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A comparative study of depression, self-esteem, family relations, peer relations, and attitudes toward mother and father of adoptees and non-adoptees

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ABSTRACT
SOCIAL WORK

WESTFALL, MARVIN E. B.A., MILLIGAN COLLEGE, 1984

A COMPARATIVE STUDY OF DEPRESSION, SELF-ESTEEM, FAMILY
RELATIONS, PEER RELATIONS, AND ATTITUDES TOWARD MOTHER
AND FATHER OF ADOPTEES AND NON-ADOPTEES

Advisor: Dr. Melvin Williams
Thesis dated: July 1991

The purpose of this comparative study was to determine whether the levels of depression, self-esteem, family relations, peer relations, and attitudes toward mother and father are the same in adoptees and non-adoptees. The level of difficulty in these areas was measured through the use of six scales from the Clinical Measurement Package. A self-administered questionnaire was distributed to 40 participants, 20 adoptees and 20 non-adoptees. It was hypothesized that there would be no difference between adoptees and non-adoptees in their scores on the six scales utilized. This research found that when there was significant difference in the two groups it was the non-adoptees who presented a greater severity or magnitude of problem in the areas tested.
This study was an attempt to provide a clear understanding of the inherent stresses adoptees and adoptive families face as well as compare their satisfaction with self, others, family, and parents with non-adoptees.
A COMPARATIVE STUDY OF DEPRESSION, SELF-ESTEEM, FAMILY RELATIONS, PEER RELATIONS, AND ATTITUDES TOWARD MOTHER AND FATHER OF ADOPTEES AND NON-ADOPTEES

A THESIS SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY

MARVIN E. WESTFALL

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

JULY 1991
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CHAPTER ONE
INTRODUCTION

Adoption is an intensely personal, private and emotional issue facing families and the social workers who have elected to be involved in family centered social work practice as well as those working in private and public agencies. Yet at the same time adoption is also an extremely public, political, and open affair because of the multifaceted level of involvement of a group of people (the biological parents, the adoptive parents, the adopted child, the social workers, the adoption agency or attorney, the court, et cetera) and because of the current legislation governing the adoption process. In the state of Georgia over the period between June 30, 1988 and June 30, 1989 there was a total of 4,880 adoptions legally finalized (State Adoption Office Records, 1990). When one takes into consideration the number of families represented, both biological and adoptive, the adopted children, other siblings in the adoptive families, the extended families and family systems it is easy to see the extent to which an adoption impacts the family.
Statement of the Problem

The question of developmental risks in adopted children is a subject of great interest to adoptive parents and biological mother who are considering allowing their children to be adopted (Sorosky, Baran, & Panner, 1984). Biological mothers who make this choice most often do so because they believe it to be what is best for the child's future. They make this decision because of either lack of support from their families or disinterest from the biological father. In either case, the mother would not want to allow the child to be placed in a situation which may be jeopardizing the child's ability to develop in a normal way when compared to other children raised by their biological parents. Therefore, the development of adopted children is a major concern to many in the adoption triangle (Sorosky et al., 1984).

To individuals not familiar with the adoption process the number of adoption disruptions (formerly called failed adoptions) can be staggering. Adoption disruption rates, according to some studies, range from 10 percent with children between 6 and 12 years of age to 14 percent for children 12 to 18 years of age (Tremitiere, 1984). The good news is that
"adoption disruptions apparently occur with less frequency than feared, and these rates appear to be decreasing" (Barth, Berry, Yoshikmi, Goodfield, & Carson, 1988, p. 231).

Adoption creates the need for a restructuring within the family system. The entry of a new family member has forced a restructuring to take place and every family member is at risk to experience discomfort or conflict around the restructuring process. Specific interventions designed to enhance the relationship between family members, strengthen the alliance between the marital pair, help the alteration of family boundaries, and the clarification of inter-generational boundaries may be utilized in situations where adopted children and their families are having difficulty with this restructuring process. As well as external, inter-generational, and family boundaries, inter-personal boundaries need to be strengthened. Hartman (1984) "supports the concept of inter-personal boundaries within the families by suggesting that people should have their own stories and memories" (p. 38). When this restructuring does not take place the adopted child may not be given an opportunity to develop feelings of his/her place in
the family, attitudes toward parents, feelings about self, and feelings about interaction with others (Zettersren, 1991).

Purpose of the Study

Adopted children, like other children, want to know that everything has been done and provided for them in an effort to contribute to successful family and personal functioning and development. What all of those contributing factors are and the degree to which they affect development and are affected by the adoption situation are important but could not be investigated in just one study. What will be investigated in this study, however, is a systematic comparison of self-esteem, self-contentment (depression), family relations, peer relations, and child's attitude toward mother and father of adoptees and non-adoptees. "Adoption is not in itself pathogenic, but when pathology does develop in an adoptive family adoption frequently lends it a characteristic and recognizable form" (Kirschner & Nağel, 1988, p. 301). The characteristic and recognizable form is often manifested in one of the many stressors related to adoption. Assuming that to be true, this comparative study set out to verify that adoptees and adopted
families are not more inclined to experience personal or family dysfunction than their non-adoptive counterparts. While the purpose of this study is not to determine family dysfunction or inability of an adoptee to function satisfactorily it will measure some of the indicators of family harmony and personal satisfaction. The level of family harmony and the potential for dysfunction may come into focus as one measures and examines the degree of family relations, attitudes toward mother and father, peer relations, self-esteem, and depression. Although family functioning and personal development of adoptees may not be revealed through the study, it is the researcher's belief that the areas tested may be viewed as strong indicators of purposeful, healthy, and normal functioning. Positive responses to family-satisfaction and self-satisfaction may very well contribute to the ability to function personally which indicates healthy development and personal growth (Zettersten, 1991). The level of sibling relations may also serve as an indicator of the level of family functioning.
The purpose of this study is to provide a comparative view of adoptees and non-adoptees in the areas of: (1) depression, (2) self-esteem, (3) family relations, (4) peer relations, (5) child's attitude toward mother, and (6) child's attitude toward father.
CHAPTER TWO

Review of Related Research

There is much discussion today among helping professionals concerning the notion that adoptees are developmentally at risk (Humphrey, 1988). Many have agreed and disagreed with that basic premise over the last 40 years. Research presented by professionals has yielded information both supporting and refuting the idea of adoptees being at risk developmentally. What we do know is that children who are adopted and the families in which they are placed are put under a great deal of inherent stresses. Whether these stresses prevent an adopted child from developing into a healthy adult intellectually, emotionally, and socially has not yet been authoritatively determined.

There has been a great deal of speculation surrounding adopted children being more prone to developing psychiatric problems (Smith, 1981). Smith (1981) states, "while it is true that a disproportionate number of adoptees are seen in psychiatric clinics, the vast majority of them are not" (p. 85). One study (Bohman & von Knöring 1979) of psychiatric illnesses among adults adopted as
infants indicates that they have a significantly higher frequency of psychiatric illnesses than did non-adopted controls. While a disproportionate number of adoptees seeking professional help may exist, there are several factors which may explain the disparity. One factor which may be the most obtrusive is that adoptive families tend to be, for the most part, well-educated, upper-middle class, success-oriented families. They are more likely to seek professional assistance to obtain help for their children when problems arise (Stewart, 1990). Services of professionals are less threatening to them than might be to less-educated, lower-class families.

A number of studies using large samples and acceptable scientific procedures for analyzing results have, on the other hand, demonstrated that, with few exceptions, adopted children develop to be as physically sound and emotionally stable as their non-adopted counterparts (Kadushin & Martin, 1988). While Kadushin and Martin's (1988) review of 24 studies suggest that 66 percent of traditional adoptions can be characterized as "unequivocally successful" a body of research suggests that adoptees
are more likely to experience emotional adjustment difficulties (Rosenthal & Groze, 1990). Families seeking help do so in order to resolve any number of issues which are related to adoption. A variety of reasons include: unresolved issues surrounding infertility, entitlement or worthiness, parent's disappointment in the development or growth of adopted child, and neurological or intellectual impairment (Smith, 1981). For the most part, these are issues which biological parents do not have to confront (Stewart, 1990), at least not from the perspective that these children are biologically from other parents. Austad and Simmons (1978) noted that additional problems arise when adoptive children do not conform to the expectations of their parents therefore causing additional distress. The expression of disappointment to children then fosters negative responses from the child.

Factors surrounding the adoption process do, indeed, have a profound effect on potential family dysfunction as the years pass. For instance, there is a greater incidence of anti-social conduct in adopted children who were received after the age of 6 months compared to those who were adopted at or
near birth (Humphrey, 1988). Other factors relating to adoption in disturbed or dysfunctional families include: mother adopting at age 30 or older with no previous child; disclosure of adoption avoided, postponed or mishandled; fear of the unknown heredity; ten or more years of childless marriage before adoption; mother haunted by a sense of biological failure; child parentally deprived before adoption; child of marriage born after adoption; third parent (natural mother or father) known to the child; child adopted to replace recent loss by death or stillbirth; and child adopted in hope of relieving mother's infertility (Humphrey, 1988). Naturally these are not all inclusive but represent the type of factors adoptive families are confronted with and may anticipate facing.

In a 1985 study by Parents For Children, a London based adoption agency, an effort was made to examine the post-adoption needs of adopters and adoptees. The study is full of examples of difficulties which disrupt many families and especially those involved in a sensitive adoption situation. Problems associated with early deprivation such as: aggressive behavior, acute withdrawal, destructiveness,
stealing, lying, self-mutilation, hyperactivity, enuresis, and encopresis were often the presenting family difficulty (Macaskill, 1985). There may also be idiosyncratic patterns of behavior such as: constantly losing things, giving things away, and hiding in curtains (Phillips, 1990).

Parents often describe themselves as being overwhelmed and feeling as if they may have "bitten off more than they could chew." These are, however, feelings biological parents could share with adoptive parents at times. In addition, high parental expectations rather than inherent difficulty in the child might well add to the difficulties adoptive families face. "Adoptive parents are usually not aware of the fact that most of the parents of children given up for adoption do have various social and emotional problems" (Stewart, 1990, p. 233). Nor are they aware that adoptive children experience more behavior and adjustment problems than do natural children in the general population as a result of the added stressors unique to adoption.

Adopted children and adoptive families are more sensitive to issues relating to their adoption and the additional burden of dealing with prejudices and
misconceptions of society surrounding the adoption process (Plumez, 1982). Therefore, those involved in the adoption process can best answer questions concerning their feelings, development, and contentment within the family. One can, however, make a cross comparison between adoptees and non-adoptees in order to see if there are any risks or dangers of dysfunction and disruption.

Major Theoretical Orientations

Since an adoption involves more than just the adopted child, much of the prominent literature and many of the writers on the subject take a broad theoretical approach when dealing with the inherent stresses facing the adoptive families. Adoption involves a shifting of roles and adding to an existing structure. The structural family theoretical framework stresses the importance of family structure, generational lines, and clearly defined boundaries. Walsh (1982), who cites Minuchin, believes a normal family cannot be distinguished from an abnormal family by the absence of problems. According to Walsh (1982) the image of "placid" normality where the normal family lives in a non-stressful state of harmony and cooperation coping with external forces
without internal strife does not exist. Quite the opposite is true. A normal family has all the pressures and external forces working on it that a dysfunctional family has yet is able to adjust and cope while constantly struggling and negotiating compromises that make life possible. This view supports the perspective of the transactional family processes where the family adapts and adjusts to changing circumstances to maintain functioning. An adoptive family is, because of the adoption, in the process of changing of hierarchy, shifting of roles, establishing new boundaries, and adjusting to the new addition to the family. The families which are not able to make the adjustment are more prone to become dysfunctional or experience difficulty than families not faced with this dilemma (Minuchin, 1974).

Is the adoptive family more vulnerable to difficulties, simply by its nature, than non-adoptive families? If it is, one of the main factors which must be taken into consideration is the family structure itself. "Although the child development literature generally demonstrates that the child's fit with the social environment determines the child's success, the child's independent contribution
to the family relationship also is a powerful factor" (Barth et al., 1988, p. 227).

In the structural family approach an emphasis is placed on hierarchy to the effective functioning of the family structure (Walsh, 1982). Within this view there is a clear distinction between executive and parental roles. Parents are part of both the spousal sub-system and the parental sub-system. The structural system is difficult for immature parents who want to be pals with their children. Clear generational boundaries must be enforced in order to insure family functioning. When a highly enmeshed parent-child sub-system breaches generational boundaries both the parental-marital unit and the child's autonomy experience the development of dysfunctional symptoms (Walsh, 1982). This difficulty of breakdown of generational boundaries impacts adoptive families who have no other children and have waited for several years to adopt. They find it difficult not to lavish the adopted child with whatever he/she wants or permits whatever he/she wants to do in an effort to please and be friends with the child.
The structural approach provides a sound framework for adoptive families who are interested in working through difficulties since it stresses the here and now without focusing on the past or history of the family for reasons and causes of dysfunction. Each transition within the family includes: 1) family boundaries, 2) alignment and cohesion, and 3) power forces (Minuchin, 1974).

Clarity of family boundaries serves as an evaluation for family functioning. The enmeshed family patterns as well as disengaged family patterns are viewed as transactional styles, not as indicators of abnormality.

In addition to the structural approach much has been written concerning approaching the adoptive family from an ecological perspective. An ecological perspective in working with adoptive families and adoptees is not new to social work (Boyd, 1982). During most family consultation with adoptive families experiencing dysfunction the practitioner must take an eco-systemic approach. Since the family is exposed to a large number of different, yet overlapping, systems, sub-systems, and systems levels the clinician must be aware of and willing to work
with all systems even remotely relevant to the presenting family. An ecological approach during diagnosis, assessment, and evaluation stages of family consultation will give the clinician a much broader perspective on the systems impacting the adoptive family crisis. This approach makes a statement concerning the delicate balance which exists between people and their environment, and the ways in which balance may be maintained and even enhanced (Hartman & Laird, 1983).

Definition of Terms

1. **Adoption** - Adoption, as it is referred to in this study, may be defined as the legal process by which a family or couple takes a child into their home and treats him/her as though born into the family. Generally speaking, adoption gives an individual all the rights, and privileges of a biological child.

2. **Independent Variable** - In systematic research, the factors which are thought to have an impact on or to cause a certain behavior are called the independent variable. In this study, the independent variable is the fact that one group has been through the process of being legally adopted into another family.
3. **Dependent Variable** - In research, the dependent variable is the reaction or impact to be measured or tested when an independent variable has been introduced. The dependent variables measured in this study are: depression, self-esteem, family relations, peer relations, attitudes toward mother, and attitudes toward father.

4. **Clinical Measurement Package** - The Clinical Measurement Package refers to a group of nine short-term clinical scales designed for repeated use with a client to monitor and evaluate progress in therapy. These scales measure the magnitude or severity of a problem the client may have with (1) depression, (2) self-esteem, (3) marital discord, and (4) sexual discord; (5) parent-child relationships as seen by the parent, (6) as seen by the child in relation to the mother, (7) and as seen by the child in relation to the father; (8) intrafamilial stress; and (9) peer relationships (Hudson, 1982).

5. **Depression** - Depression refers to emotional reactions or characteristics an individual may display. These traits may be mild, intermittent, constant and intense, or even unnoticed by others. Some of the typical emotional reactions may include:
sadness, despair, discouragement, feelings of inferiority, pessimism, and hopelessness (Barker, 1987).

6. **Self-Esteem** - Self-Esteem refers to the feelings of personal or self-worth that an individual has about himself (Barker, 1987).

**Statement of Hypotheses**

The null hypotheses for this comparative study were as follows:

1. There is not a significant difference in depression between adoptees and non-adoptees.

2. There is not a significant difference in self-esteem between adoptees and non-adoptees.

3. There is not a significant difference in family relations between adoptees and non-adoptees.

4. There is not a significant difference in peer relations between adoptees and non-adoptees.

5. There is not a significant difference in family relations between adoptees and non-adoptees.

6. There is not a significant difference in attitudes of child toward mother between adoptees and non-adoptees.

7. There is not a significant difference in attitudes of child toward father between adoptees and non-adoptees.
CHAPTER THREE

METHODOLOGY

Research Design

The research that led to the present comparative study was prompted by the belief that, (1) while adoptees and adoptive families are subject to a great deal of inherent stresses they are not doomed to experience family dysfunction, and (2) adoptees are not at risk developmentally and have equal potential to develop intellectually, emotionally, and socially as their non-adoptee counterparts. It was hypothesized that adoptees do not experience any greater difficulty in the areas of depression, self-esteem, family relations, peer relations, attitude toward mother and attitude toward father than do non-adoptees. The research design utilized to facilitate this comparative study was one considered to be a quasi-experimental design. A Post-Test Only Comparison Group was utilized to make the comparison between adoptees and non-adoptees in the area in question. The independent variable in this study was the fact that one group of samples was involved in the adoption process.
This research design involves observations (or data collected) after a specific independent variable has been introduced. In this study the independent variable is the fact that an adoption has taken place. It involved only one observation of both groups taken any time after the independent variable was introduced.

The main instrument used for comparison purposes of the adopted and non-adopted groups were scales from a clinical measurement package utilized by many practitioners. These scales are designed to monitor and evaluate the magnitude (extent, degree, or intensity) of a client's problem in a specific area. The scores from these scales can not determine whether the adopted individual has developmental problems and is in need of treatment of therapy. They may, however, be viewed as strong indicators of whether the individual has successfully completed specific developmental stages on his/her way to mature social and personal functioning.

Sampling

The population for this study fell into two different categories: adopted and non-adopted. These individuals were solicited through four
different resources. The first source for participants was through families which Save-The-Child Ministries, Inc. (a licensed maternity home in Athens, Georgia) has been involved with for counseling, adoption, or adoption referral. The second source was through a mailing circular of individuals and groups associated with Save-The-Child Ministries, Inc. asking for volunteer participants in the study. The third source was through members of an Athens, Georgia based self-help, support group involved in adoption and related issues called the Clarke County Adoption Resource Exchange. And finally, volunteer participants were solicited from the student population of the Schools of Social Work at the University of Georgia and Clark Atlanta University.

In order to encourage participation from those who the researcher did not know personally, strict confidentiality and anonymity was guaranteed. A conscious effort was made to avoid participants who are presently in any type of psychiatric or mental health treatment or on-going counseling for mental related disorders. Samples were utilized, however, without regard to known family dysfunction or stability.
The control group of individuals was selected from a volunteer pool which did not differ in any significant way from the experimental group except in the area of living with adopted or biological families. From these two groups a comparison of data was made to determine what differences, if any, there are in the areas of depression, self-esteem, family relations, peer relations, and attitude toward mother and father. The individual samples were composed of mostly college-aged or older individuals since this was the largest population available to the researcher. The college students appeared to be more sensitive to the needs of a researcher trying to collect data for research purposes.

While there are several different types of adoptions included in the total number legalized each year, such as adoption of child by step-parent, adoption of child by maternal or paternal grandparents, adoption by other members of the family, adoption by close friends of the family, et cetera, this study addressed only those adoptions in which the child was adopted by an unrelated family through either independent or licensed agency adoptions. For the most part, whether the child and the adoptive
parents knew the biological parents is not relevant to this study. What is important, however, is how the adoptee develops personally, intellectually, developmentally and socially in the adoptive home. Of specific interest and importance to this study is how the adoptee developed in the areas of contentment with self/life (depression), self-esteem, family relations, peer relations, and in their attitudes toward mother and father.

No particular effort was made on the part of this researcher to include a specific percentage of minorities or sample of a particular sex, age, educational or social background, or any other delineation. The participant surveys which were utilized were simply the first 20 of each group to respond. There were many more responses from individuals who were not adopted (approximately 50) but because of the limited number of adoptees responding, many could not be used.

Questionnaire Package

The questionnaire package consisted of eight parts. Prefacing the eight parts was a cover letter explaining the purpose of this study, suggestions concerning the way participants should approach and
complete the questionnaire, an assurance of anonymity, and an expression of appreciation from the researcher for the anticipated participation.

The first part of the questionnaire package consisted of a general information questionnaire. Information concerning age, race, sex, marital status, educational background, family size, and religious background was gleaned from this questionnaire. This part was applicable to all respondents.

The second part of the questionnaire package was applicable only to the adoptee participants. It consisted of a questionnaire asking specific information surrounding their individual adoption situation. Information concerning their age at adoption, their parents' age at the time of the adoption, siblings, family satisfaction, and information concerning whether they ever searched for their biological parents and the result of such a search was asked in this part of the questionnaire package.

The third part of the questionnaire package was the first of the clinical scales utilized in comparison of the adoptees and non-adoptees. The Generalized Contentment Scale (GCS) - is a 25-item scale designed to measure the degree, severity, or
magnitude of non-psychotic depression. The GCS has a cutting score of 30(±5), with scores above 30 indicating the respondent has a clinically significant problem and scores below 30 indicating the individual has no such problem. Reliability and validity of the GCS are both very high. The GCS has a mean alpha of .92, indicating excellent internal consistency, and an excellent (low) Standard Error of Measurement of 4.56. The GCS has good concurrent validity, correlating in two studies .85 and .76 with the Beck Depression Inventory and .91 and .81 for the two samples using the Zung Depression Inventory (Corcoran & Fischer, 1987).

The fourth part of the package consisted of the Index of Self-Esteem. The Index of Self-Esteem (ISE) is a 25-item scale designed to measure the degree, severity, or magnitude of a problem the client has with self-esteem. The ISE has a cutting score of 30(±5), with scores above 30 indicating the respondent has a clinically significant problem and scores below 30 indicating no such problem. Both Reliability and validity of the ISE are very high. The ISE has a mean alpha of .93, indicating excellent internal consistency, and an excellent (low)
Standard Error of Measurement of 3.70. The ISE has a good known-groups validity, significantly distinguishing between clients judged by clinicians to have problems in the area of self-esteem and those known not to. Further, the ISE has a very good construct validity (Corcoran & Fischer, 1987).

The fifth part of the questionnaire package consisted of the Index of Family Relations (IFR). The IFR is a 25-item scale designed to measure the extent, severity, or magnitude of problems that family members have in their relationships with one another. The IFR has a cutting score of 30(+-5), with scores above 30 indicating that the respondent has a clinically significant problem and scores below 30 indicating no such problem. The IFR has a mean alpha of .95, indicating excellent consistency, and an excellent (low) Standard Error of Measurement of 3.65. The IFR also has excellent known-groups validity and good construct validity (Corcoran & Fischer, 1987).

Part Six of the questionnaire package was the Index of Peer Relations (IPR). The IPR is a 25-item scale designed to measure the extent, severity, or magnitude of a problem the respondent has with peers.
The IPR has a cutting score of 30(+-5), with scores above 30 indicating the respondent has a clinically significant problem relating to peers and scores below 30 indicating no such problem. The IPR has a mean alpha of .94, indicating excellent internal consistency, and an excellent (low) Standard Error of Measurement of 4.44. The IPR has excellent known-groups validity, significantly distinguishing between clients judged by themselves and their therapists as either having or not having peer relationship problems (Corcoran & Fischer, 1987).

Part seven of the questionnaire package was the Child's Attitude Toward Mother (CAM) scale. The CAM is a 25-item scale designed to measure the extent of a problem the respondent has with his/her mother. The CAM has a cutting score of 30(+-5), with scores above 30 indicating the respondent has a clinically significant problem with his/her feelings toward mother and scores below 30 indicating the individual has no such problem. The CAM has a mean alpha of .94, indicating excellent internal consistency, and an excellent Standard Error of Measurement of 4.57. The CAM also has excellent known-groups validity and good construct validity (Hudson, 1982).
The eighth, and final, part of the questionnaire package consisted of the Child's Attitude Toward Father scale (CAF). The CAF is a 25-item scale designed to measure the magnitude of a problem the respondent has with his/her father. The CAF has a cutting score of 30(+-5), with scores above 30 indicating the respondent has a clinically significant problem with their feelings toward father and scores below 30 indicating no such problem. The CAF has a mean alpha of .95, indicating excellent internal consistency, and an excellent Standard Error of Measurement of 4.56. The CAF also has excellent known-groups validity and good construct validity (Hudson, 1982).

All of the scales utilized in this comparative study are tested and proven tools of clinical measurement in the field of social work. Many other clinical measurement instruments are available to the practitioner today. This researcher selected these specific instruments because of their high reliability and validity as well as the simplicity with which they may be administered and scored. Respondents could very easily complete the scales with a minimum of instructions and/or supervision.
Also included in the questionnaire package was a request for more information concerning the findings of this comparative study. This form was to be completed by the respondents interested in the findings of the study and was to be mailed separately from the questionnaires in order to assure anonymity.

Data Collection Procedure

The Questionnaire packages were given to each individual sample in the specific population allowing them to complete the questionnaires and scales at their own leisure. Special care was given to encourage participants to answer honestly and openly without fear of loss of confidentiality or privacy. They were also informed that these were not "tests" in the traditional form, therefore there are no wrong answers - only their answers. The purpose and method of testing was outlined and explained to each participant before testing or data collection began in order to make sure that the respondent understood completely what was being asked of them. The cover letter to all participants involved in the study included informed consent, a statement regarding information confidentiality, and an explanation of the purpose of the research.
Data Analysis

Mean scores were calculated for each of the six clinical scales in both the adopted and non-adopted groups. A t-test was performed for each scale to determine whether there was a significant statistical difference in the adoptee's and non-adoptee's scores in the areas of depression, self-esteem, family relations, peer relations, and attitudes toward mother and father. The calculated t-values of the t-test were then compared to the table value utilizing a two-tailed t-test with a .05 level of significance. By performing this procedure the researcher determined whether to reject or accept the null hypotheses stating that there was no significant difference in the two groups.
CHAPTER FOUR

PRESENTATION OF FINDINGS

This chapter presents the information gathered and the statistical data analysis necessary to reject or accept the earlier stated hypotheses.

Tables 1 and 2 present important demographic information regarding all of the respondents participating in the study. Table 1 gives the number and percentage of respondents in the study according to their sex, race, and marital status. The population studied in this comparative study was composed of 40 individuals (n=40). Of the 40 participants, (20 adoptees and 20 non-adoptees) 30 were female (75 percent) and 10 were male (25 percent). Eight of the respondents were black (20 percent) and 32 were white (80 percent). Of the total population of the study, 27 were single (68.5 percent), 10 were married (25 percent), 2 were divorced (5 percent), and 1 respondent was remarried after a divorce (2.5 percent).

Additional information related to the study gleaned from the general information questionnaire is presented in Table 2. Of the 40 respondents in the study, the mean age was 26.9 years of age for
TABLE 1
Sex, race, and Marital Status of Respondents

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### TABLE 2

**Mean Age, Education, and Sibling Group Size of Respondents**

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the adoptees and 23.3 for the non-adoptees. The ages ranged from 13 to 54 in the combined group. The average education in number of years of schooling completed was 13.5 for the adoptees and 14.2 for the non-adoptees denoting most of the samples either were, or are, in college or some form of post-high school educational training. Also presented in Table 2 is the mean number of siblings in the family in which the adoptees and non-adoptees grew up in. The mean number of siblings of the adoptee group was 1.9. The non-adoptee group sibling size was slightly higher at 2.85.

Other information gleaned from the questionnaire package which will not be elaborated on in this text and not directly related or connected with this study included: religious preference, frequency of religious attendance, the degree of happiness in the adoption situation they experienced, the age at which the adoptees were told they were adopted, where that information originated, whether the adoptees ever searched for biological parents and at what age that search was initiated, what their adoptive parent's responses was to the search, whether a search for biological parents affected their relationship with
their adoptive parents, and reasons for searching for origins. This information is of interest to the researcher and may be utilized at another time. These data are presented to better define the population of the study as well as define each specific group.

It was broadly hypothesized that there would be no significant difference between the adoptees and the non-adoptees in the scores from the six clinical measurement package scales utilized in this study. When t-tests were performed comparing the results of the scales it was found that two of the six scales showed a significant difference in their mean scores. The mean scores for all six scales in both groups were, however, well below the cutting score of 30(±5), denoting the respondent does not have a clinically significant problem in that specific area. When there was significant difference, it was noted that the adoptees scored lower on the clinical scales than did their non-adopted counterparts. They actually had, according to the results of the scales, significantly better attitudes and feelings in the two areas showing significant difference in the mean scores.
The first null hypothesis states that there is not a significant difference in the area of depression between the adoptees and the non-adoptees. Figure 1 represents the mean scores for all of the six clinical scales. The first mean scores are those of the depression scale as recorded on the Generalized Contentment Scale. On the GCS the adopted and non-adopted groups scored identical mean scores. Adopted - 19.1 and non-adopted - 19.9. A two-tailed t-test revealed no significant difference in the adoptees and non-adoptees with regard to depression. These findings support the null hypothesis. In the adopted group only three respondents scored higher than 30 (the cutting score indicating a clinically significant problem with depression), compared to six respondents in the non-adopted group. There were only two from each group with scores in the 50's and 60's indicating the potential for major problems in the area of depression. Most, however, were well below the cutting score, indicating no problem. The results of the two-tailed t-test in regard to depression of the two groups was $t = .45$, with a .05 level of significance.
FIGURE 1
Mean Distribution of Six Clinical Measurement Scales
The second null hypothesis states that there is not a significant difference in self-esteem between adoptees and non-adoptees. Figure 1 presents the mean self-esteem scores as recorded on the Index of Self-Esteem for both the adoptee and non-adoptee groups. While the adoptee group's mean score was slightly higher than the non-adoptee's (27.3 to 25.4), this was not considered to be a significant difference. A two-tailed t-test revealed no significant difference in the adoptee and non-adoptee groups with regard to self-esteem, \( t = -0.81 \), with .05 level of significance. These findings support the null hypothesis. In the adopted group there were eight respondents who scored higher than the cutting score of 30, indicating a clinically significant problem with self-esteem. Of the non-adopted group only seven scored higher than the cutting score. There were only three respondent among the adoptees scoring in the 50's and 60's while four from the non-adoptees were in this range. Most, however, were well below the cutting score, indicating no problem with self-esteem in either group.
The third null hypothesis states that there is not a significant difference in the area of family relations between the adoptees and non-adoptees. Figure 1 presents the mean family relations scores for both groups as scored on the Index of Family Relations. Not only did the adoptee group not score higher on the IFR, as some research has indicated suggesting adoptive families being at risk of becoming dysfunctional, there was a significantly lower score when compared to their non-adoptee counterparts. The adoptees showed a mean score of 13.8 and the non-adoptees a mean score of 23.1. A two-tailed t-test revealed a statistically significant difference in the adopted and non-adopted groups with respect to family relations, \( t = 4.84 \), with .05 level of significance. These findings resulted in rejecting the null hypothesis. The conclusion drawn from these figures may be that adoptees consider their family relations to be better than do their non-adopted counterparts. Only two of the adopted group scored higher than the cutting score of 30 compared to seven in the non-adopted group. Of all the respondents only two from each group scored above the 50's indicating a clinically significant problem.
Information gleaned from the adoption information questionnaire further indicated that 19 of 20 adoptees (95 percent) responded "yes" to the question: "Would you say that you have been happy in your adoptive home?" When asked to rate their adoption experience on a scale from one to five (one meaning very happy and five meaning very unhappy), 13 adoptees (65 percent) responded with a one - very happy; five (25 percent) responded with a two - happy most of the time; and one each (5 percent) for number three - happy part of the time, and four - unhappy most of the time.

The fourth hypothesis states that there is not a significant difference in peer relations between adoptees and non-adoptees. Figure 1 presents the mean peer relations scores as recorded on the Index of Peer Relations scale. While the adoptees did score slightly higher on the IPR than did the non-adoptees (19.4 to 17.8), when a two-tailed t-test was performed comparing the results, it was found that there was not a significant difference between the two groups, $t = -0.969$, with .05 level of significance. The conclusion drawn from the results of this scale indicated that there was no greater
problem with peer relations within the adoptee group than the non-adoptee group. Only three of the adopted group scored higher than the cutting score of 30, compared to two in the non-adopted group. These findings supported the null hypothesis.

The fifth hypothesis states that there is not a significant difference in child's attitude toward mother between the adoptees and the non-adoptees. On the CAM the adopted and non-adopted groups scored very close mean scores - adopted - 15.6 and non-adopted - 16.9. In the adopted group there were only four respondents who scored higher than the cutting score of 30, compared to three respondents in the non-adopted group. As the initial data was collected it appeared that the adoptee group was scoring significantly higher on the CAM scale than were the non-adoptees. After the sample size of 20 respondents was reached, however, that did not appear to continue to be true. When a two-tailed t-test was performed comparing the results of the CAM, it was found that there was not a significant difference between the two groups in attitudes toward mother, t = .73, with .05 level of significance. The findings support the null hypothesis.
The sixth hypothesis states that there is not a significant difference in the child's attitude toward father between the adoptees and non-adoptees. Figure 1 presents the mean scores of attitudes toward father as scored on the CAF scale. A two-tailed t-test revealed that there was a statistically significant difference in the adoptee and non-adoptee groups with respect to child's attitude toward father, \( t = 5.39 \), with a .05 level of significance. These findings resulted in a rejection of the null hypothesis.

Not only did the adoptee group not score higher on the CAF, their mean scores were significantly lower than the non-adoptee group. The adoptees mean score was 12.1 compared to their counterparts score of 20.9. The conclusion which may be drawn from this finding is that adoptees had a significantly better attitude about their relationship with their father than did the non-adoptees. Only one of the adopted group scored higher than the cutting score of 30, compared to four in the non-adopted group.
It was initially hypothesized that there would be no significant difference between the adoptees and the non-adoptees in their scores on the six clinical scales utilized in this comparative study. When a t-test was performed comparing the mean scores of the two groups on each scale it was found that there was not a significant statistical difference in the areas of: depression, self-esteem, peer relations, and child's attitude toward mother. There was, however, a significant statistical difference in the scores on the scales measuring family relations and the child's attitude toward father. What was revealed through the use of the two-tailed t-test was that the adoptees scored far better (lower) in these two areas than did their non-adopted counterparts. In fact, the CAF scale showed the greatest disparity, indicating a lack of any clinically significant problem. According to the findings in this study, it must be stated that adoptees are as well adjusted as non-adoptees in the areas of: depression, self-esteem, peer relations, and child's attitude toward mother.
Additionally, the findings indicate that adoptees have a far better relationship with their families and fathers than do non-adoptees.

While two of the hypotheses were not supported, the findings, nonetheless, support the belief that adoptees do not have greater difficulties in the areas tested than do non-adoptees. In fact, they may even do better in some areas than their non-adopted counterparts.

"It is difficult, if not impossible for the researcher to isolate the factor of adoptive status from all other factors affecting the child's development" (Smith, 1983, p. 83). This writer is in full agreement with this assessment of the complexity of the child's development and measurement of life's developmental problems. If the scores on the six clinical scales utilized in this comparative study are any indication of their development and adjustment as young adults and adults, then it may be concluded that adoption in and of itself is not a valid reason to assume that an individual will experience difficulties in life. Difficulties in the areas of depression, self-esteem, family relations, peer relations, and attitudes toward
mother and father can not be directly attributed to the fact that one has been adopted. Researchers do not know all the effects adoption has on children nor the impact it will have on them and their families as they go through the developmental stages growing into adults. What is known, however, is that adoption creates the need for a restructuring within the existing family system. If the family unit is unable, or unwilling, to attempt and successfully complete this restructuring, discomfort and even conflict may result. More severe results may even be that of adoption disruption or failure.

One outstanding characteristic observed in this study and confirmed by other research (Rosenthal & Groze, 1990) was that adoptive families scored higher on family cohesion than did the normative group. This may be interpreted to mean that there is a great deal of hope that may be placed in the adoption situation. It may also mean that non-adoptive families may avoid conflict and dysfunction if a greater effort were placed on creating an atmosphere of family cohesion within their homes and families.
Limitation of the Study

One difficulty any researcher will be confronted with is that of obtaining a large and representative sample of adoptees to participate. Guaranteed anonymity and confidentiality by those involved in and arranging the adoption are factors both adoptive families and biological parents are reluctant to forfeit. Even when located, adoptees and adopters may not be willing to be the subject of a study.
CHAPTER SIX
IMPLICATIONS FOR SOCIAL WORK

While the results of this comparative study show that adoptees do not present greater levels of difficulty in the areas of depression, self-esteem, family relations, peer relations, and attitudes toward mother and father, one may safely say that adoptive families are placed under a great deal of stress that biological families will never experience. Because of these stresses and stressors the field of social work must be prepared to assist families trying to work through transitional and restructuring times. The difficulty in identifying and assisting adoptive families experiencing stress and potential dysfunction lies not only in the traditional role social workers have played in the adoption process but in the way adoption agencies and child welfare agencies approach adoption and the adoptive family. For instance, post-adoption services are, at present, rather minimal. Often the only services offered or utilized are one-year follow-up visits. Post-adoption services must be placed in a new model for use by helping professionals - a model built on the assumption that new families created by
adoption will need help at times, in the months and years that follow the adoption (Hartman, 1984). Post-adoption involvement by family centered social workers, in this model, will in no way suggest a failure on the part of the adoptive family or the adopted child when difficulty is present. Instead, a way must be found to assist the child and family in adjusting to a new and challenging life situation. In order for the adoptive family to feel comfortable enough to ask for on-going, post-adoption services or assistance in difficult times, there must be a good relationship between the family and the agency. Hartman (1984) reports that families involved in home studies and post-adoption services at times feel the agency has a judgemental attitude which in turn puts the family on the defensive and makes the whole process very agonizing. Faced with this type of characterization, not many families will voluntarily involve themselves with agencies in post-adoption services. If, on the other hand, post-adoption services were available to adoptive families on an as-needed basis throughout the developmental stages of the adopted child's life, the family may be more inclined to ask for assistance in dealing with family
difficulties and striving to maintain homeostasis. Intensive adoption preservation services, which may include in-home crisis intervention services or temporary out-of-home care, might reduce the disruption rate further and ensure benefits of adoption to even more children and families (Barth et al., 1988). After all, these services are available to non-adoptive families without questioning the quality of the family life or experiences.

Social workers working with adoptive families may also need to understand the dynamics involved in an adoptee's need to search for their biological roots. When an adopted child is intent on finding information concerning biological roots, social workers may be able to assist the searcher in examining the motives, expectations of a reunion, and the impact of this new relationship (Sachdev, 1989). What stands out when data on open communication and family origins is reviewed is the positive benefits most adopted children and adoptive families gain through successful searching for biological roots. Few regretted the experience, and many were enriched by the new meaningful relationships with their genealogical forebearers.
Significantly, most reported a deeper sense of love and appreciation for their adoptive parents, whom they viewed as their true psychological parents (Sorosky et al., 1984).

Social workers may also want to suggest adoptive families become involved in self-help, support groups with individuals experiencing the same type of difficulties and stresses. Support groups established specifically for adoptive families may be a better choice than a group whose members have family dysfunction in common. The relationship between self-help groups and the helping professional has not always been a comfortable fit. Social workers, family practitioners, and family therapists are generally in sympathy with the purpose of such groups but find difficulty in the lack of clear-cut roles for the professionals to play in the group (Balgopal, Ephross, & Vassil, 1986). For the benefit of the clients, we must be able to overcome any differences with the structure of such groups and focus on the assistance it affords the adoptive family.

As family centered social workers become more experienced in work with families in post-adoption services, many other useful and productive methods
of assessment and intervention developed by family therapists will be adopted and adapted for work with these families. The developing of guidelines and suggestions for adoptive parents to follow certainly will not solve all the problems they will face (Brodzinsky, 1984). We can, however, be prepared for family difficulties within adoptive families and develop useful strategies to aid families in crisis.

Adoptions are complex and their outcomes are determined by many factors. They are not, however, doomed to disruption, dysfunction, and failure. As long as there are children needing families and families wanting to adopt children, adoption will continue. Just like any other family, some will be successful and some will not.
References


Appendix A
Dear Respondents:

I am conducting a survey with both adoptees and non-adoptees who have agreed to participate. My purpose is to make a comparative study of the self-contentment, self-esteem, family relations, peer relations, and attitudes toward mother and father of adoptees and non-adoptees. The information gleaned from this survey will contribute to an understanding of the dynamics surrounding families with adopted children.

I am asking that you take the time to answer the enclosed surveys and questionnaires and return them to me in the enclosed self-addressed envelope. Please feel free to withdraw your participation in this study at any time. You are under no obligation whatsoever to continue. Your participation, however, is vitally important and greatly appreciated.

You will find some questions to be quite personal in nature and you might feel uncomfortable or embarrassed about answering some of the questions. Be assured that your answers will be completely anonymous. Your name will not be revealed or associated with your responses nor will anyone outside this study have access to your responses. In the event you do not wish to complete the questionnaires or continue participation in this study, please return them to me.

Your time and care in completing this questionnaire is greatly appreciated. It should only take a few minutes of time to complete but will provide valuable input.

Thank you for your help.

Sincerely Yours,

Mary Westfall
527 Oglethorpe Ave.
Athens, GA 30606
404-546-6709
PART I GENERAL INFORMATION

I am interested in finding out some general information about you as a respondent to this survey and participant in this comparative study of adoptees and non-adoptees. Please circle the appropriate number which best answers the questions for your situation. Where there is only a blank simply fill in the answer on the blank line. All of the results will be strictly confidential. No information will be revealed or associated with responses from other questionnaires you will be asked to complete.

This GENERAL INFORMATION SURVEY is for all respondents to answer regardless of adopted or non-adopted status.

1. What is your age? ____ 2. What is your sex?  
   1. Male 2. Female

3. What is your marital status?  
   1. Single 4. Divorced
   2. Married 5. Remarried
   3. Separated

4. What is your race?  
   1. Black 5. How many children do you have? ______
   2. White
   3. Hispanic
   4. Other (Specify) ______

6. How many, if any, of your children are adopted? ______

7. What is the last year of education you completed? ______

8. How many children (your brothers and sisters) were in the family you grew up in? ______

9. What is your religious preference?  
   1. Catholic 4. Agnostic
   2. Christian 5. Other (specify) ______
   3. Protestant

10. How many times per week do you attend religious services? ______
PART II ADOPTION INFORMATION

In this section I am asking questions concerning your specific adoption situation. I understand that some of this information is very sensitive and personal. Be assured that your right to privacy will be protected. No information will be revealed to any one else nor will this information be associated with your identity.

The following questions ask about your knowledge and feelings surrounding your adoption. Please circle the appropriate number which best answers the questions for your situation. Where there are blanks simply fill in the answer.

Please answer the questions to the best of your ability. If you do not know the answer to a question please leave it unanswered and continue.

1. How old were you when you were adopted? ______

2. How old were your adoptive parents when you were placed with them?
   Mother _______  Father _______

3. How many other children were in the family you were adopted into? Please state the total number of siblings (including you) both before and after your adoption.
   1. 1 adopted sibling  4. 2 born siblings
   2. 2 adopted siblings  5. 3+ born siblings
   3. 1 born sibling      6. Other (Specify) ______

4. Would you say that you have been happy in your adoptive home?
   1. Yes  2. NO

5. How would you rate your adoption experience in terms of how happy you were?
   1. Very happy
   2. Happy most of the time
   3. Happy part of the time
   4. Unhappy most of the time
   5. Very unhappy
6. At what age were you first told that you were adopted?

7. What was the source of the first information you had concerning the fact that you were adopted?
   1. Adoptive mother  
   2. Adoptive father  
   3. Both parents  
   4. Other relative  
   5. Outside source  
   6. Found papers

8. Have you ever made a search for your biological parents?
   1. Yes  
   2. NO

9. If you have searched for your biological parents at what age did you initiate your search?

10. Were you ever told why you were given for adoption?
    1. Yes  
    2. No

11. What was your reason for researching your origins?
    1. Curiosity  
    2. Identity  
    3. Unhappy adoption  
    4. Medical information  
    5. Need to find siblings  
    6. Need to pass on information

12. What was the reaction your adoptive parents had toward your search for origins?
    1. Very supportive  
    2. Kind of supportive  
    3. Not very supportive  
    4. Against it

13. How would you say that your feelings and relationship with your adoptive family was after your search?
    1. Our relationship was better  
    2. Our relationship was about the same  
    3. Our relationship was actually worse
This questionnaire is designed to measure the degree of contentment that you feel about your life and surroundings. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1. Rarely or none of the time
2. A little of the time
3. Some of the time
4. Good part of the time
5. Most or all of the time

Please begin.

1. I feel powerless to do anything about my life
2. I feel blue
3. I am restless and can't keep still
4. I have crying spells
5. It is easy for me to relax
6. I have a hard time getting started on things that I need to do
7. I do not sleep well at night
8. When things get tough, I feel there is always someone I can turn to
9. I feel that the future looks bright for me
10. I feel downhearted
11. I feel that I am needed
12. I feel that I am appreciated by others
13. I enjoy being active and busy
14. I feel that others would be better off without me
15. I enjoy being with other people
16. I feel it is easy for me to make decisions
17. I feel downtrodden
18. I am irritable
19. I get upset easily
20. I feel that I don't deserve to have a good time
21. I have a full life
22. I feel that people really care about me
23. I have a great deal of fun
24. I feel great in the morning
25. I feel that my situation is hopeless

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This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

1. Rarely or none of the time
2. A little of the time
3. Some of the time
4. A good part of the time
5. Most or all of the time

Please begin.

1. I feel that people would not like me if they really knew me well
2. I feel that others get along much better than I do
3. I feel that I am a beautiful person
4. When I am with other people I feel they are glad I am with them
5. I feel that people really like to talk with me
6. I feel that I am a very competent person
7. I think I make a good impression on others
8. I feel that I need more self-confidence
9. When I am with strangers I am very nervous
10. I think that I am a dull person
11. I feel ugly
12. I feel that others have more fun than I do
13. I feel that I bore people
14. I think my friends find me interesting
15. I think I have a good sense of humor
16. I feel very self-conscious when I am with strangers
17. I feel that if I could be more like other people I would have it made
18. I feel that people have a good time when they are with me
19. I feel like a wallflower when I go out
20. I feel I get pushed around more than others
21. I think I am a rather nice person
22. I feel that people really like me very much
23. I feel that I am a likeable person
24. I am afraid I will appear foolish to others
25. My friends think very highly of me

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3,4,5,6,7,14,15,18,21,22,23,25
This questionnaire is designed to measure the way you feel about your family as a whole. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1. Rarely or none of the time
2. A little of the time
3. Some of the time
4. A good part of the time
5. Most or all of the time

Please begin.

1. The members of my family really care about each other
2. I think my family is terrific
3. My family gets on my nerves
4. I really enjoy my family
5. I can really depend on my family
6. I really do not care to be around my family
7. I wish I was not part of this family
8. I get along well with my family
9. Members of my family argue too much
10. There is no sense of closeness in my family
11. I feel like a stranger in my family
12. My family does not understand me
13. There is too much hatred in my family
14. Members of my family are really good to one another
15. My family is well respected by those who know us
16. There seems to be a lot of friction in my family
17. There is a lot of love in my family
18. Members of my family get along well together
19. Life in my family is generally unpleasant
20. My family is a great joy to me
21. I feel proud of my family
22. Other families seem to get along better than ours
23. My family is a real source of comfort to me
24. I feel left out of my family
25. My family is an unhappy one

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This questionnaire is designed to measure the way you feel about the people you work, play, or associate with most of the time, your peer group. It is not a test so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows:

1. Rarely or none of the time  
2. A little of the time  
3. Some of the time  
4. A good part of the time  
5. Most or all of the time

Please begin.

1. I get along very well with my peers  
2. My peers act like they don’t care about me  
3. My peers treat me badly  
4. My peers really seem to respect me  
5. I don’t feel like I am “part of the group”  
6. My peers are a bunch of snobs  
7. My peers really understand me  
8. My peers really seem to like me very much  
9. I really feel “left out” of my peer group  
10. I hate my present peer group  
11. My peers seem to like having me around  
12. I really like my present peer group  
13. I really feel like I am disliked by my peers  
14. I wish I had a different peer group  
15. My peers are very nice to me  
16. My peers seem to look up to me  
17. My peers think I am important to them  
18. My peers are a real source of pleasure to me  
19. My peers don’t seem to even notice me  
20. I wish I were not part of this peer group  
21. My peers regard my ideas and opinions very highly  
22. I feel like I am an important member of my peer group  
23. I can’t stand to be around my peer group  
24. My peers seem to look down on me  
25. My peers really do not interest me

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1,4,7,8,11,12,15,16,17,18,21,22
PART VII

CHILD'S ATTITUDE TOWARD MOTHER (CAM)    Today's Date ________

NAME: ____________________________

This questionnaire is designed to measure the degree of contentment you have in your relationship with your mother. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1. Rarely or none of the time
2. A little of the time
3. Sometime
4. A good part of the time
5. Most or all of the time

Please begin.

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My mother gets on my nerves</td>
<td>______</td>
</tr>
<tr>
<td>2. I get along well with my mother</td>
<td>______</td>
</tr>
<tr>
<td>3. I feel that I can really trust my mother</td>
<td>______</td>
</tr>
<tr>
<td>4. I dislike my mother</td>
<td>______</td>
</tr>
<tr>
<td>5. My mother's behavior embarrasses me</td>
<td>______</td>
</tr>
<tr>
<td>6. My mother is too demanding</td>
<td>______</td>
</tr>
<tr>
<td>7. I wish I had a different mother</td>
<td>______</td>
</tr>
<tr>
<td>8. I really enjoy my mother</td>
<td>______</td>
</tr>
<tr>
<td>9. My mother puts too many limits on me</td>
<td>______</td>
</tr>
<tr>
<td>10. My mother interferes with my activities</td>
<td>______</td>
</tr>
<tr>
<td>11. I resent my mother</td>
<td>______</td>
</tr>
<tr>
<td>12. I think my mother is terrific</td>
<td>______</td>
</tr>
<tr>
<td>13. I hate my mother</td>
<td>______</td>
</tr>
<tr>
<td>14. My mother is very patient with me</td>
<td>______</td>
</tr>
<tr>
<td>15. I really like my mother</td>
<td>______</td>
</tr>
<tr>
<td>16. I like being with my mother</td>
<td>______</td>
</tr>
<tr>
<td>17. I feel like I do not love my mother</td>
<td>______</td>
</tr>
<tr>
<td>18. My mother is very irritating</td>
<td>______</td>
</tr>
<tr>
<td>19. I feel very angry toward my mother</td>
<td>______</td>
</tr>
<tr>
<td>20. I feel violent toward my mother</td>
<td>______</td>
</tr>
<tr>
<td>21. I feel proud of my mother</td>
<td>______</td>
</tr>
<tr>
<td>22. I wish my mother was more like others I know</td>
<td>______</td>
</tr>
<tr>
<td>23. My mother does not understand me</td>
<td>______</td>
</tr>
<tr>
<td>24. I can really depend on my mother</td>
<td>______</td>
</tr>
<tr>
<td>25. I feel ashamed of my mother</td>
<td>______</td>
</tr>
</tbody>
</table>

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2,3,6,12,14,15,16,21,24
**PART VIII**

**CHILD’S ATTITUDE TOWARD FATHER (CAF)**

**NAME:** ___________________  **Today’s Date** ___________________

This questionnaire is designed to measure the degree of contentment you have in your relationship with your father. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1. Rarely or none of the time
2. A little of the time
3. Sometime
4. A good part of the time
5. Most or all of the time

Please begin.

1. My father gets on my nerves
2. I get along well with my father
3. I feel that I can really trust my father
4. I dislike my father
5. My father’s behavior embarrasses me
6. My father is too demanding
7. I wish I had a different father
8. I really enjoy my father
9. My father puts too many limits on me
10. My father interferes with my activities
11. I resent my father
12. I think my father is terrific
13. I hate my father
14. My father is very patient with me
15. I really like my father
16. I like being with my father
17. I feel like I do not love my father
18. My father is very irritating
19. I feel very angry toward my father
20. I feel violent toward my father
21. I feel proud of my father
22. I wish my father was more like others I know
23. My father does not understand me
24. I can really depend on my father
25. I feel ashamed of my father

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2,3,8,12,14,15,16,21,24
Dear Respondents:

If you are interested in knowing the results of the survey and further information about the comparison made between adoptees and non-adoptees, please mail this letter separate from the survey and questionnaires. This will guarantee your anonymity.

Yes - I want to know the results of the survey and more about the study you are conducting.

NAME: ____________________________

ADDRESS: _________________________