THE SOCIAL WORKER IN ADOPTION PRACTICE

An Exploratory Study of 28 Adopted Children Who Were
Referred Privately to the Vancouver Child Guidance Clinic, 1953-55.

by

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ABSTRACT

Ideally, the adopted child should be placed with parents and in a home that offers a reasonable guarantee for health and happiness. If this goal is not achieved, or is threatened, it is important to determine what factors in the placement procedure have been influential, or overlooked. With this theme in mind, this thesis makes an exploratory study of the cases of twenty-eight adopted children who attended the Vancouver Child Guidance Clinic in a period of two years (1953-1955).

The social work foundations and principles of adoption practice are discussed in a preliminary chapter. Following this, the Child Guidance Clinic case records of twenty-eight adopted children are analysed, and the pertinent statistical material found therein is tabulated. Less tangible factors such as parental attitudes and feelings about the adopted child are dealt with descriptively. Case studies attempt an over-all picture of the adopted child's life experiences.

The findings reveal (a) that in many of the cases studied, one parent had not been in favour of the spouse's plan to adopt a child, or that one or both of the parents were disappointed in the child they received; (b) that many of the parents in the study group seemed to be over-demanding of the child; (c) that each adopted child presented a combination of behavioural problems to the Clinic.

The study underlines, for social workers responsible for placing adoptable children (1) the need for thorough investigation of the home and the prospective parents' attitudes about children as well as adults generally; (2) the responsibilities for helping prospective adoptive parents with their uncertainties about the whole adoption process; and (3) the need for supervision of the adoptive home during the adoption probation period.
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The widespread interest evident in the adoption placement of children is one of the most positive and interesting developments in the entire field of child welfare. The basis for this is: 1) that generally people have a natural urge and interest in producing and caring for children, and 2) the changing attitudes on the part of many members of society toward the adopted child and the adoptive parents.

Scientific knowledge has been largely responsible for this change in attitude. Since scientists have learned more about childhood development and the influence of hereditary factors on the child, many of the fears of 'risking' the adoption of a dependent child have been negated. However, there are still many people who continue to find adoption, the process of taking the child of one family into another family group, most distasteful. The chief reasons for this are: 1) the implications of adoption, the most prominent of which are illegitimacy (which even the law abhors); 2) the inability of one to have his own children, and 3) the still-prevalent superstitions and beliefs about "bad family blood" and the inheritableness of certain unpleasant family traits and characteristics.

Although it has been demonstrated to professional and lay persons that the "good" characteristics as well as "bad" are inherited by a child, the development of the child depends largely on his early life experiences. Since the family offers these life experiences we must take steps to ensure that the families with which the children are placed are those which will encourage the child, and through love and understanding facilitate his growth into a normal, healthy, happy, human being.

Social Workers have always dealt with child and family relationships, and they, along with the members of other human relations professions, have taken the lead in recognizing the family group as the basis unit of our society. They are also very much aware of the influence of family relationships on the physical and emotional development of the child.  

The family, to quote the definition of Burgess and Locke, is

"a group of persons united by the ties of marriage, blood or adoption, constituting a single household; interacting and communicating with each other in their respective role of husband and wife, mother and father, son and daughter, brother and sister and creating and maintaining a common culture."  

The attitudes of parents have a potent effect on the development of the child's way of thinking, feeling, and acting.  


3.

Much has been written about the importance of the mother's role in the physical and emotional development of the child --- her role in the gratification of the child's need for love and affection, and of good physical care during the first year of life; of patience and guidance and continued loving care, especially throughout the first five years of development; and so on through the other developmental stages.

Dr. Spurgeon O. English discusses our current tendency to forget the importance of the father's role in the development of the child and he lists the variants of the father's role as follows:

1. Companion and inspiration for the mother.
2. Awakener of the emotional potentialities of the child.
3. Beloved friend and teacher of the child.
4. Ego ideal for masculine love, ethics and morality.
5. Model for social and vocational behavior.
7. Protector, mentor, and hero of the grade school child.
8. Counselor and friend for the adolescent.

An harmonious family group consisting of mother, father and siblings can offer a child security as well as satisfaction of many of his other basic human needs. For a child, these needs consist of good, consistent, physical care which makes for a feeling of health and well-being, an opportunity to acquire knowledge and to use it, the experience of satisfactory relationships with other people, and particularly, a need to feel loved and wanted.


Dr. W.S. Langford and Miss K.M. Wickman have stated clearly how "healthy" parent-child relationships prepare the child, within the family, to adjust to situations with which he will be faced outside his family group. They have said:

"Healthy patterns of parent-child relationships permit the child to grow and develop according to his own innate pattern; which provide a setting in which the child can move from one stage to another with a minimum of disturbance to himself and to others; which establishes conditions that permit the child to accept limitations imposed by training; which provide for the child satisfaction in reacting in ways that are appropriate to his age and stage of development in which he finds himself, and which give the child the necessary warmth, security and support to go ahead in life. All of this implies a capacity on the part of the parent to deal with the child without undue anxiety or preoccupation in all aspects of day-to-day living, feeding, toilet training, sex education, health and illness, obedience, school progress..."

and a capacity eventually to perform effectively in the role of parent and to gain satisfaction from it.¹

Historical Background of Adoption Placement.

The practice of adoption placement is not recent. From the early beginnings of our civilization, there is evidence that plans have been made for the care of the dependent child. It was usually a relative who assumed the responsibility for the child who was left by his parents in many of the primitive cultures. The Plains Indians of North America allowed strangers to adopt children who appealed to them while it was the custom on some of the Islands of the Eastern Torres Straits and Melanesia to arrange

for the adoption of children before they were born. In Polynesia, childless Tahitians adopted children, and those blessed with progeny took over additional children and gave some of their own away. Adoption was also common among the early Jews, Greeks and Babylonians.

The procedures followed in adopting a child were varied. In Scriptures, the act of becoming a god-father, through Baptism, was comparable to adopting a child, while the early Nomadic tribes merely offered the hair from the head of the adopted child to the adopting parents as a token of ownership or control over the child. In England, on the other hand, parliament itself authorized the adoption of a child into the family when the purpose of his adoption was to carry on the family line. In that connection, adoption by testament, which is still in use, is a practice whereby the testator appoints a certain person as heir to his will, providing the latter assumes the name and arms of his benefactor.

On this side of the Atlantic, it was common in some American states, for a child to be adopted by deed, certified and filed as a transfer of property. This practice, a hang-over from the days of slavery, has been repealed only recently in Pennsylvania and Iowa.


Today, in the United States, Canada, Great Britain and most European countries legal provision for adoption is practically universal. However, the United States was the first country to introduce adoption home placement as we regard it, with the Massachusetts State Government passing the first Statute concerning adoption in 1851. Other States followed the precedent set by Massachusetts and they used that state's Act as a model which they modified to suit the local areas.

The British North America Act of 1867 provided that adoptions come under the jurisdiction of the Canadian Provincial Governments. The first Canadian Province to pass an adoption act was Nova Scotia in the year 1896. British Columbia's adoption act came into being in 1920. Recent amendments to the British Columbia Act were made in 1935, 1937 and 1946. The Adoption Act as amended in March, 1953 bestows the same status on the adopted child toward his adopting parent as their kin, i.e., as if he had been born in the family.

English Common Law did not provide for adoption. The first steps taken toward legalizing adoption there were seen in 1920. At that time the Home Office appointed a Committee under the chairmanship of Sir Alfred Hopkinson to consider whether it would be desirable to make legal provision for the adoption of children in England, and, if so, to make a decision as to what form the provision should take.

The findings of the Committee were not made known to the public.
and in 1921 a second Home Office Committee under the chairmanship of a judge of the Chancery Division of the High Court was organized. On the Committee were the Parliamentary Secretary to the Board of Education and other "experts". This Committee was to examine the problem of child adoption from the point of view of possible legislation and to report on the main provisions which, in their view, should be included in any Bill on the subject. This report recommended that an adoption act be introduced to the Government and, as a result of this action, England passed its first Adoption Act in 1926.

In 1936, a Departmental Committee on Adoption Societies and Agencies was set up in England to study the "evils associated with unlicensed, unregulated, and unsupervised adoption", and into the "method pursued by adoption societies". Some of the "evils" found were: 1) lack of sufficient social investigation, 2) omission of medical examination, and 3) lack of uniformity in probation policy. Some of the adoption agencies were actually selling babies, some were receiving fees from people with whom they had contact --- the mothers and putative fathers.

The recommendations of the Committee included compulsory medical and social examination of the children who were to be placed for adoption and also of the adoptive parents with whom they were to be placed; a three month probation period for the adopting parents prior to the completion of the adoption; and a prohibition of advertisements offering or seeking children for adoption.
In March, 1945, the Secretary of State for the Home Department, the Minister of Health and the Minister of Education, appointed Miss Myra Curtis to be chairman of a Committee

"... to inquire into existing methods of providing for children who, from loss of parents or from any cause whatever are deprived of a normal home life with their own parents or relatives; and to consider what further measures should be taken to insure that these children are brought up under conditions best calculated to compensate them for their lack of parental care."\(^1\)

This Committee, which became known as the "Curtis Committee" presented its findings to the British Parliament in September of 1946. The recommendations of this Committee paved the way for the passage in 1948 of England's comprehensive Children's Act.


There was some provision for the dependent child under the Feudal system in England for "if the parents died there was a certain claim for the support of the dependent child from the product of the land his father had held."\(^2\) If the child chose to leave the manor no one outside the manor was obliged to support him. During the passing of the Feudal order and up to 1536, the church, hospitals and other religiously inspired philanthropies represented the positive approach to human distress. The monasteries, before:

\(^1\) Report of the Care of Children Committee, cmd. # 6760, H.M.S.O. London, September, 1946.

their expropriation by Henry VIII (1536-39), were able to offer considerable assistance to many people suffering from some types of deprivation. They could offer care for the child left homeless; they could offer food, clothing and shelter.

At the time of the Protestant Reformation, the problem of relief for the poor and homeless became a matter of Government concern. Many acts were passed during the years which followed but the most important one concerning the welfare of children was the Elizabethan Statute of 1601, which provided that each community be allowed to tax itself for the care of destitute children. Under this act, the older children were given work or were apprenticed and the young children were farmed out or put in the poor house.

The system of indenture in England and America was a step toward adoption although many terrible things were reported to have happened to the children who were sent to people in the community to be apprenticed for trade. The "binding out" did, however, tie the child to the family and this often led to virtual adoption if not legal adoption. The religious and philanthropic groups which organized orphan asylums in Britain and America did much in working toward the removal of children from the mixed population of the almshouse. Gradually the large institutions gave way to smaller ones and in the 19th century, greater advances were seen in the scientific treatment of children. The Barnardo Homes of London (1866)
started the selected placement of children in England. The majority of children were placed in foster homes although the Barnardo Homes combined institutional and foster home care. Later, some of the children were sent to Canada and other colonies and many of these children were adopted.

About the same time as the establishment of the Barnardo Homes in England, Charles Loring Brace founded the Children's Aid Society in New York (1853). Illinois, followed by thirty or more similar State Societies, started the first state Children's homes; these were instrumental in the development of systematized child placing. The State Agencies were eventually affiliated under the name of the National Children's Home Society and later became the Children's Home and Welfare Association. In America, The Charity Organization Society,¹ emphasized the case work method. To carry out their treatment plan the organization requested the people of the Community to open their homes to children of any age. They also asked for free temporary homes, working homes and wage homes for older children, working and wage homes for mothers with a small child, and emergency temporary homes.² From such small beginnings grew a national pattern of child welfare work with adoption becoming a widespread practice.

¹ The Charity Organization Society had its beginnings in Buffalo in 1877 and in Boston in 1879.

The Children's Bureau and the Child Welfare League of America have been leaders in work toward bettering adoption procedures and creating public interest in adoption in the United States. The establishment of the United States Children's Bureau was the outcome of the White House Conference on Dependent Children called by President Theodore Roosevelt in 1909. In 1919, the Children's Bureau summoned a second White House Conference and during this committees were set up to formulate minimum standards for the protection of children in need of special care. A third conference, held in 1930, emphasized the importance of keeping families together and there was a reiteration of the need for scientific placement of children in foster homes, especially when adoption was the likely outcome. During the fourth conference, like the third, major attention was given to certain social and economic aspects of the well-being of all children.

The people who attended the fifth conference in 1950, the "Midcentury White House Conference on Children and Youth", dealt with less tangible, but perhaps more important aspects of child welfare. The statement concerning the purpose of holding the conference which was presented to the fact finding committee by the National Conference Committee was as follows:

"The Midcentury White House Conference on Children and Youth bases its concern for children on the primacy of spiritual values, democratic practice and the dignity and worth of every individual. Accordingly, the purpose of the Conference shall be to consider
how we can develop in children the mental, emotional, and spiritual qualities essential to individual happiness and to responsible citizenship, and what physical, economic and social conditions are deemed necessary to this development."

The conclusions reached by those people who attended the conference further emphasized the importance of satisfactory parent-child relationships in promoting healthy personality development in a child.

Because of the influence of parental attitudes and "feelings" on the emotional development of a child, as well as the more material influences found in the home, we must examine the adoption process from the point of view of the adoptive parent, the natural parent and the child.

Lee M. Brooks states that the good adoptive parents should be:

"The good citizen and the good neighbour, the self-supporting and the forward-looking, who can understand and love a child; those who are willing to prune away what might be considered less important interests, those who have not become dry and stiff in spirit but in whose trunk and branches there are the vitals of growth into which young life can be grafted with prospects of enrichment and fruitfulness."  

It is likely that most people who wish to adopt a child feel that they can offer to a child the type of home he requires. The real basis for the parents' need for a child may be unknown to themselves. It is, therefore, the duty of the Social Worker to analyse and evaluate the adopting parents'

2. Brooks, op. cit., p. 36.
request for a child, and to use his knowledge and experience in assessing
the home situation into which the child is to be placed.

Much can be learned about the prospective parents' attitude toward
adoption during the pre-placement and adoption probation contact between
the parents and the Social Worker. The adopting parents normally suffer
some anxiety about coming to the Agency, about the acceptance of their
application, etc. In order to determine the probable attitude of the parent
toward the child, the social worker should be concerned with the parents'
attitude regarding their own children, their attitude toward the worker,
their feeling about sterility (if that is the problem). The Social Worker
should also observe the parents' interest in receiving the child, the parents'
co-operation in obtaining medical certificates from their doctors, and so on.

Lee M. Brooks assisted by Miss Jacqueline Johnson in 1933 did an
interesting study entitled "Forty Foster Homes Look at Adoption". The
study was done at the University of North Carolina and the adoptive parents
contacted lived in the South, South-west and North of the State. Some of
the findings revealed that adoptive parents believe they are capable of hav­
ing as much as, or more, feeling of affection for the adoptive child than
natural parents. Thirty-five of the forty couples contacted stated they had

1. Rathburn, Constance, "The Adoptive Foster Parent", Child
become so accustomed to thinking of their foster children as their own children, that they had practically forgotten the earlier circumstances. With respect to the question of whether or not a child should be told that he is adopted, thirty-six of the forty adoptive parents indicated that an adopted child should be told of his status before he is ten years old. Thirty-seven of the group studied claimed that knowledge of illegitimacy in a child's background had no bearing upon their decision to adopt. "All 40 agreed that in the process of adoption the risk is serious for the child, that he may be misplaced where emotionally unstable adults can inflict irreparable damages upon mental and physical foundations that hereditarily were secure." 

The attitude of the child toward his adoption depends upon the following factors:

1. His age at the time of placement.
2. His experience prior to placement, if he was not placed at birth.
3. His parental relationships: their attitude toward each other, toward him firstly, as a child, and secondly, as an adopted child, and toward people in the community.
4. The interpretation given to him about his adoption and the time of his life that this information was given to him, and so on.

A child needs to feel that he "belongs". Dr. Florence Clothier writes that "a deep identification with our forbears as experienced originally in the mother-child relationship gives us our most fundamental security". 

1. Ibid., p. 13
The child's faith that his mother will continue to love him will give him a feeling of reassurance and security. Clotheir says further that "every adopted child, at some point in his development, has been deprived of the relationship with his mother. This trauma and the severing of the individual from his racial antecedents lie at the core of what is peculiar to the psychology of the adopted child. But the ego of the adopted child in addition to all the normal demands made upon it, is called upon to compensate for the wound left by the loss of the biological mother."

All children tend to phantasy about having other parents who would treat them better than the ones with whom they live. For the natural child, this can be a game, but for the adopted child, the fact that he has had other parents is a reality. He has been forsaken by his real parents about whom he knows nothing. He finds an easy escape from the frustrations inherent in his home education by assuming the attitude that these, his foster parents, are bad and wicked. His own, or foster parents, from whom he was "stolen" are represented in phantasy as good parents to whom he owes love and allegiance. If a child's identification with his adoptive parents is slight, he will return repeatedly to his phantasy of his natural parents. If his identification with his family is complete, he will have no need to search for his true parents.

1. Loc. cit.
Social workers and adoptive parents must be sensitive to a child's feelings about placement. He may feel that he is no good--that no one wants him. He sees placement as rejection.

Since World War 1 and particularly in the past two decades the public has become more concerned about dependent children. The League of Nations through the Committee for the Protection and Welfare of Children and Young People, a permanent advisory committee of the League, was instrumental in inspiring its member countries to consider seriously what provisions there were in their own countries for the welfare of dependent children, and if these met with the needs of the children.

In 1924, the Committee for the Protection and Welfare of Children and Young People was divided into two sections, one being the "Traffic in Women and Children Committee," and the other the "Child Welfare Committee." The Child Welfare Committee made a study of legislation and the types of service offered to children in different lands. Besides demonstrating the international picture of child welfare the study also revealed that it is the belief of people all over the world that family care is advantageous to the homeless child who is without blood ties; that institutional cases should be supplemented by family care and that adoption under proper safeguards is the most satisfactory type of foster home care for children who

have lost both parents. "By making available its findings, the Child Welfare Committee has brought about a cross-fertilization of ideas of widespread influence."¹ Many of the principles of child-caring have been borrowed by one country from another.

The Charter of the Child Welfare Committee is the Declaration of Rights of the Child and is commonly known as the "Declaration of Geneva."²

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² The Declaration of Geneva, dated 1925, states that:

(1) The child must be given the means requisite for its normal development both mentally and spiritually.

(2) The hungry child must be fed, the sick nursed, the backward child helped, the delinquent child reclaimed, the orphan and the waif succoured and sheltered.

(3) In all times of distress, the child must be first to receive relief.

(4) The child must be placed in a position to earn a livelihood and must be given protection against every form of exploitation.

(5) The child must be brought up in the consciousness that its talents should be devoted to the service of its fellow men.
The organization of the United Nations following World War II led to the formation of a new international body which was concerned with child welfare. The Division of Social Welfare operates under the Economic and Social Council of the United Nations and is concerned with the various aspects of child welfare, and family and community life.

"In the field of family and child welfare a special Working group has been established in order to co-ordinate the work of the United Nations including UNICEF,¹ and the following specialized agencies—ILO, FAO, UNESCO, and WHO.² Special efforts have been devoted to assisting Governments directly, as well as in the formulation of standards and guiding principles."³

The training of personnel and the development of services for children are the two main areas of interest at this time.

The Role of the Social Worker in Adoption Home Placement.

Although Social Work as a profession is relatively new the basis philosophy behind social work practice is as old as our civilization. With the development of new techniques and methods of treatment social workers are able to do a more skilful job in handling social problems of which the problem of adoption is one.

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The training of social case workers in the field of child welfare is most highly specialized in Canada and the United States. One difficulty in child placing, however, is the variation in laws in different areas and the differences in standards, methods and emphasis.

In dealing with child placement, the social workers have a tri-dimensional focus. They place the emphasis on the child, the natural parent, and the adopting parent.

The social worker, in considering the natural parent, tries to help the mother to keep her child and makes available to her all possible resources so that she can plan for the child herself. On the other hand, if the mother cannot keep the child the social worker helps her to work through her indecisive feelings about giving the child for adoption and tells the mother about the adopting home so that she may approve or disapprove of the home into which her child will be placed. In all cases the information about the birth of the child remains confidential.

The adopting parent, as the child and the natural parents, are protected by good agency practices. That is, a child is not placed for adoption unless it has been demonstrated that he has no mental or physical defects that would prevent a successful placement. In the adoption of every young children, the usual practice is that a child is not placed unless he has
The child who is placed for adoption is the most important person in the entire adoption plan. It is the child who suffers most should the adoption fail. For this reason the homefinder and/or the social worker who places the child in the home must see the situation as a whole. He must see the child as an individual who has potentialities which may be developed or crushed, depending on the home in which he is placed.

The Social worker's new, professional understanding of the relationships, motives, and drives within prospective adoptive families enables them to assess more accurately than ever before the prospective adoptive parent in relation to the child. The social worker looks for and evaluates many factors in the homelife and the character of applicants for a child. "There must be, of course, sufficient financial security to safeguard against want and provide for educational and vocational training; housing which will lend itself to the needs of growing children; communities which will provide

1. The criteria used by child placing agencies in determining the adoptibility of a child are:

Maternal background: normal intelligence, personality stability, and maturity, good health and no inheritable disease, no mixed racial origin, no inheritable mental illness, etc.

Paternal Background: paternity known, (plus factors as in maternal background).

Child's physical condition: no eczema, asthma, club feet, poor "inherited" traits, intelligence of not less than dull normal, no mixed parentage.
resources for wholesome play and group activities." These material and practical things are important but what is most important is the adoptive parents' capacity for parenthood. The social worker uses her professional skill to assess the strength of the marriage, the prospective adoptive parent's love for each other and their ability to share this with a child; to assess the importance and meaning of the marriage to the adoptive parents; to assess the maturity of the prospective adoptive parents to learn if they can offer to the child the kind of life which will let him grow strong physically, intellectually, emotionally and spiritually.

The United States Children's Bureau has published a list of "Minimum Standards" to be met by adoptive homes in a bulletin entitled The ABC of Foster Family Care for Children (No. 216, 1933).²

It is absolutely essential that the home situation and the child be viewed as to the probable effect of one upon the other. After the adoption placement is made, the home is supervised by the social worker whose main job is that of interpretation of the child's needs to the parent, of the parent to the child, and to provide guidance in other areas as the parent or child requires it.


2. See appendix A.
Not every child who is placed for adoption is adoptable. That is, even though he has been "given up" by his natural mother there may be some factor in his background that would prohibit his being placed for adoption at least until the child is old enough to be judged on his own merits. It is the practice of most child placing agencies to delay the adoption proceedings if the child's background history does not meet with the criteria set down by the agency. The paternity of the child may not have been established; there may be history of feeblemindedness, mental illness, diabetes or eczema in the family; this may have been the mother's second illegitimate pregnancy; the child may, himself, have some congenital condition such as a club foot, hare lip, etc; or the child may be of mixed parentage. These factors do not necessarily mean that the child will never be adopted but they are important in determining whether or not the child will adjust in the home in which he is placed.

The Child Guidance Clinic is the agency to which child placing agencies turn for a full assessment of the child's physical and emotional development.

It is the policy of the Child Guidance Clinic to give psychiatric, psychological, and physical examinations to all children whose cases are referred to and accepted by, the Clinic. The examination given to the children who are to be placed for adoption is sometimes referred to as a "pre-adoption appraisal." In this "appraisal" the child's suitability for adoption with regard to his physical development, his emotional adjustment
and his intellectual capacity is evaluated but only in terms of the child's present adjustment. The Clinic staff examines only the child and they state that the decision as to adoptability of a child would seem to be a social diagnosis and one which should be made by the social worker. In taking a child to clinic before placement for adoption, the social worker is turning to clinic for an examination of his abilities and possible potentialities at this point. When the diagnoses are received by the worker from the clinic, she considers them in the light of all other information she has about the child and also in relation to the adoption homes available.

When the term 'suitability for adoption' is used, it should be synonymous with suitability for adoption in a particular home.  

Development of Child Guidance Clinics

The introduction of the modern dynamic psychiatry of Frued, Adler, and Jung into America by Meyer, Rand and Kenmer gave further impetus to the Mental Hygiene movement which, in turn, influenced to some degree, the Child Guidance Movement.

Dr. Adolph Meyer and two Social Workers, Julia Lathrop and Allen Burns, together with Mrs. W. P. Bremmer, in an attempt to discuss the merits of a multiple approach to treatment of behaviour problems, enlisted the services of Dr. W. Healy, a psychiatrist, and Dr. Augusta Bronner, a

1. Minutes of a meeting between the Vancouver Child Guidance Clinic and child placement agencies.
psychologist. This group founded the first Juvenile Psychopathic Institute in Chicago. Mrs. Bremmer supported the clinic from her own resources for the first five years of its existence. In 1915, Healy and Bronner founded the Judge Baker Clinic in Boston.

The first work of the clinic was done in connection with the courts. It was at these two clinics that the teamwork approach - the psychologist, psychiatrist and social worker began.

From 1922 to 1927, demonstration clinics were set up in many cities in the United States and one was set up in Canada. "They gathered valuable experience in the formulation of function, organization and administration."1

The function of the Child Guidance Clinic is three-fold:

1) the primary prevention of mental illness.
2) the secondary prevention through treatment - the treatment programme is geared to deal with beginning behaviour and personality problems which can be given diagnostic, consultative and therapeutic service.
3) Research.

The Vancouver Child Guidance Clinic opened in 1932 following a request made by the Provincial Psychiatrist to the National Committee of Mental Health for help in effecting a plan for the prevention of mental illness. It operates under two departments of the Provincial Government and is closely linked with the Provincial Mental Hospital.

All of the Social Work staff of the Child Guidance Clinic, hereafter referred to as the Clinic, is employed by the director of personnel of the Social Welfare Branch of the Department of Health and Welfare. The psychiatrists, psychologists, nurses, speech therapists, clerical staff and janitorial staff are employed by the Provincial Secretary in Department of Mental Health Services. The staff at the Vancouver Clinic is made up of three psychiatrists, three nurses, eight psychologists, eight clerical workers, one receptionist, one speech therapist and fourteen social workers. Because the Clinic is supported by public funds, it must accept for service, all cases referred to it.

The Clinic offers service to two groups of individuals. One of these groups consists of children (under the age of 15 years) who are referred by their parents or guardians because the children manifest some behavioural disorder. The other group is composed of individuals who are referred to the clinic by a social agency or some other source such as a correctional institution.

The procedure followed by the Clinic in handling these cases after they are referred is basically the same. Each case is given "diagnostic service" which consists of "application" or acceptance of referral; an "intake interview" or interviews - which lead to the compilation of a "social history"; and a full "clinical examination" and "conference". ¹

In the cases which are referred to the Clinic on a private basis, that is, referred by a parent or some other person who is legally responsible for the child, children are given a full examination by the Clinic "team" which consists of a psychiatrist, a psychologist, a social worker and a public health nurse. (The psychiatrist also sees the parents of the child). The members of the team hold a conference to discuss their findings regarding the child and it is upon these facts that a treatment plan is based.

The parents of the children who are referred to the Clinic, privately, are interviewed by a social worker who seeks information concerning the background of the child and of the parents in order to complete a social history which is studied by the Clinic team. In the case of agency referrals it is the duty of the agency to provide the social history.¹

¹ 1. A copy of the "social history" outline currently in use at the Clinic is appended in Appendix B.
PURPOSE OF THIS STUDY

The purpose of this study, initially, is to explore the behaviour problems which have caused the parents of the children in the study group to refer them to the Child Guidance Clinic. Secondly, and perhaps more important than a straight approach to the behaviour problems themselves, is an attempt to analyse the reasons for the appearance of the problems. This has taken the study into the realm of analysis of the family situation of each of the adoptive families, wherever data was available to make such an analysis.

Thus, such elements as the method of placement, attitudes of parents, presence of other children in the home, age of adopting parents, age of other children in the family, education of the adopting parents, number of pre-adoption placements, age of child when referred to the Clinic, intelligence of the adopted child, religion of adoptive parents, as well as such things as whether the child was told that he or she was adopted, and at what time in their life they were told, would all be considered for the purposes of this study.

Another important aspect which cannot be measured statistically is the attitude of the adoptive parents toward the adopted child, and the parents' attitude toward the fact that the child was adopted, rather than biologically their own.

Unfortunately, all of the above listed information is not available
for all the cases studied, but it is hoped that there is enough in each case, and for the study group as a whole, to warrant drawing a few conclusions at the completion of the study. Where there may be lacks in such information, it will be pointed out.
Method of Study.

The information concerning the twenty-eight adopted children in the study was drawn from the "intake notes", the "social history", "diagnostic conference notes" and in the cases which were closed, the closing summaries, as recorded in the files of the Vancouver Child Guidance Clinic. When it was possible general impressions of the adoptive parents, as well as the social worker's evaluation of the family situation, was gained through reading the case records and through personal contact with the Clinic social workers who were treating the family members.

From the Clinic's "Intake" book in which new cases are recorded, the number of children referred by Child Placing Agencies for "pre-adoption appraisal" was established. In order to determine the number of cases which were re-opened following the initial request for service, the names of the children were recorded in a "Repeat" book. From these records information was gained concerning the service offered to the child placing agencies by the Child Guidance Clinic.

All of the children's names which were recorded in the "repeat" book were checked against the card index in an attempt to determine whether or not the child had been adopted.

Statistical material concerning the adopted child, the natural parents and the adoptive parents was compiled on a work sheet which was prepared for this purpose. 1

1. See Appendix C (study outline)
29.

In gathering the material for the completion of the work sheets special notice was made of the adoptive parent's attitudes toward their adopted child, their "feelings" about being unable to have their own children and their feelings about the background of the child as recorded by the Clinic workers.

Chapter II is largely statistical in nature but quotations were used to more clearly illustrate "parental attitudes" and the Clinic staff's impressions of adoptive parents.

Chapter III is entirely descriptive and case summaries were used to point up the combination of factors in the life experiences of seven adopted children which may have influenced the child's emotional development.

It was anticipated that the case records would illustrate pertinent background material as well as render suggestions about omissions in the original adoptive home study.
Summary

The truth of the opening remark of this thesis, therefore, becomes apparent through a study of history and law. History points out to us the changes from the mere "giving of a lock of hair," to impressive process of law as we know it in Canada today. Scientific knowledge has helped much to lift the veil of superstition and ignorance which has surrounded the mysteries of heredity. We now realize the importance of the family in the development of the child.

The development of agencies to deal with the problems of the dependent child probably began with the organization of orphanages in Britain and America when philanthropic groups worked toward the removal of children from the almshouse. About this time in England the Barnardo Homes of London started the selected placement of children while Charles Loring Brace founded the Children's Aid Society in New York. The Charity Organization Movement in the United States emphasized the case work method and to carry out the treatment plan it was necessary that the people in the community open their home to the children.

The first adoption law was passed in 1851 in Massachusetts. Since 1909, the Children's Bureau and, later, the Child Welfare League of America have been leaders in the work toward bettering adoption procedures and creating public interest in it.
Many social work methods and practices have grown up over the years and, with further knowledge about human behaviour and better case work skills there is still a need for human relations professions to continue to search for better methods, better tools, better results.

A study such as the one proposed for this thesis deals with a small number of children who make up the total population of adopted children. Even though the number is small and may be of little significance statistically it is felt that in the investigation of these cases of twenty-eight adopted children, small as the number may be, they will shed some light on difficulties which appear after the completion of the adoption of a child and should alert adoption workers to the necessity of very careful pre-placement study and follow-up.
CHAPTER II

THE CHILD, THE PARENT and the CLINIC

An adoption home presumably meets the needs of the adopted child, if established standards of adoption practice have been followed. Social work techniques have been developed so that a skilled social worker can assess the adoptive family situation and the adoptable child and "match" the two so that each will gain maximum satisfaction from the anticipated family relationships.

It can be said that the majority of adoption placements prove to be successful but in those cases where difficulties do arise it is important to analyse the situation to determine what factors in the situation caused difficulty in the family group. Chapter II is an analysis of the psychosocial factors in the home of twenty-eight adoptive parents which have bearing on the development of the child. It is the purpose of this chapter to point up some of the factors in the home situation which may have contributed to the child's difficulties.

The Chapter is divided into three distinct parts: (a) the adopted child; (2) the adoptive parents; (3) the Clinic contact with the adoptive parents and the adopted child.

Selection of Cases

A survey of the whole group of children who received service from the Clinic revealed that there were three groups of children who were adopted or who were adoptable in terms of the parent's decision.
to place the child for adoption. These three groups included:

1. Children who are referred by child placing agencies to the Child Guidance Clinic for "pre-adoption appraisal" prior to their placement in adoptive homes or during the adoption probation period. These children may not be seen again at the Clinic.

2. Children whose adoptive parents return to the clinic for continued service for the child who had been given a "pre-adoption" examination prior to his adoption.

3. Private cases of children whose adoptive parents come to the Clinic for help with behaviour difficulties in their adopted child.

According to the statistics in the "intake" book there were 140 children referred to the Clinic for "pre-adoption appraisal" during the period from April 1st, 1953 to March 31st, 1955. Of this number 31 children were referred to the Clinic by the Social Welfare Branch, 106 children were referred by the Children's Aid Society and 3 children were referred by the Catholic Children's Aid Society. In the cases of 31 children the "pre-adoption appraisal" was repeated due to a recommendation made by the Clinic Staff after the first appraisal; or because a home had been found for the child; or because the foster parents with whom he had been living wished to complete his adoption. The Children's Aid Society referred twenty-five of these cases, the Social Welfare Branch referred five cases and the Catholic Children's Aid referred one case. The Catholic Children's Aid referred two adopted children to the Clinic, while the Family Welfare Bureau referred one adopted child for treatment.
During the two year period twenty seven adopted children were referred privately to the Clinic. In these cases the Clinic contact was made at the suggestion of a doctor, a school teacher, a nurse or some other member of the community.

The cases chosen for this study are all cases of adopted children examined at the Vancouver Child Guidance Clinic during the period from April 1st, 1953 to March 31st, 1955. The group is made up of all adopted children who were referred to the Clinic privately and also three children who were referred to the Clinic for treatment by a social agency. Because of lack of information it must be assumed that these thirty cases comprised the total number of adopted children examined at the Clinic during the two year period.

Since there is no indication on the card index that children are adopted it was necessary to contact each worker at the Clinic and to ask them to check from a list of their total case loads for that period, those children whom they remembered as being adopted. In the cases where the worker was no longer at the agency and a transfer of the case had not been made it was necessary to draw all of the files to check on the "status" of the child.

Thirty cases were collected. Twenty-eight of these cases are used in this study. One of the cases that was omitted was one in which the agency had proof that the child in the family was adopted but the parents
had never been able to tell the social worker about this. The other case is one in which there was no information available. The child was a brother to one of the children who was currently being seen at the Clinic and had been on contact with the parents about this child, although the mother had said that she was going to bring the boy into the Clinic.

Of the twenty-eight cases in the study eleven cases were closed, ten children were receiving continued service, although four children had not been seen for some time although the case was considered open, in five cases the clients were considered to be receiving "continued service" and seven of the cases were still on "intake". It is interesting that since the writer requested material for this thesis, the intake supervisor has kept an account of the number of adopted children who have been referred to the Clinic since January 1, 1955. The number of children was seven. This may indicate that more than twenty-eight adopted children were seen at the Clinic over the two year period. There is no way of verifying this assumption, however.

Information Concerning the Twenty-eight Adopted Children.

Specific social background information has always constituted a vital portion in any social work study about individuals per se. Facts about age, education, sex distribution, birthplace and national origin, religious affiliation, and intelligence level, all provide helpful information in assessing people and what they are like. Hence, these facts are usually recorded
on the face sheets of each agency case record. For this reason, such a compilation is recorded about all the cases under study in this thesis, when such information is available. At the same time, it is also recognized that such information does not necessarily explain the reasons why these children experienced difficulties after they were adopted.

Three of the 28 children were referred to the Clinic by either the Catholic Children's Aid Society or the Children's Aid Society. In these cases, the adoptive parents had returned to the child-placing agencies (through which they had obtained their child) when problems arose and had been referred to the Clinic by the agency.

The largest single group of referrals resulted through doctors. Nine of the 28 cases were thus referred, while school authorities referred five. The school authorities were responsible for the second largest single group.

Two mothers came back to the Clinic because they knew that their child had been examined at the Clinic prior to the adoption.

Matching the number of cases referred by doctors was the number of cases in which the source of referral was unknown, or in which there was no record kept. Apparently, the majority of these cases came to the Clinic through the mothers' contacting the Clinic for an appointment for a discussion of her child's problems.
The ages of the children in the study group varied from four years to fifteen years at the time they were examined at the Clinic. The average age of the 28 children in the study group was found to be 8.35 years. The modal tendency for the whole group was between seven years and nine years as seen in Table 1.

A comparison of the sexes of the children in the study group shows that there were 15 males and 13 females. The concentration of children in the modal age group from 7 to 9 years showed a comparison of five boys to seven girls.

Table 1  Sex and Age Distribution of 28 Adopted Children Referred Privately to the Vancouver Child Guidance Clinic from April 1st, 1953 to March 31st, 1955

<table>
<thead>
<tr>
<th>Age</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-6</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>7-9</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>10-12</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>13-15</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>13</td>
<td>28</td>
</tr>
</tbody>
</table>

In the matter of intelligence rating, thirteen (almost one half of the total study group of 28) were tested as average. Only one of the 28 children was rated as dull normal, two were of superior intelligence and three were rated as very superior. Again, eight of the children were not
rated at all.

Table II  
Comparison of Ages with Intelligence Ratings of all Adopted Children seen on a Private Basis at the Vancouver Child Guidance Clinic from April 1st, 1953 to March 31st, 1955.

<table>
<thead>
<tr>
<th>Intelligence Ratings</th>
<th>Ages in Years</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3-5</td>
<td>6-8</td>
<td>9-11</td>
<td>12-14</td>
<td>15-17</td>
<td></td>
</tr>
<tr>
<td>Dull Normal</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Average</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Superior</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Very Superior</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Not tested</td>
<td>-</td>
<td>6</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
</tbody>
</table>

2  16  6  2  2  28

Eight of the adopted children were born of illegitimate pregnancies of unmarried women. Five of the children in the study group were born of married women. Of these five, three were born of illegitimate pregnancies, one was born of a mother who is now in a mental institution, and the fifth of a mother who is now deceased. One other child, (on whose natural mother there was information) was born of a woman divorced from her husband, but illegitimately pregnant.

In short, of the twenty eight cases, information on the natural mother was available in only fifty percent of the cases. Of these fourteen,
about whose natural mothers information was known, twelve were born of illegitimate pregnancies, and two were not.

Very little information was available concerning the natural fathers.

Table III  Placement of 28 Adopted Children Referred Privately to Vancouver Child Guidance Clinic from April 1st, 1953 to March 31st, 1955

<table>
<thead>
<tr>
<th>Placement Agency</th>
<th>Number of Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Aid Society</td>
<td>13</td>
</tr>
<tr>
<td>Catholic Children's Aid</td>
<td>3</td>
</tr>
<tr>
<td>Social Welfare Branch</td>
<td>1</td>
</tr>
<tr>
<td>Private</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
</tr>
</tbody>
</table>

In the matter of placement, thirteen of the 28 children were placed by Children's Aid Society workers, three by workers from the Catholic Children's Aid Society, one by a worker from the Social Welfare Branch and one by an agency outside British Columbia. Of the remaining ten children, four were placed in their adoptive homes through private arrangement with the natural mother or through someone acting for her. The method of placement of the remaining six children in the study group is unknown.

Of the four children who were placed privately, all were placements made outside of British Columbia. One placement was made in Ontario, one in Quebec, one in Alberta and another in England.
Table IV  Age of Children at the time of Placement in Adoptive Homes

<table>
<thead>
<tr>
<th>Under 1 mo.</th>
<th>1-2 mo.</th>
<th>3-5 mo.</th>
<th>6-11 mo.</th>
<th>1-2 yr.</th>
<th>3-4 yr.</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>28</td>
</tr>
</tbody>
</table>

Concerning ages of placement, two of the children were placed in their adoptive homes within the first month of their lives; nine children were placed during the second month, while two children were placed at ages between three and five months. (One of these children had been placed in three other homes prior to his final adoptive placement at the age of four months).

Of the three children placed in adoptive homes between the ages of six and 11 months, only one child went directly to the adoptive home, while one child had three foster home placements before being placed permanently at seven months, and the third child in this group experienced seven foster home placements in his first three months, plus a seven-month stay in an institution-like home until he was permanently placed in his adoptive home at the age of ten months.

Five children were placed in their adoptive homes between the ages of one and three years. Of these, three children experienced only one foster home placement prior to the final placement, while the fourth child lived with his natural mother for six months and for the next two years (prior to
final placement) in a foster home. The fifth child lived with his natural mother for a year (during which time he also lived in several foster homes) and another year in an agency foster home (after he had been taken into care).

One child was placed for adoption at the age of four. Her pre-placement history showed a period of one year with her natural mother, followed by ten days in a foster home, followed by three years in the second foster home.

Two children were taken by their adoptive parents directly from the hospital following their immediate post-natal period.

The case records of six children do not reveal at what age the children were taken into the adoptive homes, and in seventeen of the case records, there was no information as to the children's placement experience prior to being taken by their adoptive parents.

Thus, from the twenty-two cases in which there were available records giving the age of placement, it was found that 21 children were placed before the age of two and a half, and the twenty-second child was placed at the age of four. The trend appears therefore, to be toward early placement in adoptive homes, before the child is old enough to undergo psychological tests.

Before we go on to discuss the problems which faced the 28 adopt-
ed children in the study group, it must be pointed out that, while all the children in the study group had problems, and that all the children in the study group were adopted, the syllogism that all adopted children have these problems should not be presumed.

The classification of behaviour disorders of all the children at the Child Guidance Clinic served as a basis for the classification of the disorders presented by the twenty-eight adopted children in the study group.

Of this classification of disorders, only one of the categories set down by the clinic was used in this thesis. This category was that of "Primary Behaviour Disorders". This section of the classification is subdivided into four groups: a) habit disorders, b) personality disorders, c) neurotic disorders and d) conduct disorders. Other classifications made in this thesis were "educational disabilities" and "physical complaints".

The behaviour difficulties, as stated by the adoptive parents at the time of the referral, and as revealed in the findings of the clinic team who examined the child, fit into the six above-mentioned groups.
### Table V.
Classification of Behaviour Disorders of 28 Adopted Children Examined at the Child Guidance Clinic From April 1st, 1953 to March 31st, 1955

<table>
<thead>
<tr>
<th>HABIT DISORDERS</th>
<th>PERSONALITY DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nail biting</td>
<td>Seclusive states</td>
</tr>
<tr>
<td>Thumb sucking</td>
<td>Depressed state</td>
</tr>
<tr>
<td>Enuresis</td>
<td>Day dreaming</td>
</tr>
<tr>
<td>Masturbation</td>
<td>Excessive introspection</td>
</tr>
<tr>
<td>Temper tantrums</td>
<td>Feelings of inadequacy</td>
</tr>
<tr>
<td>Soiling</td>
<td>Sensitiveness</td>
</tr>
<tr>
<td>Feeding difficulties</td>
<td>Phantasy</td>
</tr>
<tr>
<td>Other</td>
<td>Aggressiveness</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>Negativism</td>
</tr>
<tr>
<td></td>
<td><strong>Other</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEUROTIC DISORDERS</th>
<th>CONDUCT DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tics and Habit spasms</td>
<td>Truancy</td>
</tr>
<tr>
<td>Sleep walking</td>
<td>Fighting and quarreling</td>
</tr>
<tr>
<td>Stammering</td>
<td>Untruthfulness</td>
</tr>
<tr>
<td>Overactivity</td>
<td>Stealing</td>
</tr>
<tr>
<td>Fears</td>
<td>Destruction of Property</td>
</tr>
<tr>
<td>Nervousness</td>
<td>Use of Alcohol</td>
</tr>
<tr>
<td>Nightmares</td>
<td>Cruelty</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Disobedience</td>
</tr>
<tr>
<td>Other</td>
<td>Setting fires</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>Sex Offences</td>
</tr>
<tr>
<td></td>
<td><strong>Other</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDUCATIONAL DISABILITY</th>
<th>PHYSICAL COMPLAINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor school progress</td>
<td>Physical discomfort</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>
Since each child displayed more than one behaviour disorder, the classification shows that a total of 100 "behaviour disorders" were presented by the 28 adopted children.

It may be seen from Table 5 that the total number of "habit disorders" presented by the 28 adopted children was 21. Fifteen "neurotic disorders" were evident in the 28 adopted children in the study group. There were nineteen "personality disorders", and 31 conduct disorders.

Ten of the 28 children got on poorly in school while four of them were found to be suffering from physical discomforts for which there was no physiological basis.

The disorders included in the 'other' group of the "habit disorders" were hair-pulling, nose-picking and sniffing. Those difficulties included in the 'other' group of personality disorders included confusion and unhappiness.

According to Gordon Hamilton "The classic picture of the primary behaviour disorder is an extremely aggressive child who acts out his impulses. The aggression may always be interpreted as reaction to the restrictions and frustrations of early (usually parental) environment." ¹

Miss Hamilton says that these disorders start in the first years of

a child's life and that in almost every case, a child who displays primary behaviour problems was rejected, and had in his early life an inadequate experience of love.

"All primary behaviour disorders have a pattern of trying to provoke. Such children expect punishment, which they will however, dodge if they can."  

Upon further analysis of the classification of the behaviour disorders it was seen that of the habit disorders, nail-biting and temper tantrums were the most prevalent, with enuresis being the third most common disorder.

Doctors English and Pearson state "Severe cases of nail-biting are motivated in part by the desire of the child to annoy and humiliate the parents - and the parents reaction indicates clearly that the child does accomplish his desire."  

The child who bites his nails so deeply that pain is caused may be punishing himself for his resentment to his parents. This aggression against him self is a protection against the fear of directing the aggression against his parents.

English and Pearson state that temper tantrums are a reaction to frustration. They say also that temper tantrums are universal in early

2. Ibid, p. 47.
childhood when a child is only learning to control his desires but "if they are very severe and prolonged or if they occur too frequently, the child's development is not proceeding properly." 1

A child who has never been taught to control his impulses and has been indulged too much reacts primitively to deprivation no matter how hard he wants to behave differently. English and Pearson state that they have observed that "severe temper tantrums occur when the child has been forced to be too cultured, to exert too much control, too early, or to become too independent before he is really able to do so... If the parental demand for too early and too much control is the result of a rejective parental attitude to which the child tries to adjust by doing everything possible to behave in a way that will make life with his parents at least tolerable, his temper tantrums will be most severe." 2

There are many, and varied, causes of enuresis. Those children in whom no logically scientific reason for it can be found, are the children who may be referred to the Child Guidance Clinic. Enuresis may occur either in the daytime and/or during the night. The enuresis may be of a neurotic nature; it may be a conscious or unconscious expression of hostility toward controls placed on the child by the parents or it may be the result of lack of training.

1. Ibid., p. 15
2. Ibid., p. 131
In this field of neurotic disorders, masturbation, thumb-sucking, and soiling were other disorders in evidence in the study group.

Some psychiatrists state: "All neuroses start with some frustration which produces a state of anxiety - the anxiety which is caused exerts its force through the automatic nervous system and thus produces nervousness, fears, disturbance in sleep, tics and habit spasms."¹

Nervousness was the most common disorder in the classification entitled "neurotic disorders", with nightmares being the second most common. One child displayed tics and habit spasms, two children were considered to be over-active and another of the adopted children in the study group was brought to the clinic because he stuttered.

The category entitled "educational disability" includes those children who, because of some emotional disorder, are prevented from concentrating on school. As is seen in an earlier part of this chapter, there was only one child who tested as dull normal in intelligence.

The presence of those personality characteristics listed under the heading of "personality disorders" indicate excessive deviation of the personality from the normal pattern of behaviour.

¹. Ibid., p. 324.
For the purpose of this thesis, the term "seclusive states" was interpreted to mean "withdrawn" and "anti-social". In this classification "aggressiveness" was the most common disorder, while "seclusive states" was the second most prevalent behaviour disorder.

One adopted child was considered to be overly-negative; two children were considered overly-sensitive; one child had severe phantasies, while one child was "confused" and four children were considered to be "unhappy".

Gordon Hamilton claims that conduct disorders "may be transitory and will persist only where there are severe parental frustrations, harshness, or lack of love for the child".

She says that when such treatment is continued over a period of time, the child may renounce parental love and retain aggressiveness as a characteristic pattern.

The conduct disorders presented by the 28 children in the study group showed that thirteen were classified as disobedient; four were quarrelsome; four were untruthful; and four showed their aggression by stealing. Dr. Spock states that a child may steal because he feels he needs more love and approval from home.

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Other less common disorders, each of which was presented by one of the adopted children were: destruction of property, setting fires, sex offences, and running away.

Information Concerning Adoptive Parents.

Turning now to information available concerning the adoptive parents, the records show that data concerning the ages of the adoptive parents was available in only 19 of the 28 cases. The information obtained was quite interesting, in spite of its scarcity. The ages of the adoptive fathers ranged from 28 to 57 years, while the mothers' ages ranged from 26 to 42. (These figures represent the age of the parents at the time the child was placed, not at the time the child was referred to the Clinic). The average age of the fathers was 38.05 years, while the average age of the mothers was 33.05 years. Table VI shows a central tendency for both adoptive mothers and fathers.

Table VI  Age of Adoptive Parents at the Time the Child was Placed for Adoption.

<table>
<thead>
<tr>
<th>Age</th>
<th>Fathers' Ages</th>
<th>Mothers' Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-29</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>30-34</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>35-39</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>40-44</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>45-49</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>50-54</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>55-59</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>19</td>
<td>19</td>
</tr>
</tbody>
</table>
While the adoptive parents marriage date was available in only fifteen of the 28 cases, it was seen that three of the fathers married between the ages of 24 and 29 years, and five of the adoptive mothers were married while their ages were in the same range. The average marriage age of the fathers, however, was 29 years, and the average marriage date of the mothers was 23.9 years. The number of years that these people were married before they adopted the child in the study group ranged from four to 18 years, with the average being 9.8 years. Neither adoptive parent had been married previous to this marriage.

The occupations of the adoptive fathers were found to be of middle class nature. Seven of the adoptive fathers worked in a clerical capacity; seven of the adoptive fathers were employed as skilled tradesmen; one was employed as unskilled tradesman. The occupations of twelve of the adoptive fathers was not recorded while one of the children had been adopted by a widow and therefore had no adoptive father.

Those occupations considered to be "clerical" were managerial and selling jobs; those jobs considered to be "skilled" included sheet-metal work, proof reading, welding, machinist, bus driving, construction work (foreman) and cabinet making; the job considered in the study to be "unskilled" was laboring in a canning factory.

In all cases where the work history of the fathers was recorded, there was no indication of dis-satisfaction with the job on the part of either
the husband or the wife, nor was there evidence that the adoptive father had ever experienced any long periods of unemployment. In the cases where the information was available it seemed that the adoptive fathers held their jobs for long periods of time.

A survey of the occupations of the adoptive mothers, prior to their marriages, reveals that one of the adoptive mothers was a school teacher; eight of the adoptive mothers were employed as stenographic and clerical workers; two of the adoptive mothers were employed in semi-skilled jobs which included working as a dental nurse and as a nurse's aid; and two of the mothers did unskilled jobs which included domestic work and factory work. In fifteen cases there was no record of the mothers' occupation prior to their marriages.

Little was recorded concerning the health of the adoptive parents. One of the adoptive fathers had a heart condition, while four adoptive mothers had complaints ranging from "bad nerves", in two cases, to glandular disorders and a stomach ulcer in the other two where health was discussed.

When the subject of education of the adoptive parents was entered into, it was found that in the cases of 15 of the fathers and 16 of the mothers no information was available.

In the cases of the 12 remaining fathers, (since there were 27 fathers and 28 mothers involved in the case study group, owing to the
adoption of one of the children by a widow), six of them had achieved high school standing, four left school during the grade 4 to grade 8 period, one had left before grade 4, one had one year of college, and the twelfth had attended vocational school.

In regard to the mothers' educational standard, one had left school before grade 4, one during public school, four during high school, and one after one year of college. Five had attended vocational school.

It is interesting to note that although two more men took their high school course, four more women than men, attended vocational school. (The majority of those who attended vocational school became stenographers.)

Table VII: Education of Parents of 28 Adopted Children given Service at the Child Guidance Clinic from April 1st, 1953 to March 31st, 1955.

<table>
<thead>
<tr>
<th>Education</th>
<th>Fathers</th>
<th>Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Public School</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>High School</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Vocational School</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>College (1 year)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

Only fourteen of the mothers, and eleven of the fathers recorded their religious denomination. Of the mothers, five were Roman Catholics,
eight were Protestants, and one was Jewish. In the case of the fathers, two were listed as Roman Catholics, seven were Protestants and one was Jewish, and the eleventh was Greek Orthodox.

Nine of the adoptive mothers were born in Canada, four in England and one was from Scotland. Fourteen of the adoptive mothers were not asked their racial origin.

Five of the adoptive fathers were born in Canada, two were born in Ireland, and one each in Scotland, Rumania, Austria, Finland, Russia and the United States. The birthplace of thirteen of the fathers was unrecorded.

It is interesting that in the cases where the country of birth was known almost all of the adoptive parents came to Canada (those not born here) at a very early age. The only exceptions were two of the fathers, one of whom came to Canada at the age of thirteen years and the other who came to Canada at the age of twenty years. All of the adoptive parents, however, were married in Canada.

There was little recorded on racial origin. In the cases where the birthplace of the adoptive parents was recorded, there was little definite information concerning the actual racial background. One of the mothers was Czechoslovakian in parentage, and another adoptive mother was Icelandic and another adoptive mother was Italian. The background of one father was Ukrainian.
Table VIII  Age and Sex of all Children in the Homes of 28 Adopted Children seen at the Child Guidance Clinic from April 1st, 1953, to March 31st, 1955.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Age</th>
<th>Sex</th>
<th>Age</th>
<th>Sex</th>
<th>Y.M.</th>
<th>Y.F.</th>
<th>O.M.</th>
<th>O.F.</th>
<th>Age</th>
<th>Sex</th>
<th>Y.M.</th>
<th>Y.F.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 1.</td>
<td>5</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 2.</td>
<td>7</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 3.</td>
<td>8</td>
<td>F</td>
<td>12</td>
<td>M</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 6.</td>
<td>9</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 8.</td>
<td>6</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 12.</td>
<td>5</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 13.</td>
<td>10</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 14.</td>
<td>6</td>
<td>F</td>
<td>8</td>
<td>M</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 17.</td>
<td>11</td>
<td>M</td>
<td>7</td>
<td>F</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 18.</td>
<td>9</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 19.</td>
<td>9</td>
<td>F</td>
<td>12</td>
<td>M</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 20.</td>
<td>15</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 23.</td>
<td>7</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. 24.</td>
<td>6</td>
<td>F</td>
<td>10</td>
<td>M</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Legend:  Y.M. refers to a male child who is younger than the Child attending Clinic.
Y.F. refers to a female child who is younger than the Child attending Clinic.
O.M. refers to a male child who is older than the Child attending Clinic.
O.F. refers to the female child who is older than the Child attending Clinic.
The number of other children in the home was thought to be significant. However, the study group of 28 was divided evenly between homes in which there were other children, and those in which there were no children.

Taking the fourteen homes in which there were other children, it was seen that in nine cases, the child who was referred to the clinic was the oldest in the family, three had younger sisters or brothers as well as older ones, while only two of the children referred to the Clinic were the youngest in the family.

In five of the twenty-eight families there were children born to the adoptive parents (hereinafter referred to as natural children). Of these five, two cases showed that there were only older natural children, in one family there was a younger natural child and in the remaining two, there were both older and younger natural children.

In the remaining nine cases in which there were other children in the family, there was another adopted child in the adoptive home. In addition, one of the five adoptive parents had a natural child and an adopted child, as well as the adopted child referred to the Clinic.

Seven of the adoptive couples chose for their second child, one of the opposite sex to that of their first adopted child. Three couples chose children of the same sex as their existing child, while four of the families did not adopt a second child.
In the case of the fourteen families in which there were no other children recorded, there were six cases in which no definite statement was made as to whether there was another child in the family.

Adoptive Parents' Feelings about the Background of their Adopted Child.

In four cases of the twenty-eight cases in the study there was evidence that either one or both of the adoptive parents believed that the source of their child's difficulty lay in characteristics inherited by the child.

In discussing the adoption of his child Mr. D. suggested that Dorothy's difficulty was something that was "born in" her, and confided in the social worker that the child was illegitimate.

Mrs. D. blamed her daughter's behaviour on her nationality. She said that her sister-in-law was Irish as was Dorothy and Mrs. D. wondered if they might have something to do with D.'s being "high strung".

In the case of Donald F. the psychiatrist stated, "Father admitted that he had a lurking doubt about Donald and that this may have influenced his attitude toward the boy. He mentioned that this seed of doubt seemed to have germinated as a result of a talk with a friend about the time that Donald was brought into their home. The friend had said that he did not believe that "environment could overcome heredity. "This father is quoted by the social worker as having said that the second adopted child was a "better bet" and was more likely to adjust to the home situation than
was the child who was being seen at the Clinic. Mrs. F. said that her husband preferred the second child because of her family background. The first child was born of Norwegian parents, while the second child was of Swedish parentage.

Social workers and psychiatrists experienced in adoption practice say that a child should be told that he is adopted so that he can grow up with the idea. In this way the inevitable trauma which is likely to accompany the accidental acquisition of this information can be avoided. Child placing agencies, in the past eight to ten years have strongly encouraged adopting parents to tell their adopted children that they are adopted as soon as they begin to ask questions about their origin. This study reveals that fourteen of the twenty-eight children in the group know that they are adopted children. Three of these children were told of their "status" before they were three years old; three children were told between the ages of three years and six years; two children became aware of the fact that they were not the parent's natural children between the ages of nine years and twelve years; one child, at the age of fifteen years, made his parents aware that he knew he was not their child. In five of the cases there was no indication in the record of the age at which the child was told that he was adopted.

Two of the records state definitely that the child does not know that he is adopted and twelve of the records contain no information regarding the child's knowledge of his adoption.
The difficulty that some parents have in telling their children that they are adopted is seen in a quotation from one of the cases studied. "The mother stated that she had mentioned a little to them (two adopted children) about adoption. She said that she should have let them know that B. was born of one lady and S. to another. Mother said 'I could never bring myself to telling them that they had another mother.' Mrs. H. seemed to feel that she could give her no reason for taking them and she wonders if they will ask why their mothers gave them away." In another case, to quote from the case record, of a child ten years of age, "Patient does not know that he is an adopted child. Mother says she has not told him because "he is not ready for it - I'm afraid he would hurl it at us in a fit of temper sometime."

Of the fourteen children who know that they are adopted, two learned of their adoption accidentally. There is no indication in the case records that the trauma caused by the child learning of his adoption accidentally precipitated the behaviour problems but it is interesting that two children were referred to the Clinic the year following the time that they learned that they were adopted. A third child who had his "fear of adoption" confirmed by his mother at the age of fifteen years was committed to a mental institution about three months after he was told that his parents were not his natural parents. This particular child told the social worker that he could remember his mother telling him that he was not her child when he was about five years old.
It is suspected that the child who feels "different" because of his status would repress this feeling and for that reason it would not be evident in the parts of the case recorded that were studied. In one case, however, the child stated that her misbehaviour was "born in her" as she was born illegitimately.

The fact finding committee of the Mid-century White House Conference on Children and Youth set forth the chief factors and theories, as currently conceived by many competent scientists and professional workers, regarding what is required for healthy development of personality in childhood and youth. A section of the report that was issued on the conference dealt with "the importance of parent-child relations. The report stated that: "Studies indicate that parents' attitudes toward their children and their feelings about them are more important determinants of children's health of personality than the particular techniques of child rearing they employ". With this in mind it is interesting to note that in twenty-two of the cases studied where there was considerable recording, five of the fathers said that they had not wanted to adopt a child but had done so for various reasons (the usual reason stated was that the father wished to please his wife). One mother said that she had wished to adopt a girl and was disappointed when she and her husband were given a baby boy. In one

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case (in which the child adopted was a relative) the adopting mother expressed her ambivalence about adopting the child and in one instance remarked to the social worker that she had never wanted to take the child. One couple had planned for a younger child and were disappointed when they received a child who was two and one half years old.

Quotations from the case records reflect the attitudes of some of the adoptive parents toward their adopted children. In the case of Dorothy the social worker states "Mother stated quite bitterly that if it had not been for Dr. L., who thought the youngster had more possibilities, she and her husband would have given up the idea of adopting Dorothy as they were having difficulty with the child right from the time she entered their home at fifteen days." The mother remarked to the examining psychiatrist "Had we been smart we'd have turned her back at one month. It's been Hell."

Another social worker recorded that Mrs. O. said that her mother had not been in favour of her marriage to Mr. O. which had been rushed because of Mr. O's being drafted into the armed services. A child was born two years after the marriage and three years following this Mrs. O had a miscarriage and it was at this time she and her husband decided to adopt a child. Mrs. O. stated that she wanted the child for herself and her natural child. She stated that her husband had not been very enthusiastic about the adoption but finally agreed to the idea if they adopted a girl.

A quotation from a third case illustrates a mother's preference.
for a second adopted child. "Mrs. F. said that she had wanted to adopt a girl first but had taken the boy because this was her husband's preference. Now she wonders if she should have adopted a little girl when Roy was younger. Mother said that if Roy had not been the only one for several years he would have been better adjusted, but then 'I would not have had J. if I had adopted a little girl sooner!'"

Case #24 indicates indecision and hesitancy on the part of the adoptive parent and the child placing agency. In a letter to the Social Welfare Branch the Vancouver child placing agency wrote, "The natural mother requested a final visit and Mrs. C. was made aware of this. Mrs. C. was incessantly disturbed over the visit, imagining a turbulent scene which would upset the child and she spent a sleepless night mulling over this and possible outcomes.

"Mrs. C. questioned worker closely re. the physical appearance of the mother and seemed worried lest Alice be big-boned and fat. In talking about inheritance she wondered whether a predisposition toward immorality could be passed on from parent to child. She went on to comment how much more her family could offer Alice than did the E's (the foster parents) - financially, socially, and intellectually. Before the worker could retort she qualified her remark by saying that she thought that her son was lucky too.

Mr. C. remarked, (when he first saw Alice) "She was such
a far cry from the three year old daughter that I thought I wanted, I was ready to weep. He could not dream of not taking her... if we didn't, what would have become of her?"

Description of Parents by Clinic Team.

Case #1  The social worker found Mrs. D. "rigid and punitive" and wondered if the child was being brought into the clinic as punishment." The record states Worker feels that possibly the basic reason for Dorothy's behaviour disturbance is due to rejection on the part of the parents - mainly the mother.... One feels that if the basic relationship between mother and Dorothy improved, D's relationship with her father would improve as father seems to be guided a great deal by his wife's reactions to D. While D. was being seen by a social worker the mother was seen by the psychiatrist, who stated, "In view of Mrs. D.'s insistence that D. is disturbed, and from the account to date, certainly D. is fighting an up-hill battle to keep average interpersonal relationships."

Case #2.  "The worker's impression was that the mother had a basically strong ego. She is threatened by any implication that she is not a good mother. Her own feelings of illegitimacy seem to have been communicated to Timothy and perhaps has been interpreted by him as meaning that he, himself, is bad. The mother's own concern about good and bad or acceptable and unacceptable behaviour, is shown through stress placed on toilet habits. Timothy's reaction to this attitude is conjectured that all bodily
functions are bad and that pride in his own body is bad.

The mother identifies with Timothy and is inclined to expect too high a standard of behaviour. At the same time, she is anxious that he should have all of the things that she missed in her own childhood and is inclined to over-protect Timothy and to tie him closely to her.

Case #3. Patient seems to have been deprived of emotional security since birth. Mrs. O. is concerned with her own needs and the lack in her marriage, and is rejecting patient because of her need for attention and affection. Mother is inclined to project responsibility onto her husband and her ability to examine her own part more is not known.

Mr. O. is a rather passive, weak person who seems unable to give emotionally to the family. His concern centers around providing secure physical surroundings.

Case #7 It was felt that Mr. Y. had not been too enthusiastic about adopting a child in the first place and that the impetus had been entirely on the part of Mrs. Y. Father has not given Frederick enough attention and affection while mother has lacked confidence due probably, to the critical attitude present in father's personality. Frederick, too, has suffered from this... Mr. Y. needs help in understanding the importance of his role in F.'s development.

Case #9 In handling David, Mrs. E. is inclined to be quite demanding.
She gives the impression of being overly concerned about his daily attitudes and of trying to control him too much. She does not appear to accept D.'s growing masculinity and seems threatened by it. Her own tendency toward masculinity would account for conflict in this area.

Case #12 Both parents have strong dependency needs which spring from their own childhood. The father was subjected to war and revolution and terror and the early death of his parents. The mother received little warmth from her father and mother.

Case #15 The mother is quoted as saying, "Of course I know that I should not have taken him when I was already ill, but my life is really over and I felt I had to have something to live for." "Mrs. M. has suffered from multiple sclerosis for twenty-five years. "I had sclerosis when I was married and asked my husband if we could adopt a child. He said (with great feeling) "no bastard will hold my surname". After he was presumed dead she placed her name on the adoption list in Montreal. She went on to explain how she had got the child and ended up with a rather smug smile as if she was saying that the managed to give her child her husband's surname after all."

Child Guidance Clinic Contacts.

As was stated in Chapter I of this thesis, the members of the Clinic team of the Child Guidance Clinic may, at the request of child-placing agencies, examine dependent children who are over the age of
two years. If from this examination, the Clinic team believes that the child is physically and emotionally healthy enough to adjust to a suitable adoptive home, the Clinic makes this its recommendation to the child-placing agency.

Of the twenty-eight adopted children in this study group, eight were examined at the Clinic prior to the completion of their adoption. (one of these cases was seen on two occasions).

In twelve instances of the twenty-eight, the children's cases were re-opened following the initial request for service. Two children were returned twice following the first closure of the case, while in one instance a child was brought back to the Clinic for treatment four times. Thirteen of the group of twenty-eight were examined on only one occasion, this examination following their permanent placement. Thus it can be seen that for the group of 28 children, there were actually 47 contacts with the Clinic --counting each contact as being the act of being referred back to the Clinic for additional treatment after the first closure of the case.

The service offered these children included a full clinic, that is an examination by the full clinic team. In the cases where the referral of the child was for adoption appraisal, favourable recommendation was passed on to the agency concerned.

In the case of the child's referral being made by the parent, (as was the case on all occasions for the study group in this thesis), and
the recommendation by the team for continued treatment, such treatment was under the supervision of a member of the Clinic staff. (It was noted that, if for some reason, a child or parent did not continue with the treatment until regular closure of the case was made by the Clinic, yet returned within two years for further treatment, another full clinic examination was not given).

In seven of the cases under review in the study group, the case was still on intake — i.e., the application for help had been made, but the family had not been contacted by the social worker for the necessary background information for the social history.

In two of these cases it was felt by the Clinic that following the initial interview, the problem could be best handled through the resources of another agency, and the proper referral was made. One child was referred to the Clinic for Vocational testing and continued service was recommended and carried out.

At the time of the preparation of this study, a total of ten of the adopted children in the study group and/or their families were receiving continued service although four of the children or their parents had not been interviewed by the social worker for a period ranging from three to twelve months.

Eleven of the cases in the study group were closed.
Evaluation of the success of treatment by the Child Guidance Clinic.

Example 1. The D. case was closed because of the mother's inability to use the Clinic's help and because both the social worker and psychologist were leaving the agency. The social worker's evaluation of the situation in the "closing" summary was "Behavioural changes in the child indicated the use of relationship to find more acceptable means of gaining attention and security. The mother has also gained in terms of her ability to work toward a decision as to her capacity to tolerate Dorothy in the home."

Example 2. The psychiatrist felt that the case of Timothy E. was successful "in terms of the mother's growing awareness of her problems and her increased ability to handle her feelings. She still tended to over-identify with her children and to take responsibility for their actions. However, changes have been wrought through interpretation and clarification that promised to relieve some of the tensions in the home and to promote healthy parent-child relationships."

Example 3. The closing summary in the case of Teresa I. stated that "it became apparent that the parents were interested in the symptoms rather than the child herself... the mother was looking for someone to punish Teresa... the father resisted involvement in the treatment plan.

Example 4. The case was closed because the parents found a threat that would control Olga. It was the threat to send her to private school if she
did not conform to her parent's wishes. (The social worker wondered how long this conformity would last.)

Example 5. In the case of Una T. the social worker recorded, "This appears to be a situation requiring almost continuous long term supportive relationship with the mother and child. The Clinic helped the mother to function more adequately and the child has responded and has shown some improvement in her relationships at school and in her peer groups.

Father was never really drawn into the therapeutic situation. Closure of the case is indicated because of lack of co-operation."

Example 6. Mrs. D. telephoned to say that she did not wish to have further contact with the clinic. She stated, "At present we feel that everything is so much better, possibly because of your help in the past and there is no real need to return to the clinic."

Example 7. Donald was taken to a private psychiatrist and his parents heard what they wanted to hear, that Donald required severe discipline. "They have found the new method successful and wish to withdraw from Clinic contact." The social worker commented in the case record, "At the same time as there is strict discipline there has also been a greater interest in Donald on the part of both parents and this in itself has helped."

Example 8. The F. case was closed because the parents did not wish to cooperate with the Clinic. They "thought they had better drop the idea".
A few months after the case was closed a letter of inquiry came from a private psychiatrist asking for information about the child. This indicates that there was no improvement in the child's behaviour.

A review of the comments concerning the adoptive parents made by members of the Clinic staff upholds the remark made by one of the social workers at the Child Guidance Clinic when she was asked if there was anything that appeared to be similar among the group of adoptive parents. The worker stated that in her opinion, and in her experience, she had seen adoptive parents who were rigid, set too high standards for their children and were demanding of the children. The social worker stated that she believed that adoptive parents themselves were the most difficult clients to work with because of their severe guilt feeling about having failed with the child.

Also in reviewing the service offered to the adoptive parents one observes that in only one of the cases which was closed did the clinic workers feel that they had been able to help the parents and the child with their difficulties. It seems that this would indicate that the parents do not wish help with their problems or that they cannot use help. It also indicates, as was seen in the Clinic reports on the clients, that some of the adoptive parents are distressed people and are in need of special help before they can provide a home for their children which will help them to grow physically and emotionally mature.
CHAPTER III
CHILDREN WITH PROBLEMS.

Adopted children are a special group. They not only experience having more than one mother, but are often placed in one or more foster homes before they reach permanent adoptive homes. Having gained, in Chapter II, considerable information about twenty-eight adopted children and about adoptive parents, it is the purpose of this Chapter to present brief summaries of seven cases of adopted children who were seen at the Child Guidance Clinic between April 1st, 1953 and March 31st, 1955. The case summaries contain the information that is recorded statistically in Chapter II and also presented in summary form, they enable the reader to gain a fuller picture of the situation faced by both the adoptive parent and the adopted child when the child is placed in the foster home.

The seven cases were chosen from the list of children who were examined at the Clinic during the years specified in the study. The selection was based on the number of placements made by the different child placing agencies and by private arrangement. Three cases where placement of the adopted child was made through the Children's Aid Society were chosen from the group of thirteen placements, while one case was chosen from the three cases where placement had been made through the Catholic Children's Aid Society. The other categories from which cases were selected were the group of cases in which the children concerned were placed through private arrangement, through the Social Welfare Branch and
through a child placing agency outside of Canada.

In presenting the case summaries it was realized that in no way are the twenty-eight adopted children in the study group representative of all the children who are placed through the agencies which were mentioned above. It was also realized that no really conclusive evidence about the cause of behaviour problems could be derived from such a small group. Although the number is small there are certain factors in the home environment situations which are common to two or more of the cases.

The concept of "personality" has been described as "...the thinking, feeling, acting human being, who, for the most part, conceives of himself as an individual separate from other individuals and objects".

Organic factors, and perhaps more important, interpersonal relationships influence a child's growth and development. Since the first relationship a child experiences is with his mother it is important that this relationship be satisfactory to both the parent and the child. As the child grows older he extends his relationships to include his father, his siblings and his playmates. His contact with each person means a testing of the child's ability to adapt himself to new life situations; if he lacks the feeling of security that should have been instilled in him in the early years of his life, he may manifest one or a great number of behaviour disorders.

It should be noted that the first five or six years of a child's life are most important from the point of view of the development of the healthy personality, for it is in this time that it is essential that a child experience a feeling of security. He can gain this feeling of security only through consistent love and care by his mother or a mother substitute. Children who are separated from their parents at an early age, or without sufficient preparation, may suffer great anxiety and fear and react by reverting to a behaviour that is babyish and no longer appropriate for them. "It is as though this indulgence was seized upon as their one insurance against the hurt."¹

In the twenty-eight adopted children studied, all but two children suffered separation "from a family where they had already acquired a certain degree of security. Dorothy Hutchinson stated that "The most successfully placed children are those who can see and understand the necessity of their own placement."² Children at a very young age, although they may not understand words, are able to sense what is happening to them when they are removed from one home and are placed in another family group. The extent of the damage done to the child through separation or multiple placements depends on the age at which the deprivation occurs.

² Ibid., p. 48.
If a child does not receive the feeling of security which leads to the growth and development of personality, psychiatrists conjecture that he is likely to be subject to behaviour disorders as a result of poor parent-child relationships. Undoubtedly parents and children influence each other, but more is known about the influence of parents on the behaviour of children. Many studies indicate that parents' attitudes toward children and their feelings about them are more important determinants of children's health of personality than the particular techniques of child rearing they employ.¹

John Bowlby stated "all children under seven years of age are vulnerable (to emotional and intellectual retardation and perhaps physical growth) with the possible exception of infants under three months. But the damage is greater and also different when the child is thirty months when deprivation takes place than when he is older."²

It is a generally accepted belief among human relations specialists that "behaviour is caused". All behaviour is a person's reaction to the internal and external forces which act upon him. The family provides the setting in which a child may grow and develop and in this setting the external forces of the physical surroundings, which includes the family members combined with the internal forces in the child mould

². Ibid., p. 94.
the basic personality of the child. Parent-child relationships where the child's needs for consistent love and care are met, offer the child the feeling of security which he needs in order to develop a healthy personality.

The child who lacks a feeling of security which stems from his early life may react in several ways. He may become severely disturbed or he may develop certain behaviour disorders which take the form of milder aggression and hostility against himself and against his parents. He may become withdrawn to protect himself from his own feelings and impulses due to an anxiety that has developed within. An early breakdown of parent-child relationships may cause the child to regress to infantile behaviour such as thumb-sucking; and/or he may renounce parental love as his reaction to harshness and inconsistency on the part of the parent and become disobedient, quarrelsome, and/or destructive.

It is the presence of difficulties like extreme nail-biting, thumb-sucking, nervousness and so on, in the child which prompt parents to bring their children to the Child Guidance Clinic. At the Clinic if the parents wish to co-operate with the Clinic staff in a treatment plan, and if they are amenable to help, they are helped to better understand their child's difficulties and to understand their influence in the development of the disorder. After several interviews with the child and the parents by the social worker and the psychiatrist, after a psychological testing of the child by the psychologist, and after a physical examination of the child by the doctor and nurse, the Clinic "team" is able to diagnose the
problem and to set up a treatment plan.

The seven case summaries presented in this chapter show, as far as possible the limitations placed on the emotional development of the child. The limitations were intangible; in none of the twenty-eight cases of adopted children was there any evidence of physical misuse of the child by the parent who brought him to the Clinic.

Kenneth M., 1 for example, was placed in his adoptive home through a private arrangement with the child's mother. Prior to his placement in the M. home, the child had had an unhappy experience in two of the three foster homes in which he lived. The breaking of the tie between the last foster home seemed to be an extremely traumatic experience for Kenneth.

Kenneth's parents both suffered unhappy childhoods and they did not adjust satisfactorily in their marriage. The father discouraged the child from showing any overt affection and also imposed drastic eating habits on the family. Factors such as these may have contributed to the child's behaviour disorders.

The following case summaries which are intended to give a more complete picture than can be offered by statistical numeration, are divided into several headings: (1) Reason for referral; (2) Clinic

1. See summary of Kenneth M. which follows.
recommendations; (3) Background history of the Child; (4) Background of the adoptive parents; (5) Marital history; and (6) Clinic's evaluation of the family situation.

No. 4 Kenneth M. was twelve years old when he was referred to the Child Guidance Clinic by a Public Health Nurse at the suggestion of his school teacher.

Reason for Referral:

The reason for the referral was stated to be Kenneth's poor progress in school. Other problems manifest were "stuttering, stammering, anti-social behaviour, over-aggressiveness and threatening reactions when not given "his own way", confused, lazy, unhappy and physical complaints."

Clinic Recommendation:

Kenneth was given a full clinic and was estimated by the psychologist to be of average intelligence. The recommendation of the clinic team after the conference was that case work service should be offered to Kenneth and his parents.

Background History of the Child:

Kenneth is the child of an illegitimate pregnancy. Neither the natural mother nor the putative father was married. Prior to his adoption by Mr. and Mrs. M., Kenneth lived in three different foster homes. The first home in which Kenneth was placed proved to be unsatisfactory, and in the second home it was reported that he was left in his crib for hours and received little or no care. The third placement was very satisfactory. (The foster mother was the natural mother's aunt.) These people loved the child and wished to keep him but because of their housing situation and their financial position were forced to give him up.

Kenneth was very upset when he was moved from this home. Mrs. M. stated that Kenneth cried for one and one half days after they took him to their home.

Kenneth was bottle fed until he was twenty months of age. He has some food fads but these appear to be related to the father's eating habits. He was toilet trained early and his adoptive mother was very strict about keeping him clean. She stated that she gave him extremely good physical care for fear that "the welfare would take him away." Kenneth's sexual development appears to have been normal. At the age of eight years
he began to complain about aches and pains in his legs.

**Background of Adoptive Parents:**

Mrs. M. complained of the constant bickering and open fighting which took place in her own home. Her father was a very heavy drinker and was a poor provider for the family. Before her marriage to Mr. M. at the age of 28 she worked as a nurse's aid.

Mr. M. said that he had never had a good relationship with either his father or his mother. He said that his early up-bringing was strict and rigid. Mr. M. appears to have a certain allegiance to his brothers. The men used to spend their week-ends together cycling in the country. Mr. M. and his brothers were conscientious objectors and because of this Mr. M. spent two years in prison during the war. (Kenneth was between five and seven years old at this time.)

**Marital Adjustment:**

According to Mrs. M. her marriage to Mr. M. has never been satisfactory. She stated that her husband makes excessive demands on her sexually and has made her accept too much responsibility for Kenneth and for the management of the home while he is away from home working or with his brothers.

"Both parents have been concerned about their inability to have a child of their own. Mrs. M. claims that she has had a complete physical check-up which revealed that she is capable of bearing children. Mr. M., however, refused to be examined and has talked on several occasions about wanting to have affairs with other women to see whether or not he could reproduce."

**Team Clinic Evaluation of One Family Situation:**

After having seen Kenneth at the clinic the psychiatrist stated that he believed the child to be "psychopathic and suggested that he be helped in a controlled setting. The psychologist conjectured Kenneth to be very disturbed and that he fights facing the emotional situations to avoid anxiety. At the present time his disturbance seems to be handled by this evasion and distortion."

About one year after Kenneth began coming to the clinic for continued treatment, he told his mother in a fit of rage that he knew that she was not his real mother and that the social worker had given him this information. Mrs. M. handled the situation well.

During the day following the incident the boy did not leave
his mother's side. For the following week the child was exceptionally well behaved.

In later interviews with Kenneth the child told the social worker that he remembered his mother telling him when he was about eight or nine years old that he was not her child. It appeared also that Kenneth had believed that his adoptive father was his real father and that his adoptive mother was his step-mother.

After having his fear that he was adopted confirmed by his mother he began to phantasy about his natural mother and stated that he was going to blackmail his natural mother. He also wondered as to whom his maternal grandmother had left her money.

Three months after Kenneth learned that he was adopted, he was admitted to a mental institution after he had attempted to injure his mother with a knife. It was believed by the hospital staff that Kenneth could be given some help but his father removed him from the hospital before treatment was completed.

No. 21:

Terry V. was adopted by Mr. and Mrs. V. at the age of five months through a child placing agency in Europe. There is nothing in the recording of the case that would indicate that the marital situation is unsatisfactory but both of the parents felt that they had experienced an unhappy childhood.

This is the case of a child who did not meet with the hopes and expectations of his mother and whose father was unable to be demonstrative toward the child.

Reason for Referral:

Terry V. was first referred to the Child Guidance Clinic at the age of seven. The referral was suggested to Mrs. V. by a private physician. The stated presenting problem was soiling and finger-sucking.

Background History of the Child:

Nothing is known of Terry's natural parents except that his mother was unmarried and the putative father was married and was
employed as a machine shop worker.

Terry was adopted through the National Adoption Society of London, England. He was five months old when he was placed in Mr. and Mrs. V's home but no information is available about his pre-placement history.

Mr. V. stated that the only really upsetting experience that Terry had had during the war was one occasion during the London Blitz when a rocket exploded and completely destroyed their house.

Terry's personal development was normal according to his mother. He was toilet trained by the age of one year.

The family moved frequently and from one continent to another. This living in small rooms and the uncertainty of obtaining jobs that was experienced by Mr. V. did not appear to upset Terry until after the family made their second major move. After moving to Canada and the subsequent difficulty in obtaining employment and in establishing a home, there were days when Terry soiled but this seemed to follow a period of constipation which lasted for three or four days.

After her arrival in Canada Mrs. V. entered into a life of almost feverish religious activity. She feels that the day she was baptized Terry began his difficult behaviour. The behaviour became more difficult when the child went to school as he began, then, to defecate in his pants three or four times a day.

Background of Adoptive Parents:

Mrs. V. had a very unsettled, unhappy childhood in that she was placed in an orphanage when she was six years old after the death of her parents. The family was further separated when the children were placed in separate foster homes. Mrs. V. believed that she was ill-treated in the foster home but was able to rent an apartment with her sister when she won a scholarship entitling her to enter the school of music and drama.

Mrs. V. completed high school and worked as a secretary, continuing to maintain her interest in music and the stage, until she married Mr. V. at the age of 24.

Mr. V. did not consider his family life very happy. His father was a minister who believed that his children should be brought up in a very rigid and narrow environment. At the age of 14 Mr. V. left school and apprenticed as a machinist. He is presently employed as a mechanic.
Mrs. V. said that she did not wish to be reminded of the adoption, although she remarked that she did not want to adopt just any child. She wanted a baby with fair hair and blue eyes, who would resemble herself and her husband. The social worker remarked, in the record, that Mrs. V's protestation of her love for Terry is somewhat shallow and that the mother may even resent that the child is not her own, or that his presence may remind her of her own child-bearing role.

Mr. V. said that he was "not fussy about children" but that his wife was "crazy about them" and they seemed unable to have a child of their own. He stated that since coming to Canada his wife had contacted a child placing agency to apply for a second child but after talking to the children's agency worker she had decided to withdraw her application.

Marital Adjustment

Mrs. V. felt that her marriage was marred by the death of one of her brothers just two days before the marriage. It was this brother whom she thought to be like her father in that he "drank himself to death." Mrs. V. maintained that she was happily married and that she has great affection for her husband. She stated that the first year of the marriage was very difficult because of their sexual maladjustment. It was during this period that the adoptive parents understood that they were unable to have children of their own so they decided to adopt a child.

Clinic Team's Evaluation of the Family Situation:

In the record the social worker states that Mrs. V's feeling toward her husband "gives rise to much thought and it is questionable whether Mr. V. really satisfies his wife in ways that she desires, that is, being able to get on with guests, being unable to get on with friends or to make friends of his own." The worker goes on to record "There is too, a likely question around whether they (Mr. and Mrs. V.) are compatible sexually. So it would seem that a good deal of tension arises around these areas of her feeling toward her husband and son, and the whole accumulation of tensions is resulting in a strong directing and chastising conscience which forces the mother to accept or to seek a narrow conception of religion which constantly reminds her of her sin and the ultimate and inevitable punishment for sinning." During a clinic conference the psychiatrist who spoke with Mrs. V. stated that she appeared to have pathological feelings of guilt which arose during her childhood and which developed into positive coercion of Terry. He stated further that her guilt feelings suggested to her that she had gone against God's will in adopting the child and that she therefore adopted this "suffocating him with love" attitude to prevent him from leaving her. The psychiatrist suggested that Mrs. V. see a private psychiatrist.
It was the worker's impression that Mr. V. had a very shallow way of relating and that it did not seem that Mr. V. had a very deep or meaningful relationship with Terry.

In this case continued service was offered to the family members by the clinic and Mrs. V. was referred to a private psychiatrist for help in relieving some of her feelings of anxiety about her own background.

No. 7. In the U. case it was seen that Mr. Y. was never in favour of the adoption and was also overly critical of the child. The father was a domineering man who imposed a harsh diet on the members of the family.

In view of what is known about the importance of good parent-child relationships it might be assumed that the attitude of this father affected to some degree the emotional development of his child. It must be recalled also that there is some pathology in the background of the child.

Fredrick Y. was referred to the Child Guidance Clinic by his mother who knew of the clinic services because of Fredrick's previous contact there. He had been examined at the clinic prior to the completion of his adoption. He was seven years old at the time of his second examination.

Reason for Referral:
Fredrick's problems, as stated by Mrs. Y., were stealing and uncontrollable temper tantrums.

Background History of the Child:
Fredrick's natural mother was a married woman who was separated from her husband. Her own family history is one of quarreling between her parents and finally separation which led to her placement in an orphanage at the age of eleven years. There is a history of mental disturbance in her family. Her father has been described as a "sex maniac." When she was thirteen years old she was known to be prostituting. She became pregnant at the age of fifteen and at that time married a man who was not the putative father. This child was still-born.

The natural mother, who left her husband, joined the armed services at the age of eighteen. The same year she bigamously married an American sailor and a year later she was discharged from the forces because of another illegitimate pregnancy. Fredrick was the child of this pregnancy but the natural mother knew nothing of the putative father.
Fredrick was two months old when he was placed in the Y. home. His first contact with the clinic was in 1948 when he was examined to determine his adoptability. The recommendation of the clinic was that the child was of mid-average intelligence and that there were no contraindications to adoption. The adoption was completed one and one half years later.

Fredrick's health has always been good although he has suffered from some colds and attacks of diarrhoea. Mrs. Y. recalled no difficulties in the child's toilet training period. At the age of four or five he showed some exhibitionism but this was dealt with by his parents. At the age of three Fredrick had measles; in his fourth year he had his tonsils removed and at that time suffered some haemorrhaging; at five years of age he had mumps and measles.

Background History of Adoptive Parents:

The adoptive parents were married eight years before they took Fredrick into their home. At the time of their marriage Mrs. Y. was twenty-four and her husband was twenty-nine years old. Both Mr. and Mrs. Y. completed their high school and Mrs. Y. worked as a stenographer prior to her marriage to Mr. Y.

Mrs. Y. stated that her own family life had been reasonably happy in spite of the fact that her father was frequently unemployed. In recent years Mrs. Y. has not been well and she blames this fact for her impatience with Fredrick.

Mr. Y. was brought to Canada from Europe when he was two years of age. He stated that his family life was happy, that his step-father was good to him as were his siblings but that neither his mother nor his step-father were very demonstrative.

Mr. Y. is employed in an industrial office and seems satisfied with the work. His health is good.

Marital Adjustment:

Concerning the marital situation of Mr. and Mrs. Y. the worker stated that the marital difficulties seem to be "chronic rather than acute". She stated that Mr. and Mrs. Y. seem to need help in understanding each other and help in learning to co-operate in matters that concern Fredrick. Mrs. Y. stated that she feels intellectually inferior to her husband.

Mrs. Y. stated that now she knows that the adoption of the child has only increased the tensions and strains already apparent in the marriage.

During the interviews Mrs. Y. brought out a lot of feeling about being "barren", and of her disappointment at not having her own children. After many examinations the conclusion was reached that there was no physical basis for sterility in either herself or her husband. Mrs. Y. said that she wanted a baby so much that she decided to adopt one.
She discussed this with her husband who merely said that if she wanted to go ahead with a plan for adopting a child it was alright with him. Mrs. Y was encouraged by a friend in a professional position who suggested that she ask for a baby boy "to draw Mr. Y. out". The friend was confident that the presence of the child was all that would be necessary to make Mr. Y. into an entirely different person.

In discussing the adoption with Mr. Y. the worker learned that Mr. Y's reasons for adopting Fredrick were largely to please his wife and also because of his "sense of values." To elaborate on this the adoptive father said that he would describe himself as having 60% hermit instinct which was scholastic and nomastic and the other 40% was a gregarious instinct. He said that if all people lived along there would soon be only one person left in the world but there are millions and this would indicate that man is gregarious.

Clinic Team's Evaluation of the Family Situation:

At the clinic conference the psychiatrist stated that Mr. Y seemed to have a lot of feeling about the adoption of Fredrick. During the interview the adoptive father talked a good deal about the fertility examinations that he had undergone and stated that they might still have a child of their own and mentioned the possibility of adopting a four or five year old girl.

Fredrick is aware that he is adopted and throughout the interviews has made no reference to the fact. The psychologist found Fredrick had tested to be of very superior intelligence. He stated that the child has difficulty in establishing relationships on an emotional level and that he tends to relate superficially." In general, the psychologist believes that Fredrick feels that he cannot expect too much out of life but has to isolate himself and learn to take it. He seems to feel that what he gains from life is worth what effort he must put into achieving it, and because he feels that he cannot receive support from his parents in the home he must still seek satisfactory relationships outside of the home. The psychiatrist felt that Mr. Y. was overly critical of Frederick and that the child was confused about his relationship with his mother.

The case was closed because the family moved to an area outside of the city. Although the clinic workers felt that they had been able to help the family in a limited way they contemplated a referral to the Social Welfare so that Fredrick might feel that there was someone who had an interest in him alone. The most recent contact with the family situation was a letter from the Public Health Nurse who stated that Fredrick was withdrawn and unco-operative at school.

No. 5. The following case illustrates again the influence of parental attitudes on the emotional development of the child. In this case the
father stated that he had not wanted to adopt the child and the mother expressed some ambivalence in her statement that she wondered if they had waited too long before adopting the child. A further question comes to mind when one notes the difficulty which the parents have in telling Teresa that she is adopted.

**Reason for Referral:**
Teresa was four years old when her father contacted the Child Guidance Clinic at the suggestion of a friend and a private physician. He stated that Teresa is over-excitable, has difficulty sleeping, annoys and defies her parents, suffers from enuresis, sucks her thumb, tears her hair out by the roots, and has nightmares.

**Background History of the Child:**
Teresa was placed in the I. home at the age of one month. The child manifested eating difficulties at the age of six weeks. Mrs. I claims that her doctor told her that the child was a "hypertonic" baby. At the age of three months the baby weighed thirteen pounds. After much experimentation a suitable formula was prescribed by a child specialist.

Bowel training was completed when Teresa was two years of age and at the time she was brought to the clinic she still suffered from nocturnal enurises. Teresa had a severe attack of measles when she was two and she had her tonsils removed when she was two and one half years old. Her sexual development has been normal although she is a large child for her age.

Teresa's natural mother was a single woman twenty-seven years of age when the girl was born. The mother had a grade ten education and had been employed as a housekeeper, had worked in a factory, and had been in the armed services during the war.

The putative father was a married man, sixteen years older than the natural mother. He had a grade three education. He was employed as a casual labourer. He suffered from rheumatism and arthritis and was discharged from the armed services as medically unfit.

**Background History of Adoptive Parents:**
Mr. and Mrs. I. were married twelve years before Teresa was placed in their home. At the time of their marriage Mrs. I was twenty-four years old and was employed as head clerk in a large department store. She went back to the same job after Teresa was placed in the home, leaving her mother to care for the child.
Mrs. I. suffers from a nervous disorder for which she underwent chiropractic treatment.

Mr. I. had gained University entrance at the age of sixteen. He was 34 years old at the time of his marriage to Mrs. I. and has had various good jobs. He is presently employed as sales manager of a large furniture store.

Clinic Team's Evaluation of the Family Situation:

There appeared to be a fairly good relationship between the adoptive parents. Both parents were demanding of the child and neither could bring themselves to fully understand her affectional needs. However, Mr. I. told the psychiatrist that he was disappointed that Teresa was not more demonstrative and that he would have been "perfectly happy with a boy."

Mrs. I. seemed to have some fear about telling Teresa that she is adopted and she asked the social worker what her ideas were about children being told about their adoption.

Mrs. I. suggested that she had really waited too long before adopting Teresa. She said that she had not been able to think of getting another child because they have had so much trouble with Teresa. She stated that her husband had never wanted to adopt the child but that she thought that this was often the case with men. She said that she finally got her husband to consent to the idea and they were offered a boy before the war but refused the child because Mr. I. would not consider adopting a boy. Mr. I. had wanted a girl because they were quiet and easier to manage. Mr. I. went into the services and it was not until 1946 that they got Teresa.

Mr. I. stated that he did not treat Teresa as being at all different from any children they might have of their own. He added "She is adopted, you know." The social worker noted that Mr. I. "seemed touchy regarding his own feelings of not having children, saying quickly and aggressively, that all he knew was that they had been married twelve years and they had not had any children".

Mr. and Mrs. I. began to blame Teresa's problems on her heredity.

When Teresa was tested at the clinic she was judged to be of average intelligence although the tests were not completed. The recommendation of the clinic team was that case work be done primarily with the mother with additional play interview for Teresa.

The case was closed after a few contacts because it became apparent that the parents were more interested in the child's symptoms
than the child herself. Mr. I. resisted involvement in the case work plan and it was believed that Mrs. I. was looking for someone to punish Teresa.

The case was re-opened a year following the closure when the Public Health Nurse requested information concerning Teresa because she was presenting problems in school and seemed to be of a low mentality.

The following year Mrs. I. requested that Teresa be re-tested but telephoned later to say that she had enrolled her in a private school and that the child was adjusting well.

The case of Olga P. is another case in which the father was not enthusiastic about adopting the child. The maternal grandmother also disapproved. Other possible limiting influences in the family situation were the age difference between the adoptive parents and the length of time of marriage before the child was taken into the home.

Another important factor in the development of this child was that she lived the first fourteen months of her life in an institution where she suffered from lack of attention and when she was taken into the P. home she showed continued slow development.

Reason for Referral:
Olga P. was first referred to the Child Guidance Clinic for a pre-adoption appraisal at the age of three years. The recommendation of the clinic team was that there was no contra-indication to adoption.

Background History of the Child:
Olga was placed in the P. home at the age of 14 months but her adoption was not completed until she was 4 years old.

The second referral to the clinic was made by Mrs. P. at the suggestion of CCAS. The psychologist stated that he believed Olga to be slow normal in intelligence.

The problems that were evident in Olga's behaviour were nail-biting, nose-picking, masturbation. Olga was non-conforming and she annoyed and aggravated her mother.

Olga spent the first 14 months of her life in an institution. Here her development was slow and she developed a habit of rolling her eyes.
back into her head or of staring at the ceiling. After being placed in the P. home these habits disappeared.

Olga walked at seventeen months, was able to form sentences at two years, her teething was slow and she had only four teeth at fourteen months of age. Olga slept soundly but fought to stay awake. Mrs. P. stated that Olga was toilet trained easily but that she had a lot of difficulty with Olga's eating. Her physical development was normal.

Nothing is recorded of Olga's natural parental background.

Background History of Adoptive Parents:

Mr. and Mrs. P. were married for eighteen years before Olga was placed with them. Mrs. P. was 33 years of age and her husband was 57 at that time. Both parents received a primary education and Mr. P. was employed as a construction foreman.

Mrs. P. described her husband as a wonderful man, very affectionate and kind. However, she did feel that he was not strict enough with the children. (There is another adopted daughter who is two years younger than Olga.) Some difficulty has arisen between the two partners over Mr. P.'s refusal to discipline Olga and Mrs. P. has told Olga that she is the cause of their quarreling.

When Mrs. P. told Olga that she was adopted she evidently described her coming as an answer to their prayers. She is their first and special baby and that later they prayed for a sister for her and God sent "a most perfect little sister for Olga".

Mrs. P.'s mother had tried to persuade her against adopting a child but she "wanted children so much she prayed to God and they were finally given Olga". Mrs. P. said that if she wanted a baby that much he guessed it would be alright to go ahead with a plan for adopting one.

The social worker suggested that Mrs. P. wants very much to help Olga but she is so emotionally disturbed and upset herself she cannot be of much help to the child.

Clinic Worker's Evaluation of the Situation:

The case was closed because the parents found a threat that they believed would control Olga. They sent her to private school.

No. 17. The D. case illustrates the effects of over-demanding parents and the inability of parents to discuss adoption with the child. The influence of the upbringing of the adoptive parents is seen in this case to
affect the parents' handling of the child.

Reason for Referral:

Ernest D. was referred to the Child Guidance Clinic by his parents on the suggestion of a physician. Ernest was 11 years old at this time and was stealing, lying, biting his nails, was unable to get along with other people, had nightmares, was fearful and nervous and had bilious attacks.

Background History of the Child:

Nothing is known of Ernest's natural parents except that his mother was a Vancouver girl and his father an American serviceman.

Mr. and Mrs. D. adopted Ernest through the Children's Aid Society ten years after they were married. They had two natural children two and four years following the adoption placement of Ernest.

Ernest had a great deal of difficulty eating when a baby. Many formulae were tried but he was two years old before he could eat an entire meal without regurgitating. At least once a month until he was ten years old he got a bad attack of nausea and would have a high temperature. Each time he got a new tooth he went into a state of coma. He was given suppositories at eight weeks of age and movements were not normal for some time.

Background History of the Adoptive Parents:

Mrs. D. reported that she had had a "rather frustrating" childhood. Her mother was deaf and it was very difficult to carry on a conversation with her. As a consequence she became very attached to her father who she described as "uneducated and crude." She said that she was unhappy and lonely as a child. She did not get on well at school and particularly blames this on the teachers who insisted on tying her left hand behind her back so that she would have to use her right hand. She became hysterical when this happened and at the age of fourteen left school and took a business course and started to work for her father. She married Mr. D. when she was 30 years of age.

Mr. D. was 32 years of age when he was married. He blamed the delay in his marriage on the fear of "bad" women that was instilled in him while he was in the army. He joined the army before he was of recruitment age and since that time he had been employed in several jobs, each lasting a number of year. He is presently employed as a salesman.

When he was a child Mr. D. was moved back and forth from his own home to his uncle's home. He was first moved out of his own home when his mother died when he was three years of age. Some
years later he was moved from his uncle's home where he had been living back into his own home when his father re-married. Two years later his father died and he was again moved to the religious home of his uncle. Mr. D. thought that he had had a satisfying childhood although his uncle did make him work hard.

Marital Adjustment:
The couple show, at least outwardly, a considerable amount of affection (holding hands) and consideration for one another that was noticed and verbalized.

Clinic Team's Evaluation of the Family Situation:
Mrs. D. described her husband as being strict but good with the children. She stated, however, that the children seemed to be afraid of him. The psychiatrist stated after his interview with Mr. and Mrs. D. that the couple shows outwardly a considerable amount of affection (holding hands) and consideration for one another that was noticed and verbalized. He stated that he believed that their marriage is extremely important to them and that probably the standards of the marriage and the home life are maintained at all times with the children's needs coming second. The clinic team found the marriage situation to be unrealistic and isolated from other family relationships and it was felt that this pattern could not be altered. It was realized that the parents could not allow much "acting out" by Ernest and that he would require skillful handling.

It was suggested by the social worker that Mr. D. has some feeling about the adoption as he had told Ernest that his parents were killed in an accident. Mrs. D. on the other hand, seems overly concerned about what "the neighbours will think," and seems to try to behave according to their standards. She expressed considerable concern that the neighbours "expect the worst of adopted children."

The psychologist who tested Ernest believed him to be of average intelligence. After an evaluation of the situation it was suggested that Ernest's nervous habits seemed to indicate that he was under considerable pressure in the home - in his behaviour, his manners and his school performance.

After almost a year and one half of "continued service" when the stealing and lying had disappeared, Mrs. D. telephoned to say that since she felt the situation was so much improved she would not return to the clinic. The social worker felt that there were other problems which needed the attention but that in any case it was doubtful that the parents could be much more accepting to the child.
The case of David E. illustrates the influence of an over-protective mother and the concern of adoptive parents over their child's lack of warmth for them.

Reason for Referral:
David E. was referred to the Child Guidance Clinic for an evaluation of his emotional and intellectual development so that he might determine into what area he might be suited for employment. His mother contacted the clinic at the suggestion of the school principal.

Mrs. E. was concerned about her and Mr. E's inability to control David who was 15 years of age, and also about his poor school progress. Mrs. E. feared that her son was becoming delinquent as he had had several warnings from the police for committing minor offences.

Background History of the Child:
David was placed in the E. home at the age of two and one half years. Prior to this time he had lived for six months with his mother and father (the mother died and the father placed the children for adoption), and for the next two years of his life he lived in a foster home. He was completely trained when he came to the home and Mrs. E. could recall no difficulty in other areas of his development.

Background History of the Adoptive Parents:
In her own family Mrs. E. was the third youngest of eleven children. Her father drank heavily and he died when she was seven years old. She believes that her childhood was fairly happy. Mrs. E. has a grade eight education and left school at sixteen to take a business course. She married Mr. E. when she was 22 years old.

Mr. E. stated that his home life was happy although his father was an alcoholic. His father, mother and brother died when Mr. E. was seventeen and Mr. E. stated that the loss of his mother was a great shock to him. Mr. E. is employed in the fishing industry.

Mr. E. was concerned about David's behaviour but saw the various escapades as fairly normal for a boy of his age. However, he was concerned about David's coolness toward himself and his wife. His relationship with the boy seemed to be more passive and perhaps more understanding than Mrs. E's relationship with David.

David was told that he was adopted when he was eight years of age. Mrs. E. said that he was highly nervous when she told him and he just looked at her. Mr. E. stated that he showed no particular signs of anxiety when he learned of his status. He walked out of the house without saying anything. He did not mention his adoption in the next two years until one
day he refused his father stating that he was not his son anyway. It is this attitude that causes Mr. and Mrs. E. so much distress.

Marital Adjustment.
Mr. and Mrs. E. felt that they had many things in common when they entered marriage. They stated that their disappointment at not having a family was partially met through David. The social worker stated that from her observations and certain stated attitudes toward each other, it would appear that the marriage had been a successful one and that both parties were well adjusted. She noted further that there was a prevailing element of warmth and good humour in the marriage.

Clinic Team's Evaluation of the Family Situation:
In remarking on Mrs. E.'s relationship with David the social worker stated that Mrs. E. was inclined to be quite demanding of the boy. Also she gives the impression of being overly concerned about his daily activities and of trying to control him too much. Often her demands are unrealistic; for example, she expects him to do very well in school when he has never achieved better than average marks. She does not appear to accept David's growing masculinity and seems threatened by it. Her own tendency toward masculinity would account for conflict in this area.

In discussing his adoption with the social worker David said that he had no particular feeling about it.

It was felt that case work service had helped this family to a limited degree.

The cases summarized in this chapter, are, of necessity, only a sampling of those utilized in the overall study. They do, however, provide a representation of the disorders prevalent throughout the group, and reflect, also, the parental attitudes which could easily provide impetus to the disorders.

The next chapter of this thesis will summarize the results of the study, and put forth recommendations seen, by the writer to be necessary.
The family has always been the basic unit of society. It has been the medium through which has filtered the laws, concepts and mores of society, to the children of each succeeding generation. The essential ingredients of the family medium used to transmit this information have been, and still are, love, personal attention and response on the part of parents, toward the child. The bare necessities of physical needs provided by the family have been far out-weighed by these less tangible realities.

Unfortunately, family units are not always the best - not all make use of love, response and personal attention to provide the medium for transmission of ideas and ideals.

Society takes cognizance in many ways of the fact that there are "good" and "bad" family environments. One of the most striking is in the care with which it attempts to place children without families of their own, in a family, thereby providing the child with a natural element in which to grow. But, in spite of the checks and balances devised, some children are placed in families which are unable, or unwilling, to provide the proper blend of love and care, necessary for the development of the child. Natural children who come into such families, of course, are, for the most part, outside the ken of the law. Children without families - children who are adoptable - are the ones for whom the legislation and investigation is meant. However, as Robert Burns once said,
"The best laid plans for mice and men..." and nowhere is the truth of his statement more evident, nor the result more unhappy, than in the case where a child has been placed with the "wrong" type of family.

There were twenty-eight children in the study group which formed the basis for this thesis. This group is by no means representative of the over-all adoption situation, as they are merely those adopted children referred to the Child Guidance Clinic between April 1st, 1953 and March 31st, 1955. Those adopted children who have not been referred to the Clinic have not been taken into account. Hence, it must be reiterated that the group under study is an abnormal one. The common elements running through all cases in the study are that the children are adopted, they have a personality disorder, and they have been referred to the Child Guidance Clinic in the two year period mentioned above. In the nineteen cases in which information was available on the subject, there was another common factor - that of some limiting factor to the child's development within the family situation. This bears out the findings of other studies. Figure I shows the limiting family situations which were found in the nineteen cases on which any information (pro and con) was available. The chart contains material that was discussed earlier in this thesis.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Presenting Problems</th>
<th>Number of Placements</th>
<th>Age at time of Placement</th>
<th>Limiting Family Influences</th>
</tr>
</thead>
</table>
| #1      | disobedient, enuretic | none                 | 15 days                  | - mother regrets placement and feels that her doctor encouraged her to take this child.  
|         |                     |                      |                          | - parents feel cause of problem lies in child's heredity. |
| #2      | enuretic, sensitive,  | unknown              | 6 weeks                  | - mother has anxiety about people learning child is adopted.  
|         | nervous, school      |                      |                          | - father has little understanding of child's affectional needs.  
|         | difficulties         |                      |                          |                   |
| #3      | poor school progress, | 8 homes in 10 months | 10 months                | - father did not wish to adopt child.  
|         | negative attitude, nail-biting, nervous, fantasy. |                      |                          | - child did not meet mother's idealistic expectations. |
| #4      | physical complaint, unhappy, lazy, antisocial, stammers, school progress | 3 homes in 7 months | 7 months                 | - father discouraged over showing of affection.  
|         |                     |                      |                          | - father's food fads rigid during early years.  
|         |                     |                      |                          | - difficult experience when started school.  
|         |                     |                      |                          | - father absent from home between 5th and 7th year of child's life.  
|         |                     |                      |                          | - when child learned of adoption he was given no explanation of situation.  
|         |                     |                      |                          | - poor marital relationships. |
| #5      | over-excitable, sleeplessness, antasonizes, enuresis, thumb-sucking, nightmares, poor school progress | 1 | 1 month                  | - mother feels waited too long before adopting child - 12 years.  
|         |                     |                      |                          | - father never wanted to adopt child.  
<p>|         |                     |                      |                          | - parents have difficulty in discussing adoption with child. |</p>
<table>
<thead>
<tr>
<th>Case No.</th>
<th>Presenting Problems</th>
<th>Number of Placements</th>
<th>Age at time of Placement</th>
<th>Limiting Family Influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>#6</td>
<td>non-conforming, nail-biting, nose-picking, sniffing, masturbating</td>
<td>2 in 14 months</td>
<td>14 months</td>
<td>marital disharmony over child's problems. maternal grandmother raised strong objection to her daughter adopting child after 18 years of marriage.</td>
</tr>
<tr>
<td>#7</td>
<td>stealing, temper tantrums</td>
<td>1</td>
<td>2 months</td>
<td>father not in favour of adoption. father over critical. father imposed diet on the family.</td>
</tr>
<tr>
<td>#8</td>
<td>temper tantrums, poor school progress</td>
<td>unknown</td>
<td>5 months</td>
<td>parents have difficulty in discussing child's adoption with him. father has difficulty in showing affection.</td>
</tr>
<tr>
<td>#9</td>
<td>poor school progress, minor delinquent acts.</td>
<td>2</td>
<td>2 1/2 years</td>
<td>parents are over-concerned about child's lack of warmth toward them. mother is over-protective and demanding. parents were disappointed at not receiving a younger child.</td>
</tr>
<tr>
<td>#10</td>
<td>aggressiveness, nail-biting, hair pulling, disobedient</td>
<td>1</td>
<td>8 months</td>
<td>father did not want to adopt. mother had ambivalent feelings - wanted to protect child from its own mother who was mentally ill. Conflict in the home over interference of the child's natural father who was a brother of the adoptive father.</td>
</tr>
<tr>
<td>#12</td>
<td>enuretic, jealous</td>
<td>none</td>
<td>15 days</td>
<td>parents express anxiety around adoption.</td>
</tr>
<tr>
<td>#13</td>
<td>poor school progress, nail-biting, sleeplessness, aggressiveness.</td>
<td>unknown</td>
<td>2 months</td>
<td>father not accepting of initial adoption plan. father has difficulty in discussing child's adoption with him.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Presenting Problems</td>
<td>Number of Placements</td>
<td>Age at time of Placement</td>
<td>Limiting Family Influences</td>
</tr>
<tr>
<td>----------</td>
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<td>--------------------------</td>
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</tr>
<tr>
<td>#15</td>
<td>nervous, lying, stealing, non-conforming</td>
<td>unknown</td>
<td>3 months</td>
<td>- mother was a widow at the time of adoption - wanted child to fill her need for affection.</td>
</tr>
<tr>
<td>#17</td>
<td>stealing, lying, none-picking, anti-social, teasing, nightmares, fears, nervous, bilious attacks, poor school progress</td>
<td>unknown</td>
<td>6 weeks</td>
<td>- probability of too high standards being set by parents. - parents have difficulty in discussing child's adoption with him.</td>
</tr>
<tr>
<td>#18</td>
<td>high strung, hyperactive, aggressive, tense head movements, tic in facial muscles</td>
<td>unknown</td>
<td>5 weeks</td>
<td>- father suggested child's heredity to be the cause of child's difficulty. - parents expect child to conform to adult standards. - father unable to understand child's affectional needs.</td>
</tr>
<tr>
<td>#20</td>
<td>bullying, aggressive, anti-social, unhappy, lighting fires, temper tantrums</td>
<td>3</td>
<td>1 year</td>
<td>- mother wanted child of opposite sex to the child they adopted. - father sets too high standards. - marital discord.</td>
</tr>
<tr>
<td>#21</td>
<td>soiling, finger-sucking nightmares</td>
<td>unknown</td>
<td>5 months</td>
<td>- child did not meet with mother's idealistic expectations. - mother fanatically religious - feels she is being punished for adopting the child. - father not fond of any child.</td>
</tr>
<tr>
<td>#22</td>
<td>uncontrollable, lying, sex play, stealing</td>
<td>1</td>
<td>16 months</td>
<td>- parents suggested the child's heredity to be the cause of his difficulty. - marital disharmony over disciplining children. - parents are demanding of complete conformity.</td>
</tr>
</tbody>
</table>
Figure 1 continued

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Presenting Problems</th>
<th>Number of Placements</th>
<th>Age at time of Placement</th>
<th>Limiting Family Influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>#23</td>
<td>thumb-sucking, nervousness, temper tantrums.</td>
<td>unknown</td>
<td>10 weeks</td>
<td>- father severe disciplinarian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- father heavy drinker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- indication of marital conflict</td>
</tr>
<tr>
<td>#24</td>
<td>antagonistic, lying stomach aches</td>
<td>3 in 3 yrs.</td>
<td>3 years</td>
<td>- parents suggested child's heredity is cause of his difficulty.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Footnote:

1. In 9 cases the recording was not adequate enough to get a picture of the situation.
The foregoing chart was organized in an attempt to determine whether or not any one behaviour disorder was associated with any particular stress in the family. Because the group was so small this does not appear, also all of the children suffered from more than one disorder. This does, of course, indicate that behaviour is caused and that different people react in different ways to different stresses.

The chart is divided into five columns which include: the number of the case, the disorder presented by the adopted child, the number of placements the child experienced prior to his adoption, the age at which he was placed in the adoptive home and the influences in the adoptive home which may have helped, in combination with other factors, to cause the behaviour disorders in the adopted children.

The influences in the home were judged to be "limiting" if the attitudes of the parents were negative toward the child, if the standards of performance set by the parents were unrealistic in relation to what is normally expected of children in our European-American culture if there was a poor relationship between the adoptive parents, if there was some outstanding belief or "quirk" which was not generally accepted by everyone, for example, food fads.

Information for the chart was gained from the portions of the case records that were read for this thesis. From these records it was revealed that the most significant "limiting family influence" was

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Disorder</th>
<th>Placements</th>
<th>Age</th>
<th>Influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ADHD</td>
<td>3</td>
<td>5</td>
<td>Poor parents, unrealistic standards, poor relationship with adoptive parents, food fads</td>
</tr>
<tr>
<td>2</td>
<td>OCD</td>
<td>4</td>
<td>7</td>
<td>Striking belief in family, no performance standards, food fads</td>
</tr>
<tr>
<td>3</td>
<td>SAD</td>
<td>2</td>
<td>4</td>
<td>Parents negative, performance expectations based on European-American culture, food fads</td>
</tr>
<tr>
<td>4</td>
<td>AN</td>
<td>5</td>
<td>6</td>
<td>Poor relationship with adoptive parents, food fads</td>
</tr>
<tr>
<td>5</td>
<td>PTSD</td>
<td>3</td>
<td>8</td>
<td>Outstanding belief in family, performance expectations unrealistic</td>
</tr>
</tbody>
</table>

...
that one or other of the parents had not been in agreement with the other partner when the plan for adopting the child was worked out. The parent who was not in favour of the adoption reported that he, or she, consented to the adoption to place his, or her, marriage partner. The second most common "limitation" is seen in the feeling that the parents express about telling the child that he is adopted. Other factors in the home situation which are likely to have affected the development of the adopted child are the high standards that his adoptive parents set for him.

The effect of the multiple placement of children does not come through clearly in this chart but in view of what is known about the effect on a child of moving and separation from his mother figure, we can assume that, for example, in case #3 the eight foster homes in the first ten months of the child's life did contribute to the difficulties the child experienced in the home.

The study undertaken for this thesis was attended with certain difficulties because of the inaccessibility of the case records and the lack of, and vagueness of some of the information contained therein. This finding definitely points up a need for more clarity and specificity in the recorded entries of case records.

Because the process of adoption is considered by most people to be a very "personal" thing they are protected by law through the practice of the social work principle of belief in the rights of the individual. It is the right of the individual to expect that such information as the fact
that his child is adopted be kept confidential. The practice of confidentiality is carried out by all social work agencies including the Child Guidance Clinic where no reference whatsoever is made about the "status" of the child, unless he is a ward of a children's agency, is found on the card index file.

The study was further complicated by the limited amount of recorded factual material found in the case records. For example, in only eight of the twenty-eight cases of adopted children was the condition of the adoptive mother's health recorded. These conditions included stomach ulcers and multiple sclerosis. There was information concerning the health of the adoptive fathers in only five cases. Surely the physical well-being of the adoptive parents has a bearing on the way they react to the child and in their attitudes toward each other. It was observed that the marriage date of the adoptive parents was not recorded in thirteen of the twenty-eight cases and that the age of the adoptive parents was available in only nineteen of the cases studied.

The vagueness of some of the recording was also noted. This criticism might be carried over to an evaluation of the case work done by the Clinic social workers; however, this was not the purpose of this thesis. To illustrate what is meant by the term "vagueness" in recording the social worker recorded in the "M" case, "The brothers have definite ideas about the authority of Government, and during the war, because Mr. M. refused to join the army or work at compulsory work projects he spent
some time in prison." "Another instance of vagueness in recording is seen in the social worker's remark, "Mr. F. seemed to have feeling about the adoption," with no statement as to how this "feeling" was expressed or how the social worker knew that the feeling was present.

Peoples feelings and attitudes are difficult to assess. It requires a high degree of skill to judge what motivates people to do the things they do, what standards and values people possess, and how these fit in with those standards and beliefs of the community, and so on. It is for this reason, and many others and many others not listed here, that the assessment of the adoptive home and the adoptive parents is a difficult task. It is made more difficult because a bad choice of adoptive home for a particular child may aggravate behaviour reactions and cause the child to become a non-productive member of our society. Social workers in assuming the responsibility for placing children in adoptive homes have much to learn about the intricacies of human behaviour, the influence of parents upon children, and the influence of children upon their parents. There is a need for much more reliable research in the area of parent-child relationships.

This study has shown that the social worker who investigates the adoptive home and evaluates the home and the adoptive parents must take particular caution in assessing the attitudes of both of the adoptive parents toward the adopted child, the parents ability to accept a child biologically not their own, the parents ability to accept a child of an
illegitimate pregnancy, and the parent's acceptance of their inability to have their own children.

It is hoped that this thesis has pointed up the importance of investigating thoroughly the real attitudes of the prospective adoptive parents about children and adoption and that it lays some basis for further study in the area of adoption, especially adoptions which have not been satisfactory. The consistent carrying out of this practice protects the adopted child and the adoptive parents. Also, as the number of successful adoption placements is raised, social workers will meet less resistance from the community and more people will adopt their children through social agencies rather than through private sources such as doctors and lawyers.

In order to protect the adopted child from "limiting" family influences, it seems from the study that the social workers in the child placing agencies should work toward a more thorough investigation and understanding of the prospective adoptive parents' attitudes toward adoption of a child. During the pre-adoption period, right through to the end of the adoption probation period, the social worker should make regular visits to assess the family situation and to offer her help and support to the "new" parents.

Summing up the findings of this thesis, then, relative to adoption practice it is seen:
1. in the initial stages of the adoption plan several of the adoptive parents showed no positive desire to take the child;

2. Many of the adoptive parents were unable, or found it very difficult to tell the child that he was adopted;

3. all of the adopted children studied showed more than one disorder in his social and personal functioning;

4. many of the records concerning the cases of the adopted children in the study showed a lack of detail, clarity and uniformity.

A basic assumption at the outset of this thesis was that adoption is designed to meet the needs of the child. Where did the process fail in the cases in the study group? What factors in the adoptive homes led to the development of behaviour disorders in the adopted child's personality? These questions have been answered in part, but the validity of the conclusions drawn has been severely limited, if not completely improvised, first, by the number of available cases in the study group, and, second, by the paucity of information recorded in the cases themselves.

However, what can be learned from the study is that before the adopted child is placed in the adoptive home, the responsible people - the adoptive parents, the placement agency workers, and the judges of the courts - should look long and hard at the whole situation. They should not be mislead by the bright eyes, curly hair and chubby features of an innocent child into a feeling of false security. "No one could do anything harmful to this beautiful child!" Social workers must be realistic. They must be trained to assess correctly adoptive parents' real wish
for a child as well as the material things the parents can offer the child, and they must develop even better placement practices for the protection of the adopted child.
Appendix A.

Specifications from "The ABC of Foster Family Care for Children"
(No. 216 1933) Bulletin U.S. Children's Bureau

Adequate Shelter: a clean, light, well-ventilated, orderly home; properly heated in winter, with sanitary toilet facilities. The child should have a separate bed and a place in which to keep private possessions and to entertain friends.

Nutritious Food: there should be enough of it, it should be simple, well-prepared, and adapted to the age of the child; it should be served at regular hours amid attractive surroundings, and eaten at leisure in a cheerful atmosphere.

Comfortable Clothing: clean, whole, attractive garments that fit and that are individually owned, sufficient changes for cleanliness; adequate protection against inclement weather.

Health Habits: individual toilet articles, frequent baths; proper care of teeth, regular bed time and plenty of sleep, abundance of fresh air and pure drinking water; several hours of outdoor play each day; definite teaching of health rules and of wholesomeness; happy courageous attitudes; sensible instruction in sex matters.

Recreation: a safe, clean, roomy place for outdoor and indoor play; suitable play materials and tools, sympathetic supervision.

Education: attendance at a community school of good standards as long as the law requires and as much longer as the child's capacities warrant.

Vocation: development of each child's fullest capacities through high school, commercial trade school training in line with special abilities.

Family Life: a chance to live in a normal family group of differing ages without being crushed by numbers, to develop mutual attachments and a sense of responsibility for others and for the work of running a household.

Community Life: have a part in community group activities and festivities; opportunity to make friends in natural ways through entertaining and being entertained; normal associations with persons of the opposite sex.
Morals and Religion: positive teaching of standards of right and wrong aside from measures of discipline, daily contact with adults of sound character and inspiring personality; attendance at religious services of the type preferred for each individual case.
SOCIAL HISTORY OUTLINE.

A guide to preparation of Social Histories for the Child Guidance Clinics.

DATE WRITTEN:  
DATE OF EXAMINATION:  

NAME:  

BIRTHDATE:  

STATUS: (Ward, Non-Ward, etc.)  

PARENTS: (FATHER)  
(MOTHER)  
(MAIDEN NAME)  
(TELEPHONE:  

BIRTHDATE:  
BIRTHDATE:  
ADDRESS:  
SS. INDEX:  

SOURCE OF REFERRAL: (By whom and how)  

PROBLEM: (1) As stated and seen by parents, child, and any other closely involved persons.  
What help are they asking for?  
How long have parents, child or others been aware of the problem(s)?  
How do they feel about receiving help?  

(2) Social worker's general picture of problem. Estimate client's awareness of the presenting problem and other problems seen by the social worker.  
Reason for referral to Clinic at this time.  
What specific help is desired by social worker.  

DATE OF PREVIOUS EXAMINATION AT C.G.C., E.P.H., ETC. (Child or relatives)  

FAMILY HISTORY  

HOME SETTING: Pertinent and brief descriptive material of present home setting--economic and community status; housing; persons in home.  

FATHER: (1) Identifying information--name; present age; place of birth; religion.
Appendix B continued.

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(2) Social and cultural background--others in family, ages; father's description of paternal grandparents; father's estimate of his adjustment to family, school, religion, and social groups; extent of education; work record, health; any serious illnesses or operations.

(3) Family relationships -- father's feelings about and relationship to child, to wife, to others in family; Father's attitude and contribution with regard to problem(s); How does he handle it?

(4) Paternal relatives-- information pertinent to child and parents' adjustment.

MOTHER: Information as for father (1), (2), (3).

(4) Maternal relatives-- information pertinent to child and parents' adjustment.

MARITAL ADJUSTMENT: When, where, and how did parents meet? Courtship; Sexual adjustment.

STEP-PARENTS OR FOSTER HOMES: As above with dates child was with them and reasons for leaving. Indicate and evaluate relationships, adjustment, and the meaning of the experience to the child. (in chronological order)

SIBLINGS: Identifying information-- name; date and place of birth, religion. How do they fit into the family, inter-personal relationships?

PERSONAL HISTORY

DEVELOPMENTAL FACTS:

Date, place of birth; Age weaned; Bladder control at
Toilet training began; Bowel control at:
Teethed at; Walked at:
Talked at (words); (sentence formation):

DESCRIPTION OF DEVELOPMENT TO DATE: mother's health, attitudes and feelings about child during pregnancy; method of delivery; length of labour; birth injuries.
(1) Eating: Method of early feeding;
   Method of weaning, any early feeding, or present eating difficulties;
   Food fads or fussiness:
   Indigestion or any indication of gastro-intestinal disorder.

(2) Elimination: Method and attitudes in training child;
   Difficulties:
   Any indications of frequent constipation or diarrhea:
   Any incidents of enuresis;
   Soiling;
   Smearing:
   Any present unusual attitudes or habits regarding elimination.

(3) Sexual development:
   Interest in sexual information;
   Any incidents of exhibitionism
   Sex play;
   Masturbation or intercourse (describe, including age and frequency, of such incidents);
   Extent of sexual knowledge.

PERSONAL HISTORY

From whom obtained;
Evidence of development;
Age of puberty;
Attitude toward it;
If menses established is it regular? Painful?
Has someone discussed puberty and sexual role with child?
Any indication of abnormal sexual behaviour?

(4) Physical development:
   Has physical growth been normal?
   Give incidents of illness, disease (ages) sequela
disability, etc.)
Reactions of child and parents to serious illnesses,
Disabilities:
Operations and preparation of child for these (age);
Child's attitude to and estimate of present health;
Any over-compensation or over-concern.
Appendix B continued.

PERSONALITY AND APPEARANCE:

Physical description;-- any indications of nervous habits; fears; disturbances of sleep; recurrent or significant dreams.

General picture of the child's outstanding relationships and how he (she) uses these.

How does he (she) handle feelings and need such as anger, affection, dependency in relation to his (her) closest relationships. Attitudes to school, teachers, people in authority.

Interest and Recreation; adjustment to social groups, employment, particular friends of both sexes.

Ambitions and goals.

Estimate of child's insight, intelligence, humour.

SCHOOL RECORD:

Grade and teacher's report. Bureau of Measurements record if in Vancouver.

EVALUATION AND PLAN

Social worker's evaluation of case from work done by the presenting agency.


What has been done? How frequent are the contacts? How strong is worker-child relation?

What methods have been tried in working with child and parent (s)?

What has been tried by family members in dealing with problems? How successful?

What possible resources are there in family or community to help meet child's needs?

What are worker's suggestions for carrying on from the point?

Questions around which social worker would like discussion.

ALL HISTORIES SHOULD BE SIGNED BY THE SOCIAL WORKER AND FOUR COPIES SUBMITTED TO THE CLINIC.
**Appendix C**

**CASE STUDY OUTLINE**

<table>
<thead>
<tr>
<th>Present Status of Case:</th>
<th>Intake</th>
<th>Con. ser.</th>
<th>Closed</th>
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</thead>
<tbody>
<tr>
<td><strong>CHILD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td>Birth Date</td>
<td>IQ</td>
</tr>
<tr>
<td>Adoptive Name</td>
<td></td>
<td>School Grade</td>
<td>Progress</td>
</tr>
<tr>
<td>Date of referral</td>
<td></td>
<td>Service offered</td>
<td>Clinic Rec.</td>
</tr>
<tr>
<td>Date re-opened</td>
<td></td>
<td>Service offered</td>
<td>Clinic Rec.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service offered</td>
<td>Clinic Rec.</td>
</tr>
<tr>
<td>Age at time of referral</td>
<td></td>
<td>Age at time of Adoption</td>
<td></td>
</tr>
<tr>
<td>Application made by (if Private)</td>
<td></td>
<td>Suggested by (if private)</td>
<td></td>
</tr>
<tr>
<td>Method of referral (private, Agency)</td>
<td></td>
<td>Method of Placement (private, Agency)</td>
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</tr>
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</table>

**Placement History**

<table>
<thead>
<tr>
<th>Date of pre-adoption placement</th>
<th>Age</th>
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<tbody>
<tr>
<td>1.</td>
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<td>3.</td>
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</table>

Problems as stated by the parent or Agency:

---

Reason for referral at this time

What is the specific request of applicant?

**Developmental History:** (Presenting problems in relation to developmental history.)

- Eating
- Elimination

Sexual Development

Physical Development

Does the child know he is adopted? _______ At what age was he told? _______

**Natural Parents**

<table>
<thead>
<tr>
<th>Natural Parents</th>
<th>Name</th>
<th>Birth Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother:</strong></td>
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<tr>
<td><strong>Father:</strong></td>
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</tbody>
</table>

**Method of delivery**  **Length of Labour**  **Birth Injuries**

Age at time of child’s birth

<table>
<thead>
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<th>Age at time of child’s birth</th>
<th>Status</th>
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<th>Age at time of child’s birth</th>
<th>Status</th>
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</table>
Appendix C. (continued)  

Father: (Continued)

Education ____________________________ Occupation ____________________________

Health

Paternal Grandparents: Maternal Grandparents:

Health of Father ____________ Health of Father ____________

Mother ____________ Mother ____________

Occupation of Father ____________ Occupation of Father ____________

Adoptive Parents

Name ____________________________ Date of Marriage ____________________________

Address ____________________________ Previous marriages - wife ____________________________ husband ____________________________

Adoptive Mother

Birth date ____________________________ Age at time of marriage ____________________________

Nationality ____________________________ Place of Birth ____________________________

How long has she been in Canada? ____________________________ Religion ____________________________

Education ____________________________ Occupation before marriage ____________________________

Health (serious illness or operations) ____________________________

Mother's estimate of adjustment in childhood home ____________________________

Sociability (membership in clubs etc., ) ____________________________

Adoptive Father

Birth Date ____________________________ Age at time of marriage ____________________________

Nationality ____________________________ Place of birth ____________________________

How long has he lived in Canada? ____________________________ Religion ____________________________

Education ____________________________ Occupation ____________________________

Work record ____________________________

Health ____________________________

Father's estimate of adjustment in childhood home ____________________________

Sociability ____________________________

Natural Children

Name:  1. ____________________________ Age ____________________________

2. ____________________________ Age ____________________________

3. ____________________________ Age ____________________________

4. ____________________________ Age ____________________________

Adopted Children

Name: ____________________________ Source of Adoption ____________________________ Age ____________________________

__________________________ Source of Adoption ____________________________ Age ____________________________

Marital Adjustment as seen by worker ____________________________
3.

Marital adjustment as seen by husband

Marital adjustment as seen by wife

Worker's evaluation of parent-child relationships

Home setting:
Physical surroundings: Excellent ___ Good ___ Adequate ___ Poor ___

Siblings of father:
Name ___________________________ Age ______ Occupation ___________________________

__________________________  ______  ___________________________

__________________________  ______  ___________________________

__________________________  ______  ___________________________
Appendix D

BIBLIOGRAPHY

Specific References

Books:


ARTICLES


Appendix D continued.


STUDIES AND REPORTS


