

THE UNIVERSITY OF MANITOBA

ADOPTION BREAKDOWN:  
A COMPARISON OF  
ADOPTED ADOLESCENT FEMALES  
WITH  
NON-ADOPTED ADOLESCENT FEMALES  
PLACED IN AN  
INSTITUTIONAL TREATMENT FACILITY

BY  
ANN MARIE CATHCART

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## ABSTRACT

In examining an aspect of the phenomena of adoption breakdown, this study compared the level of pathology demonstrated by adopted and non-adopted adolescent females placed in a Manitoba treatment institution.

It was found that the adoptees did not differ significantly from their peers in terms of general severity of disturbance. However, it was discovered that the adoptees demonstrated a particular symptomatology which differed from the non-adopted subjects. The adoptees tended to be more disturbed for the symptom grouping of "regressive attention seeking behavior".

Analysis revealed that all subject groups responded equally to treatment at the institution. According to discharge evaluations completed by the social workers, all subject groups were found to have responded positively to treatment. All groups, however, showed less improvement for the symptom grouping of "regressive attention seeking behavior".

When the adoptees were divided into two groups, those adopted in infancy and those adopted at older ages, significant differences between the groups were not found in terms of their overall degree of disturbance. However, those adoptees adopted in infancy demonstrated significantly more problems for the symptom grouping of "social functioning" than adoptees placed for adoption when older.

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## CHAPTER I

### INTRODUCTION

Adoption establishes a legal and social relationship between parents and children, usually unrelated by birth. The relationship that is created assumes all the same rights and responsibilities that exist for natural parents and children. It is the only means by which a permanent surrogate family can be provided for children whose natural parents are unable or unwilling to care for them. (Kadushin, 1970, p.1)

Historically, adoption has served a variety of purposes which usually took precedence over fulfilling the needs of homeless children: the provision of an heir; the continuation of family religious traditions; the legitimation of an illegitimate child; and the satisfaction of the emotional needs of childless couples.

As late as the 1950's adoption policies and practices in the Western World reflected many of these traditional views about adoption. Agencies, for the most part, interpreted adoption as a service rendered to childless couples. Their practices centered on couples providing proof of their infertility, and prolonged efforts to "correctly match" children with couples on the basis of race, physical characteristics and background. Children regarded as adoptable were healthy with good family background.

Gradually traditional views have given way to current

policies and practices which instead emphasize the needs of children as being served by adoption. The policy developed in 1962 by professionals in the child welfare community reflected this emphasis.

The placement of children for adoption should have as its main objective the well-being of children. The needs of the child should be the primary determinant of the total service, with full recognition of the interdependent needs and interests of the natural parents and adoptive parents. An adoption service should not have as its main purpose to find children for families, nor should it be expected to provide help for many of the problems associated with childlessness.

(Child Welfare League of America,  
Standards, 1962, p.6.)

Traditional adoption practices were greatly affected by policies which emphasized the needs of children. A major change was the lifting of the barriers to adoption for those children previously regarded as unadoptable. With the view of adoption as a kind of permanent child care, any child in need of a home could be considered for adoption regardless of health, age, family history, or minority status. Selection of adoptive parents shifted from proof of infertility to evidence that a secure healthy homelife could be provided. The infertility of applicants as a determinant for adoptive parenthood had been relatively simple for agencies to verify. Proof of parenting abilities was far more difficult for agencies to assess.

It was in this area of the selection of adoptive parents

that the general lack of research on which to base policy and practice became apparent. There was a serious deficiency of studies which considered the characteristics of families conducive to healthy child development, or the post-placement functioning of adoptees. Based only on vague and changing assumptions of what constituted a successful adoption, agencies had been blindly arranging placements without knowledge of the long term results or outcome of their efforts.

With the focus shifting to meet the child's needs through the adoption process, studies gradually emerged in the 1960's which considered adoption outcome and the post-placement functioning of adopted children.

Writing in 1970, Kadushin (1970, pp.64-69) summarized the findings of fourteen longitudinal adoption outcome studies. He found that of the 2,236 adoptive placements reported in the studies, at follow up 74% had been judged "unequivocally successful", 11% intermediate or "fairly successful" and 15% "poor" or unsatisfactory. Kadushin's figures can only be acceptable in gross terms as the studies he selected differed greatly. However, with the very high percentage of "successful" adoptions, the literature indicates that adoption is a legitimate means of providing permanent care for many children.

Although most adoptions turn out satisfactorily, Kadushin's summary does show that approximately 15% of adoptions are not considered successful at followup. Some adoptions are so unsuccessful they conclude in adoption breakdown. This

term generally refers to the situation in which the relationship between the adoptive family members has disintegrated to the point where placement of the adoptee out of the home may be considered. The adoptive parents may even be seeking to revoke the order of adoption. In some situations, the adoptee may exhibit signs of emotional disturbance. It is the intent of this study to examine some of these very unsuccessful adoptions, focusing on the social functioning and pathology that may be demonstrated by adoptees who have sustained this very traumatic experience.

The student's interest in adoption breakdown developed through her experience as a social worker with a Manitoba child welfare agency. Often community requests for service were from parents experiencing relationship problems with their adolescents. These referrals usually involved requests for family counselling and often, for placement of adolescent they identified as the problem. In some of these families the adolescent had also been adopted. As agency counselling and placement services were rendered, the issue of adoption seemed to be an integral part of the problems faced by the family. The adoption issue seemed to further complicate the relationship breakdown which had occurred between the adolescent and his or her adoptive parents. In assisting these families in crisis, the adoptee was usually admitted to the care of the agency. Family counselling from the agency, or from other community resources, seemed unable to bridge the relationship gap between the adoptee and parents, to

prevent placement. When these adoptees were admitted to care their behavior appeared to deteriorate, often requiring their placement in more structured, treatment focused placements. It seemed possible that adopted adolescents could be more vulnerable to developing emotional disturbances following a family breakdown and placement, than adolescents not adopted. With the child welfare agency encountering fairly substantial numbers of these families, it became apparent that research conducted in Manitoba on this subject could be useful.

The main objective of this study was to generate some information about the social functioning of adolescents who have experienced adoption breakdown and placement away from home. It was anticipated that information about these adoptees and how they compared with other adolescents, could be useful to agencies providing placement and treatment services for children in Manitoba. Such information as may be interpreted from this study could help such agencies in determining if specific treatment strategies are warranted for their adopted wards, or in evaluating their existing resources for these adolescents.

The specific purpose of this study was to determine if disturbed adopted adolescents differ from disturbed non-adopted adolescents in terms of severity of disturbance, and symptomatology. In pursuit of this objective, information was collected on the pathology demonstrated by disturbed residents, adopted and non-adopted, placed at a Manitoba treatment institution for adolescent females.

## CHAPTER 2

### REVIEW OF THE LITERATURE

In the last two decades a sizeable body of research has accumulated on the topic of adoption outcome. An intense controversy surrounds the subject. There have been reports that a higher percentage of adoptees are represented in the caseloads of treatment agencies and child guidance clinics. (Schechter, 1960; Toussieng, 1962). Other reports have suggested a heightened incidence of psychopathology for adoptees (Nemovicher, 1960; Toussieng, 1962; Goodman, 1963; Schechter, 1964) and even that specific syndromes may be characteristic of adoptees. (Menlove, 1965; Reece and Levin, 1968; Offord, 1969). There has been criticism of this body of research (U.S. Children's Bureau, 1964; Kirk, 1966) and the existence of studies, similar in design, which report conflicting results. (Borgotta and Fanshel, 1965; Elonen and Schwartz, 1969; Cunningham, 1969; Hoopes, 1970). Still other studies have questioned the validity of focusing outcome studies on clinical populations, instead emphasizing the positive outcomes of most adoptions. (Bernard, 1963; Kadushin, 1967).

Resolving this controversy is not the purpose of this literature review. Rather, the intent is to integrate some of the conclusions made by researchers studying adoption outcome, in order to provide a context on which to base the present study.

The studies will be described in view of their findings in four specific areas.

1. emotional disturbances in adoptees;
2. the behavioral characteristics or symptomatology of disturbed adoptees;
3. the responsiveness of disturbed adoptees to treatment;
4. the relationship between severity of disturbance and the age of adoptee's placement in adoptive home.

#### Part I

##### Disturbances in Adoptees

There were very few studies conducted prior to 1960 which dealt specifically with disturbances in adoptees. Most of these studies were conducted in fulfillment of post-graduate degrees, and their results were not widely publicized.

Stonesifer (1942) conducted one of the first studies which examined the subject of disturbances in adopted children. She compared a group of disturbed adopted children with a group of natural children on the basis of sex, age, race, nationality, religion, ordinal position in family, economic status of family, and the date of acceptance by the agency. The cases were then compared on the basis of numbers and/or types of problems, the attitudes of parents and children, and the success of treatment. Stonesifer did not find significant differences between the two groups for any of the variables, leading her to conclude that the children were equally disturbed.

Raleigh (1954) duplicated the basic design of the Stonesifer study at the Institute of Juvenile Research in Chicago. She compared thirty adopted children with matched controls on the basis of the diagnosis and rating of emotional disturbance made by psychiatrists. Raleigh did not find significant differences between the two groups. She concluded that the few differences which emerged did not appear to be caused by the adoptive situation.

Nemovichter (1960) examined the relationship between a child's disturbances and his status as adopted, but did not select subjects from a clinic population. In his study, thirty boys adopted through an agency were matched with thirty non-adopted classmates selected at random. They were matched for socioeconomic status, religion, age, intelligence, sibling position, and grade level. Four traits--hostility, tenseness, dependency, and fearfulness were utilized as measures for the degree of disturbance evinced by each child. Evaluated by parent questionnaire, teacher ratings, and blind psychological tests, the adopted group scored significantly higher on the traits. These findings, despite being based on testing of a non-disturbed sample, did not support the results reported by Stonesifer or Raleigh.

When the controversy on the alleged prevalence of disturbance in adopted children gained momentum in the sixties, the findings of the forementioned studies were largely ignored, and rarely quoted. Instead, much of the literature was based on clinical observations made about adopted children by psychiatrists.



Eiduson and Livermore (1953) opened the debate in an article which reflected on the predominance of disturbed adopted children in their clinical practice. They claimed that a large percentage of the children they treated at the Hacker Clinic in California were extremely disturbed adopted children, who as a group, presented "unusually difficult treatment problems."

(Eiduson and Livermore, 1953, p.795.) They maintained that the fact of the child's adoption appeared to enter into the etiology of the problems presented and in the child's treatment difficulties.

A direct response to Eiduson and Livermore's remarks did not appear in the literature until Schechter (1960) commented on the seeming large numbers of adopted children in his private practice. After presenting a series of case histories of disturbed adoptees and their treatment complications, he suggested that "children who have been adopted have a potentially more fertile soil for development of neurotic and psychotic states." (Schechter, 1960, p.32.) Due to the controversial nature of Schechter's widely publicized article, the professional community was quick to respond. Schechter's views were echoed by Humphrey and Ounsted (1960). They commented on the severe degree of disturbances shown by those of their clients that had been adopted. These clients seemed to have a greater tendency to lying, stealing and destructive behavior. Toussieng (1962) claimed that during a five year period, over ten percent of the children treated at the Menninger Clinic had been adopted. He felt that this was a higher percentage than should be expected

considering the percentage of adopted children in the general population. His conclusion was that adopted children were prone to emotional disturbance and personality disorders which he hypothesized were related to "an unconscious and unresolved aversion toward parenthood in one or both adoptive parents." (Toussieng, 1962, p.65.) This view was supported and further developed by Dukette (1962).

Most of these articles based on clinical observations met with severe criticism. Goodman and Silberstein (1963) challenged the notion that there existed a higher representation of disturbed adoptees in clinic caseloads than would be expected in the general population. They demonstrated the extreme difficulty in determining the base rate of adoptions from which to compare the percentages of adopted clients at clinics. After proposing a more reliable method of establishing a base rate, they reported that there was a slight overrepresentation of adopted children in their clinic's caseloads. (2.4% as compared with their rate for the community, 1.7%) Although the percentage difference was statistically significant, they believed it was not of social consequence. Goodman and Silberstein took this argument further, by questioning the validity of predicting the vulnerability of adoptees to psychiatric problems by studying disturbed subject populations. They argued that this could be best determined through longitudinal investigations of adoptees.

Other articles were published which criticized the

clinical studies, and in particular the work of Schechter and Toussieng. Bernard (1963) criticized the lack of reliable empiracle methods used in previous studies, emphasizing that these reports did not give due recognition to the existence of many well adjusted adoptees. The Research Division of the United States Children's Bureau (1964) released a critical report which concluded that the alleged incidence of psychiatric problems among adopted children had not been demonstrated by any study. This point was reiterated by Kirk (1966) in the only Canadian study which examined this subject, and by Madison (1966). In reviewing the psychiatric literature on adopted children, Lawton and Gross (1964) recommended further studies be conducted with a non-clinic population of adoptees compared with a control population. This, they suggested, would be the only method to determine if adoptees were prone to developing emotional disturbances.

The debate on the alleged prevalence of disturbance in adoptees heightened with the emergence of studies more rigorous in design. These studies appeared to fall into two categories. The first consisted of studies, similar in design to Stonesifer's, which concentrated on the problematic functioning of adoptees in clinic populations. The remainder were longitudinal and follow up studies which assessed how adoptees were faring years after their placements.

Sweeney et al. (1963), in a study similar in design to Stonesifer's, compared a sample of adoptees with a sample of non-adoptees at a Pennsylvania child guidance center. They

found what they considered to be a high proportion of adopted children in the population of disturbed children treated at the clinic (7.2%). They remarked:

...there is something special about this group (adoptees), but from a clinical/descriptive point of view nothing stands out

...there was nothing in the presenting problems or family circumstances that differentiated the adopted children from the non-adopted in the clinic population studied.

(Sweeney et al., 1963, p.349)

Schechter responded to criticism of his earlier work by attempting to substantiate his claims about adoptees being prone to emotional problems in a slightly more rigorous study.

(Schechter et al., 1964) He distributed a questionnaire to the members of a California Psychiatric Society requesting information about patients who had been adopted. For the purposes of obtaining a comparison control group of adoptees not in a psychiatric setting, he included in some aspects of the study, a volunteer group of adoptive parents and children.

In order to obtain a control group of people manifesting emotional disturbances, he also included the outpatients of a psychiatric clinic in the study. According to the primary symptomatology, Schechter compared the adoptees in psychiatric settings with the psychiatric control group. He found that the emotionally disturbed adopted children, as reported by their psychiatrists, demonstrated significantly more ( $p < .001$ ) overt aggression and sexual acting out than the disturbed non-adopted children. For the symptomatology comparison of the adults,

Schechter found that alcoholism and sexual acting out were reported significantly more often ( $p < .001$ ) for the disturbed adopted adults. He again concluded, that despite the design limitations of the study, it seemed likely that the "adopted child may be prone to emotional difficulties." (Schechter et al., 1964, p.117.)

Stonesifer's study design was repeated in a substantial number of studies, but the results reported were rarely in agreement. Menlove (1965) hypothesized more emotionally disturbed adopted children with behavioral symptoms of aggression and delinquency would be found, than in a comparable group of non-adopted children. She compared a group of fifty-one adoptees with a group of fifty-one non-adoptees, matching for sex, age, race, occupation of parent, family income, and number of siblings. According to evidence of nine aggressive type symptoms, it was found that there were significantly more adopted children exhibiting some of these symptoms than in the control group of non-adopted children. In another study, (Simon and Senturia, 1966) it was concluded that adopted children were more likely to be diagnosed as manifesting a personality disorder or transient situational personality disorder than non-adopted children. Lifshitz et al. (1975) explored the differences between the symptomatology of thirty adopted children and a matched control group, who had been reared in a Kibbutz and referred to a child guidance clinic for treatment. The children were compared on a checklist of 132 behavioral manifestations, reported at each of

four developmental stages (age range 6-13). They found that the adoptees were "attributed with more problematic manifestations than biological children" at each of the stages. (Lifshitz et al., 1975, p.225.)

Conflicting results but similar conclusions were reported by two studies based on the same design, comparing disturbed adopted and non-adopted children. Borgotta and Fanshel (1965) found differences between the two groups of children seen at a psychiatric outpatient clinic, to be barely statistically significant. The adopted children in their study seemed to be more often involved in problems of parental defiance, unwillingness to assume responsibility, and task orientation. However, they concluded that as the differences were minimal, the adopted children were not more disturbed than the non-adopted children. They went so far as to claim that the adopted children in their study were less frequently diagnosed as psychotic. In another study (Offord et al., 1969) the severity of the children's symptoms were rated on a five point scale by a psychiatrist based on the mother's description of her child's emotional problems. Symptoms were then categorized as either behavioral disorders, neurotic disorders, or other disorders. When the total severity of illness of the groups were compared, significant differences were not noted. They concluded that the adopted children were not more seriously disturbed than the non-adopted children.

Two 1968 studies investigated samples of disturbed adoptees in psychiatric settings, but neither utilized control

samples. These studies still made an important contribution as data collection was not limited to information about disturbed adopted children. Data on the attitudes and behavior of adoptive parents was also examined. Reece and Levin (1968) reviewed 1017 cases seen at a psychiatric clinic over a ten year period and identified thirty adopted children. In twenty-three of these cases the adoptive parents complained of very serious behavioral disturbances in their children and were considering out of home placement. These children were most often recorded by the clinic intake worker as aggressive and anti-social. Information recorded on the adoptive parents of these children indicated that they were defensive, rigid, secretive, in both their denial of problems and in their projection of blame on the heredity of their children. Reece and Levin admitted that while these defenses were likely to be found in natural parents, they concluded that:

...the adoptive process is likely to reinforce such defenses and to foster concealment of information that might affect the applicant's chances of winning agency approval. Furthermore, once an adoption has been accomplished the opportunity to deny responsibility and to blame others still has a potentially firm base in reality whether the parents resort to explanations based on heredity or on the conviction that the agency or others gave them a "raw deal."

(Reece and Levin, 1968, p.108.)

The design and results of Jackson's (1968) study paralleled those of Reece and Levin. She examined forty cases of adopted

children and their families referred to a child guidance clinic. The cases were compared on the basis of factual information reported by the diagnosing psychiatrist. The very severe behavioral problems demonstrated by many of the children led Jackson to conclude:

...there is some weight of evidence to indicate that the fact of being adopted played an important part in causing these children's maladjustment...violent aggressive behavior and sexual acting out were more common among the symptoms of this sample.

(Jackson, 1968, p.398.)

Jackson also discovered that the "difficult adoptees" also had "difficult adoptive parents." The descriptive terms used by the psychiatrists to describe three-quarters of the adoptive mothers were: "perfectionistic, sadistic, over-anxious, over-moral, manic, hysterical, unstable, rejecting, deeply depressed, overpowering, immature, mentally cruel, hard, driving, rigid, paranoid, and over-protective." (Jackson, 1968, p.396.) These negative characteristics shown by the adoptive parents, Jackson linked with their children's disturbances.

Witmer et al. (1963) published one of the first longitudinal studies which followed up adoptees many years after their placement. It appeared at a time when clinical studies, claiming that adoptees were prone to emotional disturbance, were overrepresented in the literature. The Witmer longitudinal study was far better suited to explore the risk inherent in being adopted. Primarily concerned with evaluating the outcome



of independent adoptions in Florida, Witmer followed up 484 adoptive families. At the time of the study, the children were between nine and fifteen. On the basis of interviews with the adoptive parents and questionnaires, the home was given a rating. This, together with a series of "blind" psychological tests and teacher's ratings, administered in the schools of the adopted children, combined to determine adoption outcome. Testing of the adoptees social-emotional adjustment consisted of the following measures:

1. a sociometric test indicating the popularity of the child;
2. a test directed at ascertaining parent-child relations;
3. personality tests to evaluate social and emotional adjustment from the child's viewpoint;
4. questionnaires devised to secure teacher's opinions about the children's attitudes and behaviors at school; and
5. cumulative records furnished by the school on intelligence and achievement.

For each of the measures the adoptees were compared with natural children selected as controls. Witmer found that approximately two-thirds of the homes were classified as fair to excellent. They also discovered that according to the tests and rating methods used, that "the majority of the adopted children were making what appeared to be an adequate social emotional adjustment." (Witmer, 1963, p.254.) Only nine to fifteen per cent of the adoptees scored poorly on the tests or were rated as maladjusted. For IQ and school achievement, Witmer found the

adoptees and their controls to be comparable. However, for all the other tests, the adoptees were significantly more likely to have poor ratings. The adopted children were somewhat less popular than their classmates. They were less likely to be rated by their teachers as leaders and more likely to be described as aggressive. The study concluded that most adopted children, even those adopted independently, were likely to grow up well-adjusted, but slightly less well adjusted than their peers.

In another follow-up study Schwartz (1967) evaluated the social functioning and personality characteristics of a group of adopted boys a decade after their placement. He hypothesized that the factor of adoption would have a negligible effect on children who were placed in early infancy under the guidance of a social agency. For the group of twenty-five boys and a matched control group of non-adopted boys, Schwartz compared the results on a series of objective and projective personality tests. His hypothesis was not substantiated. Differences which emerged between the groups on the tests, led Schwartz to conclude that the adopted boys were more vulnerable to emotional and psychiatric problems. He anticipated that this was intensified because of parental anxieties, the child's need to know about his origins, and the problems associated with coping with rejection by natural parents. Schwartz stated:

The results showed that there is considerable uncertainty and anxiety concerning the permanence and reliability

of object relations for many of the adopted children...their approach to social interaction involves defensive non-involvement and in some cases hypochondrical withdrawal....In terms of parent child interaction the adopted boys associated fear and anxiety with parental disapproval and tended to be inhibited in expressing even mildly aggressive feelings toward parental figures.

(Schwartz, 1967, p.2518.)

Schwartz's conclusions suggest that adopted children may be prone to developing emotional problems, but some of his results contrast those of other studies. Disturbances demonstrated by the adopted children in his study concentrated on behaviors associated with social withdrawal, not on aggressive behaviors reported by other researchers.

Elonen and Schwartz (1969) reported the results of a longitudinal study of adoptive families. Data collection began in the child's infancy, prior to adoption and continued through to adulthood, with periodic interviews. The purpose of the study was to evaluate the emotional and social adjustments made by the adoptees, specifically their reactions to events and changes in their families. Most of the forty-three adoptees studied were rated as adequately adjusted on the basis of their social behavior. However, some children did have adjustment problems, particularly educational difficulties. Forty-seven per cent of the adoptees were considered to be "underachievers" throughout their school years. This was the only trend to emerge which could suggest greater problems for adopted children.

Elonen and Schwartz concluded:

...being adopted is not a causative factor, per se in the emotional problems of adopted children. As with all children, adopted or non-adopted, problems stem from their parents reactions to them, to their questions and feelings and to important events in family life.

...they (adopted children) will have severer problems if vital situations bring a reaction of fear and anxiety from significant adults in their environment.

(Elonen and Schwartz, 1969, p.78.)

Hoopes et al. (1970) followed up a group of children adopted through a social agency in a study similar in design and hypothesis as Witmer (1963). Utilizing control groups of non-adopted children at various points in the study, the children were matched on the basis of school grade, sex and social class. The general emotional health of the children was measured by a series of intelligence and "blinded" psychological tests, together with teacher's ratings and school achievement records. Their results matched those of the Witmer study. They found that most of the children adjusted very well in adoption and did not show evidence of more pathology than their controls. They concluded that the issue of adoption is not a causative factor in the development of emotional and behavioral problems. However, like the Witmer study, they found that significantly fewer adopted children were rated as functioning in the "excellent adjustment" category on the teacher's rating scales, than the control children. Hoopes also discovered, as did Witmer, that the adopted children were less likely to be

described by their teachers as showing leadership qualities or popularity with peers.

Two follow-up studies which addressed the issue of disturbances in adoptees, used adults as subjects. McWhinnie's (1967) study was based mainly on case histories and interviews with fifty-eight adult adoptees. Her results indicated that a wide range of social circumstances, and levels of adjustment were reported by the adoptees at follow up. She determined from the interviews that certain patterns seemed to be inherent in the adoptive situation. This led McWhinnie to conclude that the adoptive family situation was generally beset with potential problems.

Jaffee (1973) followed up thirty-three adult adoptees placed by agencies when they were under three years of age. His results did not support McWhinnie's conclusions. Generally, the adoptees in his study reported fairly non-problematic past and present adjustments. The degree of difficulties experienced was only weakly correlated with several independent variables. For instance, he found that less problematic adjustment was significantly correlated with adoptees receiving more information about their biological parents. Jaffee's results did not indicate that adoptive status is related to poor emotional and social adjustments in adulthood.

The literature addressing the subject of disturbances in adoptees explored another area significant to the present study. Several researchers hypothesized various explanations

for the fact that some adoptees do become emotionally disturbed. In 1975 Sorosky et al. (1975) reviewed the adoption literature with the purpose of integrating these concepts. They distinguished four arguments represented in the literature: prolongation of the family romance; complications in the resolution of the oedipal complex; disturbances in early object relations; and geneological bewilderment.

Freud (1909) originated the notion of the family romance fantasy. As part of normal development a child may periodically fantasize he is the child of other unknown parents. Several authors have suggested that, for the adopted child, this fantasy has a firm base in reality, possibly resulting in problems for the child and family. (Conklin, 1920; Clothier, 1942; Eiduson and Livermore, 1953; Glatzer, 1955; Schechter, 1960; Lawton and Gross, 1964.)

Also Freudian in origin, was the explanation hypothesizing that the resolution of the oedipal complex was particularly difficult for the adopted child. Several authors expanded on this theme, suggesting that complications at this period of an adopted child's development could lead to later emotional disturbances. (Sants, 1965; Tec, 1967; Easson, 1973.)

Other researchers attempted to explain the disturbances demonstrated by adoptees as being related to the extent of their early maternal deprivation. (Humphrey and Ounsted, 1963; Bowlby, 1965; Offord, 1969.)

Sants (1965) introduced the term geneological bewilderment

to describe the state of confusion and uncertainty characterizing the child with no knowledge of his or her natural parents. The term explains the trauma that Clothier (1942) associated with the separation of a child from his or her racial or cultural background. She believed that this trauma was central to the psyche peculiar to the adopted child.

Another explanation for the occurrence of emotional disturbances in adoptees, described in the literature, has significance for this study. Several authors have attempted to link these disturbances with the identity conflicts experienced at crucial developmental stages--particularly adolescence. Usually this argument is offered in combination with the geneological bewilderment explanation. Kornitzer (1971) suggested that the adopted adolescent's identity formation is impaired because he has knowledge that an essential part of himself--his origins--has been severed by adoption. Frisk (1964) conceptualized that a lack of knowledge about natural family background caused some adoptees to wander restlessly about or run away from home during adolescence. He interpreted this as a symbolic urge to discover their true character and to secure a sense of identity. Tec (1967) wrote that the problems which adolescence presents to all families and children are exacerbated by adoption.

Sorosky et al. (1975) elaborated on this "adolescent identity crisis" argument. As a preliminary to their investigation into the outcome of reunions between adoptees and their

birth parents, they interviewed a large number of adoptees who were searching for their birth parents. They hoped to link disturbances in adoptees theoretically with identity conflicts experienced at crucial psychosocial developmental stages-- adolescence and young adulthood. They concluded that:

...the adoptees seemed more vulnerable than the population at large to the development of identity problems in late adolescence and young adulthood because of the greater likelihood of encountering difficulties in the working through of the psychosexual, psychosocial, and psychohistorical aspects of personality development.

(Sorosky, 1975, p.24.)

Sorosky interpreted the tireless searching for birth parents by their subjects as representative of the normal rebellion and self-examination of adolescence. They generalized that adoptees were particularly vulnerable to developing problems during this period. They found that the adoptive parents seemed less able to deal constructively with their children's testing of authority, verbal confrontations and search for independence and identity. They also found that these parents were unable to see their children's threats to find birth parents as partly adolescent rebellion, partly curiosity about their origins.

...adoptive parents are especially vulnerable to such threats and often overreact with intense fear or anger which only serves to reinforce their youngster's manipulative powers. Adoptive parents are generally very insecure and uncomfortable when it comes to dealing with their child's



conception and hereditary background. Any interest shown by the adoptee in meeting the birth relatives is viewed by the adoptive parents as an indicator of their personal failure as parents or as a sign of ingratitude on the part of their children. Their fear of being abandoned by the adopted child seems to relate to old unresolved feelings of separation and loss associated with infertility and their resulting childless state. It is difficult for adoptive parents to disassociate themselves and to view their children's genealogical concerns as stemming from personal identity conflicts associated with the unique psychological experience of adoption.

(Sorosky, 1975, p.24.)

#### Summary

Since the late sixties, the controversy surrounding the evaluation of adoption outcome has dwindled considerably. Further published studies dealing specifically with the emotional disturbances of adoptees could not be identified.

The literature clearly indicates that most adoptions are successful. The results described in the longitudinal follow up studies show that most adoptees make what is considered to be good emotional and social adjustments. (Witmer, 1963; Elonen and Schwartz, 1969; Hoopes et al., 1970; Kadushin, 1970; Jaffee, 1973.)

Throughout the literature, there is also a general acknowledgement that some adoptions break down, and that some of these adoptees become emotionally disturbed. Much of the literature supports the notion that the adoption issue enters into the etiology of the disturbed adoptee. This argument was

promoted in the clinical articles (Schechter, 1960; Toussieng, 1962.) and later substantiated by more empirically reliable studies. (Menlove, 1965; Lifshitz, 1975.) Studies which examined non-disturbed samples of adoptees discovered that adoption created a unique psychological experience for the adoptee and family. (Nemovichter, 1960; Schwartz, 1967.) Even the longitudinal studies reached a conclusion that while most adoptees were generally well adjusted, they were not quite as well adjusted as their non-adopted peers. However, there is no consensus in the literature on whether or not disturbed adoptees are generally more disturbed than their non-adopted peers. This may be due to the different methods of selection and labelling of symptoms, and measuring disturbance, demonstrated by the various studies.

Various explanations have been offered for the fact that some adoptees become emotionally disturbed. (Conklin, 1920; Clothier, 1942; Bowlby, 1965; Sants, 1965; Frisk, 1964; Tec, 1967.) Significant to the design of the present study is Sorosky's (1975) argument, which links disturbances in adoptees with the identity conflicts experienced at the crucial developmental stage of adolescence.

## Part II

### The Symptomatology of Adoptees

Most of the researchers addressing the subject of emotional problems in adopted children also made claims that particular symptoms appeared to be characteristic of disturbed

adoptees. Some authors found that disturbed adoptees exhibited a significant occurrence of particular symptoms, while others went further to claim that a peculiar symptomatology or syndrome seemed characteristic of disturbed adoptees.

A review of the literature did not identify any research that demonstrated that disturbed adoptees were without particular symptomatology. Only Schechter (1960), in his first article, claimed that the symptomatic reasons for referral of adopted children for psychiatric treatment appeared to be "without specificity." In a later article Schechter (1964) revised his comments to state that adopted emotionally disturbed children showed significantly more symptoms of overt aggression, sexual acting out, and significantly less enuresis than a comparable group of non-adopted children.

Most researchers have confirmed that particular symptoms appear to be characteristic of disturbed adoptees, but rarely are the same or similar symptoms reported. Nemovichter (1960) found that a group of adopted boys demonstrated the traits of hostility, tenseness, dependency and fearfulness to a greater degree than a comparable group of non-adopted boys. Toussieng (1962) and Frisk (1964) both commented on the phenomena that some adopted adolescents seemed prone to a restless wandering, characterized by absconding from their homes. Simon and Senturia (1966) found that disturbed adoptees were more likely to be diagnosed as having a personality disorder and exhibit antisocial symptoms. Tec (1967) conceptualized that adoptees,

especially adolescents, demonstrated a similarity of symptoms, personality traits and attitudes. Schwartz (1967) found that symptoms of introversion and social withdrawal were characteristic of the adopted children in his study. Reece and Levin (1968) reported that the adopted children in their study receiving psychiatric treatment showed serious aggressive and antisocial symptoms. Violent, aggressive behaviors and sexual acting out were characteristic of the adopted children seen by a child guidance clinic in Jackson's study (1968).

Two other studies went into greater depth in exploring the hypothesis that certain symptoms or symptomatology were characteristic of disturbed adoptees. Menlove (1965) predicted that the syndromes of passive aggressive personality, sociopathic personality and antisocial personality would be more prominent in a group of disturbed adoptees than in a comparable group of non-adoptees. Her predictions were substantiated with the findings that on a list of nine aggressive-type symptoms, the adoptees in her study exhibited significantly more frequently the symptoms of hyperactivity, hostility, and negativism. Other symptoms were found to be more frequent for the adoptees, but not to levels of significance: fire-setting, impulsiveness, legal difficulties, and sexual acting out.

Lifshitz et al. (1970) in their study of adopted children living in a kibbutz examined the frequency of behavioral occurrences at four developmental stages for groups of adopted and non-adopted children. At the ages six to seven, all of the

disturbed children demonstrated significant symptoms of restlessness, lack of concentration ability, fears, learning difficulties and aggression. The adoptees were distinguished by social withdrawal, delinquent behavior (i.e. stealing and absconding) and enuresis, while the non-adoptees were distinguished by significant occurrences of temper tantrums or mood swings. At the ages eight to nine, both adoptees and non-adoptees exhibited the symptoms of learning difficulties, faulty concentration ability and restlessness. The adoptees differed in their significant occurrences of persistent fears and shallow social relationships. The non-adoptees continued to demonstrate the symptoms of temper tantrums and mood swings. Liftshitz found a greater divergence between the groups at the ages ten to eleven. The adoptees revealed symptoms of restlessness, lack of concentration ability, fears, and erotic behaviors, while the non-adoptees demonstrated more manifestations within the social sphere. (i.e. social withdrawal) At the pre-adolescent ages of twelve to thirteen, the adoptees were characterized by a lack in concentration ability and exhibition of erotic behavior, while the non-adoptees tended towards demonstrations of active aggression and temper tantrums.

The claim that particular symptoms seemed characteristic of disturbed adoptees was also made by researchers whose studies concluded that adoptees and non-adoptees did not differ significantly in severity of their emotional problems. Borgotta and Fanshel (1965) found that the adopted children in their

study were less likely than non-adopted children to be diagnosed as psychotic, or have problems of over-inhibited behavior. They found that the adoptees were more likely to be involved in problems of parental defiance and unwillingness to assume responsibility. Comparing disturbed adopted and non-adopted children for the type of primary presenting symptoms, Offord (1969) found significant differences between the groups. The adoptees had significantly more behavior problems while the non-adoptees had significantly more neurotic problems. When the severity of problems was considered the adopted children manifested significantly more antisocial behavior than the non-adopted children. Offord also discovered that the adoptees manifested their symptoms significantly more often in the community and at school. Elonen and Schwartz's (1969) results concurred with Offord's finding. In their study it was found that a significant number of the adopted children had educational difficulties with the main characteristic being underachievement.

#### Summary

A review of the literature indicates a general consensus among researchers, that the presenting symptoms or symptomatology of disturbed adopted children are significantly different than those of disturbed non-adopted children. However there is little agreement as to what symptoms are characteristic of disturbed adoptees. There are several explanations for this occurrence. An attempt was not made to differentiate between the presenting symptom complex and the other symptoms exhibited by the children

in any of the studies discussed. All of the symptoms were given equal weight in determining the children's severity of disturbance. Secondly, from study to study, there was little uniformity as to the labels of symptoms. Lastly, only the Offord study took into account the severity of each symptom demonstrated.

### Part III

#### The Responsiveness of Disturbed Adoptees to Treatment

Only one study which examined disturbances in adopted children at psychiatric clinics investigated the responsiveness of disturbed adoptees to treatment. (Stonesifer, 1942.) After comparing the disturbed adoptees with their matched controls on a variety of variables, including the success of their treatment, Stonesifer failed to find significant differences between the subjects. In her study fifteen adoptees improved while treated at the child guidance clinic as compared with seventeen control subjects. The only other reference made in the literature to the responsiveness of adoptees to treatment was Eudson and Livermore's (1953) comment that the disturbed adoptees in their clinical practice demonstrated "unusually difficult treatment problems." A review of the literature did not yield any other research which examined either the length of time in treatment or outcome of treatment for adoptees as compared with non-adoptees.

Part IV

The Significance of the Age of  
Child When Placed in Adoptive Home

Adoption policy has been permeated for decades by the belief that the earlier a child is placed for adoption the better his opportunity for a positive social and emotional adjustment. The basis for this assumption is founded on the premise linking sound mental health with nurturance. Numerous studies have documented the importance of nurturance in the development of the human personality. Other authors have addressed specifically the effects of a break in primary object relations on young children. (Freud, 1969; Yarrow, 1964; Bowlby, 1965.) Bowlby's studies led him to conclude that the absence or loss of significant parental figures created disturbances in children, which if left untreated permanently scarred personality development, and resulted in problems in forming meaningful relationships. Littner (1956) documented the traumatic effects of separation from parents experienced by children placed by child caring agencies. Studies such as these have provided the rationale for adoption policy. As all adopted children, of necessity, experience a break in primary object relations, the assumption has been that timing is a crucial issue in the planning of adoptive placements. The earlier a child is placed with parental substitutes, the less likely he is to experience and be affected by the trauma of separation from parental figures.



Many of the researchers examining adoption outcome also addressed the issue of whether the age of adoptive placement was related to the level of adjustment achieved by adopted children. Based on the existing literature, most authors anticipated that the earlier a child was placed for adoption, the better his social and emotional adjustment. However, an overview of this research indicates that there is not a clear relationship between the age of a child's adoptive placement and positive adoption outcome.

Witmer et al. (1963) in their longitudinal study of independent adoptions found that the age of adoption was only slightly associated with the child's later adjustment. They acknowledged the likelihood that a child placed later had likely experienced some trauma prior to placement. Witmer identified fifty-six children identified as "traumatized" prior to adoption. At follow-up there was little difference in the adjustments achieved by these children as compared with other adoptees placed at a similar age and in similar homes, but who had not experienced extreme "traumatic conditions."

Kadushin (1967) followed up a group of children who had been adopted when older, and found that 78% of the adoptions were considered successful with the parents satisfied and the children having adjusted well. Kadushin concluded that the deprivation experienced by these children as a result of multiple separations could be considered reversible.

McWhinnie (1967), in her follow-up study of adopted adults,

found that the age at which a child had been placed for adoption was important only within certain limits. Her conclusions paralleled those of the Witmer study. Her group of subjects, considered well adjusted, had a slightly higher percentage of adoptees placed before the age of four months. McWhinnie noted, like Kadushin, that good adjustments were often associated with later placements. Only with placements that occurred later than two years of age did McWhinnie report from her interviews with adoptees, some evidence of emotional problems.

Ripple (1968) also found a lack of association between the adopted child's adjustment at follow up and "the age at which he was placed in his adoptive home, the number of pre-adoptive placements, the apparent quality of care in those placements or the early behavior of the child." (Ripple, 1968, p.485.) The expected association between early placement and favorable outcome emerged only for very young infants. Ripple found that of the fifty children placed at less than two months of age, only 14% showed serious problems at follow up, compared with 28% for the other age groups. However, she discovered that this difference disappeared when the "problem" children were compared with the "normal" children. For each of the age-at-placement groups, Ripple found that about half of the children demonstrated some serious problems at follow up.

In another follow up study Kadushin (1970) reinforced his previous conclusions regarding the reversibility of traumas suffered by adoptees prior to their adoptions. He based his

conclusions on interviews conducted with ninety-one families who had adopted an older child. The factors age at adoption, preadoptive placement history, psychological evaluation, and rating of emotional deprivation showed remarkably little relationship to the child's later functioning. He stated:

Whatever experiences the child may have encountered earlier seems to be compensated for by the experience of living in a good adoptive home.

(Kadushin, 1970, pp.224-225.)

The most significant conclusion of this study was that older children could be placed for adoption with the expectation that the placement could work out satisfactorily. Kadushin's study showed between 82% and 87% of the adoptions were considered successful.

The percentage of successful cases in this study was compared with other follow up studies of adoptions. Despite the fact that the subjects of all these studies were infant adoptions, the level of success achieved was no different, in terms of statistical significance from the level of success achieved with these older children.

(Kadushin, 1970, p.206.)

In the Hoopes et al. (1970) follow up study, age of adoptive placement was not found to be a predictive factor in determining a child's later adjustment. Deprivation and multiple placement prior to adoption were found to be only slightly related to poorer child functioning.

Eldred et al. (1976) followed up and interviewed a sample of 432 adults who had been adopted as children in order to explore

variables associated with satisfactory adoption outcome. They categorized each adoptee's age of placement as: less than four months; four to twelve months; one to two years; or more than two years. They found that the age of adoptive placement was unrelated to the degree of psychopathology manifested by the adoptees as an adult. Neither the age of separation from natural mother, number of preadoptive placements, nor time spent in institutions prior to adoption was found to be related to the psychopathology demonstrated by the adult adoptees. This led the authors to suggest that it was the quality of the adoptee's experience prior to adoption, and the possible rupturing of a significant relationship which could be more important for later development, than the age of adoption.

Several other studies hypothesized that the age of adoptive placement would be a strong factor in determining the later adjustments of adoptees. These studies were conducted on clinic populations, with predictions that the most disturbed adopted children would be those who were older when adopted.

The majority of the disturbed children in Schechter's (1964) study had been placed for adoption prior to six months of age. A review of the symptomatology exhibited by the adoptees revealed that neither the symptoms of sexual or aggressive acting out were associated significantly with the age of adoptive placement. Schechter acknowledged the limitations of the study, but concluded that the age of adoption did not appear to have a direct relationship to the occurrence of later emotional disturbance.

Menlove (1965) predicted that aggressive and delinquent behavioral symptoms would be more characteristic of adoptees who had been adopted after the age of six months than of those children adopted before this age. Her hypothesis was not substantiated. She compared the symptomatology of children adopted prior to six months and children adopted after six months with their non-adopted matched controls. Children adopted prior to six months were found to demonstrate significantly more sexual acting out behavior than their controls. Compared on the basis of final diagnosis, significantly more of these children were labelled as having a passive-aggressive personality. For the children adopted later than the age of six months, only the symptom of hyperactivity was found to be significantly more frequent than for the controls. Menlove also discovered that significantly more control subjects than children adopted after six months were found to demonstrate the symptoms of temper tantrums and legal difficulties (i.e. delinquencies). When a direct comparison was made between the two groups of adoptees in terms of symptoms exhibited, no differences emerged. Menlove concluded that an aggressive symptomatology was not more characteristic of children adopted after six months than those adopted before this age.

Offord (1969) concluded that the age of adoptive placement was significantly correlated with the severity of anti-social symptoms demonstrated by the subjects in his study. He found that children adopted later in their lives had significantly

more behavior problems than children adopted in infancy. In order to more clearly comprehend the relationship between the age of adoption and the nature and severity of the disturbances, Offord divided the adoptees into two groups, those adopted prior to six months and those after six months. A comparison of the groups did not reveal any significant differences in the severity of disturbance. However, Offord discovered the groups tended to differ in presenting symptomatology. He concluded:

...when difficulties arise the overall severity of the disturbance may not bear any consistent relationship to the age of adoption, but those children adopted after six months will be more likely to present a behavior problem.

(Offord, 1969, p.115.)

### Summary

The majority of the adoption outcome literature suggests that there is not a clear relationship between the age of adoptive placement and later child adjustment. Most of the authors conclude that children placed later than infancy who have had traumatic preplacement experiences still have excellent prospects for good social and emotional adjustments. The studies which dealt with samples of disturbed adoptees failed to establish that children adopted when older tended to develop more severe emotional problems than children adopted in infancy. In fact, none of these studies reported any significant differences between the two groups of adoptees in terms of the severity of their disturbances.

Part V

The Hypotheses

This study was concerned with testing the following hypotheses for adolescent females requiring inpatient institutional treatment:

1. Adopted female adolescents who have experienced adoption breakdown and are placed in institutional treatment are likely to be diagnosed as more severely disturbed than a comparable group of non-adopted female adolescents.
2. Adopted female adolescents who have experienced adoption breakdown and are placed in institutional treatment are likely to demonstrate a particular symptomatology which differs from a comparable group of non-adopted female adolescents.
3. Adopted female adolescents who have experienced adoption breakdown and are placed in institutional treatment are likely to be less responsive to treatment and spend longer periods of time in treatment than a comparable group of non-adopted female adolescents.
4. The age at which a disturbed female adoptee was placed for adoption is unrelated to the severity of disturbance, or type of symptomatology demonstrated by her when placed in institutional treatment.
5. The age at which a disturbed female adoptee was placed for adoption is unrelated to her responsiveness to institutional treatment.

## CHAPTER III

### METHODOLOGY

#### The Research Design

The research design which appeared best suited to answer questions about adoption breakdown was a variation on two longitudinal survey designs--the panel and the ex post facto study designs. In the panel study, data is collected over a period of time from the same sample of subjects. The ex post facto study examines data composed primarily of subject's perceptions and recollections of events which may have occurred in the past. It was proposed that in the present study, a panel of adoptees placed in a treatment institution by a child-caring agency would be compared with a panel of non-adoptees placed in the same facility. The study could also be considered ex post facto in nature. Some of the data collected consists of perceptions about events which may have occurred in the lives of the adolescents and their families prior to the former's admission to the institution.

Several factors were considered to be important in the choice of design. It was decided that for purposed of comparison with the adoptees, the use of a non-equivalent control group was essential. Secondly, with few studies in the literature examining the responsiveness of adoptees to treatment, it was determined that this would be a useful area to examine. The design required that testing of subjects prior to admission to



the institution and at discharge be pursued in evaluating the effectiveness of the treatment program for the two groups. Finally, it was necessary to accept the collection of admission data which was primarily ex post facto in nature. It was important to obtain as large a sample of adoptees as was possible for the analysis. As the literature indicates that the percentages of disturbed adoptees in mental health settings is rarely above 12%, it was unlikely that the desired sample size of fifty adoptees could be obtained from current residents of a Manitoba institution. Therefore, a longitudinal perspective was required, which included previous as well as current residents of the institution.

#### Sources of Data

##### The Study Site

Marymound School was chosen as the study site. Marymound is a private institution located in Winnipeg, Manitoba. It is administered by the Sisters of the Good Shepherd, but also staffed by professionals. It is subsidized by the Provincial Government. Marymound offers a three-level treatment program for emotionally disturbed adolescent females.

It has three locked residential units located on the institutional grounds. In addition, Marymound has four residential group homes located nearby in the community. The institution also administers a separate school program. Residents of Marymound may move between placements in the group homes and locked units as indicated by the resident's individual treatment

program. Most residents usually attend the school program. Day treatment participants attend only the school program. Day treatment participants were not included in the study, as many were adolescent males, placed in another treatment facility not comparable to Marymound.

During the exploration of alternate sites for the study, it was determined that it would not be possible to test the hypotheses for both male and female adoptees. Most institutions in Manitoba which have a designated treatment program are not co-ed. Including adolescent males from another institution in the experimental and control samples would only have introduced variance, as there is no program for adolescent males comparable to Marymound. Therefore, it was decided to limit the testing of the hypotheses to adolescent females placed at Marymound.

Marymound was appropriate as a site for the study for several reasons. The intent of the study was to explore the degree of disturbance in adolescent adoptees placed in a treatment facility. Marymound was a logical choice as all prospective subjects were adolescents, who had already been established as disturbed prior to their admission. In addition, all Marymound residents shared several experiences in common: physical separation from their families; contact with the child welfare system; and placement in an institution by the child-caring agency in its final effort at rehabilitation.

Also important in the choice of Marymound was the nature of its selection process for residents. Marymound has a

representation of some of the most disturbed adolescent girls in Manitoba. Marymound has a program which is in high demand due to the lack of adequate community resources for disturbed adolescent girls and its solid reputation within the child welfare community. The selection of residents for Marymound is not normally carried out by program staff. When openings in the program occur, they are offered to the various child-caring agencies. The agencies usually conference their hopeful referrals, selecting those who have the greatest need for the program. Placing agencies take turns, based generally on the numbers of children in care for which they are responsible. As a result, only a few adolescent girls assessed as in need of treatment at Marymound are placed in the program. Only the most seriously disturbed girls are likely to be admitted.

#### The Research Instruments

Marymound's implementation of detailed and consistent recording procedures was also a factor in its selection as the site of this study. All the information necessary to describe the population and to test the hypotheses existed in its files and records. This wealth of secondary data was determined to be sufficient for the purposes of this study. The major sources of data utilized were Marymound's survey form and case records. For both data sources, all relevant information had been previously collected by program staff for purposes other than those of the present research, reducing the possible intrusion of researcher bias.

The major source of data for the study was Marymound's survey form (see Appendix). In April 1976 the Treatment Director augmented the existing recording procedures by implementing this detailed form. It was intended that this form would be useful for the systematic collection of data on residents which could be used in research or program evaluation. The survey form is completed during the resident's Admission Treatment Conferences. These Treatment Conferences are held for all residents usually at the time of admission, periodically during treatment, and at discharge. The conference is normally attended by the resident, members of her family, the placing agency social worker, Marymound's Treatment Director, the assigned Marymound social worker, and a representative from the School. According to the information presented at the Admission Treatment Conference, and in the referral material, the Treatment Director completes the survey form. The form is almost always completed by the Treatment Director and he has been employed in that position since prior to its implementation.

The survey form includes detailed social demographic information and an extensive list of behavioral symptoms. According to the information that unfolds during the conference the Treatment Director rates the resident on a scale of from one to ten (mild to severe) for each symptom that is evinced. The symptoms may be discussed in the review of the social history or observed at the conference.

At discharge a similar form is completed by the resident's

social worker. It includes the identical list of behavioral symptoms and other items related to the resident's discharge, such as the length of treatment. Five social workers are employed at Marymound. Since the implementation of the survey forms, Marymound has experienced some staff turnover. A maximum of ten social workers may have completed the discharge information on residents for the period of the study.

In assessing the reliability of the survey forms as research instruments, two potential problems were identified. As Marymound was known to have a high demand for its program, it was predicted that competition between agencies for placements could seriously bias the data presented by them prior to and at the Admission Conference. It was anticipated that there could be the tendency for the agencies to prove that their ward was more disturbed than the reality in order to win the placement. An explanation of the admission policies and practices provided by the Treatment Director indicated that the anticipated problem was unlikely to affect the data in a major way. It was learned that there was no pressure for agencies to prove their ward's greater disturbance at the Admission Conference, as the placement for that child was already confirmed prior to the Admission Conference. The Admission Conference at Marymound is essentially viewed as the first step of the resident's treatment program.

The other anticipated problem concerned the reliability of the data provided by the social workers on the discharge survey form. It was expected that the discharge data was

likely to be biased as a result of the evaluation of progress made by the various social workers. In determining the responsiveness of subjects to treatment at Marymount, the tendency would exist for the workers to assess their resident as having improved more than was the case. The possibility existed for this to occur as a result of the intense relationship which may have developed between the social worker and residents or due to the social workers unconsciously viewing the resident's progress as a reflection of their professional abilities.

Although the generalizability of the results of the study were likely to be affected by this problem, it was decided to conduct the study incorporating analysis which utilized the discharge data. This was decided as it was an important aim of the study to examine the responsiveness of disturbed adoptees to treatment. Only one study (Stonesifer, 1942) attempted to probe this question and not to the extent that was planned for this study. It was also learned that the Treatment Director's explicit guidelines for the rating of the symptoms and other instructions for form completion may have helped maintain some consistency in the discharge form for its use as an evaluation instrument. As well, when completing the discharge data the social workers were likely to be "blinded" to the information which had been provided at the Admission Conference, as the forms were separated, only being amalgamated by the secretary at a later date. It was also anticipated that if the study revealed that there were several subjects who did not improve during the course of their treatment at Marymount, then this would indicate that

the social workers did not always evaluate residents as having improved. Finally, if a bias was introduced by the evaluations being made by the social workers this bias was not likely to be a differential bias. All subjects would have been rated similarly regardless of whether they were adopted, fostered or control subjects. For these reasons it was determined that the discharge form could be considered reliable enough for the purposes of the study, giving some consideration to the impact of social worker biases on the results.

Supplementary sources of data used for the study were the individual case records of residents. Since 1968 these records have followed a consistent outline and include: admission, review and discharge conference notes, referral social history, psychiatric assessments and contact records of key child care worker and social worker. The Admission Conference notes were the main source of supplementary data used in the study.

Subjects for the study were drawn from a sample population of 262 residents admitted to Marymount between April 1, 1976 and July 1, 1980, for whom a survey form had been completed. Selection of subjects was limited to this time frame due to the existence of the survey forms only since 1976. As it was essential to have as large a sample of adoptees as possible, all survey forms up until the data collection began were included in the sample population.

A sample of adoptees and a sample of non-adoptees were selected from the group of 262 residents. A third sample of residents who had long term foster parents was also chosen

when a preliminary examination of the survey forms indicated a substantial number of these cases. It was felt that behavioral symptoms demonstrated by this sample could parallel those hypothesized for the adopted sample. Most of these foster placements were very long term with both foster family and resident viewing it as a permanent arrangement. In some cases, the resident had been placed with the foster family shortly after birth. In others, unsuccessful attempts at adoption had been made. Criteria were established for inclusion in this sample. The foster placement had to be a minimum of five years duration. Secondly, there had to be evidence that the resident and her foster family were of personal significance to each other. This was usually indicated by file reference to the foster family as being the resident's "family", or their inclusion in the Treatment Conference.

A preliminary examination of the survey forms also revealed that some of the subjects in the sample population had been admitted, discharged and later readmitted. As a result, several admission and/or discharge survey forms had been completed on these residents. Omission of these subjects would have resulted in reducing the potential number of adoptees in the study. Therefore, for these subjects, data was collected from the first existing admission form and the last discharge form completed. The actual first admission and final discharge dates were obtained from residents' files. This group only represented 11% of the final cases selected for the study, or five cases for the adopted group and six cases for the control group.



### Sampling Procedures

The first procedure undertaken was the identification of all adoptees in the sample population at Marymount. On the survey form, Item #9 specifies whether or not the resident had been adopted. Consulting this item on all survey forms resulted in the identification of 42 adopted residents out of a total of 262 residents admitted to Marymount, or 16%.

The Admission Conference notes in the agency files were then consulted for all 262 residents. This was done for several reasons. It was necessary to verify the accuracy of Item #9. On three survey forms, this item had been left blank. In other cases, there was some doubt as to the circumstances of the resident's adoption. It was not always specified if the resident had been adopted by a step-parent, relative, or non-relative. As predicted, all information was readily available in the conference notes.

Examination of the conference notes revealed that 39 of the residents had been adopted by non-relatives. None of the residents identified as adopted on the survey forms had been adopted by a step-parent. However, two residents had been adopted by an aunt and uncle, and one by a grandmother. It was decided to include the three relative adoptions in the study. This was done because in each of the three cases, the residents had been brought up almost exclusively by the relatives, having little knowledge of their biological parents.

The Admission Conference notes were also consulted as

the survey form was not explicit as to whether the subject could meet the criteria set for the fostered sample. From a survey of all 262 files, 16 subjects meeting the criteria for the fostered sample were identified. Three of the subjects had been fostered by relatives--two by a grandparent, and one by an uncle and aunt. The length of the placement with the foster family was also discernable from the conference notes. The average for the group was nine years, nine months.

The Admission Conference notes for the 42 adopted residents were also consulted in order to determine the age at which they were placed in their adoptive homes. The survey form did not usually specify this data, essential for the purposes of this study. The required information was obtained from the conference notes, for all but one case. For many cases, the age of adoptive placement was specific to the number of months.

The next procedure involved the selection of the control group of non-adoptees. This sample was identified by randomly selecting 42 subjects from the remaining 204 cases after the adopted and fostered subjects were omitted.

Data from the survey forms was collected on a total of 100 cases, 42 adopted, 42 control, and 16 fostered subjects.

#### The Pathology Scale

A means of measurement was needed to enable comparison of the three subject groups. A scale was designed to assess the relative degree of disturbance exhibited by the subjects

at admission and discharge. The scale was devised from the survey form's list of fifty-four items representing behavioral symptoms. It was clear that some technique of data reduction would have to be employed. The volume of data resulting from the fifty-four items was too cumbersome for statistical analysis. Some items appeared to be redundant and others were not exhibited by any of the subjects. Therefore, the statistical procedure of factor analysis was applied, identifying those items utilized in the final scale to measure the level of pathology demonstrated by residents.

The original fifty-four items were reduced to twenty-nine items, forming a scale of pathology composed of five principal factors, which accounted for 79.7% of the variance in the total scale. The minimum factor loading which was determined to be acceptable was 0.30. The items classified under each factor appeared to describe a group of related symptoms.

Factor 1 was labelled "Rebellious non-conforming behaviors" or "REBEL". Factor 1 included the following items:

1. problem with absconding from home or placement (RUN), factor loading = 0.84;
2. the ability to handle external control and the community responsibility (EXTCON), factor loading = 0.82;
3. the ability to plan and follow through with a plan (PLAN), factor loading = 0.70;
4. record of truancy (TRU), factor loading = 0.68;
5. impulsive (IMPUL), factor loading = 0.67;

6. suspicious and distrustful (TRUST), factor loading = 0.54;
7. interest level in school (SCHOOL), factor loading = 0.50;
8. alcohol abuse (DRINK), factor loading = 0.49;
9. drug abuse (DRUG), factor loading = 0.43;
10. sexual involvement (SEXINV), factor loading = 0.30.

Factor 1 accounted for 27.5% of the variance in the total scale (Eigenvalue = 5.16).

Factor 2 was labelled "Destructive Behaviors" or "DESTRUCT". This factor included the following group of behavioral symptoms:

1. temper tantrums (TANTM), factor loading = 0.78;
2. verbally abusive (VERAB), factor loading = 0.75;
3. threatening and intimidating (THREAT), factor loading = 0.68;
4. physically assaultive (ASSAULT), factor loading = 0.52;
5. problem with inhaling tonic substances (SNIFF), factor loading = 0.30.

Factor 2 accounted for 17.8% of the variance in the total scale (Eigenvalue = 3.34).

Factor 3 was labelled "Regressive attention seeking behaviors" or "REGRESS". The following items formed Factor 3:

1. compulsive characteristics (e.g. talking, eating, lying or stealing) (COMCHAR), factor loading = 0.74;
2. hyperactive (HYP), factor loading = 0.62;
3. delinquent (charges of shoplifting, break and enter, or theft) (BE), factor loading = 0.56;
4. anxiousness, restless, fidgetty (ANX), factor loading = 0.41;
5. childish whining (WHINE), factor loading = 0.35.

Factor 3 accounted for 13.2% of the variance in the total scale, (Eigenvalue = 2.47).

Factor 4 was labelled "Social functioning" or "SOCFUN" and included the following items:

1. level of problematic functioning in a group situation (GRPFUN), factor loading = 0.78;
2. level of problematic functioning in peer relationships (PEER), factor loading = 0.71;
3. manipulative (MANIP), factor loading = 0.52;
4. level of problematic functioning in adult relationships (ADULT), factor loading = 0.49;
5. sexual involvement (SEXINV), factor loading = 0.37.

Factor 4 accounted for 11.7% of the variance in the total scale, (Eigenvalue = 2.2).

Factor 5 was labelled "Dependency responses" or "DEPEND" and was comprised of the following items:

1. quiet, shy (SHY), factor loading = 0.77;
2. social withdrawal (WITHD), factor loading = 0.75;
3. passive hostility (HOSTL), factor loading = 0.45;
4. level of problematic functioning in adult relationships (ADULT), factor loading = 0.40;
5. poor self image (SIMAG), factor loading = 0.31.

Factor 5 accounted for 9.5% of the variance in the total scale (Eigenvalue = 1.78).

When the factor analysis was performed on the data, two additional factors emerged. These factors were omitted from

the pathology scale because they accounted for a minimal percentage of the variance in the total scale. The sixth factor only accounted for 7.2% of the variance in the total scale (Eigenvalue = 1.35). This factor included two items which dealt with the quality of the resident's relationships. The items were:

1. ability to form meaningful, involved relationships (GDREL), factor loading = 0.93;
2. tendency to have conforming, superficial and phony relationships (BDREL), factor loading = 0.77.

The seventh factor accounted for only 5.9% of the variance in the total scale (Eigenvalue = 1.11). These items appeared to describe symptoms related to self-destructive behavior:

1. masochistic tendencies (MASO), factor loading = 0.84;
2. suicidal attempts (wrist slashing, overdoses, pin swallowing) (SUIC), factor loading = 0.72;
3. poor self image (SIMAG), factor loading = 0.31.

Even with the omission of these last two factors, Factors 1 through 5 still accounted for 79.7% of the variance in the total scale.

To compute the score on the pathology scale for each of the 100 cases, Factors 1 through 5 were totalled. Statistical analysis, comparing the three groups, was then conducted using the total score for the scale. This total score was labelled "DISTURB", representative of the subject's degree of disturbance.

The scores obtained by each subject for each of the five factors was also used in analysis. The scores on individual factors were viewed as indicative of the subject's relative degree of disturbance in that particular problem area.

Table I

Factor Loadings Based on Principal Components Analysis  
with Orthogonal Rotations by Normalized Varimax

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
RUN	0.83512	-0.04319	-0.04127	-0.19330	0.01977	-0.09368	0.01279
TRU	0.67803	0.14976	-0.08289	0.05244	0.09226	-0.05278	0.13322
THREAT	0.19353	0.67750	-0.02303	0.12236	0.01315	0.08389	0.01663
MANIP	0.12733	0.03212	0.04161	0.52481	-0.15442	0.12295	-0.06355
ASSAULT	0.13521	0.52169	0.09595	0.24430	-0.10683	-0.09170	-0.06543
BE	0.26798	-0.07802	0.55705	0.26389	-0.09981	-0.13354	-0.09210
SNIFF	0.28303	0.30365	-0.08392	-0.07490	0.19140	0.01679	0.11849
SUIC	0.12055	0.19354	-0.18745	0.03929	0.14732	-0.13125	0.71513
DRINK	0.48599	0.05270	-0.24734	-0.12425	-0.06650	0.11213	-0.03824
TANTM	0.02983	0.77525	0.13910	0.08834	-0.11406	0.06951	0.14663
WITHD	-0.04066	-0.06020	-0.09267	0.13927	0.74674	0.00084	0.04544
VERAB	0.07493	0.74967	0.11230	-0.03479	-0.07732	0.11733	0.12490
WHINE	-0.22898	0.05569	0.35145	0.15691	-0.08458	0.22505	-0.05171
TRUST	0.54273	0.03438	0.01463	0.02923	0.34568	0.04460	-0.14278
ANX	-0.21180	0.05491	0.41167	0.08725	0.03866	0.20941	-0.01659
LYING	-0.00741	-0.12515	0.70142	0.01514	-0.10564	-0.15139	-0.05069
SHY	-0.03673	-0.19940	-0.03376	-0.10336	0.77054	0.05663	0.05601
MASO	0.14532	0.08744	-0.02019	0.07311	0.03970	-0.04561	0.84180
COMCHAR	-0.10496	0.15801	0.73943	-0.12511	-0.00994	-0.04577	0.03168
HOSTL	0.23598	0.16737	-0.02477	-0.17981	0.44938	0.22204	0.17552
SEXINV	0.30324	0.07607	0.01613	-0.36831	-0.05865	-0.03997	-0.20267
SIMAG	0.03548	-0.02957	0.22486	0.08974	0.31468	0.01397	0.30704
IMPUL	0.66895	0.19889	-0.02822	-0.03921	0.03956	-0.10507	0.07583
HYP	-0.10299	0.26140	0.62352	0.10418	0.01847	-0.05129	-0.07063
DRUG	0.43340	0.03834	0.03567	0.11109	-0.26140	-0.09862	0.05483
GDREL	0.19625	-0.01234	-0.06417	0.24598	0.01046	-0.92942	0.03939
BDREL	0.05158	0.21314	0.13566	0.00217	0.06746	0.77132	-0.11736
PEER	-0.09397	0.08303	0.07168	0.70504	0.04939	-0.20087	0.08378
ADULT	0.20798	0.23900	-0.12695	0.49130	0.39685	0.02219	-0.02794
PLAN	0.70030	-0.05741	0.09126	0.03625	0.06959	-0.03715	0.05186
EXTCON	0.81871	-0.08473	-0.06048	0.04314	-0.10864	-0.16659	0.13547
GRPFUN	0.09205	0.18553	0.09967	0.77734	0.00844	-0.13115	0.07652
SCHOOL	0.50199	0.12970	-0.09566	0.19135	0.01748	-0.00643	-0.04830

Eigenvalues 5.16

3.34

2.47

2.20

1.78

1.35

1.11



CHAPTER IV  
DATA ANALYSIS AND DISCUSSION

This chapter outlines the social demographic characteristics of the subjects and describes the results of a series of statistical tests performed on the data. The results are presented in tabular form followed by discussion.

Part I

Analysis of the Total Sample

Social Demographic Characteristics of Subjects

As previously indicated, the total sample consisted of one hundred residents placed at Marymount between April 1, 1976, and July 1, 1980, for whom survey forms had been completed. There were 42 adopted, 42 control, and 16 fostered subjects included in the study.

For the social demographic characteristics, frequency distributions were tabulated separately on the adopted, control and fostered samples. In addition a series of cross-tabulations were performed on the data in order to determine if significant relationships existed between the samples and the various social demographic variables.

Characteristics at Admission

Table 2 summarizes the ages of the subjects at the time of their first admission to Marymount. Over half of the subjects were admitted at either 14 or 15 years of age. The

Table 2

## Distribution of Subjects by Age

Age	Adopted		Control		Fostered		Total No.	Cum. Pct.
	No.	Pct.	No.	Pct.	No.	Pct.		
11	0	0.0	3	7.1	0	0.0	3	3
12	1	2.4	0	0.0	0	0.0	1	4
13	2	4.8	4	9.5	0	0.0	6	10
14	12	28.6	9	21.4	0	0.0	21	31
15	14	33.3	8	19.0	10	62.5	32	63
16	12	28.6	11	26.2	4	25.0	27	90
17	1	2.4	7	16.7	2	12.5	10	100
Total	42	100.0	42	100.0	16	100.0	100	100
Mean Age	14.9		14.9		15.5		15.1	

mean age of subjects was 15 years. The table indicates that the fostered subjects tended to be slightly older than other subjects at the time of their first admission.

Table 3 illustrates the distribution of the subjects by racial background. Slightly over half of the subjects were of native extraction; slightly less than half were Caucasian. The distribution throughout the three groups indicated that while the adoptees were more likely to be Caucasian than of native extraction, and the control and fostered subjects were more likely to be of native extraction than Caucasian, these tendencies were not statistically significant.

Table 4 describes the educational category achieved by the resident at the time of admission. Most of the subjects in each of the groups had completed some or all of their junior high school education.

In Table 5 the agency status of residents at admission is illustrated. The term status refers to the resident's circumstances with regard to guardianship. The table shows that none of the residents studied had been placed at Marymount privately. An agency was responsible for the placement in all cases. Almost three-quarters of the residents were either permanent or temporary wards under the mandate of Manitoba's Child Welfare Act, at the time of their placement. Residents' parents had retained guardianship in fewer than one-fifth of the cases. The adopted and control subjects tended to distribute similarly throughout the status categories, both

Table 3

## Distribution of Subjects by Race

Category	Adopted		Control		Fostered		Total No.
	No.	Pct.	No.	Pct.	No.	Pct.	
Registered Indian	1	2.4	6	14.9	1	6.3	8
Metis	16	38.1	18	42.9	12	75.1	46
Caucasian	25	59.5	18	42.9	2	12.5	45
Negro	0	0.0	0	0.0	1	6.3	1
Total	42	100.0	42	100.0	16	100.0	100

Table 4  
Distribution of Subjects by Education

Education	Adopted		Control		Fostered		Total Adjusted		Cum. Pct.
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	
Less than Grade 3	0	0.0	2	4.8	0	0.0	2	2.1	2.1
Grades 4 to 6	2	4.8	6	14.3	1	6.3	10	10.5	12.6
Grades 7 to 9	33	78.6	28	66.7	13	81.3	74	77.9	90.5
Grades 10 to 12	3	7.1	5	11.9	1	6.3	9	9.5	100.0
Missing data	4	9.5	1	2.4	1	6.3	5	Missing	100.0
<b>Total</b>	<b>42</b>	<b>100.0</b>	<b>42</b>	<b>100.0</b>	<b>16</b>	<b>100.0</b>	<b>100</b>	<b>100.0</b>	<b>100.0</b>

Table 5  
Distribution of Subjects by Status

Status	Adopted		Control		Fostered		Total No.	Adjusted Pct.	Cum. Pct.
	No.	Pct.	No.	Pct.	No.	Pct.			
Temporary ward	20	47.6	19	45.2	3	18.8	42	42.9	42.9
Permanent ward	10	23.8	8	19.0	12	75.0	30	30.6	73.5
Temporary contract placement (guardian- ship retained by parents)	8	19.0	9	21.4	1	6.3	18	18.4	91.9
Probation (placement ordered by Court under Juvenile Delinquents Act)	3	7.1	5	11.9	0	0.0	8	8.2	100.0
Missing data	1	2.4	1	2.4	0	0.0	2	Missing	100.0
<b>Total</b>	<b>42</b>	<b>100.0</b>	<b>42</b>	<b>100.0</b>	<b>16</b>	<b>100.0</b>	<b>100</b>	<b>100.0</b>	<b>100.0</b>

groups having the greatest number of subjects temporary wards. The distribution for the fostered subjects indicates that they were more likely to be permanent wards than temporary wards.

The distribution of where in Marymound's treatment program the subjects were placed on their first admission is shown in Table 6. The distributions for each of the subject groups emerged as quite similar. Almost two-thirds of the residents were admitted to locked residential units.

The distribution of the various agencies placing children at Marymound is shown in Table 7. Over two-thirds of the placements were made by the Provincial Government's Community Services and Corrections and by The Children's Aid Society of Manitoba. About half of the placements were conducted by agencies responsible for urban areas, and half by those responsible for rural areas.

Table 8 illustrates the living circumstances of the residents just prior to admission. Only two categories were differentiated: the resident was living with her parents or was in a private or official placement. The distributions were similar for the adopted and control groups with three-quarters of subjects being in a placement prior to admission to Marymound. The distribution for the fostered group differed in that all subjects were in a placement prior to admission. This was anticipated as all these subjects were selected for inclusion in the study on the basis of long term placement in a foster home.

Table 6  
Distribution of Subjects by Marymount Placement

Placement	Adoptees		Control		Fostered		Total No.
	No.	Pct.	No.	Pct.	No.	Pct.	
Group Home	13	31	16	38.1	9	56.3	38
Closed Unit	29	69	26	61.9	7	43.8	62
Total	42	100	42	100.0	16	100.0	100



Table 7  
Distribution of Subjects by Placing Agencies

Agency	Adopted	Control	Fostered	Total No.
CAS Winnipeg	13	12	4	29
CAS Eastern	3	1	1	5
CAS Central	5	1	4	10
CAS Western	2	2	1	5
CSC Winnipeg	4	3	1	7
CSC Rural and Other Rural	11	17	5	34
Probation Winnipeg	4	4	0	7
Probation Rural and Other Rural	0	1	0	2
Other	0	1	0	1
<b>Total</b>	<b>42</b>	<b>42</b>	<b>16</b>	

Table 8

## Distribution of Subjects by Living Arrangement

Category	Adopted		Control		Fostered		Total No.	Adjusted Pct.
	No.	Pct.	No.	Pct.	No.	Pct.		
With Parents	9	21.4	10	23.8	0	0.0	19	19.4
In a placement	32	76.2	32	76.2	15	93.8	79	80.6
Missing data	1	2.4	0	0.0	1	6.3	2	missing
Total	42	100.0	42	100.0	16	100.0	100	100.0

The distribution in Table 9 shows the marital situation of the parental home in which the resident most recently lived.

In half the cases the residents' parents (adoptive parents for the adopted subjects) were living together at the time of this placement. One-third of the residents, however, came from single parent families, broken by divorce, separation or death. Another 10% of the residents had also experienced broken homes, but at the time of placement had a step-parent.

Table 9 also indicates that the adoptees were more likely than the control or fostered subjects to have intact families at the time of their placement. A surprisingly low percentage of the adoptees' families had been broken by divorce, separation or death.

Table 10 indicates the number of siblings in the resident's family.

The distribution indicates that the adoptees tended to have considerably fewer siblings than the control or fostered subjects. The distribution for the control subjects also shows a substantial number of very large families.

Table 11 describes the employment circumstances of the residents' fathers. It is difficult to ascertain the validity of Table 11 due to the large percentage of missing data.

During the coding of the data it appeared that those cases in which the socioeconomic information was missing involved residents who no longer had contact with one or both parents. The adopted and control groups had approximately the same

Table 9

## Distribution of Subjects by Marital Situation in Parental Home

Category	Adopted		Control		Fostered		Total No.	Adjusted Pct.
	No.	Pct.	No.	Pct.	No.	Pct.		
Parents Together	31	73.8	16	38.1	5	31.3	52	57.1
Parent and Step-Parent	1	2.4	5	11.9	3	18.8	9	9.9
Single Parent	5	11.9	20	47.6	5	31.3	30	33.0
Missing Data	5	11.9	1	2.4	3	18.8	9	Missing
Total	42	100.0	42	100.0	16	100.0	100	100.0

Table 10

## Distribution of Subjects by Number of Siblings

No. of Siblings	Adopted		Control		Fostered		Total No.	Adjusted Pct.	Cum. Pct.
	No.	Pct.	No.	Pct.	No.	Pct.			
None	2	4.8	1	2.4	0	0.0	3	3.2	3.2
1	12	18.6	2	4.8	1	6.3	15	16.0	19.1
2	11	26.2	6	14.3	1	6.3	18	19.1	38.3
3	4	9.5	7	16.7	3	18.8	14	14.9	53.2
4	9	21.4	11	26.2	1	6.3	21	22.3	75.5
5	1	2.4	2	4.8	0	0.0	3	3.2	78.7
6-9	1	2.4	9	21.4	4	25.0	14	14.9	93.6
10-14	0	0.0	3	7.1	3	18.8	6	6.4	100.0
Missing Data	2	4.8	1	2.4	3	18.8	6	Missing	100.0
Total	42	100.0	42	100.0	16	100.0	100	100.0	100.0

Table 11 .

## Distribution of Subjects by Father's Employment

Category	Adopted		Control		Fostered		Total No.	Adjusted Pct.
	No.	Pct.	No.	Pct.	No.	Pct.		
Labourer	11	26.2	14	33.3	3	18.8	28	41.8
Clerical	4	9.5	1	2.4	0	0.0	5	7.5
Professional	8	19.0	3	7.1	0	0.0	11	16.4
Farmer	1	2.4	0	0.0	0	0.0	1	1.5
Unemployed	3	7.1	2	4.8	0	0.0	5	7.5
Retired	2	4.8	0	0.0	1	6.3	3	4.5
On Welfare	0	0.0	7	16.7	1	6.3	8	11.9
Father Deceased	2	4.8	3	7.1	1	6.3	6	9.0
Missing Data	11	26.2	12	28.6	10	62.5	33	Missing
<b>Total</b>	<b>42</b>	<b>100.0</b>	<b>42</b>	<b>100.0</b>	<b>16</b>	<b>100.0</b>	<b>100</b>	<b>100.0</b>

percentage of missing data, with the percentage being considerably higher for the fostered subjects.

Table 11 indicates a substantial percentage of residents whose fathers were employed as laborers. This percentage is slightly higher for the control subjects than for the adopted subjects. The fathers of the adoptees were more likely to be professionally employed than the fathers of the control subjects, and none of the adoptive fathers were supporting their families on social assistance.

Table 12 describes the employment circumstances of the residents' mothers. Again the percentage of missing data is substantial.

Two-thirds of the residents' mothers were homemakers and slightly less than half of these mothers were on social assistance. As with the adoptive fathers, the adoptive mothers seemed more likely to be professionally employed and less likely to be in receipt of welfare than the mothers of the control subjects.

Table 13 shows a distribution of the residents by annual family income. Its validity is questionable due to substantial missing data. Two-thirds of the data is missing. It is suspected that those families receiving social assistance were not included in this category. Their inclusion would likely have reduced the average annual income of the families considerably. From the data shown it appears the average income is artificially high.

Table 12

## Distribution of Subjects by Mother's Employment

Category	Adopted		Control		Fostered		Total No.	Adjusted Pct.
	No.	Pct.	No.	Pct.	No.	Pct.		
Labourer	2	4.8	3	7.1	1	6.3	6	7.9
Clerical	6	14.3	6	14.3	1	6.3	13	17.1
Professional	3	7.1	0	0.0	0	0.0	3	3.9
Retired	1	2.4	0	0.0	0	0.0	1	1.3
Homemaker	18	42.9	14	33.3	2	12.5	34	44.7
On Welfare	2	4.8	11	26.2	3	18.8	16	21.1
Mother Deceased	0	0.0	3	7.1	0	0.0	3	3.9
Missing Data	10	12.8	5	11.9	9	56.3	24	Missing
Total	42	100.0	42	100.0	16	100.0	100	100.0



Table 13  
Distribution of Subjects by Annual Family Income

Income	Adopted		Control		Fostered		Total No.	Adjusted Pct.	Cum. Pct.
	No.	Pct.	No.	Pct.	No.	Pct.			
\$ 5,000 to \$10,000	0	0.0	4	9.5	1	2.4	5	14.7	14.7
\$10,000 to \$15,000	5	11.9	4	9.5	1	2.4	10	29.4	44.1
\$15,000 to \$20,000	7	16.7	3	7.1	0	0.0	10	29.4	73.5
\$20,000 to \$25,000	3	7.1	1	2.4	1	2.4	5	13.7	88.2
\$25,000 to \$30,000	3	7.1	0	0.0	0	0.0	3	8.8	97.1
Over \$30,000	1	2.4	0	0.0	0	0.0	1	2.9	100.0
Missing Data	23	54.8	30	71.4	13	81.3	66	66.0	100.0
<b>Total</b>	<b>42</b>	<b>100.0</b>	<b>42</b>	<b>100.0</b>	<b>16</b>	<b>100.0</b>	<b>100</b>	<b>100.0</b>	<b>100.0</b>

### Characteristics at Discharge

The descriptive data on residents at discharge is not as reliable as the admission data on the survey forms. This was due to the percentage of missing data. No discharge information was recorded for 29 of the 100 subjects. The final discharge survey form could not be located for two subjects. In four more cases, discharge information had not been recorded on the resident due to her absconsion shortly after placement at Marymound. Discharge data for the remaining 23 cases was not available due to the fact that these residents were still in the program at the time of the study. With these cases omitted there remained discharge data for 71 cases, or 23 for the adopted, 35 for the control, and 13 for the fostered groups.

Table 14 describes the distribution of residents' total length of treatment at Marymound. The actual length of treatment was coded in months. The following table has been collapsed for purposes of clarity.

Table 14 indicates that most residents spent at least one year at Marymound. The average length of treatment for the adoptees was seventeen months; for the control subjects fourteen months; and for the fostered subjects thirteen months.

The validity of the table is questionable due to missing data. Seventeen of the 23 residents still in the Marymound program were adoptees and therefore data was unavailable for these subjects. The trend indicated by the table may not be accurate without the inclusion of these cases. The substantial number of

Table 14  
Distribution of Subjects by Length of Treatment

Length	Adopted		Control		Fostered		Total No.	Adjusted Pct.	Cum. Pct.
	No.	Pct.	No.	Pct.	No.	Pct.			
Less than 6 months	4	9.5	6	14.3	3	18.6	13	17.1	17.1
6 months to 1 year	5	11.9	14	33.3	4	25.0	23	30.3	47.4
1 to 1½ years	6	14.3	5	11.9	4	25.0	15	19.7	67.1
1½ to 2 years	4	9.5	8	19.0	3	18.6	15	19.7	86.8
2 to 2½ years	4	9.5	1	2.4	1	6.3	6	7.9	94.7
Over 2½ years	2	4.8	2	4.8	0	0.0	4	5.3	100.0
Still in Treatment	17	40.5	5	11.9	1	6.3	23	Missing	100.0
Missing Data	0	0.0	1	2.4	0	0.0	1	Missing	100.0
<b>Total</b>	<b>42</b>	<b>100.0</b>	<b>42</b>	<b>100.0</b>	<b>16</b>	<b>100.0</b>	<b>100</b>	<b>100.0</b>	<b>100.0</b>

adoptees still in treatment could indicate a current trend to admit more adoptees to Marymound or that these residents do tend to spend longer in treatment than the control subjects.

In order to verify whether the adoptees did tend to remain in treatment longer, data was collected on the number of months the 17 adoptees still at Marymound had been in treatment on July 1, 1980. This data is shown in Table 15. Over half of the adoptees still in treatment had already spent over one year in the program at the time of the study. This would seem to support the trend shown in Table 14, that adoptees tend to spend slightly longer in treatment at Marymound than the control samples.

Table 16 indicates the reasons explaining residents' discharge from Marymound.

Over half of the residents were discharged due to the fulfillment of their treatment plan. Over one-quarter of the residents had to be discharged because they had absconded from Marymound and they were gone so long their placements could no longer be held. With the discharge data being collected on final discharges, it is noteworthy that none of these absconding residents had been readmitted to the program by the time of the study.

In a small number of cases, the resident's behaviour or symptoms made it necessary to discharge her (i.e., not enough controls). In three cases the residents were discharged after the placing agency did not obtain guardianship of the resident through the Courts.

Table 16 shows that the control and fostered subjects seemed more likely to be discharged for the reason of progress

Table 15

Distribution of Adoptees Still in Treatment by Length of Treatment

Category	No.	Pct.	Cum. Pct.
Less than 6 months	4	23.5	23.5
7 to 11 months	4	23.5	47.0
12 to 16 months	9	53.0	100.0
Total	17	100.0	100.0

Table 16  
Distribution of Subjects by Reason for Discharge

Reason	Adopted		Control		Fostered		Total No.	Adjusted Pct.
	No.	Pct.	No.	Pct.	No.	Pct.		
Progress	13	31.0	24	57.1	8	50.0	45	59.2
Untreatable	3	7.1	2	4.8	1	6.3	6	7.9
AWOL	8	19.0	8	19.0	6	37.5	22	28.9
No Wardship	1	2.4	2	4.8	0	0.0	3	3.9
Still in Treatment	17	40.5	5	11.9	1	6.3	23	Missing
Missing Data	0	0.0	1	2.4	0	0.0	1	Missing
<b>Total</b>	<b>42</b>	<b>100.0</b>	<b>42</b>	<b>100.0</b>	<b>16</b>	<b>100.0</b>	<b>100</b>	<b>100.0</b>

than the adopted subjects.

Table 17 illustrates the various places where residents were discharged following release from Marymount. Residents were likely to either return home following discharge, or to be discharged following absconsion. Table 17 shows that the adoptees were more likely than the other subjects to be discharged home to their parents.

In Table 18 a distribution is shown of the frequency of contact residents had with their families during placement at Marymount. The frequency of family contact was evaluated by the resident's social worker according to a scale of scores ranging between one and ten. In the table, the lower scores represent frequent contact; the higher scores, little or no contact. For example, a score of ten indicates that the resident had no contact with their family while they were at Marymount. A score of five indicates moderate contact, or on the average, weekly or biweekly visits from family. A score of one indicates very frequent contact, or on the average, several visits or contacts a week from family. Almost one quarter of the residents had very frequent contact with family. Another one quarter had very infrequent, or no contact with family while at Marymount. The median score was five, or in the moderage range.

Table 18 does not indicate any substantial differences between the adoptees and control subjects in the amount of family contact. The fostered subjects, however, experienced considerably less contact with their former foster parents.

In summary, the group of subjects were likely to possess the following social demographic characteristics. They were usually admitted at either fourteen or fifteen years of age,

Table 17

## Distribution of Subjects by Where Discharged

Category	Adopted		Control		Fostered		Total No.	Adjusted Pct.
	No.	Pct.	No.	Pct.	No.	Pct.		
Detention	0	0.0	0	0.0	2	12.5	2	2.7
Home of one or both parents	10	23.8	15	35.7	0	0.0	25	34.3
Relative	2	4.8	3	7.1	2	12.5	7	9.6
Friend	2	4.8	0	0.0	0	0.0	2	2.7
Foster Home	2	4.8	1	2.4	2	12.5	5	6.8
Group Home	0	0.0	3	7.7	0	0.0	3	4.1
On Own	0	0.0	4	9.5	2	12.5	6	8.2
AWOL	9	21.4	8	19.0	6	37.5	23	31.5
Still in Treatment	17	40.5	5	11.9	1	6.3	23	Missing
Missing Data	0	0.0	3	7.7	1	6.3	4	Missing
Total	42	100.0	42	100.0	16	100.0	100.0	100.0



Table 18

## Distribution of Subjects by Family Contact Score

Score	Adopted		Control		Fostered		Total No.	Adjusted Pct.	Cum. Pct.
	No.	Pct.	No.	Pct.	No.	Pct.			
1	8	19.0	6	14.3	1	6.3	15	22.1	22.1
2	1	2.4	4	9.5	0	0.0	5	7.3	29.4
3	0	0.0	4	9.5	3	18.8	7	10.3	39.7
4	3	7.1	2	4.8	0	0.0	5	7.4	47.1
5	1	2.4	3	7.1	0	0.0	4	5.9	52.9
6	0	0.0	0	0.0	0	0.0	0	0.0	52.9
7	1	2.4	3	8.8	2	12.5	6	8.8	61.8
8	4	9.5	6	14.3	1	6.3	11	16.2	77.9
9	2	4.8	4	9.5	1	6.3	7	10.3	88.2
10	3	7.1	2	4.8	3	18.8	8	11.8	100.8
Still in Treatment	17	40.5	5	11.9	1	6.3	23	Missing	100.0
Missing Data	2	4.8	3	7.1	4	25.0	8	Missing	100.0
Total	42	100.0	42	100.0	16	100.0		100.0	100.0

and were equally as likely to be of native extraction as Caucasian. Most subjects had at least a partial junior high school education. The majority of subjects were wards of the Province. They were just as likely to have an intact family as a family broken by divorce, separation or death. Most subjects had at least three siblings. Their fathers were usually employed as laborers or professionals, and their mothers, as homemakers. The placement process was as likely to be arranged by a rural agency as an urban agency. In most cases subjects were placed in one of Marymound's locked residential units upon admission. They remained at Marymound for slightly over a year, experienced moderate family contact, and were discharged, showing signs of progress to one or both of their parents.

Social Demographic Characteristics as  
Related to the Level of Pathology

In order to determine if a relationship existed between some of the social demographic characteristics and the level of pathology exhibited by subjects, cross tabulations were performed on the data. Scores on the pathology scale were divided into categories of mild, moderate and severe levels of pathology. According to the distribution of total scores on a frequency table, the three categories were identified by dividing the scores into three groups of equal size. Analysis was then conducted on the total sample and separately on the adopted, control and fostered samples. Of the fifty-two cross tabulations, the chi square reached significance at the

acceptable level of  $p < .05$  in only two tables. These two tables are reproduced in Tables 19 and 20.

Table 19 illustrates the level of pathology for the total sample by where subjects were placed in Marymound's program at first admission. The results indicate a significant relationship between the level of pathology and where residents were placed in the program. This finding is not surprising. Most Marymound residents are placed in a closed unit on their first admission. However, as might be expected, mildly disturbed residents are more likely to be placed in a group home than moderately or severely disturbed residents. The latter are far more likely to be placed in one of the locked units, which have a substantially more structured and controlled environment than the group homes.

Table 19  
Cross Tabulation of Level of Pathology  
by Marymound Placement

Level of Pathology	Closed Unit	Group Home	Row Total
Mild	15	20	35
Moderate	21	10	31
Severe	26	8	34
Column Total	62	38	100

$\chi^2 = 8.89954$  with 2 degrees of freedom  
Significance:  $p < 0.01$

It is more difficult to account for the significant relationship between the level of pathology and race for the control subjects (Table 20). Those subjects occupying the category of most severe level of pathology were more likely to be of native extraction than Caucasian. When analysis was conducted for the total sample a significant relationship between pathology and race was not found ( $p < .09$ ). A significant relationship between pathology and race was also not found for the adopted subjects ( $p < .86$ ), or the fostered subjects ( $p < .15$ ). Numerous speculations could be made about the significant relationship between pathology and race for the control subjects. Further analysis would have to be conducted prior to reaching any conclusions. However, a comparison of Table 20 and Table 21 suggests that non adopted native children were more likely to be assessed as "severely disturbed" than adopted native children.

It is plausible that the significant relationship between pathology and race found for control subjects is a spurious finding. With fifty-two cross tabulations performed on the data it is probable that a small percentage of the table would have a significant chi square by chance alone. This may be the case for Table 20.

The remaining cross tabulations, including all calculated separately for the adopted, control and fostered subjects, did not have a statistically significant chi square at the level of  $p < 0.05$ .

Table 20  
Cross Tabulation of Level of Pathology  
by Race for Control Subjects

Level of Pathology	Native	Caucasian	Row Total
Mild	6	9	15
Moderate	5	6	11
Severe	13	3	16
Column Total	24	18	42

$\chi^2 = 6.21051$  with 2 degree of freedom  
Significance:  $p < 0.04$

Table 21  
Cross Tabulation of Level of Pathology  
by Race for Adopted Subjects

Level of Pathology	Native	Caucasian	Row Total
Mild	6	9	15
Moderate	5	9	14
Severe	6	7	13
Column Total	17	25	42

$\chi^2 = -.30711$  with 2 degrees of freedom  
Significance:  $p < 0.86$

Differences Between the Adopted,  
Control and Fostered Groups

Differences at Admission

In order to explore the hypothesized differences between the three groups upon admission to Marymount, a one way analysis of variation was employed.

The one way analysis of variance was used to assess the possible differences in the level of pathology exhibited by subjects as a function of their status as adopted, not adopted or fostered. The analysis was performed for the total score (DISTURB) on the pathology scale and for each of the five factors describing a particular symptom grouping (rebellious behavior, destructive behavior, attention seeking behavior, social functioning and dependency responses). In order to determine individual group differences the Duncan's test of means was used in conjunction with the one way analysis of variance. The results of the means and standard deviations of the subjects for the total score and each factor are reproduced in Table 22.

A one way analysis of variance testing the total scores on the scale of pathology for the three groups (DISTURB) failed to indicate significant differences between the adopted, control or fostered groups at the normally acceptable level of confidence of  $p < .05$  ( $F = 0.46$ ,  $df = 2$ ,  $p < 0.63$ ).

A one way analysis of variance testing scores for Factor 1 (REBEL) also indicated differences between the three groups which did not reach levels of significance ( $F = 1.84$ ,  $df = 2$ ,  $p < 0.16$ ).

A one way analysis of variance testing the scores for

Table 22

Summary of Subjects' Mean Scores and Standard Deviations  
on Pathology Scale for Variables at Admission

GROUP	DISTURB	REBEL	DESTRUCT	REGRESS	SOCFUN	DEPEND
Adopted	Mean: 132.29	48.26	18.19	*16.64	28.24	20.95
	S.D.: 26.65	17.32	10.14	9.37	5.91	6.43
Control	Mean: 138.08	55.17	19.02	11.90	27.12	23.07
	S.D.: 29.79	15.58	11.16	7.32	5.59	9.63
Fostered	Mean: 134.25	53.06	17.62	9.69	26.75	27.13
	S.D.: 22.39	17.16	9.30	3.46	5.46	10.79

\*Significance at  $p < .05$

Factor 2 (DESTRUCT), failed to indicate significant differences between the three groups ( $F = 0.13$ ,  $df = 2$ ,  $p < 0.88$ ).

A one way analysis of variance testing the scores for Factor 3 (REGRESS) indicated significant differences between the three groups ( $F = 6.12$ ,  $df = 2$ ,  $p < .003$ ).

A one way analysis of variance testing the scores for Factor 4 (SOCFUN) did not indicate significant differences between the three groups ( $F = 0.58$ ,  $df = 2$ ,  $p < 0.56$ ).

A one way analysis of variance testing the scores for Factor 5 (DEPEND) indicated differences which failed to reach levels of significance ( $F = 2.99$ ,  $df = 2$ ,  $p < .055$ ).

The results reported for the analysis of variance for the total score obtained by subjects on the pathology scale did not indicate that adopted residents admitted to Marymount were likely to be more disturbed than a comparable group of non-adopted residents. For four of the five factors, representing symptom groupings, significant differences between adopted, natural, or fostered residents were not substantiated. The adoptees, however, scored significantly higher than the control or fostered subjects on Factor 3 or exhibited more "regressive attention seeking behaviors". As previously indicated, Factor 3 consisted of the following items: delinquent, childish whining, anxious, compulsive characteristics (e.g. stealing, talking, eating and lying), and hyperactive.

The results indicate that the adoptees studied were more likely than the other subjects to have their disturbances focused in this problem area. The anticipated similarity between the symptoms of the adoptees and fostered subjects was not found for this



factor. The fostered subjects generally scored the same as the control subjects for the symptom grouping of "attention seeking behaviors".

#### Differences at Discharge

The one way analysis of variance was also employed to test differences between the three groups at discharge from Marymount. Table 23 summarizes the mean scores and standard deviations on the pathology scale for each of the groups.

A one way analysis of variance testing the total scores on the scale of pathology for the three groups at discharge (DISTURB2) failed to indicate significant differences between the adopted, control or fostered groups at the normally acceptable level of confidence ( $F = 0.19$ ,  $df = 2$ ,  $p < 0.82$ ).

A one way analysis of variance testing scores for Factor 1 at discharge (REBEL2) also did not indicate significant differences between the groups ( $F = 0.38$ ,  $df = 2$ ,  $p < 0.69$ ).

A one way analysis of variance testing the scores for Factor 2 at discharge (DESTRUCT2) failed to indicate significant differences between the three groups ( $F = 8.30$ ,  $df = 2$ ,  $p < 0.44$ ).

A one way analysis of variance testing the scores for Factor 3 at discharge (REGRESS2) also failed to indicate significant differences between the three groups ( $F = 2.71$ ,  $df = 2$ ,  $p < 0.07$ ). The significant differences between the adopted, control and fostered groups revealed for Factor 3 at admission were not found at discharge.

A one way analysis of variance testing the scores for Factor 4 at discharge (SOCFUN2) did not indicate significant differences between the three groups ( $F = 0.62$ ,  $df = 2$ ,  $p < 0.54$ ).

Table 23

Summary of Subjects' Mean Scores and Standard Deviations  
on Pathology Scale for Variables at Discharge

GROUP	DISTURB2	REBEL2	DESTRUCT2	REGRESS2	SOCFUN2	DEPEND2
Adopted	Mean: 89.95	32.89	9.18	13.00	18.59	16.39
	S.D.: 38.19	16.32	6.37	7.75	9.69	8.49
Control	Mean: 88.79	32.65	9.74	10.17	17.69	17.66
	S.D.: 29.14	13.83	5.54	4.28	7.48	7.67
Fostered	Mean: 95.77	37.08	11.92	8.92	20.69	17.15
	S.D.: 42.20	20.90	7.79	4.03	8.05	9.63

A one way analysis of variance testing the scores for Factor 5 (DEPEND2) failed to indicate significant differences between the adopted, control and fostered subjects ( $F = 0.16$ ,  $df = 2$ ,  $p < 0.85$ ).

A one way analysis of variance was also employed to test differences between the three groups for two other discharge variables. A one way analysis of variance was performed, testing the scores for frequency of family contact, as evaluated by the social worker. As previously indicated, for this variable, the lower scores represent frequent contact; the higher scores little or no contact. The analysis indicated differences between the three groups which failed to reach levels of significance ( $F = 0.82$ ,  $df = 2$ ,  $p < 0.44$ ).

A one way analysis of variance was also utilized in testing the scores for length of treatment at Marymount for each of the groups. Again, differences failed to meet the .05 level of confidence ( $F = 0.00$ ,  $df = 2$ ,  $p < 0.38$ ).

The means and standard deviations are summarized in Table 24.

The results reported for this test are somewhat suspect. As previously mentioned, almost one-quarter of the subjects were still at Marymount at the time of the study. As a result, no discharge data was available for these subjects. Most of these subjects were adoptees who had already spent over a year in the program. The trend indicated, of the adoptees spending slightly longer at Marymount, however statistically insignificant, may have reached levels of confidence if discharge data had been available for more adoptees.

The results reported for the one way analysis of variance for DISTURB 2 and the factors indicate that similar evaluations

Table 24

Summary of Subjects' Mean Scores and Standard Deviations  
for Variables FAMILY and LENGTH

GROUP	FAMILY	LENGTH
Adopted	Mean: 4.96	16.64
	S.D.: 3.61	9.30
Control	Mean: 5.11	13.75
	S.D.: 3.16	8.33
Fostered	Mean: 6.45	13.60
	S.D.: 3.36	7.74

of the level of functioning at discharge were likely to be reported for all three samples. The significant differences between the adoptees and the other subjects which emerged at admission for the symptom grouping "attention seeking behaviors" no longer held at discharge. The level of pathology at discharge as evaluated by the social workers was roughly equivalent for all subject groups. The results also indicated that the groups did not differ significantly when compared on the amount of contact with their families while at Marymound. It was not possible to discern from the analysis if the three groups differed in terms of their length of treatment at Marymound.

The Responsiveness of Subjects  
To Treatment at Marymound

A series of paired samples t-tests were employed to determine the relative responsiveness to treatment of subjects from each of the three groups. For the total scores on the pathology scale and for each of the five factors, the scores obtained at admission were compared with the scores at discharge. The t-tests were conducted on the total sample, and the adopted, control and fostered groups separately.

In Table 25 the results of the paired samples t-tests for the total sample are shown. The results reveal significant differences between the level of pathology exhibited by subjects at admission and the level exhibited at discharge. The

Table 25

## Pre and Post Comparisons of Pathology Scale for Total Sample

Variable	Time	N	Mean	Standard Deviation	T. Value	2-tail Prob.																																																				
DISTURB	Admission	65	126.89	28.01	9.88	0.000																																																				
DISTURB2	Discharge		90.29	34.44			REBEL	Admission	66	53.42	15.45	9.91	0.000	REBEL2	Discharge	33.59	15.96	DESTRUCT	Admission	70	10.80	1.29	7.66	0.000	DESTRUCT2	Discharge	6.24	0.75	REGRESS	Admission	71	13.61	8.90	2.22	0.030	REGRESS2	Discharge	10.86	5.75	SOCFUN	Admission	70	26.57	5.45	7.42	0.000	SOCFUN2	Discharge	18.53	8.29	DEPEND	Admission	71	23.00	9.12	4.41	0.000	DEPEND2
REBEL	Admission	66	53.42	15.45	9.91	0.000																																																				
REBEL2	Discharge		33.59	15.96			DESTRUCT	Admission	70	10.80	1.29	7.66	0.000	DESTRUCT2	Discharge	6.24	0.75	REGRESS	Admission	71	13.61	8.90	2.22	0.030	REGRESS2	Discharge	10.86	5.75	SOCFUN	Admission	70	26.57	5.45	7.42	0.000	SOCFUN2	Discharge	18.53	8.29	DEPEND	Admission	71	23.00	9.12	4.41	0.000	DEPEND2	Discharge	17.15	8.21								
DESTRUCT	Admission	70	10.80	1.29	7.66	0.000																																																				
DESTRUCT2	Discharge		6.24	0.75			REGRESS	Admission	71	13.61	8.90	2.22	0.030	REGRESS2	Discharge	10.86	5.75	SOCFUN	Admission	70	26.57	5.45	7.42	0.000	SOCFUN2	Discharge	18.53	8.29	DEPEND	Admission	71	23.00	9.12	4.41	0.000	DEPEND2	Discharge	17.15	8.21																			
REGRESS	Admission	71	13.61	8.90	2.22	0.030																																																				
REGRESS2	Discharge		10.86	5.75			SOCFUN	Admission	70	26.57	5.45	7.42	0.000	SOCFUN2	Discharge	18.53	8.29	DEPEND	Admission	71	23.00	9.12	4.41	0.000	DEPEND2	Discharge	17.15	8.21																														
SOCFUN	Admission	70	26.57	5.45	7.42	0.000																																																				
SOCFUN2	Discharge		18.53	8.29			DEPEND	Admission	71	23.00	9.12	4.41	0.000	DEPEND2	Discharge	17.15	8.21																																									
DEPEND	Admission	71	23.00	9.12	4.41	0.000																																																				
DEPEND2	Discharge		17.15	8.21																																																						

results appear to indicate that the subjects generally responded to treatment at Marymount. At discharge they were evaluated by their social workers as less disturbed than when they were admitted. On the pre and post comparisons of pathology for each of the five factors significant differences were noted to a level of confidence of  $p < .03$ .

Table 26 shows the results of the pre and post comparisons of the pathology scale for the adoptees. The findings indicate significant differences between the scores obtained at admission and at discharge on the pathology scale for most of the factors. The adoptees generally responded to treatment at Marymount. Significant differences between the level of pathology at admission and at discharge were indicated for the total score ( $t = 3.93, p < .001$ ), and for Factors REBEL ( $t = 3.64, p < .002$ ), DESTRUCT ( $t = 4.24, p < .000$ ) and SOCFUN ( $t = 3.64, p < .002$ ). However, differences for the remaining factors failed to meet the .05 level of confidence (REGRESS,  $t = 2.00, p < .058$ ; DEPEND,  $t = 1.89, p < .07$ ). The results seem to suggest that although the adoptees generally responded to treatment they did not respond as well in the problem areas of "attention seeking behaviors" and "dependency responses".

Table 27 shows the results of the pre and post comparisons of the pathology scale for the control subjects. Significant differences between the scores on the pathology scale obtained at admission and at discharge were revealed for the total score, DISTURB, ( $t = 9.01, p < .001$ ) and for factors REBEL ( $t = 8.04,$

Table 26

## Pre and Post Comparisons of Pathology Scale for Adoptees

Variable	Time	N	Mean	Standard Deviation	T. Value	2-tail Prob.
DISTURB	Admission		133.26	27.39		
DISTURB2	Discharge	19	89.95	38.19	3.93	0.001
REBEL	Admission		48.21	15.12		
REBEL2	Discharge	19	32.89	16.32	3.64	0.002
DESTRUCT	Admission		19.82	11.06		
DESTRUCT2	Discharge	22	9.18	6.37	4.24	0.000
REGRESS	Admission		19.21	11.21		
REGRESS2	Discharge	23	13.00	7.75	2.00	0.058
SOCFUN	Admission		27.09	5.79		
SOCFUN2	Discharge	22	18.59	9.69	3.64	0.002
DEPEND	Admission		20.35	6.76		
DEPEND2	Discharge	23	16.39	8.50	1.89	0.072



Table 27

Pre and Post Comparisons of Pathology Scale for Control Subjects

Variable	Time	N	Mean	Standard Deviation	T. Value	2-tail Prob.
DISTURB	Admission		138.70	30.44		
DISTURB2	Discharge	33	88.33	29.46	9.01	0.000
REBEL	Admission		54.88	15.08		
REBEL2	Discharge	34	32.65	13.83	8.04	0.000
DESTRUCT	Admission		19.91	11.42		
DESTRUCT2	Discharge	35	9.74	5.54	5.68	0.000
REGRESS	Admission		11.51	6.76		
REGRESS2	Discharge	35	10.17	4.28	1.05	0.303
SOCFUN	Admission		26.60	5.35		
SOCFUN2	Discharge	35	17.69	7.48	6.47	0.000
DEPEND	Admission		23.60	9.61		
DEPEND2	Discharge	35	17.66	7.67	3.36	0.002

$p < .001$ ), DESTRUCT ( $t = 5.68$ ,  $p < .001$ ), SOCFUN ( $t = 6.47$ ,  $p < .001$ ), and DEPEND ( $t = 3.36$ ,  $p < .002$ ). Differences for factor REGRESS were so slight that they did not reach significance ( $t = 1.05$ ,  $p < .303$ ). The results seem to indicate that, according to the discharge assessments made by their social workers, the control subjects also generally responded to treatment at Marymount. However, the results seem to indicate that the control subjects, like the adoptees, did not respond to treatment as readily for the symptom grouping of "attention seeking behaviors".

Table 28 shows the results of the pre and post comparisons of the pathology scale for the fostered subjects.

Despite the small number of fostered subjects included in the analysis (thirteen of sixteen possible), significance levels were reached for the total score and for all but one factor. The total score on the pathology scale had a  $t$  value = 3.99,  $p = .002$ . Factor REBEL had a  $t$  value = 5.67,  $p < .001$ ; factor DESTRUCT a  $t$  value = 2.78,  $p < .017$ ; factor SOCFUN, a  $t$  value = 2.28,  $p < .042$ ; and factor DEPEND, a  $t$  value = 2.20,  $p < .048$ . Again, for factor REGRESS differences did not reach significance ( $t = 0.27$ ,  $p < 0.79$ ). These results seem to indicate that like the adopted and control subjects, the fostered subjects responded to treatment, but seemed less responsive in the problem area of "attention seeking behaviors".

The findings comparing levels of pathology for admission and discharge support the contention that the subjects studied,

Table 28

## Pre and Post Comparisons of Pathology Scale for Fostered Subjects

Variable	Time	N	Mean	Standard Deviation	T. Value	2-tail Prob.
DISTURB	Admission		137.62	23.64		
DISTURB2	Discharge	13	95.77	42.20	3.99	0.002
REBEL	Admission		57.23	16.11		
REBEL2	Discharge	13	37.08	20.91	5.67	0.000
DESTRUCT	Admission		19.38	19.32		
DESTRUCT2	Discharge	13	11.92	7.79	2.78	0.017
REGRESS	Admission		9.31	3.01		
REGRESS2	Discharge	13	8.92	4.03	0.27	0.794
SOCFUN	Admission		25.61	5.42		
SOCFUN2	Discharge	13	20.69	8.05	2.28	0.042
DEPEND	Admission		26.08	10.71		
DEPEND2	Discharge	13	17.15	9.63	2.20	0.048

as evaluated by Marymound staff, responded to treatment. As viewed by staff, Marymound's program seemed to prove effective in reducing the level of pathology significantly for most problem areas. However, when analyzed separately, all three groups seemed less responsive to treatment for their "attention seeking behaviors" than for the other symptom groupings.

## PART II

### Analysis of Adopted Subjects:

#### The Significance of the Age of Child When Placed in Adoptive Home

It was hypothesized that the age of adoptive placement would be unrelated to the severity of disturbances demonstrated by adopted residents at Marymound. In order to test this secondary hypothesis, data was collected on the ages at which the adoptees were placed in their adoptive homes. The distribution of their ages is shown in Table 29. The adoptee's average age of placement was slightly over 2½ years.

Adopted subjects were separated into two groups according to their age of adoptive placement. Group I consisted of all subjects adopted at twelve months or less. Group II consisted of all adoptees placed at thirteen months or greater (see Table 30).

The adoptees divided fairly evenly between the categories, enabling analysis comparing the two groups. Table 29 indicates that most adoptees in Group I were placed in their adoptive

Table 29

Distribution of Adoptees by Age  
at Placement in Adoptive Home

Category	No.	Pct.	Adj.Pct.	Cum.Pct.
1 month or less	4	9.5	9.8	9.8
2 months	3	7.1	7.3	17.1
3 months	2	4.8	4.9	22.0
4 months	1	2.4	2.4	24.4
5 months	1	2.4	2.4	26.8
6 months	3	7.1	7.3	34.1
7 months	0	0.0	0.0	34.1
8 months	1	2.4	2.4	36.6
9 months	1	2.4	2.4	39.0
10 months	1	2.4	2.4	41.5
11 months	1	2.4	2.4	43.9
12 months	1	2.4	2.4	46.3
Between 1 and 2 years	5	11.9	12.2	58.5
Between 2 and 3 years	2	4.8	4.9	63.4
Between 3 and 4 years	4	9.5	9.8	73.2
Between 4 and 5 years	3	7.1	7.3	80.5
Between 5 and 6 years	1	2.4	2.4	82.9
Between 6 and 7 years	1	2.4	2.4	85.3
Between 7 and 8 years	2	4.8	4.9	90.2
Between 8 and 9 years	1	2.4	2.4	92.6
Between 9 and 10 years	0	0.0	0.0	92.6
Between 10 and 11 years	3	7.1	7.3	100.0
Missing data	1	2.4	Missing	
Total	42	100.0	100.0	100.0

Table 30  
Distribution of Adoptees by Age  
at Placement in Adoptive Home  
(Collapsed Table)

Category	No.	Pct.	Adj.Pct.	Cum.Pct.
<u>Group I</u>				
12 months and less	19	45.2	46.3	46.3
<u>Group II</u>				
13 months and older	22	52.4	53.7	100.0
Missing Data	1	2.4	Missing	100.0
Total	42	100.0	100.0	100.0

homes in early infancy. The adoptees in Group II tended to be placed at considerably older ages. The mean age for Group I was 4 months; the mean age for Group II, 4½ years. It was hoped that the division of the adoptees would enable the comparison of infant placements with placements of older children. The substantial differences between the mean ages of the two groups enabled this comparison, supporting the age of twelve months as the appropriate point of division.

Social Demographic Characteristics  
of Groups I and II

Cross tabulations were employed to determine the social demographic characteristics of both groups of adoptees. Generally, this analysis showed both groups of adoptees sharing the same social demographic characteristics for both admission and discharge data. The only statistically significant trend emerged for the independent variable of race. Table 31 shows that the adoptees in Group I were more likely to be Caucasian than of native extraction. Conversely, the adoptees in Group II were more likely to be of native extraction than Caucasian. For the remainder of the social demographic variables, Groups I and II were not found to differ significantly.

Table 31  
Cross Tabulation of Adoptees  
at Age of Adoptive Placement by Race

	Caucasian	Native	Row Total
Group I	15	4	19
Group II	9	13	22
Column Total	24	17	41

$\chi^2 = 6.31$       Significance:  $p < .04$

Number of missing observations = 1



Differences Between Groups I and II

A series of t-tests were employed to determine if Groups I and II were significantly different in terms of their level of pathology, at admission and discharge, and their responsiveness to treatment.

The results of the t-tests on admission data for the two groups are shown in Table 32. The findings indicate that adoptees in Groups I and II generally scored the same on the pathology scale. The only significant difference between the groups which emerged was for Factor 4 (Social Functioning), comprised of items: manipulative; sexual involvement; and level of peer, adult, and group functioning. For SOCFUN the t-value = 2.46,  $p < .02$ , with Group I having the higher mean score. These results denote that the age of adoptive placement seems to be generally unrelated to the degree of disturbance exhibited by adoptees admitted to Marymount. The only exception is that adoptees placed at one year or less were more likely to be evaluated as having problems in the area of social functioning.

The results of the t-tests conducted on the discharge data for Groups I and II did not indicate any significant differences between the groups for the scores obtained on the pathology scale. The t-tests are reproduced in Table 33.

Two additional discharge variables were tested: the frequency of family contact (FAMILY), and the length of placement (LENGTH) at Marymount. It was for the variable FAMILY

Table 32

## T-Tests Between Adoptee Groups I and II: Admission Data

Variable	Group	N	Mean	Standard Deviation	T. Value	2-tail Prob.
DISTURB	I	19	135.68	33.20	0.71 (separate)	0.48
	II	22	129.41	20.57		
REBEL	I	19	46.00	19.72	-0.70 (pooled)	0.49
	II	22	49.86	15.57		
DESTRUCT	I	19	20.21	9.96	1.09 (pooled)	0.28
	II	22	16.73	10.40		
REGRESS	I	19	18.37	11.28	1.01 (pooled)	0.32
	II	22	15.36	7.54		
SOCFUN	I	19	30.53	5.41	2.46 (pooled)	0.02
	II	22	26.18	5.81		
DEPEND	I	19	20.58	5.67	-0.34 (pooled)	0.74
	II	22	21.27	7.21		

Table 33

## T-Tests Between Adoptee Groups I and II: Discharge Data

Variable	Group	N	Mean	Standard Deviation	T. Value	2-tail Prob.
DISTURB2	I	8	91.25	50.68	0.13 (pooled)	0.90
	II	10	88.80	30.27		
REBEL2	I	8	31.38	18.08	-0.30 (pooled)	0.77
	II	10	33.80	16.57		
DESTRUCT2	I	10	9.10	6.86	-0.12 (pooled)	0.90
	II	11	9.45	6.50		
REGRESS2	I	11	15.27	10.29	1.26 (separate)	0.23
	II	11	11.09	3.89		
SOCFUN2	I	11	19.18	12.42	0.27 (pooled)	0.79
	II	10	18.00	6.86		
DEPEND2	I	11	17.00	11.08	0.44 (separate)	0.67
	II	11	15.36	5.68		
LENGTH	I	13	15.23	8.78	-0.58 (pooled)	0.570
	II	11	17.45	10.14		
FAMILY	I	11	2.55	2.62	-3.73 (pooled)	0.001
	II	11	7.09	3.08		

that the only significant difference at discharge emerged between the groups. Adoptees placed for adoption at one year or less were found to have significantly less family contact while at Marymound than adoptees who had been placed for adoption at greater than one year of age ( $t = 3.73, p < .001$ ).

A series of paired samples, t-tests were employed to determine the two groups' responsiveness to treatment at Marymound. The results of these tests for Group I are reported in Table 34 and for Group II in Table 35.

It was anticipated that adoptees would be equally as responsive to treatment at Marymound, as evaluated by staff, despite differences in their age of adoptive placement. However, with the small number of valid cases for Groups I and II (average of only ten), it was expected that few statistically significant differences between the pathology demonstrated at admission and at discharge would emerge. This was anticipated despite the fact that significant differences between admission and discharge data were apparent from t-tests performed with adopted subjects. However, for Group II, the total scores and all factors except Factor 3 (Attention Seeking Behaviors) ( $t = 1.88, p < .09$ ) showed significant differences between pathology exhibited at admission and at discharge. With approximately the same number of valid cases, Group I only showed significant differences between admission and at discharge for Factor 2 (Destructive Behaviors) ( $t = 2.79, p < .02$ ) and Factor 4 (Social Functioning) ( $t = 2.62, p < .03$ ), indicating

Table 34

Pre and Post Comparisons of Pathology Scale for Adoptees: Group I

Variable	Time	N	Mean	Standard Deviation	T. Value	2-tail Prob.
DISTURB	Admission		134.00	34.48		
DISTURB2	Discharge	8	91.25	50.68	1.80	0.12
REBEL	Admission		43.88	16.04		
REBEL2	Discharge	8	31.38	18.08	1.66	0.14
DESTRUCT	Admission		21.30	10.52		
DESTRUCT2	Discharge	10	9.10	6.86	2.79	0.02
REGRESS	Admission		22.27	13.05		
REGRESS2	Discharge	11	15.27	10.29	1.18	0.27
SOCFUN	Admission		29.73	5.29		
SOCFUN2	Discharge	11	19.18	12.42	2.62	0.03
DEPEND	Admission		5.10	5.11		
DEPEND2	Discharge	11	11.08	11.08	0.76	0.46

Table 35

Pre and Post Comparisons of Pathology Scale for Anoptees: Group II

Variable	Time	N	Mean	Standard Deviation	T. Value	2-tail Prob.
DISTURB	Admission		132.90	23.97		
DISTURB2	Discharge	10	88.80	30.27	4.19	0.002
REBEL	Admission		50.90	15.02		
REBEL2	Discharge	10	33.80	16.57	3.09	0.013
DESTRUCT	Admission		19.18	12.18		
DESTRUCT2	Discharge	11	9.45	6.50	3.05	0.012
REGRESS	Admission		16.82	9.19		
REGRESS2	Discharge	11	11.09	3.89	1.88	0.090
SOCFUN	Admission		23.90	5.13		
SOCFUN2	Discharge	10	18.00	6.86	2.26	0.050
DEPEND	Admission		20.73	8.60		
DEPEND2	Discharge	11	15.36	5.68	2.37	0.040

that Group I may have been less responsive to treatment, as evaluated by Marymound staff, than Group II. However, this can only be speculated. In order to reach a firm conclusion further analysis such as a two way analysis of variance would have to be conducted on the data.

### Summary

The results seem to suggest that the age of adoptive placement of the adoptees residing at Marymound is generally unrelated to their social demographic characteristics, and the severity of their disturbances.

The comparison of adoptees placed in infancy with those placed after one year of age resulted in the identification of a few significant differences between the groups. Adoptees placed in infancy were usually Caucasian; those placed as older children were usually of native extraction. Adoptees placed in infancy, when they were taken into treatment, tended to have more problems in the problem area of "social functioning". These problems appear to diminish by the time of their discharge. Adoptees adopted in infancy also seemed to experience considerably less family contact while at Marymound, than adoptees placed for adoption at one year of older. All adoptees, as evaluated by their social workers, generally responded to treatment at Marymound, but it appeared that those placed in infancy may not have responded as readily as their peers placed as older children. Further analysis would have to be done prior to reaching this conclusion.

## CHAPTER V

### CONCLUSION

#### Summary of the Findings

Analysis of the social demographic characteristics of the Marymound residents included in this study revealed that they possessed the following characteristics. They were usually admitted to the program at age fourteen or fifteen. They were as likely to be of native extraction as Caucasian. Most had completed at least part of their junior high school education. Most were wards of the Province of Manitoba. They were as likely to have an intact family as a family broken by death, separation, or divorce. Most subjects were placed in one of the locked institutional units on their first admission. They were usually discharged following a year, to one or both parents, after being assessed by their social worker as having shown progress.

The sample of adopted residents differed from the larger population of subjects on several social demographic items. The adoptees were more likely to be Caucasian than of native extraction. They usually had intact families unbroken by death, separation or divorce. Their parents were more likely to be professionals and less likely to be supporting families on social assistance. The adoptees also tended to come from smaller families than the non-adopted subjects.

The level of pathology demonstrated by all subjects



was found to be significantly related to where in Marymound's program residents were placed on their first admission. Mildly disturbed residents, according to scores obtained on the pathology scale, were more likely to be placed in a group home than either the moderately or severely disturbed residents. The latter were more likely to be placed in a locked institutional unit, with a more structured and controlled environment. This was an anticipated finding. However, the significant relationship between the level of pathology and how controlled an environment residents were assessed as needing does offer support to the accuracy of the pathology scale. The scale, previously untested as to its validity, appears to measure what it was intended to measure in this study.

The most salient finding of this study was the discovery that the adoptees at Marymound were not more seriously disturbed than their non-adopted peers. This finding concurs with several studies in the literature, similar in design, utilizing populations of disturbed subjects. (Stonesifer, 1942; Raleigh, 1954; Borgotta and Fanshel, 1965; Offord, 1969.) However, this finding is contrary to what was reported by Schechter (1964), Menlove (1965), Simon and Senturia (1966) and Lifshitz (1975).

It was also discovered that the adoptees at Marymound differed from their peers on the basis of the symptom grouping of "regressive attention seeking behaviors". They were found to be significantly more disturbed for the symptoms of: delinquent; childish whining; anxiousness, fidgetty, restless;

compulsive characteristics (talking, eating, stealing, lying); and hyperactivity. This finding seems to suggest that disturbed adoptees may demonstrate a particular cluster of symptoms or syndrome.

This was the conclusion reached by many of the researchers in the literature. (Menlove, 1965; Tec, 1967; Schwartz, 1967; Reece and Levin, 1968; Jackson, 1968; Offord, 1968; Lifshitz, 1975). In most of these studies disturbance was measured in terms of evidence of various symptoms. Some of the research determined the severity of disturbance to be demonstrated by evidence of antisocial and aggressive symptomatology. (Reece and Levin, 1968; Jackson, 1968; Offord, 1969.) Other studies measured severity of disturbance as being evidence of sexual acting out (Lifshitz, 1975) or introversion and social withdrawal (Schwartz, 1967).

As none of this research took into consideration groups of related symptoms as indicative of disturbance in a particular problem area, it is difficult to make comparisons between the findings in the literature and those of this study. It is interesting, however, that three of the five items which comprise "attention seeking behaviors" are reported in several studies as representative of disturbed adoptees. Menlove (1965) found the adoptees in her sample to demonstrate significantly more often the symptom of "hyperactivity". They also demonstrated more frequently than their controls the symptoms of "legal difficulties" and "fire-setting". Lifshitz

(1975) found that the disturbed adoptees in his study, at several pre-adolescent developmental stages, to exhibit more symptoms of "delinquency" and "restlessness".

One of the difficulties encountered in conducting this study was formulating a hypothesis about disturbances in adoptees which reflected the findings of previous studies in the literature. Due to the contradictions in the literature, a prediction on which to base the hypothesis had to be made on the basis of casework experiences with both adoptees and non-adoptees. These experiences seemed to suggest that adopted adolescents in the care of a child welfare agency were more disturbed than non-adopted adolescents in the same circumstances. However, this first hypothesis was not supported by the finding that the adoptees at Marymound were not generally more disturbed than their peers. With the second hypothesis being substantiated by the finding that the adoptees appeared to demonstrate a particular cluster of symptoms, an explanation can be suggested for why the adoptees in the author's casework experiences appeared more disturbed. These adoptees may have appeared more disturbed as they may have been exhibiting more frequently particular symptoms which were more "visible". For example, - one item of "attention seeking behavior"-- "delinquent"--is a common reason for referral to a child welfare agency. An adolescent's sustained delinquencies are likely to become a highly visible symptom of disturbance and source of frustration to the social worker. Hence, the adoptees

dealt with in casework appeared more disturbed.

The fact that there is little agreement in the literature on whether disturbed adoptees are more disturbed than their peers, may be attributed to the lack of consistency throughout the literature, in the selection of symptoms of disturbance measured. Different studies measured different symptoms of disturbance.

The third hypothesis was not supported by the finding that the adoptees were not less responsive to treatment than their peers. All of the subject groups seemed to respond positively to treatment. At discharge they were evaluated by their social worker as being less disturbed than when they were admitted. Marymound's program seemed effective, as evaluated by staff, in reducing the levels of pathology significantly for all symptom groupings. However, all three groups, when analyzed individually, seemed less responsive to treatment for their "attention seeking behaviors" than for other symptom groupings. It was also found that the adoptees did not respond as readily in the problem area of "dependency responses", comprised of items: social withdrawal; quiet, shy; passive hostility; poor self image; and level of functioning in adult relationships. For this symptom grouping, the adoptees' scores at discharge failed to be significantly lower than their admission scores.

The only study in the literature which examined the responsiveness of disturbed adoptees to treatment (Stonesifer, 1942) found that the adoptees were just as responsive as their

peers to psychiatric treatment at a child guidance clinic. The finding of this study concurs with Stonesifer's results. However, the present study, which went into further detail in analysis, found that the adoptees differed slightly from their peers in being less responsive to treatment for their "dependency responses".

It is worth noting that the first item of "dependency responses", "social withdrawal", is one of the most frequent symptoms measured in the adoption literature as evidence of emotional disturbance. Although all of the studies analyzed data prior to admission, and this finding was based on data collected at discharge, it was frequently reported that adoptees were significantly more disturbed in this problem area. (Schwartz, 1967; Lifshitz, 1975.)

Several interesting findings emerged when analysis was conducted on the adoptees to examine the significance of their ages when they were placed in their adoptive homes. It was found that adoptees adopted in infancy were significantly more likely to be Caucasian than of native extraction. Adoptees adopted later on in their lives were more likely to be of native extraction. This finding is not surprising in view of the problem faced by many Canadian adoption agencies. It has been documented in the literature that children of native extraction tend to receive a disproportionate amount of child welfare services, and a significant number of these children become available for adoption. (Ryant, 1975, p.44.) When

these children are admitted to care, they tend to be older, and there is a fair chance they may remain in care on a long term basis unless they are adopted trans-racially. The unfortunate fact is that it has usually been more difficult for adoption agencies to find homes for children of mixed racial origins or minority status and therefore they tend to wait even longer for adoptive placements.

Some of the studies which examined samples of disturbed adoptees were unable to establish that children adopted when older tended to develop more emotional problems than children adopted in infancy. (Schechter, 1964; Menlove, 1965; Offord, 1969). On the basis of this literature it was anticipated that in the present study the age of adoptive placement would be unrelated to the overall severity of the adoptees' disturbances. This hypothesis was substantiated. When the adoptees were divided into two groups, those adopted in infancy, and those adopted at older ages, significant differences did not emerge in terms of their total scores on the pathology scale.

It was also hypothesized that the age of adoptive placement would be unrelated to the cluster of symptoms or symptomatology demonstrated by the adoptees. This hypothesis was not substantiated. Adoptees at Marymount, who had been placed for adoption when they were less than one year old, were found to have significantly more problems in the area of "social functioning" (items: manipulative, sexual involvement, and level of peer, adult and group functioning) than those placed when

they were older than one year. Offord (1969) also examined differences in terms of presenting symptomatology of adoptees placed in infancy and those placed later. However, his results indicated that the adoptees placed for adoption when older tended to demonstrate more behavioral problems than those adopted in infancy.

It was hypothesized that the adoptees would be equally as responsive to treatment at Marymound despite differences in their ages at adoptive placement. The results did not support this hypothesis. Adoptees placed at ages greater than twelve months, as evaluated by Marymound staff, were found to be generally responsive to treatment in all problem areas except for "attention seeking behaviors". However, this latter symptom grouping was the problem area which seemed least amenable to treatment for all the subjects. The adoptees placed in infancy (one year or less) were not generally responsive to treatment at Marymound. Significant differences between their scores on the pathology scale at admission and discharge were only found for the symptom groupings of "destructive behaviors" and "social functioning". Direct comparisons between the two groups' responsiveness to treatment were not made in this study, for instance by using a two way analysis of variance. Although this analysis would have to be done prior to reaching any firm conclusions, it could be speculated on the basis of the results reported that the adoptees placed in infancy may not have responded as readily to treatment at Marymound, as their peers placed as older children.

### Limitations of the Study

Several limitations of the study were identified and taken into account during the problem formulation stage of the research. These limitations stemmed from the selection of a study site such as Marymount, with only disturbed subjects available for testing. Therefore, it was ascertained that in examining the phenomena of adoption breakdown, it would not be possible to determine the risk inherent in being adopted. It was also not possible to test whether or not adoptees have a greater tendency to developing emotional problems than natural children.

This study was limited to testing how adopted teenaged girls placed in institutional treatment differed from their peers. It was anticipated that the results could be generalized to other treatment settings or institutions for adolescent females. It was also expected that findings could be generalized to other adolescent girls who have experienced adoption breakdown and have entered the care of child welfare agencies, or are seen by child guidance clinics and other psychiatric facilities.

Other limitations of the study emerged during the process of gathering and organizing data. These limitations must be taken into account in assessing the validity and reliability of the study.

As previously mentioned, several serious limitations stemmed from the inclusion of the discharge data in the study.



This data did not appear as reliable as the data collected at the time of admission due to the social workers' subjective evaluation of the residents' progress. It was expected that this subjectivity would bias the results.

This issue of subjectivity of all of the evaluations at admission and discharge is in itself a serious limitation. The Treatment Director's evaluation at admission is also to a certain extent a subjective judgement. The validity of the study would certainly have increased and the results have greater impact if all evaluations of subjects' disturbances at admission, and progress had been assessed by independent raters. However, this was not feasible. The Treatment Director's extensive experience with disturbed adolescents and consistency in form completion justified attempting the study. As well, at the time the Treatment Director was collecting data at admission conferences, there was no knowledge that the information would be used in any research.

The limitations of the discharge data due to the evaluations made by the social workers presented a more serious problem. This affected the validity of the data used to test the hypothesis concerning the responsiveness of adoptees to treatment. It was anticipated that the social workers would tend to evaluate "progress" more favorably than reality as they had coordinated the treatment and were in a sense evaluating their own degree of success. Due to these evaluations it would be a serious error to determine the overall success of Marymount's

program on the basis of the results of this study.

The discharge data was the source of another limitation to the study. This was associated with the missing or lost data on the discharge survey forms. During the data collection phase it was expected that some panel attrition would occur from all subject groups. However, it was discovered that the main source of missing discharge data was from the adopted group. A substantial 40% of the discharge data for the adoptees was missing as these subjects were still residents of Marymount at the time of the study. Another source of missing discharge data which was discovered were those subjects who absconded and were discharged very soon after placement. As there was limited involvement, a discharge form was not always completed by the social workers. These subjects, so resistant to treatment that they have the determination and ingenuity to abscond so quickly, could represent a subgroup of very disturbed girls. Eliminating these subjects from the discharge analysis likely contributed to the artificially high success rate for residents treated at Marymount.

Another limitation to the study involved the discharge data for the absconded subjects for whom a discharge form had been completed. The outcome of treatment for a substantial 30% of subjects from all three groups was not determined in the study as they were discharged due to absconsions. This group may represent a group of girls who were perceived differently by Marymount social workers in their evaluations of

progress as they were discharged under unfavorable circumstances. This provides another rationale for why outcome regarding the responsiveness of subjects to treatment needs to be qualified to include only those subjects completing Marymound's treatment program.

Although the inclusion of the discharge data in the study appeared to be beset with problems, it was decided to not exclude it in the analysis for several reasons. Inclusion would only add somewhat to the time element for data collection, but with possible substantial benefits. Inclusion would not affect the data used in analyzing the major interest of the study--the disturbances of adoptees admitted to a treatment facility. Secondly, only one study in the literature (Stonesifer, 1942) considered the responsiveness of adoptees to treatment as compared with non-adoptees, and this study did not examine this aspect in the depth planned for the present study. Thirdly, the data collected by the social workers was according to specific guidelines set out by the Treatment Director and the social workers were blinded to the original scores when they completed the discharge survey forms. The admission and discharge forms were only combined by clerical staff following the discharge form's completion. It was also anticipated that the discharge data would be considered more reliable, and the concern for the tendency of the social workers to overestimate "progress" lessened if residents could be identified that did not improve at Marymound. Fortunately, this data was collected by the social workers as an item on the discharge survey form. Out of the data available for the subjects, six were discharged for failure to improve over a reasonable period of

time as Marymound's program was not effective in treating them. The source of these "untreatable" subjects was not from any particular group: three subjects were from the adoptees, two from the control and one from the fostered groups. As well, if a bias was introduced by the evaluations being made by the social workers, this bias was not likely to be a differential bias. All subjects were likely to be rated in a similar manner, regardless of whether they were adopted, fostered, or control subjects. Finally, the biases to the results concerning subjects who were discharged due to absconsions was also thought to be limited to a certain degree by the fact that very few residents had not absconded several times during their treatment. Often such subjects were discharged and readmitted when they were located. It was likely that many of these absconded subjects were readmitted in the months following the completion of the data collection phase

For the reasons described, it was anticipated that the benefits of including the discharge data in the study could outweigh the limitations as long as these were taken into account in determining the validity of the results.

#### Recommendations for Further Research

If this study is to be followed up, there are several matters which could be addressed. As this study found that disturbed adoptees at Marymound possessed a particular cluster of symptoms, it would be useful to consider testing these same symptoms of disturbance individually, and as a symptom grouping

in other settings. With the literature indicating little consensus on the types of symptoms demonstrated by disturbed adoptees, additional testing in other settings would help ascertain if the findings of the present study are trustworthy.

Another suggestion for follow up research concerns rectifying the most serious limitation of the current study. The validity of the results were limited by the fact that the evaluations of disturbances of subjects at admission and discharge were made by Marymount staff. If this study is to be followed up the validity of data could be greatly enhanced by a design which utilizes independent rating of subjects over time, not evaluations by staff.

It would also be interesting to compare the results of this study with those obtained from an examination of adoptees and non-adoptees at the time of the initial crisis of family breakdown. Such a study would involve studying those adoptees, non-adoptees and their families who are seeking advice and/or placement services from child welfare agencies or child guidance clinics. Data could be gathered on subjects at the point that they are placed away from their families, and periodically while they are in care. In this way additional information about how adoptees respond to separation from their adoptive families could be traced. It would be interesting to discover how many of the adoptees as compared to non-adoptees finally required placement in a treatment institution such as Marymount. A study such as this could address a research question which

was an initial premise in the problem formulation stage of this research, but not considered due to site selection: Are adopted adolescents at greater risk than their peers when they experience family breakdown and placement away from home? Information which may be interpreted from research of this nature could prove invaluable to the many child caring agencies responsible for treatment and placement services for children.

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APPENDIX  
MARYMOUND'S ADMISSION AND  
DISCHARGE SURVEY FORM

UNIT NAME:

ADMISSION INFORMATION

Page 1.

		NAME	
		BIRTHDATE	
		Age at date of admission to this unit	
		Living with someone other than parent prior to original Marymount placement	
		Living with parent at point of original placement at Marymount	
		Parents together	
		Parent & Step-parent	
		Single parent	
	Yes	WAS FATHER EMPLOYED?	EMPLOYMENT AND ECONOMIC STATE OF FAMILY AT POINT OF PLACEMENT
	No		
	Yes	WAS MOTHER EMPLOYED?	
	No		
	Father	TYPE OF EMPLOYMENT	
	Mother		
	Approximate family income		
	Is Family on a Public Assistance Program?		
	Adopted Child? Yes or No		
	Position in sibline and number of children (i.e. 2nd of 4)		
	Temporary Ward		WARDSHIP STATUS
	Permanent Ward		
	Probation with permission to place		
	Temporary contract placement		
	Placement Number	CLOSED GROUP	DESCENDING ORDER OF PLACEMENTS AND THEIR LENGTH IN A MARYMOUNT RESOURCE AND NUMBERED FIRST TO LAST (i.e. 1,2,3,4, .... etc.)
	Admission & discharge dates		
	Length of placement in months		
	Placement Number	HOME GROUP	
	Admission & discharge dates		
	Length of placement in months		
	Placement Number	TREATMENT DAY	
	Admission & discharge dates		
	Length of placement in months		
	DATE PLACED ON THIS OCCASION		

ADMISSION INFORMATION

WHERE POSSIBLE, PLACE ON A SCALE OF VALUE FROM 1 TO 10 TO INDICATE SEVERITY OF SYMPTOM. (I.E. The number 1 or no number at all would indicate lack of the symptom, and 9 or 10 the symptom in severe degree).

		Running	
		Truency	
		Threatening, Intimidating	
		Manipulative	
		Physically Assaultive	
		Shoplifting, Theft, Break & Enter	
		Sniffing	
		Suicidal Attempts (wrist slashing, overdose, pin swallowing, etc.)	
		Drinking	
		Currently pregnant	
		Occasional	DRUG ABUSE
		Heavy	
		Psychotic Symptoms	
		Bedwetting	
		Stuttering	SPEECH DEFECTS
		Lisp	
		Temper Tantrums	
		Difficulty with limits & authority	
		Social Withdrawal	
		Depression	
		a) Ability to form meaningful, involved relationships	RELATIONSHIP QUALITY, DEPTH, MEANING (Complete only "A" or "B" not both)
		b) Tendency to have conforming superficial and phony relationships	
		Verbally Abusive	
		Firesetting	
		"Babyish" whining	
		Suspicious & Distrustful	
		Takes poor physical care of self, dirty, unkempt	
		Incest or suspected incest	
		Self-centered	
		Fidgetting, restless, anxious	
		Lying	
		Stubborn	
		Quiet, shy	
		"Rocking" behavior	
		Evasive of work and responsibility	
		Supersensitive	
		Masochistic (creates self-hurt)	
		Sadistic (enjoys hurting others)	
		Compulsive characteristics (i.e. lying, talking, stealing, washing)	
		Passive Hostility	
		Inappropriately sexually aggressive	
		Homosexual tendencies	
		Promiscuous relationships (with many)	
		Suspected sexual relationship with boyfriend or girlfriend	
		Self-image	
		Impulsive	
		Hyperactive	
		OTHER	

ADMISSION INFORMATION

**SUBJECTIVE ASSESSMENT OF FUNCTIONING AREAS UPON ADMISSION.** (No number or the number "1" would indicate positive functioning. Number "0" or "10" would indicate extreme problematic functioning)

**STRENGTHS AND INTERESTS**  
(i.e. list intelligence, sports, music, sensitive, etc.)

**HISTORY OF RESIDENCE AND PLACEMENTS IN THE CHILD'S LIFE UP TO ORIGINAL PLACEMENT IN MARYMOUNT. LIST IN CHRONOLOGICAL ORDER FROM BIRTH TO PRESENT. DON'T INCLUDE DETENTION OR MANITOBA YOUTH CENTER AS A PLACE--MENT. SIMPLY STATE THE NUMBER OF DETENTIONS. (i.e. Own home "1"; Foster Home "2"; etc.)**  
**LIST URBAN PLACEMENTS IN BLUE NUMBER. LIST RURAL PLACEMENTS IN RED NUMBERS.**

Peer Relationships			
Parent Relationships			
Adult Relationships			
Ability to plan and follow through with a plan			
Interest level in constructive activities, hobbies, etc.			
The ability to handle the community responsibly. External control.			
Ability to function in a group			
Interest level in schoolwork			
OTHER			

Detention, M.Y.C.			
Receiving home, Shelter home			
Own Home			
Mother's home			
Father's home			
Adoptive home			
Adoptive mother's home			
Adoptive father's home			
Relative's home			
Grandparent's home			
Friend's home			
Foster home			
Group home (other than a M.M. group home)			
T.B. Sanitorium			
General Hospital			

Children's Hospital			
Psychiatric wards			
In General Hospital			
Brandon Mental			
Selkirk Mental			
Children's Home			
Man. Home for Girls			
Indian Res. School			
Lindenview			
Man. Home for Boys			
St. Joseph's			
Knowles School			
St. Hugh John Hostel			
Other (YWA, etc.)			
On own (where plan approved by guardian)			

OTHER			
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		White	RACIAL ORIGIN	
		Eskimo		
		Native Indian		
		Oriental		
		Black		
		Metis		
		Physical Deformity, Crippled	HEALTH	
		Obesity		
		Eyesight		
		Hearing		
		Skin disorder		
		Tonsillitis		
		For medical reasons		miscarriages during pregnancy
		For birth control		
		Okay		
		O T H E R		
		Duration of acting out and problematic behavior. (in number of months) prior to original first placement in Maryland resource (i.e. 5 months, 10 months, 25 months, etc.)		
		Period of time between the first placement in the child's life and the original (first) placement in any of the Maryland units. Indicate in number of months or years and months (i.e. 11 mos. or 2 yrs. & 5 mos.)		
		EDUCATION: Write in grade or level or Special Ed. class child is now taking as described in social history on admission. (i.e. O.E. 8; Grade 7, etc.)		
		Placing Agency		
		Placing Agency Worker		
		New admission to a M.M. closed group or group home. (no previous experience with either of these M.M. resources)		TYPE OF ADMISSION
		New admission to Day Treatment from community (beyond a M.M. group home)		
		Direct transfer from one M.M. treatment group to another without an interruption in the treatment period (i.e. from "closed" to group home or vice versa)		
		Admission to Day Treatment following discharge from M.M. "closed" unit or group home.		
		Admission to M.M. "closed" group or group home because of failure in Day Treatment		
		Readmission to Maryland "closed" group or group home following a previous placement in Maryland and discharge from it		

ADMISSION INFORMATION

Page 4.



IN CASES OR READMISSION, IS IT OCCURRING BECAUSE?

<p>1) Girl discharged from Mary-mound closed group or group home because she ran away and we had to discharge her. (we're readmitting her from the "sun".)</p>	<p>2) Although discharged legitimately (by plan), the plan broke down in the community</p>	<p>3) We're readmitting her from our Day Treatment Program or from our group home because her behavior is more than can be coped with in that program. (too many tantrums, too much running, etc.)</p>	<p>4) Girl was discharged from Mary-mound "closed" group or group home to terminate a pregnancy but we're readmitting her because her treatment period is not completed</p>	<p>5) There was a lack of a more appropriate community resource or follow up program.</p>

DISCHARGE INFORMATION

DATE OF DISCHARGE		REASONS FOR DISCHARGE FROM THIS UNIT OR DAY TREATMENT	RATING OF SEVERITY OF SYMPTOM UPON DISCHARGE FROM EACH UNIT OR DAY TREATMENT. (i.e. Place on a scale of value from 1 to 10 to indicate severity. The number 1 or no number at all would indicate lack of symptom, 9 or 10 would indicate symptom in severe degree.)	
		Length of placement in this unit or Day Treatment in weeks, months, or years and months (i.e. 2 weeks, 3 mos., 1 yr. 3 mos.)		
		Fulfillment of treatment plan and progress		
		Because child's symptoms or behavior made it necessary to discharge her from the unit (i.e. too much to cope with, not enough controls, etc.)		
		Because child ran away and was gone so long she had to be discharged.		
		Due to lack of wardship		
		OTHER		
		Running		
		Truancy		
		Threatening, intimidating		
		Manipulative		
		Physically assaultive		
		Shoplifting, theft, break & enter		
		Sniffing		
		Suicidal attempts (wrist slashing, overdose, pin swallowing, etc.)		
		Drinking		
		Currently pregnant		
		Occasional	DRUG ABUSE	
		Heavy		
		Psychotic symptoms		
		Redeeming		
		Stuttering	SPEECH DEFECT	
		Lisp		
		Temper tantrums		
		Difficulty with limits & authority		
		Social withdrawal		
		Depression		
		a) Ability to form meaningful, involved relationships	RELATIONSHIP QUALITY, DEPTH, MEANING (Complete only "A" or "B" not both)	
		b) Tendency to have con-forming superficial & phony relationships		
		Verbally abusive		
		Firesetting		
		"Babyish" whining		
		Suspicious & distrustful		
		Takes poor physical care of self, dirty, unkempt		
		Incest or suspected incest		
		Self-centered		
		Fidgetting, restless, anxious		
		Lying		
		Stubborn		
		Quiet, shy		
		"Rocking" behavior		

**DISCHARGE INFORMATION**  
 Residence Child placed in upon discharge from Unit.  
 LIST URBAN PLACEMENTS IN BLUE INK. LIST RURAL PLACEMENTS IN RED INK.

(8)

		Detention, M.Y.C.
		Receiving home, Shelter home
		Own home
		Mother's home
		Father's home
		Adoptive mother's home
		Adoptive father's home
		Adoptive home
		Relative's home
		Grandparents' home
		Friend's home
		Foster home
		Group home (other than Marymount group home)
		T.B. Sanitorium
		General Hospital
		Children's Hospital
		Brandon Mental
		Selkirk Mental
		Psychiatric wards in General Hospitals
		Children's Home
		Manitoba Home for Girls
		Indian Residential School
		Lindenview
		Manitoba Home for Boys
		St. Joseph's
		Knowles School
		Sir Hugh John Hostel
		Other (i.e. YWCA, etc.)
		On own (where plan approved by guardian)
		College
		Machray
		St. John's
		Chestnut
		Marymount closed group
		O T H E R
		Child placed in Marymount Day Treatment Program upon discharge from any Marymount residential unit
		Family involvement during placement (Includes visits with the child and contacts with M.M. Rate on a scale of value from "1" to "10". The No. "10" would indicate no contact, "0" or "1" lots of contact. Family is natural, adoptive and long range foster family placements, (5 years and more)
		Name of Placing Agency Worker
		Placing agency worker involvement during placement (includes visits to child and general contact with M.M. personnel. Rate on scale from "1" to "10". The No. "10" would indicate no contact, "0" or "1" lots of contact.
		Strengths and Interests discovered throughout placement. List in total.

PSYCHIATRIC SERVICES  
 OTHER INSTITUTIONS  
 MARYMOUNT GROUP HOME

		Evasive of work & responsibility
		Somersensitive
		Masochistic (creates self-hurt)
++		Sadistic (enjoys hurting others)
		Compulsive characteristics (i.e. lying, talking, stealing, washing)
		Passive hostility
		Inappropriately sexually aggressive
		Homosexual tendency
		Promiscuous relationships (with many)
		Suspected sexual relationship with boyfriend or girlfriend
		Self-image
		Impulsive
		Hyperactive
		<b>O T H E R</b>
		Peer relationships
		Parent relationships
		Adult relationships
		Ability to plan and follow through with a plan
		Interest level in constructive activities, hobbies, etc.
		The ability to handle the com- munity responsibly. External control.
		Ability to function in a group
		Interest level in schoolwork
		<b>OTHER</b>

SYMPTOMS (cont'd)

DISTANCE INFORMATION

SUBJECTIVE ASSESSMENT OF FUNCTIONING AREAS UPON  
DISTANCE. (No number or No. "1" would indicate  
positive functioning. The No. "99" would indicate  
extreme problematic functioning)

DISCHARGE INFORMATION		TYPE OF SUPPORT RESOURCES UTILIZED FROM BACKGROUND DURING PLACEMENT	TYPE OF COMMUNITY RESOURCES UTILIZED AT SAME TIME DURING BACKGROUND PLACEMENT
	School		
	Isolation Rooms		
	Recreation		
	Summer Camp		
	Education	CONSULTING SERVICES	
	Psychiatric		
	Psychological		
	Medical		
	Nursing		
	Special Programs (Crafts, Music, Swimming)		
	Big Sister	VOLUNTEER	
	Visiting Home		
	Tutorial or Special interest (I.E. Music, Craft)		
	OTHER (SPECIFY)		
	Regular Community School		
	Community Work Experience		
	Some form of vocational training, I.E. Hairdressing, R.B. Russell etc.		
	Community Arts, Crafts, Theatre or Music Programs		
	Physical Education Programs (I.E. Swimming lessons, Dancing lessons)		
		HEALTH:  DESCRIBE ANY MAJOR MEDICAL ATTENTION RECEIVED DURING PLACEMENT	(9)