DOCUMENT RESUME

ED 323 735 EC 232 165

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TITLE Adoptive and Birth Family Adjustment to Rearing Retarded Children.
SPONS AGENCY National Inst. of Child Health and Human Development (NIH), Bethesda, Md.
PUB DATE May 90
CONTRACT NICHD-21993
NOTE 14p.; Paper presented at the Annual Meeting of the American Association on Mental Retardation (14th, Atlanta, GA, May 27-31, 1990). Funds were also provided from St. Mary's College of Maryland Faculty Development Grants.
PUB TYPE Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adjustment (to Environment); *Adopted Children; Adoption; *Biological Parents; *Child Rearing; Comparative Analysis; Depression (Psychology); Family Characteristics; *Family Environment; *Mental Retardation; Mothers; Placement

ABSTRACT

The study identified 81 families who adopted children with mental retardation or at risk for mental retardation, and compared them with 61 matched families with similar birth children. For birth families, the initial diagnosis was a time of crisis, with high depression scores, while scores at follow-up (an average of 5.3 years later) indicated no significant depression. Adoptive families showed no significant depression at initial placement of the child or at follow-up. Birth mothers reported more limits on family opportunities, more family disharmony, more concern with the lifespan nature of the commitment to the target child, more financial stress, and more acknowledgement of the personal burden of caring for the target child than adoptive mothers. No differences were found on the lack of personal reward, terminal illness stress, or the preference for institutional care. Adoptive mothers scored higher on measures of family pride, family accord, and marital happiness and consensuality. It is concluded that: (1) adoption is a successful intervention for children with disabilities as measured by parent and family functioning; and (2) birth parents recover from their depression at the time of diagnosis and become better adjusted. Includes five references. (JDD)

Adoptive and Birth Family Adjustment to Rearing Retarded Children

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Paper presented at the May 1990 annual meeting of the American Association on Mental Retardation, Atlanta, Georgia. The research was supported, in part, by Grant No. 21993 from NICHD and from St. Mary's College of Maryland Faculty Development Grants, all to the first author.

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Children with handicapping conditions come into care for a variety of reasons. Sometimes a birth family is unable to cope with the rearing of a child with handicaps and relinquishes guardianship rights to the child. Other times, children are removed from their families because of neglect or abuse. Increasingly, these children are being placed in substitute homes either on an adoptive or permanent fostering basis. The short- and long-term outcomes of these placements are of interest because they can inform policy and practice in child placement.

They also have theoretical value, however. For many years, child development researchers have emphasized the negative features and the pathology surrounding the rearing of a handicapped child. In studying families who choose to rear a handicapped child and who are usually well-prepared for the entrance of that child into their home, the positive aspects of the impact of the child on the family are more readily observable. Once identified, these positive aspects can be explored in birth families as well, perhaps reversing the current professional attitude that the birth of a handicapped child signals the onset of chronic sorrow.

The current research compares families who have adopted children with mental retardation or who are at risk for mental retardation, with matched families with similar birth children. Although data collection is still ongoing, the present paper will examine the results f. 81 adoptive families and 61 birth families. In the long run the dataset from these families will

be extraordinarily rich, consisting of a number of standardized self-report instruments, as well as responses to a semi-structured interview of more than 150 questions. However, today, I will report only on selected sample characteristics and the results of several parent and family adjustment measures.

Sample Characteristics

Table 1 displays the characteristics of the participating families. As can be seen from this table, adoptive and birth families are approximately matched on many important demographic indicators. There are no significant differences between them on family income, occupational status, maternal educational level, percentage of mothers currently married, maternal religious affiliation, or maternal race. The adoptive mothers in the sample are, however, older than the birth mothers. There are also signficantly more children in the adoptive than in the birth families.

In addition to the approximate matching on family characteristics, matching was also attempted for some important child characteristics. Table 2 summarizes the most important of them for the target adoptive and birth children. There were no significant differences between adoptive and birth children on age at interview, race, sex, or the percentage that were currently functioning in the retarded range. No analyses were done on the primary diagnoses, but there appear to be only small differences between the two samples.

Table 1

Characteristics of Adoptive and Birth Families[a]

Characteristic	Adoptive (n = 81)	Birth (n = 61)
Family Income ($)	39876	34142
Occupational Status	46	44
Maternal Age (yrs.)	42	34
Maternal Educational Level (yrs.)	13.6	12.9
Mothers Currently Married (%)	76	87
Maternal Religion-Protestant (%)	70	53
Maternal Race-Caucasian (%)	74	82
# Nontarget Children in Family	4.1	1.6

[a]Numbers are means unless otherwise indicated.

[b]The MSE12 is an index of occupational status which varies from a low of 13 to a high of 88 (Featherman & Stevens, 1982).

Table 2

Characteristics of Adoptive and Birth Target Children[a]

Characteristic	Adoptive	Birth
	N = 81	N = 61
Age at Interview (mos.)	75	81
Race - % Caucasian	55	81
Sex - % Female	48	38
% Currently Retarded	70	80
Primary Diagnosis (%)		
Developmental delay/unknown origin	24%	15%
Cerebral palsy	19%	13%
Down syndrome	14%	18%
Other chromosomal/genetic	5%	18%
Low birth weight, brain damage or other organic	9%	23%
Alcohol or other drug related	8%	0
Other	21%	13%

[a]When more than one target child is in the family, only the oldest is represented here.

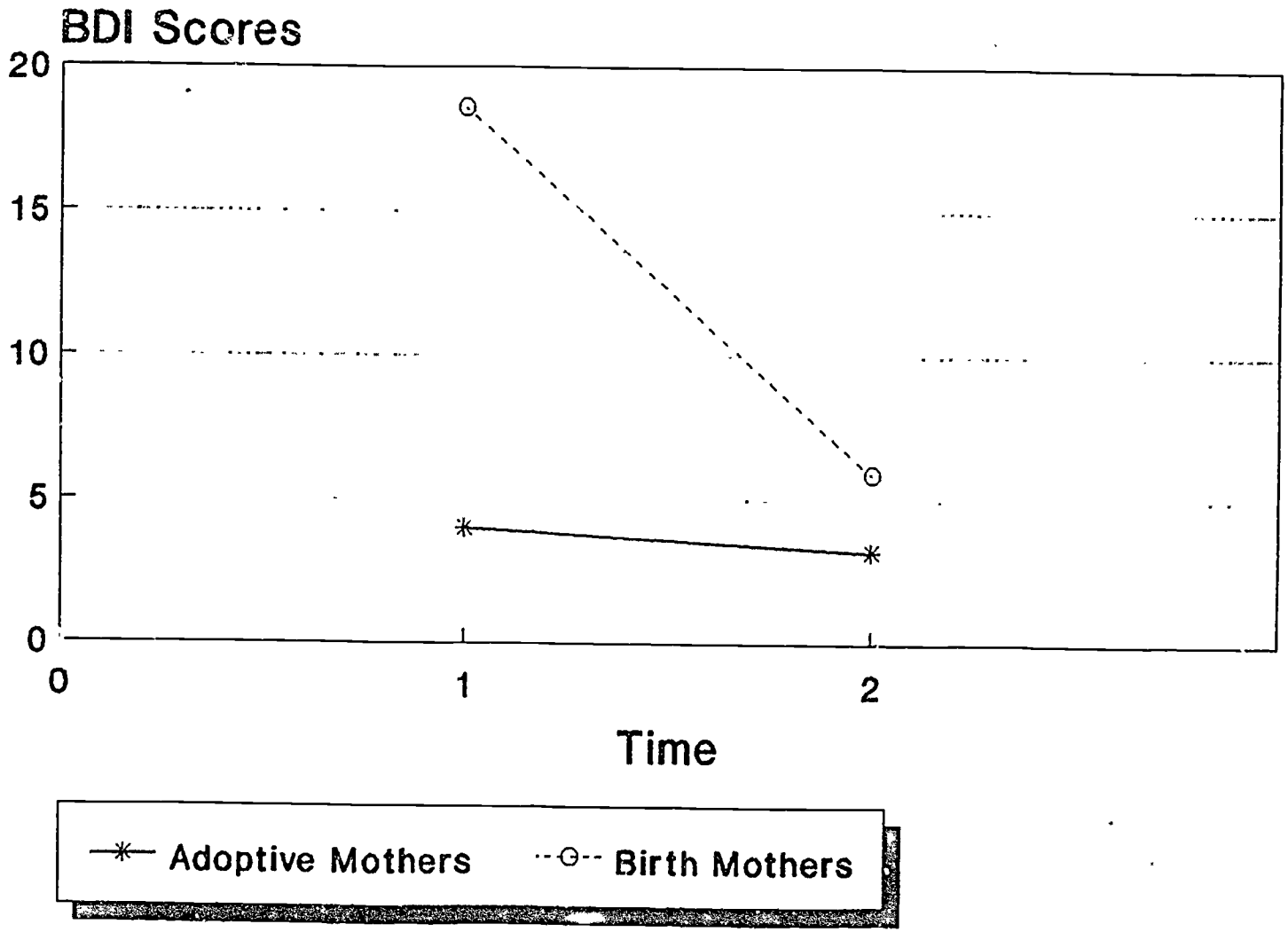
Results

The initial reaction of birth and adoptive mothers to the diagnosis/placement of the target children was quite different. The scores on the Beck Depression Inventory (BDI) is one measure of this reaction. Each respondent completed the BDI twice during the semi-structured interview. For the first administration, respondents were asked to remember how they felt during the first few weeks after the diagnosis or placement of the target child. For the second administration, respondents were asked to complete the BDI for how they were feeling currently. The average time between the placement/diagnosis and the interview was 5.3 years.

Figure 1 presents the results of the BDI scores for both birth and adoptive families. It is clear that for birth families the initial diagnosis was a time of crisis, with high BDI scores, whereas scores for current functioning indicate no significant depression. For adoptive families, however, there is no difference in depression of mothers between the time when the adoptive child first came into the home and the current time. This interaction was significant in a Family Status (Adoptive vs. Birth) x Time analysis of variance ($F = 57.8$, $df = 1, 136$, $p < .001$. The main effects of family status ($F = 65.8$, $df, = 1, 136$, $p < .001$) and time ($F = 75.2$, $df = 1, 136$, $p < .001$) were also significant.

Although the BDI scores indicate similarity between birth and adoptive families in current functioning, the results of three other measures do not. Table 3 presents mean scores for maternal responses to the Holroyd Questionnaire on Resources and Stress (QRS), a self-report instrument which contains 66 true-

Depression in Birth and Adoptive Mothers



Time 1=Child Diag/Entry; Time 2=Interv

false questions, yielding 11 factors as listed in Table 3 (Holroyd, 1985). Some of the factors related specifically to child characteristics, some to parent reactions, and some to family functioning.

As can be seen in Table 3, adoptive and birth mothers responded similarly for the three scales that contain items that are essentially descriptions of the child's characteristics. No significant differences were found for the Dependency/Management, the Cognitive Impairment, and the Physical Limitations scales. This equivalence is a validation of the adequate matching of child functioning in the adoptive and birth samples.

On the other hand, the scales that primarily reflect family functioning or personal reaction to the child's disability present a more mixed picture. Birth mothers report more limits on family opportunities, more family disharmony, more concern with the lifespan nature of the commitment to the target child, more financial stress, and more acknowledgment of the personal burden of caring for the target child. However, no differences were found on the Lack of Personal Reward, the Terminal Illness Stress, or the Preference for Institutional Care scales. Taken together, then, the QRS results suggest that the birth mothers perceive the care of their child with a developmental disability as somewhat more stressful than do the adoptive mothers.

The findings from the other two instruments reported here support this conclusion. Table 4 presents the results for mothers for the Family Strengths Inventory (Olsen, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1985) and the Locke-Wallace

Table 3

A Comparison of Adoptive and Birth Mothers on the Holroyd QRS--Short-Form

Category/Scale	Adoptive	Birth	t-test
	N = 75	N = 57	
Dependency/Management	1.58	2.05	1.81
Cognitive Impairment	3.72	3.72	0.00
Limits on Family Opportunities	1.07	2.36	4.88*
Lifespan Care	3.01	4.26	3.87*
Family Disharmony	0.48	0.96	2.80*
Lack of Personal Reward	0.61	0.91	1.47
Terminal Illness Stress	1.15	1.60	1.77
Physical Limitations	1.39	1.44	0.16
Financial Stress	1.96	2.75	2.93*
Preference for Institutional Care	0 76	0.82	0.42
Personal Burden for Respondent	3.52	4.21	2.92*

*p < .01

Table 4

Maternal Ratings of Family Strengths and Marital Adjustment

Scale	Adoptive (N = 76)		Birth (N = 55)		t-test
Family Strengths	Mean	SD	Mean	SD	
Pride	31.8	3.2	28.6	5.7	4.00*
Accord	18.0	4.3	14.6	4.5	4.40*
Total	49.7	6.4	43.1	9.0	4.87*
Locke-Wallace	(N = 58)		(N = 49)		
MAT	121	21.5	100	33.5	3.93*

*$p < .01$

Marital Adjustment Test (Locke & Wallace, 1959). The Family Strengths Invenotry is a 12-item instrument, with 7 statements that relate to family pride and 5 statements that relate to family accord. The respondent must indicate level of agreement with each statement on a 5-point Likert scale. Maximum scores on the family pride and family accord subscales are 35 and 25. respectively. The Locke-Wallace inventory consists of 15 items which assess overall marital happiness as well as the degree of consensuality within the marriage. Scores can range from 2 to 158, with higher scores indicative of greater happiness, intimacy, and consensuality within the marriage.

As is displayed in Table 4, adoptive mothers scored significantly higher than did birth mothers on both instruments. Comparison with data from other studies (Webster-Stratton, 1988; Donovan, 1988) and with norms in the case of the Family Strengths Inventory suggest that the adoptive mothers scored unusually high for families in general, as well as for families with a disabled child.

Summary and Conclusions

The results from the present research clearly support the conclusion that adoption is a successful intervention for children with disabilities, at least as measured by parent and family functioning. On all measures of current functioning with the exception of depression, adoptive mothers scored significantly better than did birth mothers. Thus, when children are disabled or at risk for disabilities and birth parents are unwilling, unable, or deemed unfit to rear them, social service

systems must be able to move quickly to place children in substitute, but permanent homes. Systemic barriers to these placements must be abolished and agencies should operate to facilitate these placements.

In addition, the conclusion with regard to birth parents is also one of optimism. Although they appear to be less well-adjusted than do the adoptive mothers, they are similarly non-depressed, having recovered from the worst of the symptoms that they experienced at the time of diagnosis. And one can view the parent/family factors on the Holroyd QRS that did not show adjustment differences between adoptive and birth families (Lack of Personal Reward, Terminal Illness Stress, Preference for Institutional Care` as an indication of excellent adjustment. Clearly, additional analyses of this dataset will help to delineate the domains of adjustment and maladjustment, the strengths and weaknesses of both adoptive and birth families who are rearing children with developmental disabilities.

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