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ANXIETY LEVELS OF INVOLUNTARILY INFERTILE COUPLES CHOOSING ADOPTION

The Ohio State University

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ANXIETY LEVELS OF INVOLUNTARILY INFERTILE COUPLES CHOOSING ADOPTION

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By
Leah Pendarvis, B.A., M.A., M.B.A.

*****

The Ohio State University
1985

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CHAPTER 1
INTRODUCTION

There is a relationship between anxiety and involuntary childlessness or infertility. Anxiety causes infertility by interrupting the reproductive process. Conversely an interruption of the reproductive process, namely the diagnosis of infertility, produces anxiety. The conceptual model for understanding how anxiety can be both causal of and reactive to the diagnosis of infertility is presented as Appendix A.

For couples desiring children the diagnosis of infertility is a crisis which can be psychologically threatening, financially expensive, emotionally stressful and physically painful. This crisis can place stresses on a marriage in areas of communication, sexual activity and future planning and can entail feelings of mourning, depression, guilt, frustration and loss - loss of health, loss of self-worth, loss of control of one's destiny (Menning, 1975). The loss is vague; it is the loss of what might have been, the elimination of a potential. Further, as Mazor (1979) observed, the loss is "invisible" and not marked by any formal rituals.
Just as the diagnosis itself causes anxiety, the procedures used to study infertility, the decision to adopt a child, and the adoption process itself can foster anxiety. For example, the procedures used to assess infertility status may be intrusive and assaultive in nature and the individual may feel traumatized by medical technology. All too frequently professionals fail to consider the emotional context of their investigations (Mazor, 1979). According to Starr, Taylor and Taft (1970), part of the pain associated with the discussion and psychological resolution of infertility may be a reflection of the hardship endured during the medical procedures or the "work-up." Psychiatric consultation may be necessary in dealing with the outcome of the work-up (Berger, 1980).

As outlined below there is a relationship between anxiety and the selection of the adoption alternative:

```
\begin{align*}
\text{diagnosis of infertility} & \quad \text{medical procedures to assess and remediate infertility} \\
\text{acceptance of infertility status} & \quad \text{anxiety} \\
\text{adoption alternative} & \quad \text{adoptive study}
\end{align*}
```

When involuntary childlessness is resistant to medical remediation, couples can choose adoption, artificial insemination or childfree living as a coping strategy. Selecting the adoption alternative entails the acknowledgement of
one's "inadequacy" and the acceptance of a chronically infertile status. Because there are not enough adoptable children, couples applying to an adoption program must be prepared to prove the legitimacy of their infertility claim (Bachrach, 1983). The anxiety which couples already experience with respect to their infertility is easily intensified. Very often couples find that they must deal with issues of qualification including age, years married, religion, geographic location, number of children already in the home, financial ability and other personal matters. In short, no aspect of a couple's lifestyle is immune from scrutiny by the social worker in the adoption agency.

There is also a relationship between anxiety and the adoption process. The purpose of an adoptive study is to evaluate prospective adoptive couples and to prepare them for their role as adoptive parents. Preparation includes the acceptance of both infertility status and the necessity of adoption. The waiting period, the interviews and the assessment techniques used by the adoption agency may be perceived as invasive and disturbing. What the adoption process will entail, how long the adoption procedure will take, and whether the couple will finally receive a child

1There are few healthy white infants available for adoption because of the decline in the birthrate and the growing number of women who choose to keep their out of wedlock babies (Ladner, 1982). Nonrelative adoptions have been dropping steadily from a 1970 peak of 89,000 (Encyclopedia of Social Work, 1977).
are questions which may be neither asked nor answered. Anxiety is experienced by couples who are waiting for an unclear procedure which will occur at an unspecified time and conclude with an uncertain outcome.

It is widely acknowledged (Cottereau, 1979) that couples must adjust to or resolve their feelings about infertility and adoption itself if the adoptive placement is to be successful. Unless a couple is reasonably accepting of the fact of their infertility, adoption brings emotional confusion and serves as a constant reminder of the unsolved problem of infertility (Conlon, 1983). When such resolution fails to occur, the emotional well-being of the child and the parents is jeopardized. The anxiety level of the parents before, during and after the adoption process is implicated in the high incidence of psychological disturbance in adoptees.

Thus anxiety is related to the diagnosis of infertility, to the selection of the adoption alternative, and to the adoption process itself. The present review suggests, as did Rickarby's (1978), that anxiety is a factor which must be evaluated in potential adoptive couples. The purpose of this study is to explore anxiety in involuntarily childless couples as a function of the adoption process itself. The study will examine how each step in the adoption procedure - the interview, the assessment techniques and the acceptance for placement of a child - serves to
change the anxiety level of adoptive couples. It will also determine whether waiting for the procedure to begin affects anxiety level.

The Involuntarily and Voluntarily Childless

So much public attention has been directed in recent years to the problem of rapidly increasing population in many of the developing countries that the equal but opposite problem of subfecundity is easily overlooked. The World Health Organization (1975, 1976) contends that in parts of Gabon, Cameroon, Central African Republic and Zaire, the rates of involuntary contraceptive failure among women now aged 50 years or more are as high as 40% with even higher rates among younger women. The major causes of infertility in developing countries are gonorrhea, syphilis, genital tuberculosis, postabortal or postpartum sepsis, obstetrical difficulties, and other systemic or local infections.

Decker and Loebl (1979) indicate that 15% of all couples in the United States have impaired fertility. Approximately 10 million men and women between the ages of 18 and 40 experience difficulty conceiving a baby (U.S. Department of Health and Human Services, 1982). Milne (1976) predicted that since fertility decreases with age and as couples are marrying later, the rate of infertility will become higher. Weir and Weir (1961) established the terminal infertility rate or the percent of American couples who reach the end of their childbearing years without children as 12%. This
percentage was based on couples having received no treatment for infertility. Waller, Rao and Li (1969) in a sample of 2393 couples found that 11% were involuntarily childless. Of all involuntarily childless couples, approximately 80% were diagnosed medically. The most common problems were ovulatory difficulty in women and sperm production deficiency in men. The problem was found to be primarily a female one in 50% of cases, primarily a male one in 30% of cases, and a shared problem in 20% of cases. Of those couples diagnosed medically, approximately 50% can be helped to achieve pregnancy (Kraft, Palombo, Mitchell, Dean, Meyers, & Schmidt, 1980, p. 620).

Couples who are eligible for adoption in most adoption agencies are involuntarily childless. Poston (1976) conducted an investigation drawing data from a 1965 National Fertility Study which took a representative sample of fertility behavior from 5600 interviews. His sample included 440 white married women under age 55 who had no children and were not pregnant. On the basis of responses on questionnaires, he divided his sample into three groups: the voluntarily childless, the involuntarily childless and the temporarily childless who were biologically capable and infertile by choice but intending to have children in the future. In comparing the involuntarily childless group with the voluntarily childless group, Poston found no marked differences across a number of demographic, socioeconomic,
In a study of 72 voluntarily childless couples, Gustavus and Henley (1967) found that the expressed negative attitudes about fertility included, from most to least frequently espoused: population concern, health, career, age (too old), dislike for children, economics, fear of pregnancy and world conditions. This group of couples had the following characteristics: their socioeconomic status was higher than that of the general population of married couples; they were more likely to be from urban areas, to be married at least five years, and to have no religious preference or a liberal denomination. In another study of voluntarily childless couples, Veevers (1972) in Canada conducted in depth unstructured interviews with the wives. Of those interviewed, one-third decided before marriage not to have children while two-thirds remained childless as a result of ongoing decisions to postpone having children. This postponement was related to their career alternatives. It is assumed that the negative attitudes about fertility and decisions about career alternatives are not shared by the involuntarily childless couples who select the adoption alternative.

Anxiety as a cause of involuntary infertility.

Some demographers explain population subfecundity in the following way:

The responsibilities and the decisions which overburden the man of today, the greediness produced by
unlimited possibilities, driving him to chase after whatever can be reached resulting in continuous overstrain, those manifest excitations that affect people of big cities and are therefore followed by chronic stress play a vital part in the origin of our problem (subfecundity) and should not be underestimated (Hochstaedt & Langer, 1959, p. 254).

Eaton a sociologist and Mayer a psychiatrist (McFalls, 1979, p. 27) believe that when a population has high fertility, it is due to the absence of stress-induced subfecundity factors. In the first half of the twentieth century, some observers were convinced that stress could lower population fecundity. For instance, the anthropologist Pitt-Rivers (1927) believed that the decrease of population in Malanesia was to a great extent due to the declining birthrate brought about by stress. Another anthropologist suggested that subfecundity in central Africa was caused by contact with Europeans who "created in certain tribes emotional conditions or psychological trauma potent enough to inhibit reproduction" (Romaniuk, 1968, p. 219). Mosley (1977) an epidemiologist explained the 40% decline in crude birthrate of the Bangladesh during the 1974-1975 famine by the reduced conception rate brought about by anxiety during the crisis conditions. It is to be noted that other factors like nutrition and the amount of sexual activity would also have an effect on the rate of conception.

Stress has frequently been held responsible for interruptions in the reproductive process. These interruptions in women have been described at the psychological level in

The stress-related interruptions in the reproductive process of men have also been described at the physiological level in studies of sperm count (Amelar & Dubin, 1973; Belonoschkin, 1962; M. Michael, 1956; Milojkovic, Simic, & Dzumhur, 1966; Palti, 1969; Walker, 1978) and urethral spasm
(DeWatteville, 1957) and at the neuroendocrinological level (Franklin, Malinak, & Dukes, 1967; Hendry, 1975; MacLeod, 1971; Rowley & Heller, 1972; Schellen & Beek, 1972).

**Anxiety as a reaction to involuntary infertility.**

Van Keep and Schmidt-Elmendorff (1975) compared 75 involuntarily childless couples with 75 couples who were biological parents with at least one child. These involuntarily childless couples had presented for treatment at an infertility clinic. Since proven infertility is a requirement at most adoption agencies, these couples are comparable to those who seek to adopt. On the basis of interviews, the experimenters concluded that marriages of involuntarily childless couples have a different basis from those of couples with children. The childless couples have more communication, more common opinions, and less acceptance of infidelity. Being involuntarily childless had an emotional impact on couples. Personal happiness diminished when the couple acknowledged their failure to produce a desired child but increased once medical advice was sought.

That parenthood is still a meaningful role in society — a role not easily replaceable by other relationships and activities — is addressed by Bierkens (1975) who collected data on how marital partners cope with involuntary childlessness, the extent of their concealed grief, and the influence of childlessness on the marital relationship. In designing his study, he assumed that childless couples were
involuntarily so. "I believe it can be safely assumed that for most of these couples their childlessness is involuntarily" (p. 177). Questionnaires were sent with a cover letter by eleven family doctors to all of those couples in their practices who were childless and of fertile age in several towns and villages in the Netherlands. The doctors omitted couples they considered "undesirable on psychological grounds". When questionnaires are sent to involuntarily childless couples who are seeking to adopt, the return and answering rate are usually 100%. What proved most interesting about the Bierkens' study was the number of questionnaires returned - 42% - and the number of respondents who left core questions unanswered - 35%. Very few of the couples in Bierkens' study even mentioned the questionnaires to their doctors. One possible interpretation of these findings is that the topic of childlessness is anxiety-producing and results in a decision not to complete the questionnaires and not to discuss them with their doctors.

According to Smith (1978), the distress suffered by involuntarily childless couples should not be underestimated. Infertility may "profoundly affect their perceptions of themselves and of the marital relationship and shatter the meaning which they have attributed to marriage and the development of their lives" (p. 51). In a sample of 74 involuntarily childless couples, Smith found quite severe levels of anxiety. Some couples described their feelings
about childlessness as "absolutely desperate". Couples felt distressed, isolated and confused by their professional workers. The physicians and hospital staff did not give them enough information about the infertility investigation and/or treatment and the couples found it difficult to ask questions or seek clarification. Of the medical investigations undertaken, couples remarked as follows: "you are only a number"; "they treat you like cattle"; "it's degrading". Thirty-five of the couples described the depression experienced weeks and months after the medical intervention. The couples also experienced a lack of understanding from friends and relatives who were reluctant to discuss the couple's infertility or to express what it meant to them (Brashear & Ebling, 1983). Renne (1977) estimated that 60-70% of infertile couples are still experiencing shock, protest and despair two to three years after the initial diagnosis.

**Sex differences in anxiety about involuntary infertility.**

Humphrey (1977) explored the relationship between parenthood and contentment and between parenthood and sexual identity. He asked 50 involuntarily childless couples and 40 parental couples to view photographs and to select those individuals who manifested certain traits. These traits included contentment, motherliness, fatherliness, self-assurance, femininity or masculinity and congeniality.
Finally the couples were asked to imagine that all of the people in the photographs were married but only half were parents and to select those who seemed most likely to be parents. By determining which traits were associated with being parents, Humphrey concluded that women are more emotionally invested in motherhood as a source of fulfillment than men in fatherhood. A wife suffers more acutely than the husband from involuntary childlessness. On the other hand according to Humphrey, men are more sensitive to reproductive failure as such, which may cause them to doubt their "masculinity." Thus an involuntary childless woman may need to compensate for her lack of material fulfillment by finding outlets for her loving care (e.g., volunteer work) while an involuntarily childless man may need alternative proof of his masculinity (e.g., athletic prowess). In similar manner, an involuntarily childless man may underestimate his wife's agony during their prolonged quest for resolution of their infertility problem while a involuntarily childless woman may not appreciate her husband's apprehension during the medical part of the infertility investigation.

Brennan (1977) explored male-female differences in symptom distress levels of fertile and infertile couples choosing adoption. Fertility was evaluated by self-report while anxiety at one point in the adoption process was assessed by a psychiatric self-rating symptom scale. In
general, infertile adoptive couples were more anxious than the fertile adoptive couples. The results were as follows: infertile adoptive men were more anxious than fertile adoptive men, especially when they alone were the infertile ones. Infertile adoptive men who shared the infertility cause with their wives were as anxious as infertile women whose husbands were fertile. Women who shared the infertility with their husbands were more anxious than husbands who shared their infertility with their wives. There appears to be a marital interactive process whereby wives tend to assume more of the negative aspects of the responsibility for the infertility than their husbands. In couples with idiopathic infertility, the wife is anxious while the husband is defensive (O'Moore, O'Moore, Harrison, Murphy & Carruthers, 1983). Asch and Rubin (1974) similarly concluded that even when the problem of infertility is not hers, the woman tends to view the "failure" as her own.

Colombo, Brighenti and Scorretti (1981) interviewed twenty-eight infertile couples. In 75% of the cases, the woman took the initiative in managing the problem. Women were more eager to clarify the problem, took more initiative in contacting the clinic, and were more vocal in interviews with the doctor. Women were more upset over the prospect of not having a child and expressed more interest in adoption. Couples tended to hide the fact of the husband's infertility to preserve his pride. Male infertility tended to be an
impetus toward strengthening conjugal ties. Men tended to deny their anxiety over infertility. Cheema (1974) found that in both members of the couple, anxiety was higher in those with negative attitudes toward childbearing. Whether anxiety over infertility is manifested by one or both members of the couple, successful adaptive coping is displayed when the overt emotional distress is followed by acceptance of infertility and anxiety reduction (Bresnick, 1981).

Psychological aspects of involuntary infertility.

The label "psychogenic" infertility is used when there is scant or no medical explanation for the condition. A review of conception rates in women attending infertility clinics provides evidence that some infertility, whatever its reason, may be overcome. Raymont, Arronet and Arrata (1969) followed 500 women with a wide variety of presenting problems at an infertility clinic in Montreal. Of the 500, 269 conceived but 27 of these failed to produce a viable pregnancy. These investigators concluded: 1) as age increases after 30, the prognosis for pregnancy gets worse. 2) those women with an earlier age of menarche had a higher pregnancy rate. 3) eighteen months after registration at the infertility clinic, there was a rapid deceleration of conception rate. Once overcome, infertility may correlate with other problems. Swyer (1953), who gathered data on 207 women attending an infertility clinic, concluded that those women who do achieve pregnancy have a greater risk of labor
and delivery complications. Many studies have been conducted to describe the characteristics of infertile women and are shown in Table 1. This selection of studies shows that for over 40 years the questions asked have remained the same: how is the infertile woman different from the fertile one? what are the unique physical and psychological characteristics of the infertile woman? how can infertility itself be further subdivided and psychologically described based on whether diagnostic procedures reveal a causative medical condition? In general, psychogenically infertile women have been depicted as competitive and aggressive, dependent and immature or protective and motherly.

Recently Netter (1977) attempted to delineate variables which are predictive of infertility risk in women. The variables identified were: A-psychosomatic complaints with respect to reproductive behavior; B-wanted/unwanted pregnancy; C-use of contraceptives; D-frequency of intercourse; E-years of marriage; F-number of previous deliveries; G-number of previous abortions; H-consultation about infertility. Multivariate contingency structure analyses revealed higher order interactions between psychosomatic complaints and patterns of reproductive behavior including use of contraceptives, frequency of intercourse and years of married life in primiparae and, in addition, wanted pregnancy in secundiparae. Netter (1977) further suggested a cycle working in both directions without the possibility of
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<td>Eisner, 1963</td>
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<td>Richardson, 1972</td>
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<td>types of nulliparae</td>
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<td>Brand, 1983</td>
<td>organic/functional comparison</td>
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tracing a starting point:

Psychosomatic complaints (A) \[\rightarrow\] Desire of pregnancy (B) \[\rightarrow\] Consultation about infertility (H)

Infertile couples as reproductive units have been studied using objective diagnostic signs (MacLeod & Gold, 1953; MacLeod, Gold & McLane, 1955) and prognostic indicators (Turner, Davis, & Carter, 1955). Infertile couples have been studied psychiatrically with the emphasis on concerns with reproduction (Morris & Sturgis, 1959) and eventual conception rates (Cheema, 1974; Peberdy & Snaith, 1960). Mai and Rump (1972) found no difference between fertiles and infertiles, husbands or wives on a neuroticism scale. Furthermore Mai and Rump (1972a, 1972b) found no differences among fertiles and infertiles on any psychiatric or psychological measure. When a variety of measures of intrapersonal, interpersonal and life stress variables were used, Dunne (1976) found that fertile and infertile males differ just as do fertile and infertile females. His study revealed the importance of exploring psychological variables in infertile couples. Kraft (1980) added that the way in which infertility affects couples depends on a variety of factors including which marital partner causes the infertility.
Platt, Ficher and Silver (1973) hypothesized that infertile individuals believe that significant events in their lives are under the control of external, capricious forces rather than under the control of their own efforts. They also hypothesized that infertile persons have significant discrepancies between their perceptions of their present selves and their perceptions of their ideal selves, their perceptions of the average male and female and their perceptions of their fathers and mothers. Finally they hypothesized that infertile individuals differ from fertiles along personality dimensions and show more emotional disturbance. Platt and his associates compared 25 couples who were private infertility patients with 15 control couples using the following measures: Internal-External (I-E) Control, Semantic Differential and Group Personality Projective Test (GPPT). The hypothesis about control was wholly supported. Both male and female infertiles saw their present selves as more dissimilar to their ideal selves and their fathers and mothers than did the fertile controls. Infertile females had greater anxiety, higher neuroticism, and lower succorance scores on the personality test; infertile and fertile men showed no difference in performance.

In summary: (1) involuntary childlessness is both a cause of and a reaction to anxiety; (2) men and women respond differently to involuntary childlessness, and (3) depending on the instrument used, infertile individuals can
be psychologically differentiated from fertile individuals.

The Adoption Alternative

The trend in the prevalence of infertility (see page 5) among American couples points to an increasing demand for adoption (Bachrach, 1983). Bonham (1977) stated that 4% of the women in the United States adopt a child, other than a stepchild, by the time they complete their childbearing years (age 44). Between the 1950s and the 1980s there has been a major change in who adopts. In the 1950s, adoption was more concentrated among infertile, childless women while by the 1980s, over half of those who adopted had biological children with the majority having given birth before rather than after adoption. Women who adopt are found in all racial, religious and socioeconomic groups. As contrasted with the 1960s when it was estimated that there were 104 applicants for every 100 children available for adoption, in the 1970s there were 200 applicants for every 100 children available. The increased number of births of the 1950s caused this increase in the applicant-child ratio in the 1970s and 1980s (Encyclopedia of Social Work, 1977).

The negative aspects of adoption.

Smith (1978) discussed the motives for adoption. "People's real motives are often hidden from themselves. People in a highly emotional state are not ready to adopt a baby" (p. 53). The difficulties of adoptive parenthood include the sorrow about one's inadequacy which may bring
about resentment toward the child and the negative cultural attitude toward infertility (Brinich, 1980). Kent and Richie (1976) asserted that the extent to which parents accomplish their "grief work" around the issue of loss of reproductive function is directly related to the quality of relationship they can achieve with their adopted child. Two coping patterns commonly manifest by couples upon the discovery of their infertility are: (1) a matter-of-fact reaction followed by the decision to adopt, (2) 6 months to 1 year of low mood, crying spells and periodic anger gradually leading to the decision to adopt. Kent and Richie remark that the latter pattern is healthier and that adopting parents who do not come to terms with their loss "have not really been able to accept the substitute child who confirms their lack of physical integrity" (p. 521). Kraus (1978) further concluded that if a couple adopts to fulfill their own needs and if a subsequent child is born to them, the adoptee's role is lost, the parents' attitudes become negative and the adopted child manifests psychological symptoms.

Ziatek (1974), in a survey of research (1948 to 1970) on problems of adoptive children and their families, concluded that one of the basic problems is deprivation of maternal tie and that this deprivation results from mother's heightened anxiety level. Similarly Bourgeois (1975) remarked upon the "common psychopathology among adoptees
characterized by a history of maternal deprivation and abandonment" (p. 103). Some couples are highly anxious when they seek to adopt a child. This anxiety contributes to the high incidence of psychological disturbance and behavioral dysfunction in adoptees and the disproportionate incidence of adoptive families appearing in mental health clinic populations (Taylor & Starr, 1972). Marion and Hayes (1975a) contend that adoptees, who constitute 2% of the population of children comprise 10-15% of the outpatient psychiatric population. Other studies have described the serious degree of disturbance in adopted persons coming for psychiatric help (Goodman, Silverstein, & Mandell, 1963; Humphrey & Ounsted, 1963; Kirk, Johassohn, & Fish, 1966; Launay & Soule, 1970; Reece & Levin, 1968; Schechter, 1960; Toussieng, 1962). Deutsch, Swanson, Bruell, Cantwell, Weinberg and Baren (1982) in part attributed the high rate of attention deficit disorder in adoptees to stress of adoptive families. Wieder (1978) asserted that the source of an adoptee's distress lies in the relationship with the adoptive parents and not with the fact of adoption itself.

Adoption is not viewed in completely positive terms by potential adopters. In a sample of 267 unmarried undergraduates at a state college, Buckhout (1972) found that 72-80% would adopt if they could not conceive but, only 44-49% would adopt if they were fertile. Katz (1980) concluded that despite the fact that adoptive families have the same
range of problems as biological families, adoption in and of itself puts a family at some degree of risk.

Conception after adoption.

Some studies have addressed the question of whether medical consultation or adoption increases the probability of conception. One view is that any procedure reduces the anxiety about childlessness which may in turn help couples overcome their infertility. Sandler (1961) claimed that infertility has been "cured" by calling for an appointment with a fertility specialist; by having a semen analysis done; by having a vaginal examination or having sound passed into the uterus or having an endometrial biopsy - all of which are presumably diagnostic not treatment techniques. Success has also been attributed to reassurance from an authority figure like a physician (Cooper, 1971) and to placing one's name on a list for adoption. Cohen (1961) found conception occurring after the signing of adoption papers while Marsh and Vollmer (1951) observed the phenomenon of pregnancy occurring post-adoption after years of infertility. Benedek (1952) acknowledged that adoption can enable a woman to overcome anxieties about motherhood.

Sandler (1965) randomly selected 208 infertile couples from 600 couples seen over seven years. Of these 208, 188 had detectable defects while 20 did not. The pregnancy rates were 45.5% in couples with detectable defects and 55% in couples without detectable defects. If the sterile
couples are removed from the 188 couples, the rate increased to 53%. Sandler's second group included 32 couples who were advised to adopt after a course of treatment; five of them chose not to adopt. Of the remaining 27 couples, 18 (65%) eventually became pregnant. Sandler then compared the rates of pregnancy: the defective minus sterile group, 53%; the no defect-emotion group, 55%, the adoption group, 65%. The length of infertility in each of the groups was not published. Sandler suggested that adoption relieved emotional tension because, in his clinic, the rate of pregnancy incidence at one and six and nine months after initial contact was similar for those in the no defect-emotion group and those in the adoption group. Both groups can be conceptualized as employing an anxiety-reducing technique: one was infertility treatment, the other was adoption. Sandler concluded that adoption facilitates conception in those couples in whom organic factors have been adequately treated but in whom there is continuing emotional tension present.

Other studies have indicated that adoption does not increase the probability of conception. Weir and Weir (1966) presented data on infertile couples collected over 18 years. Their original sample of 736 consecutively admitted couples was reduced to 438 couples when they eliminated the couples who became pregnant during clinical treatment, the couples who had previously conceived a child and the couples in whom one partner was sterile. The remaining 438 couples
were potentially fertile with a maximum duration of infertility of 1-1/2 years; all had received treatment for infertility and all had received information about adoption. Of the 438 couples, 197 adopted. There was no difference in the conception rates of the adopters and the nonadopters. The issue of whether the nonadopters had chosen not to adopt or had been turned down as potential adoptive parents was not addressed.

Rock, Tietze, and McLaughlin (1965) selected two groups of infertile subjects: the nonadopting group was composed of 113 couples chosen from 3940 studied in the clinic; the adopting group was composed of 249 couples from 1000 adoptive couples in a multifunction child agency. The first group was selected by a small group of trained investigators while the second group was selected by a large number of physicians reviewing reports. The pregnancy rate was 35% in the nonadopting group and 23% in the adopting group. However, the nonadopting and adopting groups were not comparable since the mean number of years of infertility also varied with the first group having a mean of 5.6 years and the second group 7.7 years.

Kraus was more specific about what increases conception rates in adoptive couples. Kraus (1976) found that conception rates varied depending on whether medically identifiable reasons for infertility were present. Within six years of adoption, a child was born to 36% of previously childless
couples with no medically identifiable reason for infertility while a child was born to 11% of previously childless couples with known reasons for infertility. Thus the absence of medical reasons for infertility can be used as an indicator of adoption applicants' greater childbearing potential. Another factor which may influence conception rate in adoptive couples is attitude. Cheema (1974) showed that negative attitudes of infertile couples toward childbearing correlated with a lower occurrence of conceptions.

In summary, while there is an increasing demand for adoption, there is also evidence that adoption is negatively viewed because of its association with infertility and childlessness. Adoptive couples seek a solution to their childlessness. While some adoptive couples remain infertile, others conceive after adoption.

The Adoption Process

Characteristics of adoptive couples.

One might ask if there is anything unique about involuntarily infertile couples who undertake the adoption process. To measure the value they placed on children, La Manna (1977) interviewed 50 couples who were biological parents and 50 couples who were involuntarily infertile and had become adoptive parents. All the couples were white and had at least one child under 15. One difference between the two groups was that the adoptive couples were married longer before becoming parents. Using a 32-scale Semantic
Differential, La Manna concluded that there are gender differences with men tending to value achievement and conformity of children and their own role in socializing children and women tending to value the fun and novelty of childish behavior and their role in loving and being companions with children. Adoptive mothers while deriving great meaning in parenthood tended to be more tense. Biological mothers were similar to adoptive mothers but did not demonstrate the intense emotional gratification of adoptive mothers. Biological fathers while placing high value on children tended to be emotionally detached and to be oriented to the child's satisfaction of normative expectations. Adoptive fathers were intermediate between mothers and biological fathers. La Manna suggested that the nature of the adoption process or the voluntary character of adoptive parenthood may result in fathers who resemble mothers in emotional involvement and intrinsic enjoyment of children.

Helperin (1979) compared attitudes toward children of fertile and infertile adoptive parents. In her study, 102 adoptive parent volunteers completed the Maryland Parent Attitude Survey (MPAS). The status of the subjects' fecundity was established by self-report. Using the rejection, protection, indulgent and disciplinarian scales of the MPAS, Helperin found that infertile adoptive fathers were significantly higher on the indulgent scale than were fertile
adoptive fathers, thus suggesting a tendency to "spoil" youngsters. Furthermore fertile adoptive fathers were significantly higher on the protective scale thus making them more likely to fear for the child's safety. In general, the MPAS revealed that infertile adoptive parents have less favorable attitudes toward childrearing than do fertile adoptive parents. However, the least favorable attitudes were displayed by infertile adoptive mothers. Helperin suggested that infertile adoptive mothers are more defensive than infertile adoptive fathers.

Jacobs (1975) studied the specific problems confronting childless adoptive parents to determine if a need existed for some type of preparatory experience for childless adopters. Consequently questionnaires were sent to a group of childless adopting couples and a group of family counselors experienced in adoption. There was a divergence of views between the adopting couples and the family counselors. For example, with respect to reasons for adoption, the childless adopting parents professed concern with the mutual needs of both the child and themselves. The counselors, however, considered that a majority of the adopters were primarily concerned with seeking adoption as a means of satisfying their own basic needs. The adopting parents emphasized the parents' relationship with each other and the parents' relationship with the child. The counselors stressed the parents' relationship with each other,
particularly the ability of two adopters to reconcile themselves to their infertility. The adopting couples generally believed that the adoption would be beneficial to the husband-wife relationship. The marriage counselors were more guarded in their views and suggested that the impact of the adoption depended on the particular couple. The divergence in views documents the positive way in which adoptive couples try to present themselves. Adoptive couples' tendency to idealize their relationship is counterproductive to preparation for a successful adoption (Humphrey, 1975).

Differences between biological and adoptive parenthood.

Toussieng (1971) contended that adoptive parenthood must be regarded as completely separate from and not to be compared with biological parenthood - that the requirements for belonging to each other as adoptive family members are different in every way from those requirements in a biological family.

Because the family members do not have a "blood claim" on each other, the mutual knowledge of the fact of adoption in itself causes anxiety in some families. Because they were unable to conceive together, the parents may perceive their marital bond as being in more jeopardy than might be concluded from observing their relationship with each other. In the same way, because the child is not their biologic child, adoptive parents who continue to compare themselves with biologic parents may find it difficult to believe their child will really "belong" to them. On his side, the child who is aware of being adopted, who senses his parents' insecurity, and who compares himself with biologic children may start to fear abandonment. The child may come to view his ties to the parents as much more tentative and fragile than they appear to the professional observer.
Thus the lack of a biologic tie becomes the source of an inordinate amount of anxiety. It leads the three persons involved to see their mutual ties as being in constant jeopardy, because they have not come to accept that their situation is different from, and should not and cannot be compared with, a biologic family situation.

If the difference in the adoptive family - that it is based on the lack of a mutual biologic tie - is accepted by the parents, and they in turn convey it to the child, the reason for mutual anxiety falls away (p. 324).

According to Ward (1979), the pivotal question during the adoption procedure is whether the infertile couple can disregard the norm of biological parenthood successfully enough to be adoptive parents and in the process develop a sense of entitlement - a sense that this child is mine.

Attitudes of adoptive parents toward infertility.

Kraft, Palombo, Mitchell, Dean, Meyers and Schmidt (1980) have concluded that an adaptive resolution of the psychological dimensions of a couple's infertility is a condition for successful adoptive parenting, and that failure to resolve these psychological tasks leads to interference in adequate parenting. Resolution is accomplished by the expression of appropriate sadness, anger and grief and by an accepting resignation. When couples were able to grieve for their infertility and the biological unfulfilled parental function, they could then comfortably consider issues of the adoptive child's illegitimacy, medical and legal risks of adoption, and the how and when of telling the child about adoption. When resolution failed to occur, couples had difficulty with their own self-image as
defective human beings and were anxious about the previously mentioned issues as well as the child's potential wish to seek his or her biological parents. Renne (1977) remarked, "Infertility, human sexuality and an adopted child's identification process are interlinked and successful integration occurs only with resolution" (p. 470). In other words, without resolution, the infertility which led to the necessity of the adoption alternative in the first place remains part of the family climate.

Wiehe (1976b) further explored infertile couples' attitudes about their infertility and adoptive parenthood. His subjects were 22 couples who having unsuccessfully sought medical assistance for infertility had made application with a private midwestern adoption agency. The subjects were between the ages of 22 and 45, had at least high school education and had become informed about their infertility two to six months prior to the study. The subjects were administered the Semantic Differential and an attitude checklist. The stimuli used in the Semantic Differential were as follows: false pregnancy, fertility test, unable to have a child, basal temperature, virility, productive, sperm count, infertility and inability to reproduce. For the most part, the subjects displayed a neutral to slightly positive evaluation of infertility. Many subjects, however, characterized themselves as defensive and low in self-awareness on the adjective checklist. The possibility of a response bias
on the Semantic Differential must be considered even though "subjects were assured their participation in the research would in no way affect their application to adopt". The 100% response points to the highly motivated orientation of infertile couples seeking adoption.

Attitudinal change is expected to occur as a function of the adoptive study. As subjects experienced the adoption procedure, Wiehe (1973, 1976a) used the Semantic Differential to assess change in attitudes toward infertility, unmarried parents and disclosure of his adoption to the adoptee. His subjects were 33 prospective adoptive couples in a private sectarian social agency in the Midwest. These couples were either childless or, having had a biological child, unable to have another. They were 22 to 45 in age and had achieved an education level from high school diploma through master's degree. The couples had been aware of their infertility diagnosis from two to six months. Attitudes toward unmarried parents and disclosure to the adoptee changed while the attitude toward infertility did not change significantly. Subjects tended at the beginning of the adoptive study to view their infertility more positively than at the end. This evident lack of progress in the applicant's comfort with infertility is associated with unreadiness for parenthood (Wiehe, 1976b).

Post-adoption attitudes toward infertility and adoption.
Rothenberg, Goldey and Sands (1971) described their experience at a child guidance center in Manhasset, New York. This agency, although not an adoptive facility, offered support groups for adoptive families. In their post-adoption groups, these investigators found that infertility was an ongoing factor exacerbated by the rules of most adoption agencies that demand detailed medical confirmation of infertility.

The implication of prospective parents' proving that they are "damaged", and the meaning of this "proof" for their self-image and sexual identification, is given insufficient attention in many adoption studies (p. 591-2).

They found that there are contradictions and confusions inherent in agency practice.

Having established this difference, i.e., their sterility and then having received a child, parents are left to carry on the functions of parenthood as if that painful difference had been eradicated (p. 592).

They further ascertained that the power of the agency to grant or withhold a child stimulates rage and fear that is not necessarily eliminated or even reduced by the placement of the child. Rothenberg and her colleagues concluded that the vicissitudes of the adoption process are conditioned by its association with rejection and abandonment, by the demand to prove infertility, by the intrusion of the biological parents and by the bereavement over the child one will never produce.
Marion and Hayes (1975b) conducted an informal psycho-educational group for adopting parents. They found that all nine members of the group: 1) experienced extreme feelings of powerlessness with respect to agencies, 2) remained angry even post-adoption, 3) conveyed their feelings when they spoke of their bodies' inability to reproduce. Writing from the perspective of a nurse who adopted a child as a single woman, Thompson (1978) conveyed how she viewed the social worker as having enormous power.

No matter how compassionate my social worker was, no matter how encouraging her words, there remained an inner fear that was almost devastating. This person had the power to allow or not to allow me to become a parent...What right had this person to make such an important decision in my life (p. 248).

Kirk (1964) has pointed out that the adoptive couple may feel threatened, tested and manipulated and find it difficult to be judged. The encounter between the agency and the perspective parents is one in which the potential adoptive parent has everything to lose; it is an all or nothing gamble. Dillon (1968) reports that one worker in charge of an adopting parents group:

was shocked to learn that, having performed a helping role - which was to elicit pertinent questions, encourage honest answers, engage in role playing, and foster group interaction to draw out individual members - the couple saw the help as coming only from the group (p. 302).

The resentment of infertile adoptive couples according to Houghton (1977) is comprised of three parts: (1) the sense of inward grief at not having a child. (2) the sense of
anger, shared by the involuntarily childless, at the social pressure directed toward them and the stigma attached to them. (3) The sense of anger at the treatment received from adoption agencies.

The grief is unfocused, centered around what might or should have been rather than on the child that never was. The experience brings to the fore a sense of personal inadequacy and a loss of confidence. Sometimes it results in over-compensation and aggressive assertion of the right to experiences similar to those of parenthood. Adopting is not necessarily a solution, however, as a number of people who have adopted still retain these feelings. The result is at best a painful reappraisal of the goals and objectives of one's life and at worst a collapse of morale to the point of breakdown (p. 227).

Romm (1976) found that one of the main sources of post-adoption anxiety was unhappiness about infertility. Cashman (1979) observed that

one of the great revelations post-adoption was the fact that many adoptive parents still had unresolved feelings about their sterility and were therefore unable to help their children accept and forgive the natural parent who had given them up (p. 17).

Fitzgerald (1979) has pointed out that on occasion there is a disruption in the adoption process - that is, an interruption after placement and before confirmation through the legal procedure. In 14 families in disruption, 11 had unresolved feelings about childlessness and other difficulties. According to the author, the inability to cooperate with the social worker was a presenting problem which in part masked anxiety about infertility.
Dolan and Reeves (1979) conducted a retrospective study of the process of adoption by sending questionnaires to 240 couples who remained in the geographic area of the adoption agency which had completed 775 placements. Of these 240 couples, the parents of 90 adopted children responded. These adoptive parents recalled "the period of waiting" as provoking anxiety. As late as 12 years after placement, some couples resented not being kept up to date with the progress of their application. The interviews and assessment procedures were described as an "ordeal". In fact, 37% of the respondents declared that the pressures and uncertainties of the adoption process had, before the adoption was finalized, inhibited the growth of their love for the child. In the majority of couples, it was implicitly agreed that the adoptive mother would disclose the fact of adoption to the child, an assumption which can increase her anxiety. It was frequently suggested by these couples that the criteria for acceptance and rejection should be clarified to the potential adoptive couple in advance. In general, according to Dukette (1979, p. 8) "agencies are often seen as arbitrary and sometimes as unfeeling, given to rigid procedures and disinclined to individualize". A two-year study (1975-1977) by the Child Welfare League of America (Meezan, Katz & Russo, 1978) found that agencies are blamed for rigidity because adoptive parents want a quick painless resolution of their dilemma. Ripple (1968) found that
adoptive couples during the adoption process make every effort to keep the social worker from getting to know them too well. The couples may be considered too old, too irreligious, or too nontraditional to merit babies. Chappelear and Fried (1976) further discovered that adoptive couples post-adoption effectively shut out the social worker and the agency.

In summary, when couples undertake an adoption procedure, they are already anxious because of their infertility and childlessness. The adoption process itself may add to these feelings. The anxiety about infertility does not necessarily decrease with the placement of a child nor the passage of time.

The Problem

While anxiety at a single point in time in the adoption process has been investigated previously, there is an absence of research on how anxiety level changes while couples wait for or undergo the adoption procedure. Two aspects of this particular interest are differences in male-female anxiety levels during these procedures and differences in anxiety level depending on whether the responsibility for infertility is assigned to one, both or neither of the partners.

By comparing the anxiety levels of couples waiting for the adoption procedure with those undergoing the procedure, the study will explore how anxiety level changes over the
course of the evaluative phase. During the evaluative phase, the couple submits an application, provides medical and fertility information, participates in an exploratory interview and responds to a variety of questionnaires. One factor assessed during this phase is the couple's anxiety about their infertility and about the necessity of the adoption alternative.

The goal of this study is to understand more about the dynamics of anxiety during the adoption process and to determine how adoption workers can modify their practice to make adoption as benign an experience as possible. The ultimate goal is to serve the best interests of the adopted child and his adoptive parents. As Thompson (1978) stated:

There is no real reason why the mechanics of adoption should wring the hearts of applicant parents. Nor is the resulting vacuum of emotional exhaustion a healthy climate in which to bring up the new child (p. 248).

Hypotheses

Hypothesis I. There is no statistically significant difference in anxiety between the couples waiting for the adoption procedure and the couples undergoing the procedure.

Hypothesis II. There is no statistically significant difference in anxiety over the course of the adoption procedure.

Hypothesis III. There is no statistically significant difference in anxiety between involuntarily childless males selecting the adoption alternative and involuntarily
childless females seeking the adoption alternative.

Hypothesis IV. There is no statistically significant difference in anxiety among individuals who are members of a couple with a wife caused infertility problem, with a husband caused infertility problem, with a mutually caused infertility problem, and with an unexplained infertility problem.
CHAPTER 2
METHODOLOGY

Setting

The private, non-sectarian adoption agency which provided the subjects is a psychiatric/psychological outpatient facility located near Chicago. The basic entry criteria for adoption applicants at this agency are as follows:

1) Geographic boundaries: Lake, McHenry and parts of Cook, DuPage and Kane Counties. According to the U.S. Bureau of Census (1980), a population of approximately 2.5 million is served.

2) Age bracket: 21-43 years inclusive, with one member of the couple under 40.

3) Length of marriage: At least four years.

4) Number of children: No more than one child already in the home with that child being at least 18 months old.

5) Medical/fertility status: Medical exploration of infertility or evidence of some medical condition which makes conception ill-advised.
The agency accepts the standards for adoption service specified by the Child Welfare League of America (Lindholm & Touliatos, 1976b). These state that applicants should be evaluated on motivation, readiness for children, feelings about childlessness, marital relationship, personality and emotional maturity. These factors are evaluated by the caseworker using the Motivation and Potential for Adoptive Parenthood Scale (Lindholm & Touliatos, 1976a) which contains subscales to assess: reasons for wanting to adopt, attitudes toward adoption and biological parents, acceptance and flexibility with regard to adopted children, ability to use help, relationships with one's family of origin, relationships with one's spouse and friends, positive experiences with children, the ability to enjoy and have a relationship with a child, the assumption of responsibility for others, and the handling of previous life situations. The caseworker is also interested in the couple's handling of their infertility.

The steps which comprise this particular adoption program are as follows:

1) Initial information meeting after which the couples decide whether to complete an adoption application. The adoption application appears as Appendix B.

2) If they apply, medical and fertility forms sent to their physicians. These forms appear as Appendix C.
3) Upon return and review of all forms, interview with individual couple by adoption intake worker.

4) Diagnostic evaluation using a variety of questionnaires and tests.

5) Either a turn-down letter or a roundtable (RT) interview for formal acceptance. The turn-down letter appears as Appendix D.

6) Following RT, couple meets with the adoption worker to discuss adoption issues.

7) More meetings with the adoption worker and a home visit.

8) Placement of the child.

9) Follow-up meeting of adoptive couple with adoption worker.

10) Legal completion of adoption.

Steps 2 through 5 are viewed as evaluative in nature while steps 6 and 7 are viewed as preparatory. The process is depicted in Figure 1.

Subjects

Thirty-six couples who met the basic entry criteria and who made application to the adoption program were randomly assigned to either the experimental group or the control group. All couples had applied to adopt healthy, Caucasian infants and were adopting for the first time. The couples were either childless or had a biological child but were not able to have more children of their own.
Figure 1. The steps of the adoption program. (Couple can choose to drop out of the program at any point before the adoption is legally completed.)
Age. - The subjects ranged in age from 26 to 43. The median age of the 72 subjects was 33 years. The mean age of the male and female subjects was 34 and 32 years respectively. The distribution of subjects by age group can be seen in Table 2.

Academic Achievement. - Most subjects were college graduates. Thirty-five percent had advanced degrees, as can be seen in Table 3.

Religion. - The group of 72 subjects consisted of 39% Protestants, 36% Catholics, 22% Jews and 3% no religious affiliation. Among male subjects, the percentages of Protestant, Catholic, Jew and individuals with no religious affiliation were 39%, 33%, 22% and 6% respectively. Among female subjects, the percentages of Protestant, Catholic and Jew were 39%, 44% and 17% in the experimental group and 39%, 33% and 28% in the control group. The distribution of subjects by religion category is presented in Table 4.

Income. - The mean family income of experimental couples was $49,661 while the mean family income of control couples was $53,698. The discrepancy in experimental and control group mean family income is accounted for by the control group males having a mean ($40,985) more than $4,400 greater than the experimental group mean ($36,517). The control group females have a mean ($12,713) $400 less than the experimental group mean ($13,144). The median family income was $43,800 for the experimental group and $43,333
Table 2

Distribution of Subjects by Age, Experimental
or Control Group and Sex

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<tr>
<td>38</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>39</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3
Distribution of Subjects by Highest Academic Level Achieved, Experimental or Control Group and Sex

<table>
<thead>
<tr>
<th>Highest Academic Level Achieved</th>
<th># of Ss in Experimental Group</th>
<th># of Ss in Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n=18)</td>
<td>Female (n=18)</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Some College</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>College Graduate</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Advanced Degree</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 4
Distribution of Subjects by Religion Category, Experimental or Control Group and Sex

<table>
<thead>
<tr>
<th>Religion Category</th>
<th># of Ss in Experimental Group</th>
<th># of Ss in Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n=18)</td>
<td>Female (n=18)</td>
</tr>
<tr>
<td>Protestant</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Catholic</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Jewish</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Table 5
Distribution of Subjects by Income, Experimental or Control Group and Sex

<table>
<thead>
<tr>
<th>Income</th>
<th># of Ss in Experimental Group</th>
<th># of Ss in Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n=18)</td>
<td>Female (n=18)</td>
</tr>
<tr>
<td></td>
<td>Male (n=18)</td>
<td>Female (n=18)</td>
</tr>
<tr>
<td>0</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>1 - 4,999</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5,000 - 9,999</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10,000 - 14,999</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>15,000 - 19,999</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>20,000 - 24,999</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>25,000 - 29,999</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30,000 - 34,999</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>35,000 - 39,999</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>40,000 - 44,999</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>45,000 - 49,999</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>50,000 - 54,999</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>55,000 - 59,999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60,000 - 64,999</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>65,000 - 69,999</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>70,000 - 74,999</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>75,000 - 79,999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80,000 - 84,999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85,000 - 89,999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90,000 - 94,999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>95,000 - 99,999</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>100,000 and above</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
for the control group. The distribution of subjects by income can be seen in Table 5.

**Years Married.** - The mean number of years married in both the experimental and control group is 8 years, as can be seen in Table 6.

**Previous Marriages.** - None of the male subjects had been married previously. Two of the female experimental subjects and three of the female control subjects had been married previously.

**Biological Children.** - Most subjects did not have biological children: one experimental male and three control males had biological children; none, however, resided with the applicant couples. Two experimental females and three control females had biological children; all of these children resided with the applicant couples. In no instance did each member of an applicant couple have a biological child.

**Responsibility for Infertility.** - Based on the opinion of fertility specialists (see Appendix C), the couples were designated as being infertile because of a problem on the part of the wife, the husband, both or neither. The experimental and control group were almost equivalent in terms of this classification system, as can be seen in Table 7. Infertility specialists generalize that infertility is primarily a female problem in 50% of cases, primarily a male one in 30% of cases, and a shared problem in 20% of cases. This sample has more couples with a shared problem than that
Table 6

Distribution of Couples by Years Married and Experimental or Control Group

<table>
<thead>
<tr>
<th>Years Married</th>
<th># of Couples in Experimental Group (n=18)</th>
<th># of Couples in Control Group (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 7

Distribution of Couples by Responsibility for Infertility and Experimental or Control Group

<table>
<thead>
<tr>
<th>Responsibility for Infertility</th>
<th># of Couples in Experimental Group (n=18)</th>
<th># of Couples in Control Group (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>3 (17%)</td>
<td>5 (28%)</td>
</tr>
<tr>
<td>Wife</td>
<td>8 (44%)</td>
<td>7 (39%)</td>
</tr>
<tr>
<td>Both</td>
<td>5 (28%)</td>
<td>5 (28%)</td>
</tr>
<tr>
<td>Neither</td>
<td>2 (11%)</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>
generalization would suggest.

Procedure

Having attended an informational meeting and having returned an application to the agency, couples were grouped on the basis of the date of receipt of the application and then randomly assigned to the experimental or control group. The homogeneity of the adoptive population justified random assignment. All couples had been informed at the informational meeting that the adoption evaluation process itself might take as long as six months. This span of time was allowed so that control group couples would not become discouraged with their seeming lack of progress and quit the program. The experimental couples went through the adoption evaluation process in a timely manner. That is, they had an interview with a social worker, completed 3-6 hours of psychological assessment and were accepted as adoptive parents at a roundtable interview. The control group couples, having submitted their application, medical and fertility forms waited for the next step in the program which did not occur until the research was completed. The control group can be conceptualized as being "in" an adoption program since waiting on a list for as long as five years is not unusual agency practice.

Each member of the matched experimental and control couples was administered anxiety questionnaires at each of the following steps in the adoption process (hereafter to be
called Steps 1, 2 and 3 respectively) which the experimental group was experiencing:

1) After agency receipt of the application
2) After the initial interview with the social worker.
3) After the roundtable.

All questionnaires were presented to each member of the experimental and control couples accompanied by a cover letter. The subjects were asked in the cover letter to respond to the instruments as individuals and not to discuss their answers with their partners. Also the subjects were assured that these responses were not used in the evaluation of their application for adoption. The three cover letters used appear as Appendix E.

The anxiety level measured at Step 1 served as a baseline for future measurements. The anxiety level measured at Step 2 occurred after the experimental couple had their first face to face contact with a social worker. The anxiety level measured at Step 3 occurred with the acknowledged termination of the evaluative process by the experimental subjects.

**Instruments**

The IPAT 8-Parallel-Form Anxiety Battery which is suitable for measuring anxiety fluctuations at short intervals (Scheier & Cattell, 1973) was one measure used to evaluate what happens to anxiety level as couples proceed through the evaluative steps of the adoption process.
According to Cattell (1974), this instrument is based on the assumption that anxiety is a disorganizing force which affects judgment, ability to plan and reactions to events. Anxiety includes a lack of confidence, a sense of guilt or worthlessness, an unwillingness to venture forth, a dependent style, a readiness to become fatigued, an irritable and discouraged uncertainty about one's self, a suspicion of others and a general tenseness. Cattell assumes that anxiety can be quite high in normal persons for purely situational reasons. The mean score on the IPAT 8 is 6.0 with a standard deviation of 1.2.

The construct validity of the test is provided by correlations of each form with a 600-item anxiety estimate for 94 college undergraduates ranging from .50 to .68 with a median coefficient of .54 (Scheier and Cattell, 1973). Scheier and Cattell report interform reliabilities from .36 to .67 with means per form ranging from .41 to .57. These reliabilities were obtained by administering all eight forms of the battery on one occasion to 94 undergraduates. Bendig and Bruder (1962) report interform reliabilities of .60 to .85. These reliabilities were obtained by administering all eight forms at intervals of two to seven days to 48 undergraduates. Philip (1970) administered all eight subtests to a class of 19 students on two different occasions. He found differences between persons and differences between test forms on one occasion but no interaction
of test form and occasion.

To construct the IPAT 8, a total of 350 items was selected from 900 anxiety measure items in a large factor analytic study. These items were allocated to the eight forms randomly. The three forms of the test which have the highest correlation with the anxiety factor, namely forms B, D, and F, were used in the present study. According to Scheier and Cattell (1973), the correlations with the anxiety factor are .54, .64 and .68 respectively. The inter-form reliability of forms B, D and F with the mean of the other seven forms is as follows: .53, .50 and .57. Counterbalancing was used in the order of administration among forms.

According to Miller, Fisher and Ladd (1967), the IPAT 8-Parallel-Form Anxiety Battery correlates significantly with Taylor's Manifest Anxiety Scale (MAS), Psychasthenia (PT) scale, Welsh's Anxiety Index (AI), and Welsh's First Factor (A) at the .01 level of confidence. Thus the construct validity of the IPAT 8 is supported by its correlation with these Minnesota Multiphasic Personality Inventory (MMPI) indices of anxiety.

The IPAT 8-Parallel-Form Anxiety Battery is an effective instrument for measuring changes in anxiety situations. Capel, Youngblood and Stewart (1970) assessed four highly trained aquanauts 15 minutes prior to a deep sea dive and 30 minutes after a 48-hour dive. They found that prior to a
deep sea dive, the divers demonstrated low levels of anxiety as compared to the general population. Upon surfacing, when the maximum danger was passed, anxiety levels approached the population norm. One of the surface personnel who was also a diver showed the same pattern of anxiety as the deep sea divers while a surface person who was not a diver showed more anxiety prior to the dive and less anxiety upon surfacing. Knapp, Capel, and Youngblood (1976) used five forms of the anxiety battery with nine divers over a more extended period of time than the previous study. The tests were administered at the following times: at the dive site 3-4 days prior to the dive, 30-45 minutes before the dive, during the dive in a hydro-lab habitat - the time of greatest danger, 30 minutes after surfacing and 10 days to 3 weeks after the dive. In general, 32 of the 45 measurements indicated less anxiety than the general population. Their findings confirmed that the anxiety levels of experienced divers are lower prior to and during the dive as compared to the general population but rise as the dives are completed. One possible explanation for these findings is that these subjects have developed appropriate defenses against anxiety since they are aware that anxiety leads to life-threatening misjudgment and failure. These defenses may be temporarily reduced during the period of relief which follows the stressful encounter. Novices were less anxious than the more experienced divers throughout the study. As divers
learn more of the dangers of diving, anxiety control increases in difficulty.

In a different type of situation, Morgan (1970) found that college wrestlers had lower prematch anxiety than preseason anxiety regardless of perceived difficulty of the competition. Philip, Cay, Vetter and Stuckey (1979) used the IPAT 8-Parallel-Form Anxiety Battery to explore fluctuations in anxiety in patients with myocardial infarction during the interval between their transfer from the coronary care unit and discharge from the hospital. Anxiety was measured on the first, fourth, seventh, and tenth day in the ward after transfer and on the day prior to discharge. The results indicated that anxiety was highest immediately after transfer from the coronary care unit and lowest the day before discharge. Between those periods, anxiety was relatively stable, and its level was within normal limits. High anxiety was shown to be associated with poor rehabilitation outcome and this study demonstrates that the time at which anxiety is measured is important. Ziegler (1974) administered five forms of the IPAT 8 over a five week period to newly incarcerated inmates. The mean scores of subjects receiving any form of anxiety treatment consistently decreased across testing periods.

The A-state scale of the State Trait Anxiety Inventory was also used to assess what happens to anxiety level as couples proceed through the evaluative steps of the adoption
process. According to Spielberger, Gorsuch and Luchene (1970), this instrument is based on the assumption that A-state anxiety is a transitory, emotional state. Such anxiety includes tension, nervousness, worry and apprehension. It will be increased in circumstances in which failure is experienced or when personal adequacy is evaluated. The median score on the A-state scale is 35.

The validity of the A-state scale has been demonstrated in a wide variety of studies. In general, the technique is to give the A-state scale to subjects under two different instructional sets, one being a normal set and the other being a set to envision oneself in a stressful situation. The scores on the A-state scale increase under the stress-imagination condition as compared to the normal circumstance. Test-retest reliabilities for state anxiety are reported separately for males and females, as follows: at 20 days, .54 (males) and .27 (females); at 104 days, .33 (males) and .31 (females). Alpha reliability coefficients range from .83 to .92.

The A-state scale has been used as a repeated measure in a variety of studies. Smith (1972) found that state anxiety scores of private pilot students were higher before solo flights than before flights with an instructor. Trussel (1978) concluded that treatment for speech-anxious undergraduates could be successful in lowering anxiety as measured by the A-state both after treatment and at a
six-week follow-up. Bahrke and Morgan (1978) demonstrated that state anxiety could be reduced immediately following and ten minutes after relaxation training, whether the training was exercise or meditation. When Archer (1979) and Archer and Stein (1978) measured state anxiety at three points in an experiment exploring the expectancy of control over events, they found there was not a simple inverse relationship between degree of control and anxiety. When Naylor, Elsworth and Astbury (1980) administered the A-state scale to primigravid women during the third trimester, in labor and during postpartum, they concluded that labor provoked the highest score.

While the A-state scale has been widely used, it is open to faking and examinees' bias. Smith (1974) showed that simulated stress instructions led to "faking bad" and suggested that "faking good" would be just as easily accomplished. He remarked on the need to ascertain to what degree examinees would be likely to bias their responses and in what direction. According to Johnston and Hackmann (1977), the A-state scale is not subject to response set. When it is used as a repeated measure (Spielberger, Gorsuch & Luchene, 1970) there is great reliability in differentiating among subjects. In the present study correlations between the A-state scale and IPAT 8-Parallel-Form Anxiety Battery were determined.
CHAPTER 3
RESULTS

A 2 (experimental vs. control) x 2 (males vs. female) x 3 (steps of the adoption procedure) analysis of variance with repeated measures on the steps of the adoption procedure was conducted to test Hypotheses I through III. Table 8 summarizes the ANOVA results on the IPAT 8 and Table 9 summarizes the results on the A-state scale. On the IPAT 8, the ANOVA yielded significant main effects for the experimental vs. control group factor, $F(1, 68) = 10.14$ ($p < .01$) and for the steps of the adoption procedure factor, $F(2, 136) = 3.14$ ($p < .05$). However, a significant interaction effect was also obtained: experimental vs. control by steps of the adoption procedure, $F(2, 136) = 4.22$ ($p < .05$). Figure 2 indicates that the control group has higher A-state scale scores at every step in the adoption procedure. The $t$ values are shown in Table 10. The only significant difference is between the experimental and control groups at Step 2.
Table 8
Anova of IPAT 8 Responses of Experimental and Control, Male and Female Ss at 3 Steps of the Adoption Procedure

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Experimental vs.</td>
<td>33.37</td>
<td>1</td>
<td>33.37</td>
<td>10.14**</td>
</tr>
<tr>
<td>Control Group)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B (Sex of Respondent)</td>
<td>.967</td>
<td>1</td>
<td>.967</td>
<td></td>
</tr>
<tr>
<td>AB</td>
<td>.205</td>
<td>1</td>
<td>.205</td>
<td></td>
</tr>
<tr>
<td>Subjects within</td>
<td>224.122</td>
<td>68</td>
<td>3.29</td>
<td></td>
</tr>
<tr>
<td>groups (error)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C (Steps of Adoption</td>
<td>2.837</td>
<td>2</td>
<td>1.419</td>
<td>3.14*</td>
</tr>
<tr>
<td>Procedure)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AC</td>
<td>2.405</td>
<td>2</td>
<td>1.203</td>
<td></td>
</tr>
<tr>
<td>BC</td>
<td>.109</td>
<td>2</td>
<td>.0545</td>
<td></td>
</tr>
<tr>
<td>ABC</td>
<td>.039</td>
<td>2</td>
<td>.0195</td>
<td></td>
</tr>
<tr>
<td>C x Subjects within</td>
<td>61.48</td>
<td>136</td>
<td>.452</td>
<td></td>
</tr>
<tr>
<td>groups (error)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* = p < .05
** = p < .01
Table 9
Anova of A-state scale Responses of Experimental and Control, Male and Female Ss at 3 Steps of the Adoption Procedure

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Experimental vs. Control Group)</td>
<td>576.90</td>
<td>1</td>
<td>576.90</td>
<td>6.56*</td>
</tr>
<tr>
<td>B (Sex of Respondent)</td>
<td>264.45</td>
<td>1</td>
<td>264.45</td>
<td></td>
</tr>
<tr>
<td>AB</td>
<td>1.67</td>
<td>1</td>
<td>1.67</td>
<td></td>
</tr>
<tr>
<td>Subjects within groups (error)</td>
<td>5979</td>
<td>68</td>
<td>87.93</td>
<td></td>
</tr>
<tr>
<td>C (Steps of Adoption Procedure)</td>
<td>164.57</td>
<td>2</td>
<td>82.29</td>
<td>3.30*</td>
</tr>
<tr>
<td>AC</td>
<td>210.06</td>
<td>2</td>
<td>105.03</td>
<td>4.22*</td>
</tr>
<tr>
<td>BC</td>
<td>14.11</td>
<td>2</td>
<td>7.06</td>
<td></td>
</tr>
<tr>
<td>ABC</td>
<td>19.86</td>
<td>2</td>
<td>9.93</td>
<td></td>
</tr>
<tr>
<td>C x Subjects with groups (error)</td>
<td>3388</td>
<td>136</td>
<td>24.91</td>
<td></td>
</tr>
</tbody>
</table>

* = p < .05
Figure 2. A-state scores of experimental and control subjects at each step of the adoption procedure. (Standard deviations appear in parentheses.)
Table 10
Comparison of Mean A-state scale Scores of the Experimental and Control Groups at Each Step of the Adoption Procedure

<table>
<thead>
<tr>
<th>Step</th>
<th>Experimental Group</th>
<th>Control Group</th>
<th>t value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>27.61</td>
<td>28.25</td>
<td>.36</td>
</tr>
<tr>
<td>2</td>
<td>23.33</td>
<td>28.66</td>
<td>3.34**</td>
</tr>
<tr>
<td>3</td>
<td>25.81</td>
<td>27.58</td>
<td>1.14</td>
</tr>
</tbody>
</table>

**p < .01

When Figures 2 (A-state scale) and 3 (IPAT-8) are compared, it can be seen that the patterns are approximately the same: the experimental group shows a sharp drop between Steps 1 and 2 and a more gradual rise between Steps 2 and 3; the control group remains higher and essentially flat. In both figures the differences between the experimental and control group are from highest to lowest: Step 2, Step 3, Step 1.

For sex on the IPAT 8 and A-state scale, there was no main effect and no interaction effect. As Figures 4 and 5 illustrate, within experimental and control groups, females do have higher anxiety scores than males at every step of the adoption procedure. As Figures 4 and 5 also illustrate, the experimental groups do show a marked fluctuation between Steps 1 and 2 and between Steps 2 and 3 while the control groups do not.
Figure 3. IPAT 8 scores of experimental and control subjects at each step of the adoption procedure. (Standard deviations appear in parentheses.)
Figure 4. IPAT 8 scores of male and female subjects at each step of the adoption procedure. (Standard deviations appear in parentheses.)
Figure 5. A-state scale scores of male and female subjects at each step of the adoption procedure. (Standard deviations appear in parentheses.)
A 4 (responsibility for infertility factor) x 2 (experimental vs. control) x 3 (steps of the adoption procedure) analysis of variance with repeated measures on the steps of the adoption procedure was conducted to test Hypothesis IV. Table 11 summarizes the ANOVA results on the IPAT 8 data and Table 12 summarizes the results on the A-state scale data. On the IPAT 8, there was a significant effect for the experimental vs. control group factor, \( F_{(1,136)} = 32.65 \) (\( p < .01 \)). There was also a significant interaction effect involving responsibility for infertility factor by experimental vs. control, \( F_{(3,136)} = 29.94 \) (\( p < .01 \)). Figure 6 indicates that the IPAT 8 scores from highest to lowest in the experimental group are: male caused, female caused, both caused, neither caused. The IPAT 8 scores for the control group are similar to one another except scores are higher in both caused group. The values are shown in Table 13. The experimental and control groups are significantly different in the both caused and neither caused groups. On the A-state scale, there were significant main effects for the responsibility for infertility factor, \( F_{(3,136)} = 4.04 \) (\( p < .01 \)) and for the experimental vs. control group factor, \( F_{(1,136)} = 50.09 \) (\( p < .01 \)). There was also a significant interaction effect involving responsibility for infertility factor by experimental vs. control, \( F_{(3,136)} = 130.52 \) (\( p < .01 \)). Figure 7 indicates that the control group has higher A-state scale scores for
Table 11
Anova of IPAT 8 Responses of Experimental and Control Ss by Responsibility for Infertility at 3 Steps of the Adoption Procedure

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Responsibility for infertility)</td>
<td>3</td>
<td>3</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>B (Experimental vs. Control Group)</td>
<td>16</td>
<td>1</td>
<td>16.00</td>
<td>32.65**</td>
</tr>
<tr>
<td>AB</td>
<td>44</td>
<td>3</td>
<td>14.67</td>
<td>29.94**</td>
</tr>
<tr>
<td>Subjects within groups (error)</td>
<td>66</td>
<td>136</td>
<td>.49</td>
<td></td>
</tr>
<tr>
<td>C (Steps of Adoption Procedure)</td>
<td>1</td>
<td>2</td>
<td>.50</td>
<td></td>
</tr>
<tr>
<td>AC</td>
<td>3</td>
<td>6</td>
<td>.50</td>
<td></td>
</tr>
<tr>
<td>BC</td>
<td>1</td>
<td>2</td>
<td>.50</td>
<td></td>
</tr>
<tr>
<td>ABC</td>
<td>0</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C x Subjects within groups (error)</td>
<td>2576</td>
<td>272</td>
<td>9.47</td>
<td></td>
</tr>
</tbody>
</table>

** = p < .01
Table 12
Anova of A-state scale Responses of Experimental and Control Ss by Responsibility for Infertility at 3 Steps of the Adoption Procedure

<table>
<thead>
<tr>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Responsibility for infertility)</td>
<td>69</td>
<td>3</td>
<td>23.00</td>
</tr>
<tr>
<td>B (Experimental vs. Control Group)</td>
<td>285</td>
<td>1</td>
<td>285.00</td>
</tr>
<tr>
<td>AB</td>
<td>2228</td>
<td>3</td>
<td>742.67</td>
</tr>
<tr>
<td>Subjects within groups (error)</td>
<td>774</td>
<td>136</td>
<td>5.69</td>
</tr>
<tr>
<td>C (Steps of Adoption Procedure)</td>
<td>80</td>
<td>2</td>
<td>40.00</td>
</tr>
<tr>
<td>AC</td>
<td>57</td>
<td>6</td>
<td>9.50</td>
</tr>
<tr>
<td>BC</td>
<td>103</td>
<td>2</td>
<td>51.50</td>
</tr>
<tr>
<td>ABC</td>
<td>108</td>
<td>6</td>
<td>18.00</td>
</tr>
<tr>
<td>C x Subjects within groups (error)</td>
<td>86757</td>
<td>272</td>
<td>318.96</td>
</tr>
</tbody>
</table>

** = p < .01
Figure 6. IPAT 8 scores for experimental and control groups within each responsibility for infertility group. (Standard deviations appear in parentheses.)
Table 13
Comparison of Mean IPAT 8 Scores of the Experimental and Control Groups within Each Responsibility for Infertility Group

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Experimental Group</th>
<th>Control Group</th>
<th>t value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4.99</td>
<td>4.96</td>
<td>-.13</td>
</tr>
<tr>
<td>Female</td>
<td>4.45</td>
<td>4.94</td>
<td>2.34</td>
</tr>
<tr>
<td>Both</td>
<td>3.93</td>
<td>5.43</td>
<td>4.35**</td>
</tr>
<tr>
<td>Neither</td>
<td>3.42</td>
<td>5.09</td>
<td>3.41**</td>
</tr>
</tbody>
</table>

** p < .01

every responsibility for infertility group except the neither caused group. The t values are shown in Table 14. The experimental and control groups are significantly different in the both caused group.

On both anxiety measures the male caused group tends to be high in anxiety and the female caused group somewhat less so. On both measures the both caused group has lower anxiety if they are undergoing the adoption procedure vs. waiting for the adoption procedure to begin. The neither caused group does not follow any pattern which may be explained by the small sample size.

Despite the small number of subjects in each subgroup, it is interesting to look at the difference between males' and females' responses in each of the responsibility for infertility groups. The mean scores for these groups are
Figure 7. A-state scale scores for experimental and control groups within each responsibility for infertility group. (Standard deviations appear in parentheses.)
Table 14
Comparison of Mean A-State scale Scores of the Experimental and Control Groups within Each Responsibility for Infertility Group

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Experimental Group</th>
<th>Control Group</th>
<th>t value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>29.17</td>
<td>29.40</td>
<td>.13</td>
</tr>
<tr>
<td>Female</td>
<td>25.73</td>
<td>28.62</td>
<td>1.84</td>
</tr>
<tr>
<td>Both</td>
<td>24.40</td>
<td>29.27</td>
<td>3.59**</td>
</tr>
<tr>
<td>Neither</td>
<td>25.92</td>
<td>25.33</td>
<td>-.12</td>
</tr>
</tbody>
</table>

** p < .01

presented in Appendices F and G. In the experimental group on the IPAT 8, the male members of couples with a male caused infertility problem have higher anxiety scores than the female members. In the experimental group of couples with a female caused, mutually caused or neither caused infertility problem, the female members have higher anxiety scores than their male counterparts. In other words, females in the experimental group have more anxiety except when the male alone is responsible for the infertility. In the control group, no pattern was found.

On the A-state scale, a similar male-female differential in the experimental group is noted. However, female members of couples with a male caused infertility problem have higher anxiety scores than the male members at Step 1 of the adoption procedure and have the same score as male
members at Step 3. For all other responsibility for infertility groups, females have higher anxiety scores than males, except at Step 3 among couples with a female caused infertility problem. In the control group on the A-state scale, females have higher anxiety scores than males, except at Step 2 among couples with a female caused problem, at Step 1 among couples with a mutually caused problem and at Steps 2 and 3 of a problem assigned to neither.

Table 15 shows the correlation matrix for the IPAT 8 and the A-state scale. Substantial and consistent positive correlations exist between the two measures. The correlations for all subjects ranged between .62 on step 3 and .65 on step 2 and were all significant at the p < .0005 level.

Appendix H shows the correlation matrix for certain demographic variables and anxiety in each responsibility for infertility group. There are no significant correlations between anxiety scores and income, age, and years married within responsibility for infertility groups. The highest correlations are the ones between years married and the IPAT 8 in the neither caused group.
Table 15

Correlation of the IPAT 8 and the A-state scale

<table>
<thead>
<tr>
<th>Steps</th>
<th>All Subjects n=72</th>
<th>Experimental Subjects n=36</th>
<th>Control Subjects n=36</th>
<th>Male Subjects n=36</th>
<th>Female Subjects n=36</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.6418 (.0001)</td>
<td>.5230 (.0011)</td>
<td>.7629 (.0001)</td>
<td>.7352 (.0001)</td>
<td>.6165 (.0001)</td>
</tr>
<tr>
<td>2</td>
<td>.6478 (.0001)</td>
<td>.4228 (.0201)</td>
<td>.6858 (.0001)</td>
<td>.6868 (.0001)</td>
<td>.6159 (.0001)</td>
</tr>
<tr>
<td>3</td>
<td>.6168 (.0001)</td>
<td>.5717 (.0003)</td>
<td>.5943 (.0001)</td>
<td>.7511 (.0001)</td>
<td>.4797 (.0031)</td>
</tr>
</tbody>
</table>

Note. p values appear in parentheses.
CHAPTER 4
DISCUSSION

This exploratory field study investigated the anxiety levels of couples who, involuntarily childless, had chosen to seek parenthood by adoption. The purpose of the research was to compare the anxiety levels of couples waiting for the adoption procedure to begin and couples undergoing the procedure. The study explored how anxiety levels change over the course of the evaluative phase of the adoption process. It assessed whether these changes were related to the sex of the applicant or to which member of the couple was responsible for the infertility (infertility status). This investigation is an extension of previous designs (Brennan, 1977; Cottereau, 1979; Dolan & Reeves, 1979; Rickarby, 1978) which had measured anxiety at only one point in the adoption process and had not hypothesized that anxiety level would change during the adoption process itself.

In this study the first anxiety measurement was made after agency receipt of the adoption application and served as a baseline for comparing the experimental and control couples. The second measurement was made after the experimental couple (the couple proceeding through the
adoption evaluation process in a timely manner) had an initial face to face contact with a social worker. It seemed reasonable to expect that anxiety level would change with the realization by the couple that they were in fact "in" the program and that after perhaps years of unwanted childlessness, they had begun a process that could rectify that condition. The final measurement was made after the roundtable interview during which the experimental couple was formally accepted as adoptive parents. It was expected that anxiety level would change when the goal of obtaining a child was clearly in view. Approximately one month elapsed between each of the measurements.

Thirty-six couples who met the basic entry criteria were randomly assigned to the experimental (proceeding) group or control (waiting) group; the control group waited as long as six months for the process to begin. The two groups were homogeneous with respect to the following variables: age, academic achievement, religion, income, years married, number of previous marriages and infertility status. The IPAT 8 and the A-state scale were used to measure anxiety. Previous research (reviewed earlier) has shown that both instruments are sensitive to variation in anxiety levels in normal groups.

At the beginning of the study, all potential adoptive couples were dealing with three issues: 1) infertility, 2) childlessness, 3) waiting itself. As was anticipated, the
anxiety levels of couples awaiting the adoption procedure differed significantly from those of couples undergoing the procedure. The waiting couples had higher levels of anxiety at each step in the adoption procedure. On both measures of anxiety the greatest difference between the waiting and proceeding couples occurred at Step 2 of the adoption procedure with the proceeding couples having the lower scores. At Step 2 the waiting couples knew they were on a waiting list but had no further contact, other than questionnaires, with the agency. The proceeding couples had had an interview with a social worker. This interview was a concrete indication that the waiting was over. The difference at Step 2 is parallel with the experience of clinicians. One adoption intake worker has remarked on the relief and anxiety reduction experienced by couples during the course of their interviews with him. At the beginning of the meeting, couples are nervous and have difficulty talking. By the end of this meeting, they talk freely and explicitly express how this interview was their first opportunity to "really talk" about their situation with a professional adoption worker.

On one measure of anxiety a difference between the waiting and proceeding couples occurred at Step 3 of the adoption procedure with the proceeding couples having the lower scores. The approval by the adoption committee for placement of a child (Step 3) has two aspects: it relieves
to some extent the problem of childlessness while it allows the issue of infertility to continue. Because of these dual and simultaneous issues in the contest of seeking approval, the couple's response is complex. Much of what is known about a couple's reaction to being approved for placement is known only months and years after placement. The initial and public response is one of enormous joy. The couple is afraid to show any negative reaction fearing that the wanted and now approved outcome be subsequently reversed by the agency. The couple may have waited as long as 10 years for a baby and they are not about to let any self-disclosure ruin their opportunity. The ostensible willingness to cooperate with agency demands and the underlying resentment about having to do so has been documented in the earlier review (Dillon, 1968; Dolan & Reeves, 1979; Dukette, 1979; Houghton, 1966; Kirk, 1964; Meezan, Katz & Russo, 1978).

What happens is that couples behave in whatever way they perceive is necessary for accomplishing a placement (Wiehe, 1976b).

In their private moments, couples are filled with doubts: Can we handle this stranger in our home? Will we be able to accept him/her as our own? What if he/she is a product of rape or incest? What if he/she isn't as smart as the rest of the family? What if he/she turns out to be ugly? What if the baby requires expensive surgery or develops an illness? And finally and most importantly, they
wonder why they couldn't have a family like everyone else and not have to worry about all these questions.

At Step 3 the waiting couples are still dealing with three issues: 1) infertility, 2) childlessness, 3) waiting itself while the proceeding couples are dealing with only two: 1) infertility, 2) childlessness. After years of trying to resolve their childlessness, the proceeding couples are relieved by their direct involvement in the adoption program. However, even when the long-sought goal is seemingly achieved, they continue to deal with what brought them to their adoption decision to begin with - their infertility. As suggested by Wiehe (1973, 1976a), attitudes about infertility are persistent even when other attitudes related to the adoption process (attitudes about the biological parents, about disclosing information to the adoptee) are subject to change. This study maintains that throughout the course of the evaluative phase of the adoption procedure, the negative attitudes about infertility are not ameliorated. The inability to lay to rest the issue of infertility reflects our societal and familial input about the naturalness and ease of conception. There is little preparation for infertility because it rarely occurs to anyone that he or she may have infertility problems which cause childlessness.

In summary, the present data showed that undergoing the adoption procedure results in lower but more fluctuating
anxiety levels while waiting for the procedure results in higher but more consistent anxiety levels. These group differences can be conceptualized in terms of the issues with which childless couples seeking adoption struggle: 1) the infertility issue is one that remains salient regardless of the status of the couple within the adoption program, 2) the childlessness issue is resolved to a greater extent in the couples who are undergoing the adoption process, 3) the waiting itself is resolved to a greater extent in the couples who are undergoing the process. Within that process, the initial interview reduces anxiety about waiting while the acceptance interview reduces anxiety about childlessness. The anxiety about infertility is not permanently reduced.

The finding that anxiety levels are higher in the waiting couples supports the major hypothesis of this study. It is a finding consistent with Dolan and Reeves (1979) who found that the period of waiting provokes anxiety. Waiting from one to five years is standard operating procedure in most agencies. The reasons for the waiting include: 1) an insufficient supply of adoptable babies and/or 2) an oversupply of qualifying couples 3) a breakdown in the system for gathering and evaluating information about the couple 4) the legislated changes in adoption procedure which require additional paperwork 5) the philosophy that waiting is necessary for adjustment. The practice of keeping applicant
couples waiting promotes high levels of anxiety. It is possible that a prolonged waiting period could contribute to anxiety levels so chronically elevated that they would not be amenable to change even with the shift from waiting to proceeding status. From a wider perspective, it can be suggested that every aspect of agency practice needs to be examined for its role in exacerbating or remediating anxiety levels.

Many studies have shown how agency practice exacerbates feelings about infertility (Cashman, 1979; Marion & Hayes, 1975b; Romm, 1976; Rothenberg, Goldey & Sands, 1971; Thompson, 1978). Adoption applicants enter the program with feelings of loss and abandonment kindled by acknowledged failure. Their experience is bereavement over the child they will never have. In this context, they undergo the ordeal of having to prove their infertility through medical documentation to the agency. The knowledge that they will be evaluated as marriage partners and the risk of being rejected as potential parents add to the impact of this highly charged situation. On the one hand the agency can have interventions for helping a couple reduce their anxiety about infertility. One the other hand, the agency may ignore the importance of this issue and by its routine practices including a waiting period actually increase anxiety levels. Just as an agency conceptualizes itself as primarily in the business of child placement, it must also
look at its responsibility for anxiety management. It must review its standard operating practices and its requirements to determine their impact on anxiety levels. Whenever possible procedures which reduce anxiety rather than increase it should be initiated. For example the practice of keeping a waiting list for as long as five years can be eliminated; the adoption program can simply be closed when there are enough potential adoptive couples. Similarly as much as possible the requirements of the program can be clarified so that the couple themselves can assess their eligibility. The couple can then begin to see themselves as participants in rather than victims of the adoption process. With the agency's careful consideration of the meaning of infertility and the anxiety it produces, couples can be better prepared for the complexity of adoption. With this care, perhaps the high rate of psychiatric illness in adoptive children can be reduced. Why adopted children present more often for treatment than biological children is a topic worthy of study. A tentative notion is that the ongoing differences between biological and adoptive parenthood have not been sufficiently explored and understood so that guidelines can be offered the adoptive parents. Kirk (1984) stated that "rejection of difference" is the single greatest factor impeding the adoptive family and that ongoing efforts to "nail down" the child, to truly integrate the adoptive child within the family, must be
made. Kirk (1984) stated that "the child enters the family and the couple thinks their needs are settled. In truth, all their needs are just beginning."

The idea that infertile females have higher anxiety levels than infertile males has been widely reported (Asch & Rubin, 1974; Brennan, 1977; Columbo, Brighenti & Scorretti, 1981; O'Moore, O'Moore, Harrison, Murphy & Carruthers, 1983). While a statistically significant sex difference in anxiety levels was not found in the present study, at all three steps in the adoption procedure, females had higher anxiety levels than males. Humphrey (1977) contended that women are more invested in motherhood than men in fatherhood and that their suffering over reproductive failure is more pronounced. La Manna (1977) found that adoptive mothers derive greater meaning in parenthood than adoptive fathers but are also more tense. Brennan (1977) noted that women take more responsibility for resolving childlessness while Dolan and Reeves (1979) determined that the adoptive mother is implicitly expected to tell the child about his/her adoption. All of these findings are supportive of the female in a nurturing social role.

Infertile adoptive couples can be subdivided on the basis of which member is responsible for the infertility. When the infertility was male caused, there was no difference between the waiting and proceeding couples. When the infertility was female caused, there was a tendency for the
waiting couples to have higher anxiety levels than the proceeding couples. When the infertility was mutually caused, the waiting couples had a significantly higher level of anxiety than the proceeding couples. When the infertility was neither caused, the results on the two measures of anxiety were inconsistent. These findings suggest that couples who have a mutually caused infertility problem are likely to experience the greatest reduction in their anxiety levels as they change from waiting to proceeding status. Of all the infertile adoptive couples, they may be the ones for whom the issue of infertility is most resolved by adoption. One member of the couple being responsible for infertility may mean that both members of the couple are not equally invested in the adoption alternative. The sharing of the problem of infertility may enable couples to respond more favorably to a mutually sought resolution.

Couples with a neither caused diagnosis are called "psychogenically infertile." A study devoted to these couples would be worth considering. When the agency which provided the subjects for this study has had an "unsuccessful" adoption (the couple divorces, presents for psychiatric care or gives up the child) it has usually been with a couple who had infertility of unspecified causation. On the one hand not having any explanation may enable a couple to cling to their hope and allow their infertility to loom large as an issue year after year. On the other hand, if
such a couple does eventually have a biological child, the adopted child becomes superfluous. So strongly do some agencies feel about this matter, that unspecified causation automatically excludes couples from making application.

Efforts to explore male-female differences within each responsibility for infertility subgroup are thwarted in the present study by small group size. A future study could specifically address the difference in the anxiety level in members of a couple depending upon who is diagnosed as being responsible for the infertility. It may well be that the difference in anxiety between the husband and wife is more diagnostic than their individual anxiety levels.

Weakness of Present Study

While the main thesis of this investigation was supported, the research is open to some points of criticism. In the responses to questionnaires, the subjects were influenced by a social desirability factor which the experimenter tried to minimize through anonymity. It is not at all clear why the experimental group and the control group did not have more similar scores on IPAT 8 at Step 1 of the adoption procedure; at that point, no manipulation had been made and the difference can only be attributed to random factors. The assessment instruments while consistent with one another could be further strengthened with additional techniques including interview material and physiological measurements. The number of potential adoptive
couples studied could be increased.  

Recommendations

This study has suggested that infertility and childlessness are separate factors; while childlessness can be alleviated, infertility remains a fact of life. The infertility issue in and of itself puts individuals and a marriage at enormous psychological risk. When individuals are fully committed to childbearing, the inability to have a biological child is a fundamental hurt with implications that last a lifetime. If one cannot be a biological parent, one cannot be a biological grandparent or great grandparent. For some the pain is so intense that they are crippled or even destroyed by it. Their feelings about marriage are altered as are their feelings about themselves. The desperation which a diagnosis of infertility invokes must be addressed professionally. Infertile pre-adoptive couples and infertile adoptive families need ongoing helping services. The agency which provided the subjects for this study has undertaken a new pre-adoption preparatory program. (The text of the brochure is presented as Appendix I.) The goal is to facilitate the resolution of the infertility issue. Infertility is neither a temporary or static concern. It changes but continues over the course of a marriage. Early in the marriage infertility means the couple cannot have a biological child. Post-adoption infertility means than any undesirable behavior on the part of the child
can be attributed to hereditary or unknown factors for which the adoptive parents cannot hold themselves responsible. When the adopted child grows up, infertility means that grandchildren are not blood related and may be "disowned." Infertile adoptive couples need to acknowledge these differences between biological and adoptive parenthood and explore their implications for themselves and for a growing child. Quite recently at this agency a twelve-year-old adoptee (adopted at birth) was "returned" because of acting out problems and the adoptive parents stated that "no child of ours would do such things." When people adopt, their expectations are high. The couple has waited so long for this child to resolve their childlessness. When the child fails in any way, as fail he must, the parents can only blame the child and then ultimately either themselves or one another for this unfortunate reminder of their infertility.

An analogy can be drawn between infertile adoptive families and families with a physically disabled child. Infertile adoptive families are "infertility disabled" and have one or more "infertility disabled" children. While adoption is a resolution of childlessness, it is not a resolution of infertility. The adoptive parents are a disabled couple with a child who will be more or less affected by what to the couple is a tragic impairment. Adoption is not a happy ending; it is, at best, a tenuous beginning.
APPENDIX A

IN Voluntary CHildlessness as a mind/body integration:
A conceptualization
Involuntary childlessness or infertility is an example of a mind/body integration. Using statistical, subjective or social criteria, there is no concise definition of involuntary infertility. Although one factor may outweigh others in determining involuntary infertility, there is multifactorial etiology including enduring predispositions or vulnerabilities of genetic or acquired origin, current susceptibility and psychic and/or somatic reactions of the individual to noxious agents ranging from physical, chemical, and biological to symbolic.

Involuntary infertility is a dynamic process with etiological factors continuing to influence its course. Psychosocial stress contributes to infertility onset, course and outcome. The social environment is an instigator of goal-directed thought and action and is a source of stimulation and information about infertility which gives rise to somatic perceptions and alters cerebral function so as to impair adaptive capabilities.

The perception of infertility is determined by: 1) Intrapersonal factors which include age, gender, constitution and past experience. 2) Interpersonal factors which encompass all relationships including those with infertility specialists and adoption caseworkers. If infertility is diagnosed in a setting of interpersonal conflict, namely marital upheaval, its impact may be greater, its course more stormy, its recovery more protracted. 3) Pathology-related
factors which include the infertility itself, its perceived causation, the rate of onset, its progression and duration. A diagnostic label can trigger emotional responses which exacerbate the original symptoms. 4) Sociocultural and economic factors which involve the shared values, beliefs and attitudes about infertility. 5) Non-human environmental factors which impact on the individual by providing input or deprivation and by influencing mood. The infertility specialist's office and the offices of the adoption agency are two examples of non-human environmental factors.

Influenced by these multiple determinants, the individual responds to infertility at three levels: the intrapsychic, the behavioral and the social. At the intrapsychic level, the individual's perception of symptoms, the diagnostic label, the nature of the infertility and the family members' responses constitute infertility-related information which the individual perceives and appraises with respect to his own needs, values, hopes, beliefs, and fears. The resultant ongoing meaning assigned the information shapes the patient's perceptions, mood, communications, decisions and relationships throughout his lifespan. The subjective meaning assigned by a patient to infertility is determined by whether childbearing/childraising provide a source of pleasure, pride or self-esteem, whether they help maintain relationships with others, whether they aid the alleviation of intrapsychic conflicts and protect against
painful affects, whether they enhance the sense of personal identity, self-concept and body image and whether they help maintain one's social role and occupational capacity. Infertility can be a threat eliciting anxiety and defensive coping strategies; it can be an actual or symbolic loss; it can provide gain by conferring status and can offer relief by enabling one to avoid an unwanted role; it can be devoid of personal meaning.

At the behavioral level, the individual may cope adaptively or maladaptively with infertility onset and course. On the one hand, he may seek expert advice, cooperate with therapeutic intervention, or find substitutes for lost satisfactions. On the other hand, his behavior may be characterized by withdrawal, surrender, dependence or self-destruction. Strategies can include tackling the problem with an activist attitude, sometimes in the extreme defying medical/psychological advice, capitulating to the problem with withdrawal or dependent clinging or avoiding the problem by active denial.

At the social level, the individual may adopt a "sick role" whereby he is relieved of certain premorbid obligations, is obliged to seek competent assistance and is required to surrender his sick "self" as quickly as possible.

Infertility, then, can create a condition broadly conceptualized as the "crisis of infertility." While
responding at the intrapsychic, behavioral and social levels, the person experiencing the crisis of infertility tends to pass through a series of stages in which psychological and somatic variables become integrated. Stage one is symptom perception frequently brought about by a couple's observation that pregnancy has failed to occur. Stage two is decision-making conditioned by one's perception of infertility, the attitudes and expectations with regard to the helpgiving process, and one's own definition of "illness." While one may define oneself as "infertile," this definition may be unproblematic and thus engender no action. Stage three is helpgiving contact during which a diagnosis is made by an expert, the diagnosis being dependent upon the helpgiver's own orientation with respect to psychological and somatic variables. The physician may diagnose the set of symptoms as "anovulation" while the psychiatrist may diagnose the same set of symptoms as "anxiety." Stage four is acute illness whereby the individual may demonstrate some degree of dependence, undergo confinement for appropriate procedures, and experience uncertainty about the outcome. Stage five is convalescence and rehabilitation during which personality traits as well as interpersonal relationships can determine the speed of recovery. Stage six is chronicity which includes factors like time of onset, rate of onset, progression of the infertility, its reversibility and compensability. In many instances of involuntary
infertility, medical treatment proves ineffective and convalescence and rehabilitation are defined in psychological terms; thus the individual is said to have "adjusted to" or "resolved" his/her childless state. Because involuntary infertility may be resistant to remediation, the individual often becomes "chronically infertile" and compensates by choosing the adoption alternative. It should be pointed out that the placement of an adoptive child does not necessarily lead to the dismissal of the chronic "sick role" and may in some instances simply verify and add credence to it. The child in effect becomes an ongoing reminder of the individual or couple's inadequacy.

Involuntary infertility as an example of a mind/body integration is represented in Figure 8. In summary, involuntary childlessness is an "event" at many levels. It is a part of the social environment; it is a stimulus input; it is a piece of perceived information; it entails physiological changes, psychological changes and coping strategies; it changes the central nervous system; it can be defined in terms of the hypothalamus, the autonomic nervous system (ANS), the endocrine system and the immunologic system. Each level is simultaneously reactive and causal. For example, the diagnosis "infertile" can be caused by a collection of physiological symptoms and can also be the cause of physiological symptoms. The secretion of gonads can be modified by a stressful stimulus input and can also
become a stressful stimulus input. The hypothalamic discharge can be caused by a psychological event and can also cause a psychological event. A coping strategy can be shaped by a particular social environment and can also modify that social environment. The ANS can be altered by perceived information and can alter perceived information.

A scenario of the individual who eventually defines him/herself as involuntarily childless might evolve in this way. The individual whose social environment emphasizes the importance of childbearing takes for granted that he/she will eventually have children. With time, one perceives one's failure to become pregnant or impregnate. The meaning of this information depends on the individual's needs, values, beliefs, and fears. It may represent a potential loss experience. As such it will be defined as a stressful event. However it is perceived, the failure to get pregnant or impregnate will change the individual. If expert opinion is then sought and a diagnostic label supplied, this new piece of information will similarly change the individual. Over the course of acquiring what is essentially a chronic patient role, the meaning of the situation will be in an ongoing state of flux. Whether there is a definable functional or organic impairment becomes important only to the extent of the stimulus input and consequent information it provides; to have no definitive functional or organic impairment can be for some people as "meaning-full" as
having a well-defined, even painful, hopeless or terminal condition. Each individual uses coping strategies in response to perceived information. One coping strategy of the involuntarily childless couple is the process of defining themselves as potential adoptive parents.
Figure 8. The psychosocioneuroendocrinology of mind/body integration.
APPENDIX B

ADOPTION APPLICATION
ADOPTION APPLICATION

(All information herein is strictly confidential)

Please feel free to use the backs of the pages to elaborate on any answer or to provide additional information which you think would be helpful.

Mr. and Mrs.

(husband's first) (middle) (last)

(wife's first) (maiden)

Address:

(number and street) (city) (county)

(state) (zip)

Home Phone Number:
Work Phone: (husband) (wife)

I. LIFE HISTORY

Husband

A. Birth: Date:
Place:

B. Nationality Descent:

C. Religious Affiliation:

D. Description:
Height: Weight
Hair Color: Eye Color

Wife

Height: Weight
Hair Color: Eye Color

E. Education:

Last grade completed or degree

When:

Where:

F. Previous Marriages:

To Whom:

Date: Place: Date: Place:

How Terminated: Death: Divorce

Date: Death: Divorce

Date:
Page 2 - Adoption Application

Children: (from previous marriage)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Whereabouts</th>
<th>Name</th>
<th>Age</th>
<th>Whereabouts</th>
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G. Military Service:

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<th>From:</th>
<th>To:</th>
<th>Branch:</th>
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<th>To:</th>
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</table>

Type Discharge: ____________ Type Discharge ____________

H. Criminal Record:

Have you ever been arrested and/or convicted of a felony?

Yes No
If "yes", explain circumstances: Yes No
If "yes", explain circumstances:

II. FAMILY BACKGROUND

Husband    Wife

A. Parents: Father    Mother    Father    Mother

Name: _____________________________________________________

Age now (or age at death and date of death): __________________________________________

Year of Marriage: __________________________________________

Occupation: ______________________________________________
(If retired list former occupation)

Divorce? (year) __________________________________________

Remarriage? (Year): ______________________________________
B. Brothers and Sisters:

<table>
<thead>
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<th>Sex</th>
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<th>Occupation</th>
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</tr>
</tbody>
</table>

III. CURRENT SITUATION

A. Residence:
- Number of rooms: ___ Apartment: ______ House: ______
- Rent: ___ Monthly Payments: ___ Mortgage Balance: ___
- How long at present address: _____________________________
- Previous Address: ____________________ How long there?: ___

B. Present Marriage:
- Date: ______ Place: (city) (county) (state)
- Length of Courtship: _____________________________
- Children (this marriage)

<table>
<thead>
<tr>
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<th>Birthdate (mo./day/yr.)</th>
<th>Biological or Adopted</th>
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</tbody>
</table>
Page 4 - Adoption Application

If you have an adopted child, check whether the placement was arranged through an agency____ or privately____.

If this placement was arranged through an agency, indicate the name and address of the agency.

_____________________________________________________________________________________

C. Others in Home:

<table>
<thead>
<tr>
<th>Name</th>
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<th>Relationship</th>
</tr>
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<td>2.________</td>
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<tr>
<td>3.________</td>
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</table>

D. Employment

<table>
<thead>
<tr>
<th>Husband</th>
<th>Wife</th>
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</table>

Five Year Work History (Most recent listed first)

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<th>Hours:</th>
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<tr>
<td>Position:</td>
<td>Annual Income:</td>
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<td>Annual Salary:</td>
<td>Annual Salary:</td>
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<td>Position:</td>
<td>Annual Income:</td>
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<td>Position:</td>
<td>Annual Income:</td>
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<td>Date of termination:</td>
<td>Date of termination:</td>
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</table>
Employment continued: Husband   Wife

Position: ___________________________   ___________________________

Date of termination: ___________________________

Other Sources of Income: ___________________________

E. Financial Situation:

Total annual income: ___________________________
(include salaries, interest, dividends, etc.):

Life insurance (Give name of company and amount on each partner):

Health insurance (Give name of company and amount on each partner):

Debts (Give amount and kind and name of source):

Savings (Give amount and kind and name of savings institution):

Investments (Give amount and kind):

IV. MEDICAL INFORMATION

Husband   Wife

Date of most recent physical exam: ___________________________

Medical Form will be submitted by the following Physician: ___________________________

Address: ___________________________
Medical Information continued: Husband Wife

Fertility Form will be submitted by the following Physician(s):

Address:

Are you currently undergoing counseling of any kind? Is so, please give the name and address of the helpgiver.

V. REFERENCES

A. Relatives (list two):

<table>
<thead>
<tr>
<th>Name</th>
<th>Street</th>
<th>Town</th>
<th>Zip</th>
<th>Phone</th>
<th>Relationship</th>
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</table>

Close friends (list three):

<table>
<thead>
<tr>
<th>Name</th>
<th>Street</th>
<th>Town</th>
<th>Zip</th>
<th>Phone</th>
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Our signatures below certify all the preceding information to be accurate to the best of our ability, and authorizes the Family Counseling Clinic to contact any resource for verification and/or additional information.
A photocopy of this statement and our signatures constitute authorization as if it were the original.

Date:______________________________

Husband's Signature
Social Security Number______________________

Wife's Signature
Social Security Number______________________
Statement of Understanding

Our signatures below indicate that we understand the described sequence of events including the fact that the fees are non-refundable and that our application might be turned down.

It is the policy of Family Counseling Clinic not to share with adoptive applicants the reasons for which the agency may decide not to place a child with a family.

Adoption Application

Upon the evaluation of your application, within six weeks, you will receive either your medical and fertility forms or written notification that your application has been turned down.

Medical/Fertility Forms

Within six months of receipt and review of your completed medical and fertility forms, you will receive a notification either that an interview is to be arranged or that your application has been turned down.

Initial Interview

Interview

Upon completion of your interview, a questionnaire date will be arranged.

Questionnaires

The questionnaires are answered individually by each member of the couple. The questionnaire administration takes three to six hours. The questionnaires explore a wide-range of subjects including your background, your personality, and your current relationship. We ask questions about money, about religion, about work, about sex - about all areas of human concern. Upon successful completion of your questionnaires, within six weeks you will receive notification either that a roundtable date is to be arranged or that your application has been turned down.

Roundtable:

The roundtable is a meeting with one or more of our staff for the purpose of continuing to explore your relationship.
Upon successful completion of the roundtable, you will be assigned to an adoption worker.

In our efforts to continually improve our adoption procedures, we, on occasion, collect data from our applicants. This data is often gathered by questionnaires mailed to you during the adoption process. These mailed questionnaires are not part of the diagnostic phase of our program. Any information obtained on these mailed questionnaires is treated with utmost confidentiality. Should any professional publications result from our ongoing study of the program, all identifying information will be deleted.

We have read and understood the foregoing Statement of Understanding and agree to cooperate with agency policy, including the answering and returning of questionnaires.

Date:___________________ __________________________ Husbands Signature

Date:___________________ __________________________ Wifes Signature
APPENDIX C

MEDICAL AND FERTILITY FORMS
ADOPTION PROGRAM

FEMALE MEDICAL FORM

Date: _______________________
Name: ________________________________ Age: ______
Address: _______________________________________________________

MEDICAL HISTORY

Review of systems

Skin __________________________________________________________

HEENT _________________________________________________________
Breasts _______________________________________________________
Cardiorespiratory ____________________________________________
Gastrointestinal _______________________________________________
Genitourinary ________________________________________________
Central Nervous System ______________________________________
Endocrine ____________________________________________________

Individual History

Childhood Diseases: Measles___Rubella___Mumps___Chicken Pox___
Whooping Cough___Scarlet Fever___Rheumatic Fever___
Major Illnesses: Diabetes___Hypertension__
Coagulation Disorders___Kidney Disease___
Congenital Defects___
Menstruation history: Age of onset__________________________
Periodicity: Regular___Irregular___
Comments:__________________________________________

Venereal Disease___________________________________________
Pregnancy History__________________________________________________________________
Medical History

Difficulties
Contraceptive History
Vaginal Infection History
Hospitalization
Surgery
Injuries
Medication
Tobacco
Alcohol
Drugs
Diet
Allergies

Family History

Familial disorders and diseases:
Allergies
Cancer
Diabetes
Heart disease
Hypertension
Other

PHYSICAL EXAMINATION

General
B.P. _____ Temp. _____ Pulse _____ Resp. Rate _____ Wt. _____ Ht. _____

General
Skin
Head and Eyes
Ears, Nose, Throat
Thyroid
Breasts
Female Medical Form
Physical Examination

Cardiovascular

Abdomen

Extremities  Lymph Nodes

Neurologic

Comments

Reproductive Organs

External Genitalia  B and S Glands

Outlet  Vaginal Mucosa

Cervix  Corpus

Adnexa  Rectal

Tone of Inlet: Loose  Average  Tight

Clitoral Adhesions: Yes  No

Attitude of patient during pelvis examination:

  Relaxed  Tense  Other

Comments

REQUIRED TESTS

Complete Blood Count  VDRL

SMA - 12 Screening Test

Tuberculin Skin Test or Chest X-Ray

Other, as indicated
In your opinion, is there any anatomical anomaly or physiological dysfunction which prevents this individual from sexually functioning in a completely adequate manner?

Yes____ No____

Comments:________________________________________

__________________________________________________

__________________________________________________

In your opinion, is there any anatomical anomaly or physiological dysfunction which prevents this individual from becoming a biological parent?

Yes____ No____

Comments:________________________________________

__________________________________________________

__________________________________________________

Is this individual in a state of good general health and free of contagious diseases?

Yes____ No____

Comments:________________________________________

__________________________________________________

__________________________________________________

Does the physical condition and medical history indicate adequate and continuing physical ability to care for an adopted child?

Yes____ No____

Comments:________________________________________

__________________________________________________

__________________________________________________

__________________________________________________
Is there any reason to predict that this individual will not survive the first eighteen years of the child's life?

Yes [ ] No [ ]

Comments:________________________________________________________

________________________________________________________

(Signature of examining physician)
ADOPTION PROGRAM

MALE MEDICAL FORM

Date:_____________________

Name:_______________________________________________ Age:_____

Address:________________________________________________________________

MEDICAL HISTORY

Review of systems

Skin_____________________________________________________

HEENT________________________________________________________________

Chest_________________________________________________________________

Cardiorespiratory___________________________________________

Gastrointestinal___________________________________________

Genitourinary________________________________________________________________

Central Nervous System________________________________________________________________

Endocrine_____________________________________________________________________

Individual History

Childhood Diseases: Measles_Rubella_Mumps_Chicken Pox__

Whooping Cough_Scarlet Fever_Rheumatic Fever__

Major Illnesses: Diabetes_Hypertension__

Coagulation Disorders_Kidney Disease__

Congenital Defects__

Venereal Disease_____________________________________________________

Impregnation History___________________________________________

Difficulties__________________________________

Contraceptive History__________________________________________

Hospitalization__________________________________________
Page 2 - Male Medical Form

Medical History

Surgery ___________________________________________________

Injuries __________________________________________________

Medication ________________________________________________

Tobacco _____________________ Alcohol ___________ Drugs ______

Diet ____________________________ Allergies __________________

Family History

Familial disorders and diseases:  Allergies

Cancer ____________________________

Diabetes __________________________

Heart disease ______________________

Hypertension ______________________

Other ______________________________

PHYSICAL EXAMINATION

General

B.P. ____ Temp. ____ Pulse ____ Resp. Rate ____ Wt. ____ Ht. ____

General ___________________________________________________

Skin ______________________________________________________

Head and Eyes _____________________________________________

Ears, Nose, Throat _______________________________________

Thyroid __________________________________________________

Chest _____________________________________________________

Cardiovascular _____________________________________________

Abdomen __________________________________________________

Extremities ____________________________ Lymph Nodes ________

Neurologic ________________________________________________
Physical Examination

Comments

Reproductive Organs

Penis_______________________ Circumcised: Yes___No___ Testes___

Rectal________________ Prostate________ Svs________

Attitude of patient during examination:

    Relaxed________ Tense________ Other________

Comments

REQUIRED TESTS

Complete Blood Count________________ VDRL

SMA - 12 Screening Test________________

Tuberculin Skin Test or Chest X-Ray________________

Other, as indicated________________
In your opinion, is there any anatomical anomaly or physiological dysfunction which prevents this individual from sexually functioning in a completely adequate manner?

Yes____ No____

Comments:__________________________________________________________


In your opinion, is there any anatomical anomaly or physiological dysfunction which prevents this individual from becoming a biological parent?

Yes____ No____

Comments:__________________________________________________________


Is this individual in a state of good general health and free of contagious diseases?

Yes____ No____

Comments:__________________________________________________________


Does the physical condition and medical history indicate adequate and continuing physical ability to care for an adopted child?

Yes____ No____

Comments:__________________________________________________________
Is there any reason to predict that this individual will not survive the first eighteen years of the child's life?

Yes  No

Comments:__________________________________________

__________________________________________

__________________________________________

(Signature of examining physician)
ADOPTION PROGRAM
FERTILITY REPORT

Date:__________________________________________________________
Name:_________________________________________________________
Surname Husband's given Wife's given

Female Fertility:
1. Tubal Patency:
   Hysterosalpingogram Date_______Findings______________

2. Metabolic Study Findings______________________________

3. Ovulation Study - Method Used:
   Basal Temperature Chart__________Hormone Assay___________
   Endometrial Biopsy_______________Other (specify)__________

4. Post-Coital Test (Sims - Huhner): Good____Fair_______
   Poor____None______

5. Laparoscopy Findings:____________________________________

6. Emotional Evaluation:
   _________________________________________________________

7. Other:___________________________________________________

8. Your evaluation of female fertility:__________________________
   _________________________________________________________
9. Etiology of infertility:

Anatomical ___________ Neurophysiological ___________

Functional ___________

Comments: ________________________________________________

Male Fertility:

10. Sperm Analysis:

Number of Semen Analyses: ______________

Count per CC: Date ___________ Findings ___________
              Date ___________ Findings ___________

Mortality studies: Date ___________ Findings ___________
                   Date ___________ Findings ___________

Other (specify, Morphology, etc.) ______________

11. Male Fertility is consistently high ______ fair ______ poor ______

12. Emotional Evaluation: ________________________________

13. Your evaluation of male fertility: _______________________

14. Etiology of infertility:

Anatomical _____ Neurophysiological _____ Functional _____

Comment: ______________________________________________
Page 3 - Adoption Program
Fertility Report

Conclusions/Recommendations:

15. Have the fertility studies been entirely completed?
   Yes____ No____ In process____

16. How long has attempt been made to achieve pregnancy?

17. Specify with date: pregnancies, miscarriages, stillbirths

18. What is the possibility of pregnancy?

19. What is the possibility of carrying to term?

20. Is there any reason why this couple should not continue to try to have their own child?

21. What further treatment is recommended?

22. Does the physical condition and medical history indicate adequate and continuing physical ability to care for an adopted child?

23. What role do emotional factors play in the infertility problem?

24. Comments:

Physician's signature
APPENDIX D

TURN-DOWN LETTER
Dear ____________:

After careful review of your materials, our adoption committee has not approved your application.

Thank you for your interest in our program.

Sincerely yours,

Adoption Committee
APPENDIX E

COVER LETTERS
Dear Adoption Applicant,

Enclosed you will find a questionnaire booklet and answer sheet with your name on it as well as a self-evaluation questionnaire. The directions for the questionnaire booklet are included in the booklet. Please complete this questionnaire first. Then complete the self-evaluation questionnaire. Please note that the self-evaluation questionnaire has two sides and a total of 40 items.

These materials as described in the adoption application are a part of our effort to improve our adoption procedures. They are not used in the evaluation of your application. All information is treated with utmost confidentiality.

Would you kindly answer the questionnaires in one sitting and as soon as possible. When you are finished, please put the questionnaire booklet, the answer sheet and the self-evaluation questionnaire in the enclosed envelope and mail it back to us.

Since we are interested in obtaining a wide range of data, it is important that each member of the couple respond independently without discussing the answers with the other partner.

Thank you very much for your cooperation.

Sincerely yours,

Adoption Committee
Dear Adoption Applicant,

Enclosed you will find a questionnaire booklet and answer sheet with your name on it as well as a self-evaluation questionnaire. These materials are similar but not identical to the ones you completed previously. The directions for the questionnaire booklet are included in the booklet. Please complete this questionnaire first. Then complete the self-evaluation questionnaire. Please note that the self-evaluation questionnaire has two sides and a total of 40 items.

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Thank you very much for your cooperation.

Sincerely yours,

Adoption Committee
APPENDIX F

Mean IPAT 8 Scores
by Experimental and Control Groups,
Responsibility for Infertility,
Sex and Step of the Adoption Procedure

<table>
<thead>
<tr>
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<th>Female Caused</th>
<th>Mutually Caused</th>
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APPENDIX G

Mean A-state Scale Scores
by Experimental and Control Groups,
Responsibility for Infertility,
Sex and Step of the Adoption Procedure

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<td>Female: 28.43</td>
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<td>29.80</td>
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APPENDIX H

Correlations of Variables by Responsibility for Infertility

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<th>IPAT 8 Step 1</th>
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<th>IPAT 8 Step 3</th>
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<tr>
<td>Income</td>
<td>.2634 (.32)</td>
<td>.1146 (.67)</td>
<td>.2064 (.44)</td>
<td>-.0734 (.79)</td>
<td>.2249 (.40)</td>
<td>-.0614 (.82)</td>
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<tr>
<td>Age</td>
<td>.4667 (.07)</td>
<td>-.0665 (.81)</td>
<td>.1080 (.69)</td>
<td>.4715 (.07)</td>
<td>-.0309 (.90)</td>
<td>-.0349 (.90)</td>
</tr>
<tr>
<td>Years</td>
<td>.5389 (.03)</td>
<td>.2822 (.29)</td>
<td>.3027 (.25)</td>
<td>.5327 (.03)</td>
<td>.4189 (.11)</td>
<td>.0655 (.81)</td>
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<tr>
<td>Income</td>
<td>-.1544 (.42)</td>
<td>-.1805 (.34)</td>
<td>-.3945 (.03)</td>
<td>-.1904 (.31)</td>
<td>-.0702 (.71)</td>
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<td>Age</td>
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<td>-.1051 (.58)</td>
<td>.1356 (.47)</td>
<td>-.0282 (.88)</td>
<td>.1845 (.33)</td>
<td>.2657 (.16)</td>
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<td>.1858 (.33)</td>
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<td>.1704 (.37)</td>
<td>.2041 (.28)</td>
<td>.2574 (.17)</td>
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<td>.0047 (.98)</td>
<td>.1591 (.50)</td>
<td>-.0132 (.96)</td>
<td>-.0539 (.82)</td>
<td>-.2496 (.29)</td>
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<tr>
<td>Age</td>
<td>-.3139 (.18)</td>
<td>-.3168 (.17)</td>
<td>-.1262 (.60)</td>
<td>-.1992 (.40)</td>
<td>-.0660 (.78)</td>
<td>-.1351 (.57)</td>
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<tr>
<td>Years</td>
<td>.1397 (.56)</td>
<td>.3537 (.13)</td>
<td>.3202 (.17)</td>
<td>.1046 (.66)</td>
<td>.3073 (.19)</td>
<td>-.0115 (.96)</td>
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<tr>
<td>Income</td>
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<td>-.1795 (.73)</td>
<td>-.1430 (.79)</td>
<td>-.5015 (.31)</td>
<td>-.3216 (.53)</td>
<td>.2422 (.64)</td>
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<tr>
<td>Age</td>
<td>-.1132 (.83)</td>
<td>.1539 (.77)</td>
<td>.2613 (.62)</td>
<td>-.4990 (.31)</td>
<td>-.3096 (.55)</td>
<td>.5585 (.25)</td>
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<tr>
<td>Years</td>
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<td>.7312 (.10)</td>
<td>.8879 (.02)</td>
<td>-.0806 (.88)</td>
<td>.0247 (.96)</td>
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<tr>
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**Note:** p values appear in parentheses.
APPENDIX I

BROCHURE
INFERTILITY, CHILDLESSNESS

AND ADOPTION

Infertility means that you've been trying to get pregnant for longer than one year or have been unable to carry a pregnancy to term. With care from a specialist, the situation is not hopeless.

Preparation for adult life presumes there will be children. We take for granted our potential fertility. For infertility and childlessness, there is little if any preparation.

Infertility is a concern which couples share. Sometimes the problem is caused by the male, sometimes the female, sometimes both. Occasionally there is no medical explanation for infertility. One in six couples in the United States is experiencing infertility.

For some, infertility and childlessness are very painful issues that can make you feel frustrated and anxious. Infertility is neither a temporary or static concern. It changes but continues over the course of a marriage. You need to acknowledge these changes and explore their implications for yourself and a growing child.

The uncertainty connected with infertility, childlessness and adoption may inhibit interaction with family and friends and even with one another. You may feel alone and unsupported.

Before adopting, it is important to understand the cause of your infertility and to accept that you may never be biological parents. If you accept your infertility, it is easier to deal with the demands of an adoption program and the special needs of the adopted child.

The agency requires diagnostic testing and interviews. You may resent having to show an agency that you are ready for adoptive parenthood. You may not be accustomed to talking about so many aspects of your lives.

Adoption is a new beginning for families and children. If you feel comfortable with the adoption process, you are ready to begin an experience that will change your life forever.
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