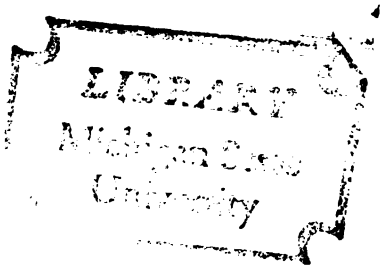
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A STUDY OF ADOPTED CHILDREN WHO HAVE BEEN KNOWN TO THE LANSING CHILD GUIDANCE CLINIC

by

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A PROJECT REPORT

Submitted to the School of Social Work
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The writer wishes to express grateful appreciation to all those who offered assistance so unselfishly and in so many ways in order to make the completion of this project possible. Particular thanks are due the staff of the Lansing Child Guidance Clinic, the faculty of the School of Social Work, Michigan State University, and the writer's fellow students.

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CHAPTER I

INTRODUCTION AND DISCUSSION OF RELATED LITERATURE

During the writer's brief experience at the Lansing Child Guidance Clinic, it seemed that a high number of adopted children was being seen. A check of the clinic records indicated that approximately ten per cent of the children seen for diagnostic study had been adopted. It was further determined that when a problem arises, adoptive families tend to return to the agency which made the placement. In the case of private agencies these families are seldom referred to the clinic. It was estimated that less than three per cent of the children in Michigan are adopted.[1] In view of this, it appeared that a high number of problems was developing in this group.

The hypothesis of this study is that adoption creates special problems of adjustment for a child in addition to those which children normally encounter. The study is an attempt to determine what sort of problems are being encountered and whether they are related to the adoption.

The Setting

The Lansing Child Guidance Clinic offers diagnostic and treatment facilities on an out-patient basis for children

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[1] This estimate was made by dividing the Michigan birth rate for 1955 and 1956 into the number of revised birth certificates issued by the Department of Health during those years.

with emotional problems. In addition the staff has accepted responsibility for prevention of mental illness through educating the public in sound mental health practices and early recognition of psychological problems. The clinic is open to any child from birth to sixteen years of age or until graduation from high school. Four counties, Clinton, Eaton, Ingham, and Livingston, are served with approximately two-thirds of the clients coming from Ingham County. No fees are charged. The clinic is financed jointly by the Michigan Department of Mental Health, Community Chest, County Boards of Supervisors, and Boards of Education.

In most cases, the referral to the clinic is made by the child's parents. A team approach is used. A psychiatric social worker is responsible for talking with the parents to learn more about the child's problem and to gather information about his relationships and his general emotional and physical development. The child is seen by both a psychiatrist and a psychologist for testing and evaluation. Following this, a staff conference is held for the purpose of reaching a tentative diagnosis and making plans for helping the child. This conference includes not only the clinic staff but also representatives of other agencies who have known the child. Following the staff conference, the parents and, whenever feasible, the child are invited back to discuss the

findings and recommendations. When a child is accepted for treatment, his parents are usually seen at the same time.[2]

The Child

Prior to the collection of data, reading was done concerning adoptions and informal discussions were held with workers in the fields of child placement and child guidance. From the reading and discussions were formulated the following broad concepts concerning the adoptive child and his parents.

Very little has been written about the problems which an adopted child must face. Although many writers have recognized that the child who is placed in a boarding home is called on to deal with feelings related to the separation from his parents and the necessity for forming a relationship with a new family, this knowledge has not been generalized to include the adopted child who may be faced with the same adjustments. Once the child is placed in his adoptive home his feelings and reactions are often considered to be the same as those of a natural child. The traumatic separation is ignored and, unless the child displays behavior unacceptable to

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[2]. For a discussion of the historical development of the Lansing Child Guidance Clinic see: Jean E. Wright, "A Study of School Referrals to a Child Guidance Clinic for the Year 1954," Unpublished Master's Research Project Report, School of Social Work, Michigan State University, 1956.

both the parents and the worker, little effort is made to help the child in expressing his feelings about the situation. Even when the child can act out some of his problems, he is said to be testing his new home and will grow out of it. He still has received no help in handling his previous unpleasant experiences.

Littner[3] lists four psychological tasks which the foster child must face: (1) mastering the feelings aroused by the actual separation from his own parents; (2) mastering the feelings initially stirred up by being placed with new parent-figures; (3) dealing with any kind of subsequent separation from the new parents; (4) mastering the threat of closeness to them. There are few people who would question these "tasks" in relation to the older child, but what of the infant? Most authorities agree that in order to grow and mature in a healthy way, an infant needs mothering on a one-to-one basis from a single mother figure. If this is true, separation from that mother figure, whether natural mother or boarding mother, would have some effect on the child. Because the infant does not recognize them on a conscious level, he and those around him may never be aware of the existing conflicts. Nevertheless, it is probable that these

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3. Ner Littner, "Traumatic Effects of Separation and Placement," Casework Papers (New York: Family Service Association of America, 1956), 121-140.

conflicts do exist in the child's unconscious where they can be activated if his security is threatened at a later time.

Separation from one's parents carries with it a strong sense of rejection and often a feeling of guilt. Rejection is difficult to face, and it may be easier to handle if the rejected person can feel that he had some control over it. Frequently this is done by assuming responsibility for one's own rejection. "I was bad, so I was sent away." The child may develop a need to be punished in order to expiate the guilt. He may feel that the separation resulted from some feeling or action on his part, for example, he was angry with his father and was sent away. When this occurs, he will expect rejection if these actions or feelings recur, and so may try to repress and control them. Unless the child's fears and fantasies concerning the separation are handled, there is a risk of developing a personality pattern which will be harmful to him and to others.

It may seem that these feelings are peculiar to the older child who is adopted. At some time in his life nearly every adopted child learns of his adoption. When this happens, questions about his natural parents arise. He wonders why his parents gave him up. Feelings of rejection and unworthiness may appear and the same behavior pattern found in the older child is instituted.

At the same time that the child must deal with his feelings which result from separation, he is expected to

relate to and become a part of a new family. This can be extremely threatening to the child. He has just been "thrown out" by those closest to him. He may avoid further close relationships, expecting the same treatment. He is also threatened by closeness to these new parents because of difficulty in seeing them in relation to his former parents. He may fear retaliation from his parents if he becomes too close to these new parents, with the implication of disloyalty to the old. In this new situation the child does not know what he can do, or what is expected of him. He fears rejection on the one hand and acceptance on the other. If he has been in several homes before coming to the adoptive home, these feelings are intensified. All of these fears and reactions can lead to pathology in the development of personality. At the time of the placement, it may seem that the child has made a good adjustment to his home, but unless he has really worked through his feelings they will remain in the background to be reactivated at some stressful time in the future.

As the young child grows older, he probably will learn of his adoption. Unless the parents have been able to work through their own feelings about adoption, they may not be able to help the child live with this knowledge. In a study done at Smith College,[4] it was found that of the thirty

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[4]. Barbara Raleigh, "Is Adoption a Factor in Child Guidance Treatment?," Smith College Studies in Social Work, XXV:1 (1952), 53-71.

adopted boys studied, about one-half had not been told that they were adopted, and in the remaining cases the parents had handled the problem inadequately. A child may learn of his adoption in a number of ways. If he is not told by his parents, he will probably hear about it from friends or relatives. He can be accustomed to the idea gradually or have it thrown at him in a moment of parental anger. No matter how the problem is handled, agonizing moments will probably follow.

The word "adoption" carries a certain sense of impermanence and "not belonging." To the child who is somewhat insecure, the knowledge that he is adopted may serve to increase his feelings of temporariness and the fear that he may be uprooted and moved. He needs continued reassurance of his own worthiness and of the love which both his adoptive parents and his natural parents have for him. The thought that his natural parents did not love him and did not want him can be devastating to the child's self-concept, for if he was not worthy of their love how can he ever expect to be loved by anyone?

Before leaving this discussion of the adopted child, one more matter must be mentioned. Almost every child at some time of stress dreams that these people with whom he is living are not his real parents. He usually imagines his "real parents" as famous personages from whom he has been kidnapped. Generally the child can give up this fantasy when the stress has passed, but the adopted child knows these are not his real parents. He tends to project unrealistic, superior or inferior

qualities onto his natural parents, to the detriment of his adoptive parents. From a mental health standpoint, this fantasy can be damaging when continued over a period of time.

Adoptive Parents

Most writers[5] agree that the basic factor which differentiates adoptive parents from natural parents is the reason for the adoption. In most cases this is sterility. The knowledge that he cannot produce offspring is a blow to the self-concept of most people. The bearing of children is a traditional role of women, while procreation has long been considered a sign of masculinity. The manner in which this problem has been handled will affect the adjustment of any child placed in the home. If the parent has been unable to resolve the conflict of his infertility, the child may be perceived as a constant reminder of parental inadequacy. Where the parent's self-concept has been badly damaged, it may be extremely difficult or undesirable for the child to identify with him.

Often no organic basis can be found for infertility. Not a great deal is known about the psychological factors which are present in these situations. Helene Deutsch[6] feels

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5. Among these are Ruth Michaels, "Special Problems in Casework with Adoptive Parents," Social Casework, XXXIII:1 (1952), 18-24; and Helene Deutsch, Psychology of Women (New York: Grune and Stratton, 1945), II, 393-433.

6. Deutsch, op. cit., pp. 394-400.

that they may result from such factors as fear of childbirth, inability to assume the parental role, or fear that the partner cannot accept this role. Because the psychologic reactions of the parents are so important to the adjustment of the child, great care must be used in assessing the real reason for adoption.

In order for the parent-child relationship to be mutually satisfying, the parents must have a narcissistic identification with the child. For natural parents, this identification is more or less "built in" since the child is literally a part of them. The ease with which adoptive parents can identify with the child is dependent on a number of factors including, primarily, their acceptance of adoption as an institution and of their own reason for adoption. Those who are able to identify positively with the natural parents of the child will be better able to identify positively with the child himself. Where no narcissistic identification takes place, there is a tendency to blame all the child's shortcomings on heredity and often to anticipate problem behavior which is expected to arise. This is damaging to both parents and child in view of Kohlsaat's statement that as far as general character structure goes, children tend to become what parents consciously and unconsciously fantasy they will become.[7]

With the ratio of prospective adoptive parents to available children about ten to one, it is obvious that

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7. Barbara Kohlsaat, "Some Suggestions for Practice in Infant Adoptions," Social Casework, XXXV:3 (1954), 91-97.

everyone who wishes to adopt a child cannot do so. Since adoption has become such a widely accepted institution, agencies are able to be highly selective in their choice of adoptive parents. Many agencies have somewhat arbitrary standards concerning such factors as age, race, and religion. In addition, increasing emphasis is being placed on less tangible factors affecting the psychological makeup of the prospective adoptive parents. Considered most important among these are:

> ...the personal adjustment of each of the prospective parents; their relationship to each other; their relationship to their own parents and siblings; their deeper as well as their expressed motives in seeking a child; their reasons for not having their own child; their attitude toward childlessness and toward infertility; their ability to accept an adopted child; and their understanding of children and their needs.[8]

Unfortunately not much research has been done to determine how these factors can best be assessed. At present the study which precedes an adoptive placement can be only as reliable as the adoption worker's judgment.

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[8] Florence Brown, "What Do We Seek in Adoptive Parents?," Social Casework, XXXII:4 (1951), 157.

CHAPTER II

METHODOLOGY

The sample selected consists of all adopted children seen at the clinic for diagnostic study during the calendar years of 1955 and 1956. For the purpose of this study, children who had been legally adopted by a step-parent, with a natural parent remaining in the home, were eliminated from the sample since it was felt that problems frequently exist which are peculiar to this group. All cases which were opened or re-opened for diagnosis during the specified time were examined in order to locate the sample. With the exception of one case, all the adoptions had been legally completed at the time the child was seen at the clinic. The final sample consisted of forty-one cases. It had been hoped that a larger number of cases covering a longer period of time could be used, but realistic limitations of time made this impossible.

A schedule was constructed which covered four main areas: (1) identifying information (age at intake, presenting problem, diagnosis, etcetera); (2) information regarding the adoption (age at placement, prior boarding home experience, etcetera); (3) descriptive information concerning the adoptive family (reason for adoption, number of siblings, etcetera); (4) family relationships and parental attitudes.[9] It

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[9]. A copy of the schedule is included in Appendix A.

was hoped that the information available in the clinic records might be supplemented by and validated against the original adoption records; however, these records were not available in the majority of cases.

In the collection of data, only material available at the time of the diagnostic study was used. This included a social history, psychological and psychiatric evaluations, staff conference notes, and in some cases supplementary information furnished by the referring agency. Where a child had been seen for re-evaluation, both diagnostic studies were used. If the child had been accepted for treatment prior to the beginning of this study, the recording of the treatment interviews was disregarded.

The data were classified and tabulated by the hand sorting method. Following the original tabulation, those factors which appeared relevant were cross-tabulated. Contingency was computed, but the sample was too small to permit significant differences in most instances. The data were analyzed in relation to existing literature and questions were posed for further study.

CHAPTER III

ANALYSIS OF DATA

A study done by Marianne Marin[10] was used for purposes of comparison. Her sample consisted of forty-seven children who represented all referrals received during the second quarter of 1955. Wherever possible, the data of the present study were tabulated in the same manner that was used previously so that a comparison might be made.

In many ways the group of adopted children[11] is comparable to the general clinic population. The adopted sample contained thirty boys and eleven girls as compared to thirty-three boys and fourteen girls in the previous study, (Table 1). The age range in both cases was identical, three to seventeen; however, the spread was more even in the adopted sample. The number of children in this group who were living with step-parents, single parents, or foster parents was much smaller, due to the fact that the adoption study tends to eliminate those couples who are physically unfit for parenthood or who are having serious marital difficulty. An attempt was made to determine the occupation and education of the adoptive parents; however, the information was so frequently lacking

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[10] M. Marianne Marin, "A Study of Community-Clinic Relationships as Reflected by Referrals to Lansing Child Guidance Clinic, April through June, 1955." Unpublished Master's Research Project Report, School of Social Work, Michigan State University, 1956.

[11] Hereafter referred to as the adopted sample.

Table 1. Characteristics of Two Groups of Children Seen at Lansing Child Guidance Clinic 1955-56.

Characteristic	Adopted Children 1955-56	All Cases Opened Apr.-June 1955
Total	41	47
Sex:		
Male	30	33
Female	11	14
Age:		
3-5	6	7
6-11	18	24
12-17	17	16
Living with:		
Both Parents	36	33
1 Parent & 1 Step-parent	4	10
1 Parent, Relative or Foster Parents	1	4
Intelligence Quotient:		
Below Average (to 89)	10	9
Average (90-109)	10	18
Above Average (110-above)	11	10
Not Tested	10	10
Ordinal position		
Oldest	11	21
Middle	5	7
Youngest	9	11
Only	16	6
Not Ascertained	0	2
Source of referral:		
Parent	6	18
School	2	12
Social Agencies	12[a]	7[b]
Physicians	9	6
Courts	6	4
Other	2[c]	0
Not Ascertained	4	0

[a]Includes visiting teacher, county health department, Michigan Children's Aid Society, and Catholic Social Service.

[b]Includes visiting teacher, Catholic Social Service, Michigan State University Psychological Clinic, and Adult Mental Health Center.

[c]Includes one minister and one friend.

or of such a general nature that it was impossible to draw any meaningful conclusions. The intelligence quotient of the adopted children was more evenly spread over the range of below average-average-above average than in the case of the general population. In considering the ordinal position of the child seen at the clinic, a much larger percentage of the adopted sample were only children. This might be expected since most adoptive parents cannot have their own children. Many agencies discourage more than one adoption in a family, and frequently parents do not request a second child. Although the categories of middle and youngest children were approximately equal in both samples, the proportion of oldest children in the adopted group was smaller than in the general population. This might be explained by the fact that the time span used in the study of the general clinic population was one during which school referrals are most numerous so a higher proportion of older children would appear. This fact would also account for the wide discrepancy in the number of school referrals in the two samples. At the same time, the adopted sample contained a slighly higher proportion of children who were said to be having school problems at the time of referral.

One question which this study attempted to answer was whether the clinic received referrals of a disproportionate number of adopted children because adoptive parents were more aware of the community resources which were available. An affirmative answer to the question is not supported by this study. A much smaller proportion of these children

was referred directly by their parents than was the case in the general population. Although a greater number were referred by social agencies, the difference is represented by five referrals from county health departments.[12] The group representing the general population had no referrals from this source.

The problems stated at the time of referral were classified into five categories: Projective behavior, introjective behavior, school failure, habit disorders, and illness without physical cause. These categories were defined to include problems such as the following:[13]

1. Projective behavior-- temper, disobedience, stealing, quarreling, sex play, fighting, lying, running away.

2. Introjective behavior--nervousness, restlessness, timidity, seclusiveness, day dreams, depression, slowness.

3. School failure--lack of interest in school, poor grades, specific disabilities, slow learner.

4. Habit disturbance--speech, enuresis, masturbation, soiling, thumbsucking.

5. Psychogenic illness (illness without physical cause)--pains, tics, allergies, stomach disorders, kidney disturbance, and nosebleeds.

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[12] Until recently, practically no referrals were received from this source, but the number is rapidly increasing.

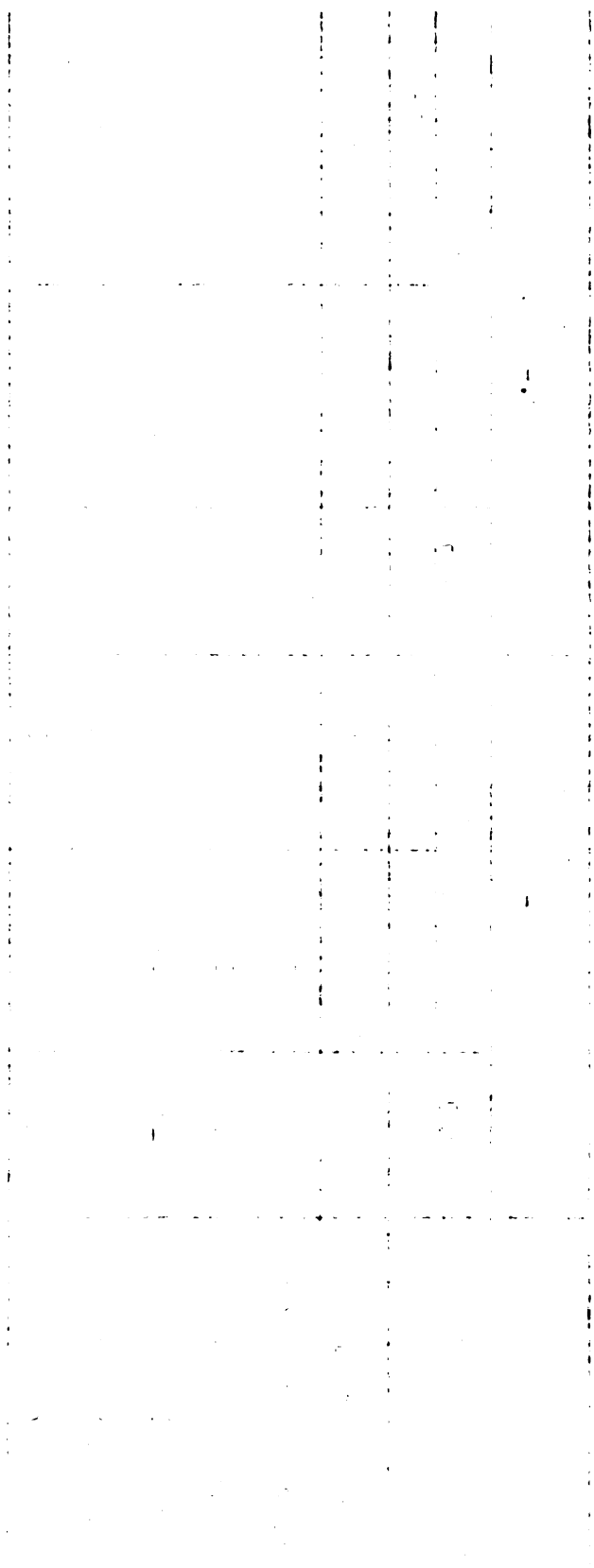
[13] Classifications found in Ruth Cartland's study, Psychiatric Social Service in a Children's Hospital (Chicago: University of Chicago Press, 1937) as quoted in Marin, op. cit.

Table 2. Presenting Problem of Two Groups of Children Seen, Lansing Child Guidance Clinic, 1955-56, by Age

Presenting Problem	Adopted Children 1955-56				All Cases Opened Apr.-June, 1955			
	Total	Age			Total	Age		
		3-5	6-11	12-17		3-5	6-11	12-17
Number of Cases	73	11	36	26	90	15	43	32
Projective Behavior	25	4	8	13	29	3	13	13
Introjective Behavior	14	2	7	5	22	3	9	10
School Failure	18	2	12	4	21	0	13	8
Habit Disturbance	10	3	6	1	9	5	4	0
Psychogenic Illness	6	0	3	3	8	4	4	1

Table 3. Presenting Problem of Two Groups of Children Seen, Lansing Child Guidance Clinic, 1955-56, by Sex

Presenting Problem	Adopted Children 1955-56			All Cases Opened Apr.-June, 1955		
	Total	Sex		Total	Sex	
		Boys	Girls		Boys	Girls
Number of Cases	73	52	21	90	66	24
Projective Behavior	25	18	7	29	25	4
Introjective Behavior	14	10	4	22	16	6
School Failure	18	12	6	21	16	5
Habit Disturbance	10	7	3	9	4	5
Psychogenic Illness	6	5	1	8	5	4



Since the majority of the children had problems falling in more than one category, the total number of problems exceeds the number of cases.

When the presenting problem is cross-tabulated with the age and sex of the children, an interesting variation between the two samples occurs. The sample in both cases is too small for any difference to be statistically significant; however, certain factors appear sufficiently divergent to warrant further study. In the categories of projective behavior and school failure, a higher proportion of girls appeared in the adopted sample than was found in the general population. Many more habit disturbances and cases of psychogenic illness were found among the adopted boys, with a decreasing incidence among the girls. The problems encountered by the girls in the general population were much more evenly spread over the five categories than in the case of the adopted girls. Fewer adopted children in the age group of six to eleven were referred because of projective behavior, while the proportion of adopted children with this type of problem was increased in the other two groups with the more marked increase coming in the twelve to seventeen age group. Among this sample, there was a decrease in habit disturbances in the three to five age group. In the general population, psychogenic illness was almost evenly divided between the three to five and six to eleven age groups, while the adopted children were evenly divided between six to eleven and twelve to seventeen. There is a

significant difference between the two groups in terms of the age at which psychogenic illness is noted, while the difference in the age at which habit disturbances appear is almost significant. If these problems are related to emotional development, it appears that the adopted child is emotionally retarded. That is, problems normally found in the Oedipal stage appear during the latency period for the adopted child, problems of latency appear during adolescence. Fewer problems per child were recorded for the adopted children. The adopted children showed less introjective behavior than the general population.

Only nine of the records examined had any information about whether the child knew of his adoption. In three cases the child learned of his adoption from someone outside the home; in three cases the parents told the child themselves but admitted to being extremely uncomfortable in discussing the subject and had refused to answer the child's further questions; one family told the child that he was adopted in an attempt to shame him into changing his behavior; in the remaining two cases, there was nothing to indicate how or when the child learned of his adoption. In thirty-two of the forty-one cases studied, there is no indication of whether the child knew he was adopted. None of the records contained any information about how the child had reacted to the knowledge of his adoption.

Five of the forty-one records mentioned surgery or sterility as the reason for adoption. The other thirty-six

had no information on the subject. None of the records gave any indication of how the family had reacted to the problem.

This is probably not a true estimate of the frequency with which these two factors are discussed with the client. Much of the intake interview is not recorded; however, in view of the influence these factors have on the adjustment of the adopted child, it seems important that they be discussed in each intake interview and included in the recording.

The adoptions were evenly divided between court placements, independent placements, and agency placements. Half the children were in their adoptive homes before they were one year of age. Hospitalization was recommended at the staff conference for twelve, or 29.3 per cent, of the forty-one children studied. A similar recommendation was made for approximately 15.1 per cent of the general population during 1955.[14] Eight of the twelve hospitalized children were placed in their adoptive homes after they were one year old. Eleven of the twelve were referred for projective behavior.

In nineteen cases, the parents were felt to be openly rejecting. This was a dichotomous classification of rejecting-non-rejecting. Rejection was based on statements such as "He's never been a member of the family," "We can give him up if it's best" (unsolicited), or an attempt by the parents

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[14]Figures were not available for 1956.

to have the adoption terminated. The children of eleven of these rejecting parents were recommended for hospitalization. The parents of children placed under one year of age were less openly rejecting than those placed over one year.

Natural parents were mentioned in nineteen of the records. In each instance, the facts recorded were negative. It would appear that the adoptive parents knew none of the positive aspects of the natural parents' characters. In the majority of cases, these factors were mentioned either as a trait which the adoptive parent had to guard against or as something which the child had inherited.

CHAPTER IV

IMPLICATIONS AND RECOMMENDATIONS

The adopted children showed less introjective behavior than the general population (Table 2). A greater proportion of the problems of projective behavior and school failure was attributed to the adopted girls than was the case in the general population. Adopted boys, on the other hand, were responsible for a greater proportion of habit disturbances and cases of psychogenic illness. There was also a variation in the frequency with which the problems were seen in the three age groups in the adopted population as compared to the general population (Table 3). While the size of the sample is inadequate, it appears that adopted children express their problems in a different way than do children in the general population. If this is true, it may support the hypothesis that these children are experiencing different problems than those seen in other children. It may also be evidence of the existence of a different emotional developmental pattern to be found in adopted children. In order to test this possibility, a study is needed which would utilize a much larger group of both adopted children and children from the general clinic population. A similar group of non-clinic children should also be used.

Adoptive parents did not appear to be better acquainted with agency resources. Fewer referrals were

received directly from parents, with an increase in the number received from sources such as physicians and courts. The proportion of school referrals was drastically decreased, due to the fact that the study of the general population covered a time span during which school referrals were unusually high. Although there does not appear to be any greater knowledge of resources among the adoptive parents, it seems to the writer that there may be less resistance to using these resources once they are pointed out. These parents have already gone through the process of asking for help once with a successful outcome. It appears also that adoptive parents can more easily avoid the responsibility of the difficulty by blaming the problem on heredity, which could conceivably create additional problems for the child and make therapy with the parents more difficult.

Two factors which are considered important to the adjustment of the adopted child were covered inadequately in the clinic records. These are the child's knowledge of his adoption and how he reacted to that knowledge and the parents' reasons for adopting a child and how these had affected their own adjustment. In addition, information about the child's experiences prior to adoption was not included in the records except for such information as the adoptive parents might have. The records were not intended as research records. It is probable that the worker had the information, in many cases, but did not record it. In view of their effect on the child, it would seem imperative that these factors be covered in the record of every adopted child seen.

A high proportion of adopted children was recommended for hospitalization. In all but one of these cases, the parents were felt to be extremely rejecting. It is the writer's impression that hospitalization is being used as a method of removing children from their home in a manner which will be more acceptable to the parents than a plan such as boarding care. Research is needed to determine for what purpose hospitalization is being used, in the general population as well as among adopted children, and whether this purpose is being met.

Among those children who were placed in their adoptive homes after they were a year of age, there were twice as many who were later hospitalized as were found among those placed before they were a year of age. This appears to be an indication that the older child is bringing certain problems of adjustment to the adoptive placement, and that these problems are not being handled. It is therefore recommended that the staff of the Child Guidance Clinic be increased so that all children over a year of age might be evaluated prior to placement and given treatment if and when it appears necessary.

This study has raised more questions than it has answered. There is evidence which indicates that adopted children are maturing emotionally at a slower rate than are children in the general population. There is a high proportion of adopted children being hospitalized which may or may not be an indication of the severity of their problems. These findings would tend to support the hypothesis of this

study that adoption creates special problems of adjustment for a child in addition to those which children normally encounter. Little is known about the adopted child once the legal procedure is complete. More research in the area is needed.

APPENDIX A

SCHEDULE

Name: Sex: Case No:

Race: Adoption Agency:

Age at Intake: I.Q: Referred by:

Presenting Problem:

Diagnosis:

Recommendations:

Age at Release: Reason for Release:

Boarding home experience:

Adoption arranged by: Age at placement:

Length of Supervision: Relationship of adoptive parents to child:

Education of Adoptive mother:

Education of Adoptive father:

Occupation of Adoptive father: Reason for adoption:

No. of other Adopted children: No. of siblings in adoptive home:

Pertinent birth and developmental history:

Pertinent family history:

Attitude of family toward child and other family members:

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