss (Domar, Zuttermeister, & Friedman, 1993). Couples therapy can be effective in helping to lower any marital distress during the infertility grieving. In addition, cognitive therapy or cognitive behavioral therapy can alleviate the thoughts of poor self worth and depression that accompany reproductive loss (Levin & Goldman Sher, 2000). Successful treatment requires a balance of feeling expression and meditation on the past experiences (Jaffe & Diamond, 2010). The clinician can use psychoeducation as a way to inform the couple of the frequency and normalcy of their experience in relation to other couples grieving their reproductive loss (Jaffy & Diamond, 2010). Finally, dividing the counseling process into three stages creates easier work for the clinician. Peterson, et al. state that the three categories are: "implications and decision making, support counseling, and short term crisis counseling" (2012).

It is important for me as the researcher to state that the adoption home study process is different than clinical therapy and should be approached with different priorities which are clearly laid out to the client. While therapy hopes to empower healing and change in the client, the home study is merely a professional assessment of the family. However, the relationship between a family and an adoption social worker

should be therapeutic and involves equally clinical interventions as in therapy. The process of joining, rapport building, trust, support, openness and empowerment are important for the social worker to accomplish while working with prospective adoptive families. An agency is impacted by many outside entities that will affect their assessment practices including their accreditation, state laws, international policies, foreign country law, and whether the organization is accredited by the Hague Adoption Convention.

Given the lack of research on adoption home studies, and the services given to clients, this study aims to fill a void in the adoption social work profession's knowledge. This research intends to explore the experience of families with reproductive loss history, and how adoption services address their experience of grief while simultaneously preparing them to be adoptive parents. Given the previously cited evidence based practices, there are data to suggest that social workers would be able to greatly improve the experience of the home study process for individuals with a reproductive loss history through the means of those cited therapeutic methods.

Conceptual Framework

Reproductive loss and infertility are the source of varying degrees of sorrow and heartache for many couples and individuals that endure the inability to carry a biological child (Levin & Goldman Sher, 2000). The extent to which this experience impacts a couple will differ depending on their specific circumstances and skills (Burns, 2007). Equally, the couple's ability to use healthy skills to process and adapt to the loss will depend on their specific resources and capabilities (Burns, 2007).

When someone experiences the death of a loved one, Western mainstream society has various coping rituals to resolve the loss, including receipt of a death certificate, the

rituals of a funeral and the tokens of empathy in cards and gifts (Bets & Thorngren, 2006). When a loss is not publicly "recognized and legitimized" it is less likely the family will receive support from their community (Bets & Thorngren, 2006).

The theory of Ambiguous Loss, first conceptualized by Pauline Boss, provides a framework through which to view this experience and its impact on the adoption home study process. Pauline Boss asserts that ambiguous loss is significant in that it is defined by the outside perception of a person's experience (Boss, n.d.). Because a person's support system or community cannot concretely recognize the loss, the grief is exacerbated for the individual (Boss, n.d.). The grief associated with transitioning from infertility to adoption is ambiguous in that it is not conventionally recognized by society and it is difficult to articulate and therefore understand. Pauline Boss' model is well suited for the structure of this research as it gives the profession of social work an outside understanding of the personal internal discord of individuals and couples who have experienced reproductive loss or infertility prior to the adoption process.

Pauline Boss suggested in a speech in 2000 that ambiguous grief is ongoing and unacknowledged and the usual rituals for mourning are generally not available due to the nature of the loss. This means that individuals may experience a grief that is stuck and difficult to move on from (Seifter Abrams, 2001). Individuals and couples that grieve the ability to have a biological child may struggle to move forward because of the unresolved desire. Boss suggests that Ambiguous Loss Theory can be used in practice with clients through addressing six areas: finding meaning, tempering mastery, reconstructing identity, normalizing ambivalence, revising attachment and finally, discovering hope (Boss, n.d.).

Infertility has the potential to be experienced by individuals and couples as a profound grief and disappointment, just like the loss of a loved one. However, the external recognition, such as a funeral or a card, is missing for the family experiencing infertility. Pauline Boss defines the term ambiguous loss as losing something that is incomplete and uncertain (Boss, n.d.). Clinicians have begun recognizing attachment more greatly in families struggling with infertility because of the modern advances in pregnancy like ultrasound pictures and seeing the egg before in vitro fertilization, which allows families to more concretely understand their pregnancy as a child (Jaffe & Diamond, 2010). Resiliency is important in recovering from loss and specific characteristics can strengthen a person's ability to move forward (Seifter Abrams, 2001). These distinguishing aspects include being able to make sense of the loss, drawing value from the lesson, and maintaining hope, which are all important because loss that is ambiguous does not resolve itself (Seifter Abrams, 2001). Bets and Thorngren state in their research "For the family who experiences ambiguous loss, the situation is stressful and oftentimes cruel in its unending torment; because the loss is intangible or uncertain, the mourning process for family members becomes complicated" (p. 359, 2006).

Research Questions

The review of the literature led to these research questions:

1. Do individuals and families with a reproductive loss or infertility history experience this problem as profound grief?
2. How does the history of reproductive loss or infertility impact a person's experience of the adoption home study process?

3. Does current adoption social work practice address the specific needs of families in grief surrounding reproductive loss and infertility?
4. How can adoption social workers better help families with reproductive loss and infertility prepare to be adoptive parents?

It is important for professionals to address the grief associated with infertility in a way that is appropriate for their field (Peterson, et al, 2012). While clinicians should be the professionals to conduct therapy with a client (Peterson, et al, 2012), adoption social workers can acknowledge the loss and refer clients to resources during the home study process. Although there has been no study done to show causation between depression and infertility, many researchers have recognized a link between the two issues in individuals (Wilkins, Warnock, & Serano, 2010). For the purpose of this research the term profound grief is described in the survey as "sorrow, pain and heartache due to a loss." Additionally, this research expects to find that an individual's experience of reproductive loss and infertility adversely impacts their experience of the home study process. This author predicts that current adoption social work practice does not address the specific needs of these families and that social workers should explore how the service can be improved in order to better prepare individuals for adoptive parenting.

Methods

Research Design

Data was collected by means of the Reproductive Loss and Adoption Survey (Appendix A), which was written by this author and includes quantitative and qualitative questions. The purpose of the study was to measure the impact that reproductive loss and infertility have on an individual or couple's experience of the adoption home study

process, and how social workers can better help families with reproductive loss while they are adopting a child.

Sample

Various adoption service organizations initially agreed to distribute the survey by providing a web link and contact information regarding the survey so that their clients were able to complete it at their convenience. It is unclear which of these organizations distributed the survey. The study used nonprobability convenience sampling to a group of individuals that were reached through the agency, clinic or organization. The Reproductive Loss and Adoption Survey was distributed and received 31 respondents. Of the 31 respondents, five did not consent to the research and were excluded, while the other 26 consented to the research and completed the survey (83.81%). However, some participants skipped some questions. This is reflected in the results section.

Informed Consent, Confidentiality and Protection of Human Subjects

Participation was voluntary and no incentive was offered for participation. The research conducted for this study was reviewed and approved by St. Catherine University's Institutional Review Board. Before beginning the survey, participants were informed of the nature of the research, the risk involved, and the time commitment through a written consent form. After reviewing this material participants were asked to check a box to indicate their understanding of the terms of the research. Some participants did not check the consent box and therefore their responses were not included in this research.

The potential risk related to participating in this research was minimal, but it is possible the risks did include complicated feelings of anxiety and sadness after reflecting

on the difficult experience of reproductive loss and infertility. The consent form (Appendix B) included the following statement:

> *"Complicated feelings of anxiety and sadness may arise after reflecting on the experience of reproductive loss. If you feel adverse symptoms at any point during the survey, you may cease responding to the questions. If you are feeling any adverse symptoms after the survey is completed you are encouraged to reach out to a mental health professional to receive support around your grief and loss. Resources will be provided upon exit from or completion of the survey."*

Participation in the research was kept confidential. Participants were informed that they could cease responding to the survey at any point without penalty. Their identifying information (e.g. name, email address, etc.) was not requested and thus this author has no access to their demographic data. Social media groups, agencies and service organizations distributed the link to the survey and received no access to information regarding participation of their clients.

Data Collection Instrument, Recruitment Process, Agency and Institutional Support

The data was collected by means of the Reproductive Loss and Adoption Survey (Appendix A) distributed primarily through social media groups of adoption professionals and parents. The individual participants were asked to complete the survey online. The survey for this research was administered through the computer program Qualtrics. This allowed the data to immediately be saved confidentially so that identifying information was never disclosed to the researcher. The survey asked initial questions to gather information on whether the participants had experienced some form of reproductive loss, gone through the adoption home study process, and received

services for their adoption from a licensed social worker during this process. The survey began with ten closed ended questions, with five of them offering an "expand if needed" selection so that participants could elaborate on their answer. At the end of the survey, there were three, open ended questions that served the purpose of allowing participants to write at length about their experiences, or include information on specific topics that were of interest to the researcher but could not be addressed in a quantitative question. The variables measured in the survey were based off of concepts and themes in current research as presented in the literature review like grief, loss, infertility and perceived helpfulness of the social worker.

Data Analysis

The survey (Appendix A) collected information on the respondents to better understand their experience. Due to a flaw in the construction of the survey, the questionnaire did not allow participants to select yes or no in addition to typing an answer in the "expand if needed" field. As a result, only individuals who did not select yes or no were able to write a response to these questions. Responses that were typed but that fell clearly into a yes or no category were recoded into yes and no responses when the data was cleaned. On numerous questions there were some participants that chose not to answer.

The first question in the survey asked "Have you or your partner experienced the inability to biologically carry a pregnancy due to one or more of the following issues?" The answer options were: "reproductive health issues," "non-reproductive health problems (examples include heart problems, epilepsy, and cancer treatment, genetic issues, injury, etc.)," "neither my partner nor I have experienced the inability to

biologically carry a pregnancy due to a health, or other issue," and "other." This question was analyzed through a frequency distribution.

The first research question "Do individuals and families with a reproductive loss or infertility history experience this problem as profound grief?" was addressed through the survey question "While expanding your family did you experience the loss of having a biological child as profound grief? (Profound grief meaning sorrow, pain, and heartache due to loss)." The variable being measured by this question was adverse emotions in regards to reproductive loss. A frequency distribution measured the number of families responding affirmatively and negatively to this statement.

An additional question was included in the survey in regards to grief and the ambiguousness of it. All respondents were asked "Would you characterize the grief you felt due to infertility or reproductive loss as ambiguous (i.e. not widely recognized by others)?" The possible answers included: "yes," "no," and "expand if needed." A frequency distribution was used to analyze the yes and no responses.

The second research question "How does the history of reproductive loss or infertility impact a person's experience of the adoption home study process?" was addressed through the open ended, survey question "How, if at all, did reproductive loss or infertility impact your experience of the adoption home study?." I and another research student coded the survey answers to this open ended question, and found particular patterns and themes.

The third research question, "Does current adoption social work practice address the specific needs of families in grief surrounding reproductive loss and infertility?" was addressed through four survey questions. First, "Do you feel your adoption social work

professional addressed your grief around reproductive loss in the adoption process" was analyzed using a frequency distribution. The possible answers to this question included "yes," "no," and "expand if needed." Second, "Do you feel your adoption social work professional provided you with resources to process your grief around reproductive loss and infertility in the adoption home study process?" was analyzed using a frequency distribution. The possible answers to this question included "yes," "no," and "expand if needed." Third, the question "Overall how well do you feel your adoption professional helped you process your grief around reproductive loss or infertility?" was analyzed with a frequency distribution. The possible answers to this question included "very well," "well," "moderately," "poorly," and "very poorly." Fourth, the question "Overall how well do you feel your adoption professional prepared you to adopt a child after experiencing reproductive loss or infertility?" was analyzed with a frequency distribution. The possible answers to this question included "very well," "well," "moderately," "poorly," and "very poorly."

The fourth research question "How can adoption social workers better help families with reproductive loss and infertility prepare to be adoptive parents?" was addressed through the responses participants gave to two open ended questions: "What, if anything, do you feel made you (and your partner if applicable) unique in the adoption process that you wish your social worker understood better?" and "Is there any way that you feel your adoption social worker could have helped you to better process your grief around reproductive loss and infertility in the face of adoption?" The answers to these questions measured the variables of grief processing and adoption social work

effectiveness. I and another research student coded the survey answers to the two open ended questions, and found particular patterns and themes.

Validity and Reliability

The same survey (found in Appendix A) was distributed in the same manner to all participants in order to ensure reliability. Definitions for any unclear concepts were provided so that participants could respond to what the research intended to measure. The survey questions were peer reviewed by other social work students to confirm that questions were easily understandable for participants, and that the questions measured the concepts stated in the literature review.

Findings

Reproductive Loss vs. Infertility

When participants were asked to indicate the reason that they are not able to have a biological child they were given three options: reproductive health issues, non-reproductive health problems (examples include heart problems, epilepsy and cancer treatment, genetic issues, injury, etc.), and "other, please explain." Table 1 shows that 22 respondents (91.6%) indicated they were not able to carry a biological child due to reproductive health issues. No participants for this research selected the answer "non-reproductive health problems (examples include heart problems, epilepsy and cancer treatment, genetic issues, injury, etc.)." The participants that answered "other," explained their responses by stating: *"don't know"* and *"have never tried to get pregnant"* which could mean they did not understand the question or the concept of infertility versus reproductive loss.

Table 1.
Rate of Reproductive Health Issues

	Frequency	Percent
Reproductive Health Issues	22	91.6
Other (please explain)	2	8.3
Total	24	100.0

Profound grief – Research Question #1

Participants were asked to indicate whether they experienced the loss of biologically carrying a child as profound grief while expanding their family. Table 2 shows that 10 participants (47.6%) answered "yes," and 11 participants (52.3%) answered "no." Two participants chose not to answer the question and three typed an answer explaining their response. They shared *"unsuccessful IVF tries,"* and *"always thought adoption was a good option,"* and *"no way! Adoption is totally joy!."* These answers show that the participants may have interpreted the question differently than how the research was intended. Responding with "unsuccessful IVF tries" indicates they may have believed they were being asked about the nature of their infertility. Responding with *"no way! Adoption is totally a joy!"* could mean that the participant was responding in regards to their current feelings about infertility and adoption. If they are currently parenting a child they may no longer feel their infertility is a loss because of all they've gained through adoption. The possible fluidity of grief and loss over time is addressed in the discussion section.

One participant elaborated *"…I did experience profound grief and loss during the fertility process, and it was very traumatic. However, once we had our first child (adopted her), any urge or sense of loss for a biological child evaporated."* Another added *"I did not understand the loss connected with infertility at the time – I just wanted*

to be a mom." An additional participant stated *"We were sad that IUI [fertility treatment] didn't work for us, but just moved on and started looking into adoption, which was an option we had previously discussed even before finding out that we could not have biological children."*

Table 2.
Profound Grief

	Frequency	Percent
Yes	10	47.6
No	11	52.3
Total	21	99.9

All participants were then asked whether the grief they felt could be categorized as "ambiguous." Table 3 shows that 16 participants (72.7%) answered "yes," and 6 participants (27.2%) answered "no." Two participants chose not to answer the question and two typed an answer, but did not choose "yes" or "no." One shared *"I suppose, but once we agreed to adopt, I didn't care less that I couldn't have a biological child."* The other shared an answer that indicated that they felt the question was not applicable to them.

Table 3.
Grief as Ambiguous

	Frequency	Percent
Yes	16	72.7
No	6	27.2
Total	22	99.9

Impact of Infertility on the Home Study Experience – Research Question #2

This research question was addressed through a qualitative question in the survey: "How if at all, do you feel reproductive loss or infertility impacted your experience of the home study process?" Some participants experienced no impact on their home study: *"it didn't," "I completed the grieving process," "not at all,"* and *"not at all really."* Another participant elaborated: *"To me they were two separate things, so I didn't associate our loss in any way with the adoptive process or have any expectations that the social worker address the loss in any way…."* Finally, one participant felt the infertility had no impact on the study process, but did emphasize their experience of loss: *"I don't think infertility impacted the home study process but the ambiguous loss never goes away."* Finally, there was one participant who expressed strongly that grief and loss do not have a place in the adoption home study process. They stated, *"A person shouldn't be living the grief if he or she is awaiting the joy of the arrival of their child. I feel this study is totally missing the point of adoption."*

While some participants found no relationship between their infertility and the home study, others felt their history did impact the adoption process. One respondent stated:

> *"We pursued adoption earlier than we would have otherwise. (We always wanted to adopt, but have biological children first). We also feel that the adoption process is much more emotional as you have more riding on completing an adoption to start your family. There is also a heightened sense of loss of control, as you have no real control over the adoption process. At the same time, we felt a renewed sense of hope, as an opportunity still was available to have the family we always wanted."*

One participant spoke of the adverse impact that infertility had on the home study experience, *"The pain of infertility made the home study process seem even more frustrating long and intrusive. It felt like adding insult to injury."* One participant had the insight to connect their loss with the birth parent loss and states:

> *"We were overwhelmed with the emotion of knowing that our greatest joy would mean another person would experience their greatest pain, handing a life over to another human being to raise. In our minds she would feel the same loss we felt as we lost our bio babies, even though our loss occurred in two completely different ways."*

Another participant spoke to the pressure of getting the home study right, *"I wanted to make sure we met all the requirements from forms to be submitted, to completing required training. I wanted us to be deemed as viable candidates."*

Social Work Profession Meeting Needs – Research Question #3

Participants were asked to indicate whether they felt their adoption social work professional addressed their grief around reproductive loss. Table 4 shows that eight participants (36.3%) answered "yes," and 14 participants (63.6%) answered "no." Two participants chose not to answer the question and three chose to refrain from selecting "yes" or "no" and instead typed an answer explaining their response. One shared *"This was not relevant, we were looking forward to a successful adoption."* Another respondent added *"Almost too much, she assumed we were really broken down about it when really we were ready to move forward with adoption."* After consultation with the research committee chair it was determined that this response would added to the statistics as a "yes" due its affirmative answer. This is reflected in table 4. An additional

response stated *"I recall I mentioned my need to have a hysterectomy because of recurring, massive fibroids. I don't feel that we talked much about how I felt about it."* Finally another stated, *"That wasn't her job. She's rightly taking for granted that you are beyond that, and ready to start the joy of adoption."*

Table 4.
Social Worker Addressing Grief

	Frequency	Percent
Yes	8	36.3
No	14	63.6
Total	22	99.9

Participants were asked the question "Do you feel you adoption social work professional provided you with resources to process your grief around reproductive loss and infertility in the adoption home study process?" and answer options provided were "yes" or "no." Table 5 shows that four participants (19.0%) answered "yes," and 17 participants (80.9%) answered "no." Two participants chose not to answer the question and five chose to refrain from selecting "yes" or "no" and instead typed an answer in the "expand if needed" field. An additional participant also just answered *"n/a"* (presumed to mean not applicable to the respondent's case) and another simply stated *"I didn't need resources, as I did not experience profound grief."* Finally one participant gave the feedback *"I totally feel this isn't appropriate. This again is not her responsibility. If someone is still suffering such grief, they aren't ready to adopt."*

After consultation with the research committee chair, two participants who typed in responses were added into yes or no categories. One participant shared *"Again, almost too much. She insisted that I attend grief counseling with an outside therapist but I didn't*

feel it was necessary. We had stopped with the fertility treatments a while ago and were ready to move forward." This response was added to the category of "yes" in the statistics due to its affirmative answer. Another respondent answered, *"No, however, we started our Home Study after we found our birth mother on our own so we were on an emotional high from that and our emotional grief was at a different point during that time."* This response was added to the category of "no" because of its negative response.

Table 5.
Social Worker Provided Resources

	Frequency	Percent
Yes	4	19.0
No	17	80.9
Total	21	99.9

Participants were asked to indicate on a scale how well they felt their adoption professional helped to process their grief surrounding reproductive loss and infertility. Table 6 shows that one participant (5.9%) answered "very well," two participants (11.8%) answered "well," three participants (17.6%) answered "moderately," seven participants (41.2%) answered "poorly," and four participants (23.5%) answered "very poorly." Nine participants chose not to answer the question despite all participants having the option to share a response.

Table 6.

Professional Helped Process Grief

	Frequency	Percent
Very Well	1	5.9
Well	2	11.8
Moderately	3	17.6
Poorly	7	41.2
Very Poorly	4	23.5
Total	17	100.0

Participants were asked to indicate on a scale how well they felt their adoption professional prepared them to adopt a child after experiencing reproductive loss or infertility. Table 7 shows that four participants (22.2%) answered “very well,” two participants (11.1%) answered “well,” four participants (22.2%) answered “moderately,” five participants (27.8%) answered “poorly,” and three participants (16.7%) answered “very poorly.” This means that of 18 responses, only six (33.3 %) felt that their social worker did “well” or “very well” in preparing them to adopt a child. Of the 18 responses, the majority of respondents (12 or 66.6%) felt their social worker did “moderately,” “poorly,” or “very poorly” of a job in preparing them to parent a child. Comparative to other questions in the survey that received 25 or 26 responses, these scaling questions received fewer answers, with only 17 and 18 respondents respectively.

Table 7.
Professional Prepared Client

	Frequency	Percent
Very Well	4	22.2
Well	2	11.1
Moderately	4	22.2
Poorly	5	27.8
Very Poorly	3	16.7
Total	18	100.0

Adoption Social Work Improvement – Research Question #4

One question in the survey (Appendix A) approached the topic of distinctiveness and uniqueness as a client. Participants were asked "What, if anything, do you feel made you (and your partner if applicable) unique in the adoption process that you wish your social worker understood better?" This question was answered by twelve survey respondents. The question was open ended and allowed for participants to type their response. One respondent answered *"I'm not sure she really understood infertility."* Another said *"I wish we could have shared more about how long we have struggled to start a family. My reproductive health issues were not addressed in depth."* Another participant spoke to the inexperience of their workers:

> *"Our original social workers were inexperienced, recent bachelor-level graduates, who were at least ten years younger than us and had never had any experience with grief or loss. Their sympathy seemed forced. Our next case worker was nearing retirement and had a very "abrupt" personality. He did not show sympathy or empathy at all. Social workers should be more empathetic, or at the very least, help us find others who truly do understand our grief."*

Another added that *"I feel that this grief is so specific that only those who have "been there" truly understand. I don't think a social worker can help process it, unless he/she has experienced it him/herself."* This client felt that their unique experience was not reflected in personalized care.

The last question of the survey asked participants to reflect on possible improvements to adoption social work services. It asked "Is there any way that you felt your adoption social worker could have helped you to better process your grief around reproductive loss and infertility in the face of adoption? This question prompted participants to give very concrete suggestions to the field of adoption social workers. One respondent stated "they should have a list of counselors that were experienced in infertility grief counseling." Another participant stated, *"I wish our adoption worker had been able to give us more statistics on in-country adoptions with families who have biological kids. I also wish she would have given us more information regarding foster adopting."* Another said *"…the only way they could've helped us process it better would have been to put us in touch with other couples who had gone through similar issues."*

One responder felt that the social work professional was not an appropriate person for processing their grief, stating, *"I am not sure I would have wanted to go through that with the social worker – for us the home study was just an administrative requirement we had to fulfill in order to pursue adoption."* Another participant explained that there was nothing that could have helped them at the time because *"I did not understand the loss connected with infertility at the time – I just wanted to be a mom."*

Finally, a respondent to the survey shared generously their emotions in regards to the topics of this research. They address their grief, the ambiguousness of it, and the significance that infertility played in their path to becoming a parent:

> *"I think the agencies and social workers can just be very sensitive to the fact that they are dealing with a couple that is possibly grieving (probably unconsciously grieving) and may not even be aware of or in touch with those feelings, since society doesn't acknowledge them and/or the situation is often very private. The agencies and social workers can realize that, to the couple, it feels like a major violation of privacy and dignity and feels punishing and extremely unjust, given that biological parents go through none of this. Remember that anyone who has just gone through fertility treatments has already been experiencing a huge sense of violation, invasion of privacy, complex emotions, expenses, complicated logistics and physical discomfort with the drugs and shots and gynecological exams. So the home study process happens on top of all that plus the loss – so much effort for no return. The home study is like pouring acid on an open wound. The adoptive parents can't help but feel that it's all very unfair. I didn't feel that as much with our second adoption, but we had been through the process before, weren't as emotional and saw in it a more clinical way. But that first time was very upsetting. It's so invasive. You feel so violated."*

Discussion

The purpose of this research was to explore how the history of infertility and reproductive loss impacts a person's experience of the adoption home study process. The findings of this research provide insight into the experiences of adults with infertility

history and shed light on the relationship between client and social worker in the adoption home study process.

Grief, Loss and Ambiguousness

It was not until very recent years that the medical profession began to recognize the significant distress endured by people with infertility and reproductive loss (Domar, Zuttermeister, & Friedman, 1993). When asked if they experienced the loss of having a biological child as profound grief, more participants answered “no” than those that answered “yes.” This contradicts literature reviewed for this research which found that there is a correlation between an experience with infertility and adverse feelings such as profound grief and loss and occasionally depression and anxiety (Hammer Burns, 1990; Peterson, et al, 2012 Wilkins; Warnock, & Serrano, 2010).

The fact that more respondents to the study answered “no” rather than “yes” to the question about their experience of grief seems to contradicts the fact that later in the survey when asked if their grief could be characterized as ambiguous more participants answered “yes” than those that answered “no.” Additionally, many participants gave feedback in the open ended questions about their grief processing in the home study process. It is possible that participants did not feel comfortable confirming that the loss of a biological child was experienced as profound grief because their distance from the loss leaves them with a different, more complicated feeling. If they are currently happily parenting a child through adoption then they may not easily access those feelings of loss that were so fresh during the struggle to add to their family. While this survey did ask if parents were currently parenting a child, it did not explore if they feel the adoption was successful, and if they and their child are adjusted and satisfied. It is also possible that

the respondents that indicated that their infertility was not a source of profound grief and loss really did not experience these emotions. Although this would be contrary to the literature reviewed, it is possible that some individuals do not feel this sense of loss around their ability to carry a biological child.

Current literature suggests that loss which is ambiguous does not easily resolve itself (Seifter Abrams, 2001), however some respondents to the study felt that their grief surrounding fertility was not profound, and that the loss was not experienced as ambiguous. Another participant even felt that at the time they could not comprehend what the loss was. They stated: *"I did not understand the loss connected with infertility at the time – I just wanted to be a mom."* Additionally, it is possible that participants who once experienced profound grief around their reproductive loss and infertility had this feeling resolved once they either started the adoption process or began parenting their child. This is reflected in one client's statement: *"…I did experience profound grief and loss during the fertility process, and it was very traumatic. However, once we had our first child (adopted her), any urge or sense of loss for a biological child evaporated."*

Implications for Practice

Because the grief experienced by those with infertility and reproductive loss can be ambiguous and diverse, there will be no one theory or practice to address all clients' needs and experiences (Betz & Thorngren,2006). However, some patterns have been found in individuals and couples that experience few distressing symptoms in regards to their grief. One such study found that when both individuals in a couple accept blame for their reproductive loss or infertility, they are more likely to experience high distress (Peterson, et al., 2006). This has implications for social work adoption professionals in

that they can encourage clients to release the blame that they put on themselves for their loss.

While adoption social workers do not conduct therapy with their clients, they can address and acknowledge the grief associated with infertility and reproductive loss. However, this should be done with permission from the client and only if it will be helpful to the unique needs of that family. One participant in this research shared their experience of feeling that this support was not necessary for them: *"I am not sure I would have wanted to go through that with the social worker – for us the home study was just an administrative requirement we had to fulfill in order to pursue adoption."* However, the diversity in the clients' needs is displayed by a contradicting statement from an additional participant stating that they did feel the need to have their grief addressed: *"I wish we could have shared more about how long we have struggled to start a family. My reproductive health issues were not addressed in depth."* This client could have been helped by methods addressed in literature. A theory created by

Sensitivity to diversity is important in addressing reproductive loss and infertility. This includes cultural, religious and gender diversity. Researchers in Iran recognized patterns in Muslim women that caused them to have higher rates of depression in regards to their infertility, and they concluded that this was because of their culture's strong value of family and childbearing (Ramezanzadeh et al., 2004). Gender is important in how individuals experience their grief because of the weight put upon women to carry a pregnancy biologically (Peterson, et al., 2006). Addressing the uniqueness of each client and family means that social workers have to spend time getting to know their clients, asking questions, and being present emotionally to what is going on in the assessment.

One participant shared in their response of their need to feel some level of sympathy from their social worker:

> *"Our original social workers were inexperienced, recent bachelor-level graduates, who were at least ten years younger than us and had never had any experience with grief or loss. Their sympathy seemed forced. Our next case worker was nearing retirement and had a very "abrupt" personality. He did not show sympathy or empathy at all. Social workers should be more empathetic, or at the very least, help us find others who truly do understand our grief."*

One action that adoption professionals can take with their clients that falls clearly within the roles of the assessment process is to give education to clients about the correlation between infertility and depression. They can also refer clients to therapeutic resources and equip them with options to use in case the need arises for further support outside of the adoption home study process. One participant stated: *"they should have a list of counselors that were experienced in infertility grief counseling."* Another said *"…the only way they could've helped us process it better would have been to put us in touch with other couples who had gone through similar issues."* These individuals could have benefited from a support group or an individual or family therapist.

It is important for social workers to educate themselves on the issues impacting the population of clients that they are directly working with. Some participants of this research indicated that they did not understand what they were going through themselves, so it is necessary for adoption workers to provide education on the impact that infertility can have on a person pursuing adoption. One respondent answered *"I'm not sure she really understood infertility."* in regards to their social worker. Because infertility and

reproductive loss is the main impetus for families pursuing adoption (Van Laningham, Scheuble, & Johnson, 2012), the issue is very applicable to the home study assessment and should be an issue that adoption professionals are highly educated in.

Because participants frequently contradicted each other in their experiences of grief and the home study it is apparent that not all loss is equal for individuals with infertility and that it is possible that the grief and loss changes with time and circumstance. Although some participants felt that the exploration of their loss by the social worker was a poor use of time, others felt that their experience was brushed over and not recognized. The purpose of the social worker is to tend to the needs of the prospective parents, while protecting the children in the welfare system. While it may feel frustrating to have such a comprehensive evaluation done, it is important that professionals are able to comprehensively understand their clients' experiences. This research shows that there are some clients slipping through the cracks of the current adoption home study process. Individuals reported feeling that their social worker was not empathetic, that they were misunderstood and that they were left without resources. The experience of the home study felt like an added pain on top of the loss of a biological child. Adoption cannot replace that loss, and while becoming a parent was shown in this research to be a healing process for one of the participants, it is important that social workers help their clients to prepare for the experience of parenting a child coming to them through adoption.

Implications for Policy

One concern that I find in the child welfare system is that the social workers evaluating the family for adoptive parenting are also the social workers providing

resources and building a therapeutic relationship. This could be a conflict of interest as a client may want to divulge their pain, loss, and sorrow, but feel that it could compromise their ability to have an approved home study. On the other side, a professional may feel they need to take extra clinical care with a client in the assessment process but is bound by the very task oriented and time limiting structure of the home study. Although many families may find that having another "hoop to jump through" in the journey to parenthood would adversely affect them, requiring a limited experience in therapy prior to starting the home study process could take this conflict of interest between clients and home study social workers away.

Although the Hague Convention requires Hague accredited agencies to follow strict protocol when approving families for international adoption, it is currently optional for agencies to pursue accreditation through the convention (Crea, 2009). This means that agencies can operate with no oversight other than their state's licensing, and the requirements for each state is varied depending on the culture and norms of that area (Crea, 2009). Thus the process of assessing a family for stable mental and physical health, access to resources, and skills to parent special needs rests solely on the shoulders of the family social worker. The Hague Convention has provided safeguards to protect the rights of children and birth parents in sending countries and I believe that it should be a required license for agencies conducting home studies in the United States (Crea, 2009). At the very least the United States needs a standardized, enforceable, "best practice" process for conducting family assessments and home studies, so that we are closer to ensuring the safety and wellbeing of children placed in adoptive homes. My research has shown that infertility and reproductive loss has the potential to greatly

impact a family and cause emotional distress. While this is not always present in pre-adoptive families, it will be easier for social workers to assess for unresolved grief and loss if there is a standardized assessment template.

Implications for Further Research

Processing reproductive loss alongside the family's adoption is a lifelong commitment, one that both social workers and parents need to make. The findings of this research lend themselves to many topics of study within reproductive loss, adoption and professional social work. One such issue is the varying nature of adoption services. While adoption social workers are often as diverse as their clients there are currently very few best practices used across agencies and professionals.

One surprising finding of this research was the fact that no participants responded that their lack of biological children was due to non-reproductive health issues. Based on research cited in the literature review (Serene Jones, 2001) I had grounds to believe that the inclusion of non-reproductive health problems was important because of the profound grief that can occur with the inability to have a child due to a history of problems like cancer, epilepsy, dwarfism, heart conditions, genetic problems or other issues not related to reproductive health. While this study by L. Serene Jones (2001) recognized the difference between infertility and reproductive loss due to other health issues, it seems that very few researchers or professionals recognize this difference. One study compared the grief associated with cancer, heart disease and other chronic illness with the depression related to infertility, without ever addressing the fact that some of the health problems referenced cause infertility as a byproduct of the disease (Domar, Zuttermeister, & Friedman, 1993). Initially I believed that this research study would produce evidence

to show that there is grief associated with reproductive loss caused by health problems, chronic illness, genetic conditions, or disability. However, this was not found due to lack of participants with health related reproductive losses. The profession of social work would benefit from further research that explores the rates of infertility vs. reproductive loss with a larger population of people.

An important response that was gathered from this survey was the experience of one individual that stated they always planned to adopt, but because of their infertility they were led to the home study process earlier than expected. Research on an adult's interest in adoption prior to infertility versus an adult's interest in adoption solely based on infertility would bring important information to social workers if patterns were found in the two populations. It is possible that if an individual or family had always had interest in adopting they would find infertility to be less of a loss and be able to offer much strength to a child placed in their home.

The varying responses from clients in regards to their adoption professionals shows that services are not consistent, and the interpretation of the home study assessment is not consistent across populations of clients. In the process of examining current literature, no information was found on current adoption assessment or home study practices. Further research needs to be conducted to explore the patterns and inconsistencies in home studies across agencies, states and countries.

While one study focused on depressive symptoms in fathers in the post adoption stage of their family (Foli & Gibson, 2011), most research found focused on the *female* experience of reproductive loss, infertility, and adoptive parenting. Additionally, every article found in the literature review focused on heterosexual couples, and also included

no mention of single adults. Further research should focus on all adults, despite where they fall on the spectrum of gender identity or sexual orientation. Because of the strong focus on the female experience of infertility and reproductive loss in literature, there is a gap that should be filled through researching individuals with other gender identities that suffer from reproductive loss or are partnered with someone suffering reproductive loss.

Limitations

There were numerous limitations in this research. The time, resources, and structure of the research limited the scope of exploration. Ideally the research would have been able to reach a vast, diverse population of adults with reproductive loss and a completed adoption home study. Requiring these two characteristics of my sample (both infertility/reproductive loss *and* a completed home study) significantly narrowed the possible respondents because these two occurrences are not common in the majority population of adults.

Since there were not resources available in this project to survey random large samples of adoption home study clients, this research focused on a convenience sample of participants who elected to fill out the survey. Participants were reached online through social media websites and groups. This means that people who may have fit the characteristics of this study, but who do not participate in social media, were not able to be included in the research. Additionally, the survey was only provided in English, eliminating from the study those potential participants who do not possess adequate English literacy.

Having a small population of respondents changed the nature of this research. Given a higher response rate it would have been beneficial to quantify some experiences

of the participants and the relationship between things like grief, type of infertility, satisfaction with the professional and demographics of the respondents. While the survey was written in a way that could be statistically analyzed, the low number of respondents limited the analysis.

A flaw in the implementation of the survey may have changed some answers for respondents. The online survey tool only allowed participants to choose yes, no, or an option to "expand if needed," rather than either yes or no *and* expansion on their answer. This meant that some answers typed into "expand if needed" had to be selected by the researcher manually to be added into the "yes" or "no" categories. However, the fact that on numerous occasions participants chose to "expand if needed" and typed an answer that wasn't easily categorized as "yes" or "no" meant that it's possible that these questions were simplifying the topics for participants. "Yes" or "no" could be poor responses to accurately reflect the participants true feelings. It also limited the number of explanations because once participants selected "yes" or "no", they were not able to additionally type in extra feedback.

The topics explored in this research were potentially emotionally triggering and it was difficult to ask clients to access those feelings for the sake of the survey. It is possible that a limitation of the research was the nature of the topics involved. Through consultation with committee members it was determined that the reason that relatively few responses were gathered may have been due to the title of the study, which contained topics that were emotionally triggering. Although understanding issues like loss, grief, parenthood, and health are important for the professionals delivering services, it is not important to clients that they meditate on painful experiences so their contribution to the

research was generous. It is possible that many participants chose not to complete the survey due to the lack of incentive, time requirement and the painful subject matter.

Strengths

Because there is little information available on the specific experience of families with reproductive loss in the adoption process this study has begun to fill a gap in the literature. This survey was relatively short and easily accessible online, allowing participants to complete it at any time convenient to them. An additional strength is that this research gathered data directly from the individual experiencing reproductive loss and the home study process.

The survey distributed to participants collected information from clients without the bias of being associated with any adoption organization or agency. This meant that clients were able to share their genuine feelings and opinions about the services they received and their experiences in the home study. By ensuring participants of anonymity the researcher was able to receive responses that were emotionally vulnerable and generous. Careful consideration was made to the wording of the questions and the ability for participants to answer in a way that accurately represented their experiences.

Conclusion

The reason that this research is so important is because at the heart of adoption is the need of a child. Although adoptive parents are the clients of the home study, it is the children being adopted that are the main priority in adoption social work practice. The adult experience of reproductive loss can impact a child that is adopted through various means including the parent's ability to foster attachment and a sense of identity in the child. A child adopted into a family with infertility history could harbor a sense of

indebtedness to their parents. This indebtedness could translate into the child feeling pressured to be grateful for their adoption because of the perceived act of goodwill on the part of their parents. There is a risk that these children could grow up with the awareness that their existence in the family was a backup plan for the ideal circumstance which was a biological child. The post adoption experiences of these families with infertility should continue to be supported and it is important for social workers to prepare families for the long term reality of adoptive parenting after infertility or reproductive loss. Families are incredibly diverse, however, and the possibility of the parent experiencing these adverse emotions, and the possibility of the child experiencing pressure to be grateful is going to vary depending on the circumstances of the family.

The current literature on grief and loss in individuals with infertility shows that the experience is important to fully process. Sensitive adoptive parenting requires extensive knowledge in attachment, trauma, birth family dynamics, cultural diversity, racism, and other social issues. The adoption profession currently has no best practices established for evaluating prospective parents and preparing them for adoptive parenting after a history of infertility. This research brings forward the voices of adoptive parents with infertility histories in an attempt to aid social workers in their understanding of their clients.

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Appendix A

Reproductive Loss and Adoption Survey

Have you or your partner experienced the inability to biologically carry a pregnancy due to one or more of the following issues:
(_) reproductive health issues
(_) non-reproductive health problems (examples include heart problems, epilepsy and cancer treatment, genetic issues, injury, etc.)
(_) neither my partner nor I have experienced the inability to biologically carry a pregnancy due to a health, or other issue.
(_) other:____

Have you ever fully completed an adoption home study with a licensed social worker?
(_) Yes (_) No

While expanding your family did you experience the loss of having a biological child as profound grief? (Profound grief meaning sorrow, pain and heartache due to a loss.)
(_) Yes (_)No
Expand if needed:
____

Would you characterize the grief you felt due to infertility or reproductive loss as ambiguous (i.e. not widely recognized by others)?
(_) Yes (_)No
Expand if needed:
____

Do you feel your adoption social work professional addressed your grief around reproductive loss in the adoption process?
(_) Yes (_)No
Expand if needed:
____

Do you feel your adoption social work professional provided you with resources to process your grief around reproductive loss and infertility in the adoption home study process?
(_) Yes (_)No
Expand if needed:
____

Overall how well do you feel your adoption professional helped you process your grief around reproductive loss or infertility?
(_) (5.) Very well
(_) (4.) Well
(_) (3.) Moderately

(_) (2.) Poorly
(_) (1.) Very Poorly

Overall how well do you feel your adoption professional prepared you to adopt a child after experiencing reproductive loss or infertility?
(_) (5.) Very Well
(_) (4.) Well
(_) (3.) Moderately
(_) (2.) Poorly
(_) (1.) Very Poorly

Are you currently parenting an adoptive child?
(_) Yes
(_) No

Are you currently waiting to receive your adoptive child into your home?
(_) Yes
(_) No

Qualitative
How, if at all, do you feel reproductive loss or infertility impacted your experience of the adoption home study?

____
____
____
____

What, if anything, do you feel made you (and your partner if applicable) unique in the adoption process that you wish your social worker understood better?

____
____
____
____

Is there any way that you feel your adoption social worker could have helped you to better process your grief around reproductive loss and infertility in the face of adoption?

____
____
____
____

Appendix B

Consent Form for Participation in a Research Study
St. Thomas University/University of St. Catherine

Infertility, Reproductive Loss and the Adoption Process; a Study on the Experiences of Individuals and Couples in the Adoption Home Study Process

Research and Participation

You are invited to participate in a research study conducted by Emily Jacobsma and being overseen by Dr. Abel Knochel. The purpose of this research is to explore how infertility and reproductive loss impacts a person's experience of the adoption process. This research aims to understand more fully the experiences of families in the home study process and to understand how well the profession of adoption social work is meeting the needs of families with reproductive loss.

Your participation will involve answering a brief survey that will require approximately 15 minutes of your time. You will be asked about your experience with reproductive loss and the services of your adoption social worker during the home study process.

Risks

Complicated feelings of anxiety and sadness may arise after reflecting on the experience of reproductive loss. If you feel adverse symptoms at any point during the survey, you may cease responding to the questions. If you are feeling any adverse symptoms after the survey is completed you are encouraged to reach out to a mental health professional to receive support around your grief and loss. Resources will be provided upon exit from or completion of the survey.

Potential Benefits

There are no known benefits to you that would result from your participation in this research. This research may help the profession of adoption social work to better understand the experience of couples and individuals who have struggled with reproductive loss and infertility.

Protection of Confidentiality

Your identity as a participant will not be known by the researcher or your adoption service provider and will thus be kept anonymous in any paper or presentation resulting from this study. The individual or organization who provided you with access to this study will not have access to any of your information and they will not know whether you chose to participate or not. Your privacy and confidentiality will be maintained as a result of your participation in this study.

Voluntary participation

Your participation in this research study is voluntary. You will not be penalized in any way should you decide not to participate in this study or should you discontinue your participation.

Contact information

If you have any questions or concerns about this study or if any problems arise, please contact at Emily Jacobsma at jaco8143@stthomas.edu. Dr. Abel Knochel can be reached at knoc2422@stthomas.edu. If you have any questions or concerns about your rights as a research participant, please contact the St. Catherine University Institutional Review Board at 651.690.6204.

Consent

I have read this consent form and have been given the opportunity to ask questions. I give my consent to participate in this study.

By checking this box and proceeding to the survey I am indicating that I understand and agree to the information given above.

☐ **I agree**

Appendix C

Recruitment Script

When posted by the agency or social media page facilitator:
Participants are needed for a research study on infertility and the adoption home study. [Insert Agency/Group Name] is not conducting this research, nor will we know whether or not you have participated. To participate you must have a self-reported history of infertility or reproductive loss. You must also have fully completed an adoption home study. You can access the survey here: [Link to Survey]

When posted by the researcher:
Participants are needed for a research study on infertility and the adoption home study. [Insert Agency/Group Name] is not conducting this research, nor will they know whether or not you have participated. To participate you must have a self-reported history of infertility or reproductive loss. You must also have fully completed an adoption home study. You can access the survey here: [Link to Survey]