ANXIETY, LOCUS OF CONTROL AND STRESS IN ADOPTIVE AND BIOLOGICAL PARENTS OF ADOLESCENTS

DISSERTATION

Presented to the Graduate Council of the University of North Texas in Partial Fulfillment of the Requirements For the Degree of

DOCTOR OF EDUCATION

By

Thomas K. Larussa B.S., M.S.
Denton, Texas
December, 1995
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The purpose of this study was to critically examine differences in levels of anxiety, locus of control and stress between adoptive and biological parents of adolescents.

The subjects for this study consisted of 44 adoptive parents of adolescents and 44 biological parents of adolescents who were matched on race, marital status, income level and gender. All of the parents were volunteer. The largest adoption agencies in the state of Texas were utilized in contacting the adoptive parents. The biological parents were obtained through University graduate classes and local churches. Each of the parents were mailed a State-Trait Anxiety Inventory (STAI), Life Events Scale (LES) and a Rotter Internal-External Scale (I-E). These were then filled out and mailed back.

Hotellings T2 test was used to determine whether the groups differed significantly on levels of anxiety, locus of control and stress. The groups did not differ significantly on any of the variables. The Pearson product-moment correlation was used to identify any relationship between either group of parents' scores between levels of stress and anxiety and between levels of stress and locus of control.
No significant correlations were found in either group. A Chi-Square test was used to determine whether there was an association between the variable of parenting and classification of normal/high scores. No association was found to exist.

Based on this study, adoptive parents of adolescents do not have higher levels of anxiety and stress than biological parents of adolescents. Adoptive parents' locus of control is not significantly different than their biological counterparts.
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CHAPTER I

INTRODUCTION

Adoption has long been one way of forming a family and raising children. The idea of rearing another's child has been around for centuries. Part of the significance of the story of Moses is that he was adopted. Adoption continues to be a viable way for adults and children to live together as a family.

There is a growing need for mental health professionals to assist non-traditional families. At the critical stage of adolescence, with its tasks of individuation and establishment of identity, adopted families are at particular risk. Approximately 1 1/2 - 2 percent of the general population is adopted. Considering the number of individuals affected by adoption in each family, several million individual Americans are impacted by adoption issues.

Specific needs and issues can be addressed when adoptive families seek treatment (DiGiulio, 1987; Eheart & Power, 1988; Jennings, 1989; Lifton, 1988). Many authors argue that therapists in general are unaware of the differences between adoptive and traditional families and
the issues specific to that type of family (DiGiulio, 1987; Jennings, 1989; McDaniel-Mitchell, 1991). Mental health professionals tend to either undertreat or overtreat adoptive issues (Winkler, 1897; McDaniel-Mitchell, 1991). Research has shown adopted children to be at higher risk for psychiatric disorders than nonadopted children (Menlove, 1965; Yoghurt, Aponte, & Cross, 1969; Kotsopoulus, et al., 1988; Fullerton, et al., 1986; Brinich & Brinich, 1982; Brodzinsky, et al., 1987; Jerome, 1986; Weiss, 1985). The majority of these studies involved adopted adolescents. Recent research indicates movement toward a focus on family interaction and the dynamics within the adoptive family (Williamson-Wentz, 1991). Researchers have noted the importance of the adoptive parent's attitudes toward adoption and the child as being critical to the adoptive child's development (Kirk, 1964; Williamson-Wentz, 1991). Experts in the field have also called for continued research of developmental issues in adoptive families and how the parents affect and are affected by them. (Sorosky, et al., 1978; Winkler, et al., 1987; Reitz & Watson, 1992; Bonham, 1970; Brodzinsky and Huffman, 1988; Brodzinsky and Jackiewicz, 1987; Hoopes, 1982; Williams, et al., 1987).

Problems in progressing through the developmental stages of adolescence often motivate families to seek assistance from mental health practitioners. Until recently, there has been limited professional acceptance of
the role of stress and anxiety in adoptive parents as factors in understanding outcomes in adoption and the development of the adopted children. An understanding of the stress of adoptive parents and responses to their adopted adolescent's behavior is needed. Information on this issue is presented here to facilitate better understanding of the effects of being an adoptive parent.

This research may help professionals prepare adoptive parents for different ways of being a family and lessen the negative effects of the adoption process on the adopted children as well as the adoptive parents themselves.

Statement of the Problem

Is there a difference in the level of reported stress, anxiety or locus of control in adoptive parents with adolescents and biological parents with adolescents?

Related Literature

Literature on adoption has been fairly abundant since the 1950's. Research and writing have centered mainly on the history and focus of the adoption movement, effects of adoption on children, pathology in adopted children, and, to a lesser extent, studies of adoptive parents' relationships with their adopted children. This research seems weighted on the side of the study of the child, often to the neglect of the adoptive parents.
Before World War II, adoption in the United States, although partly focused on finding families for children without parents, often was centered around the needs of adoptive parents. Sealing of records in adoption was established to protect adoptive parents', biological parents' and children's privacy. Sealing records also came about to save the adoptive parents the fear of abandonment and anguish if a child wanted to search for the birth parents or vice versa (Benet, 1976; Fiegalman & Silverman, 1983). Agencies often tried to "match" the adoptive parents and child by choosing an adoptee of similar complexion, temperament, body type and ethnic and religious background as the new parents. This was directed at accommodating the needs of the adoptive parents, offering a child as much like the one they might have had if they had been fertile (Fiegalman & Silverman, 1983).

Adoption in general seems to have been understudied for some time, as evidenced by the Federal Government's failure to keep track of how many children have been adopted since 1975 (Gibbs, 1989). This declining effort at reporting adoption statistics belies the priorities of our society when it comes to adoption.

Other than estimates for recent years, most statistics in the area of adoption are from the late 1950's through the mid-1970's. Non-relative adoptions, which involve those children not adopted by family members or step-parents
marrying the birth parent, had been increasing since the early 1950's (Fiegalman and Silverman, 1983). Bonham (1977) estimated that approximately 45,000 non-relative adoptions took place in 1957, compared to 60,000 or so in 1971. Evidence suggests that after 1971, there was a decline in adoptions to 50,000 or so (Fiegalman and Silverman, 1983). The Adoption Factbook, cited in Flango (1990), estimated 51,157 non-relative adoptions took place in 1986. These low numbers may be due to the availability of birth control, an increase in abortion of unwanted pregnancies and a greater number of single parents keeping their children. The National Committee for Adoption estimates 60,000 non-relative adoptions occurred in 1988 (Gibbs, 1989).

Research on Adopted Children

As a group, adoptive children may be particularly prone to emotional and personality disturbances. The majority of these children are born to very young, single parents, putting the infants in a group of mothers known to have greater physical risks during pregnancy and birth. Most of the children had biological parents who had personal and social difficulties that prevented them from keeping their child. This pregnancy stress may have had unusual or negative prenatal effects on the child (Stott, 1969).

One of the first studies of how adopted children fared as adults was done by Theis (1924). This study of adults,
age 18-40 who had been adopted, showed a nonsignificant percentage of the subjects as being "incapable". Weinstein and Geisel (1960) examined the children of a previous study done on adoptive parents (Witmer, et al, 1963) and found significantly lower scores for adjustment for the adopted children than for the control group.

Adopted children in treatment have been shown to exhibit greater antisocial behavior and are diagnosed with more personality trait disturbances than their nonadopted counterparts (Menlove, 1965; Offord, Aponte and Cross, 1969; Weiss, 1985). Brinich and Brinich (1982) reviewed charts of 5,135 patients who had registered for their first psychiatric service at Langley Porter Psychiatric Institute between 1969 and 1978. Of the 5,135 children and adults seen during that time, 5 percent of the children were found to be adopted, more than twice the national average of adoptees. However, the representation of adoptees among adults was 1.6 percent, somewhat below the national average.

In another study of charts, Jerome (1986) hypothesized that there would be a significantly increased annual incidence of adopted children in the Madame Vanier Children's Clinic in London, Ontario, Canada, compared to the annual incidence of adopted children in the community of the province of Ontario. Computerized information was gathered on all children admitted to the clinic between 1959 and 1979. The sample consisted of 1,826 nonadopted
children. The adopted sample consisted of 166 children, representing 8.3 percent of the total children seen during this time period. These results indicated that over this 15-year period at the clinic, adopted children were seen with more than three times the expected annual incidence predicted from the community.

Fullerton, et al. (1986) studied 108 adolescents undergoing long-term treatment for personality disorders, psychosis and neurosis in an inpatient, residential treatment program. Of the 108 cases examined, 18, or 17 percent of the sample, were found to be adopted. In another study, Warren (1989), in an effort to account for the overrepresentation of adoptees in psychiatric settings, studied 3,698 adolescents from two parent families, of whom 145 were adopted. Data were derived from interviews with the subjects' parents. Log linear analysis was conducted to determine whether adoption significantly contributed to the likelihood of treatment after other factors were taken into account. It was found that adoption does increase the likelihood of psychiatric treatment, even after controlling for the fact that adoptees display more behavior problems and are more likely to be from educated families.

In 1988, Kotsopoulos et al. conducted a two-stage procedure in which the total number of adopted children referred to the child outpatient program of the Royal Ottawa Hospital from 1983 and 1984 were tabulated. Each of the 57
adoptees meeting the study's criteria were matched with a referred nonadopted child. Finally, a panel of three psychiatrists, after discussing the individual cases, gave both the adopted and nonadopted children a clinical diagnosis (Axis I) and the level of adaptive functioning diagnosis (Axis V), based on DSM III criteria.

The researchers found that the rate of referrals for adopted children was more than twice (2.4) the rate for nonadopted children, and that a higher proportion of adopted children presented with conduct disorder and a lower proportion with anxiety disorder than nonadoptees. More adopted children presented with adjustment disorder with conduct features and fewer with adjustment disorder with anxiety features than the nonadoptees.

Weiss (1984) studied the medical records of adopted and nonadopted adolescents being treated in a psychiatric inpatient facility. She found that adoptive parents were significantly more restricted in their visits to their children. They were also more likely to be reported to be involved in the precipitants to hospitalization and more likely to be referred to adjunct psychotherapy. It was concluded that the parent-child relationships may be more problematic among the hospitalized adopted than the nonadopted.
Research on Adoptive Parents

The importance of adoptive parents and their attitudes toward adoption are of critical importance. Myths about some of the superficial factors which supposedly make for a successful adoption have been exploded. The age of parents, the financial security of the family, the age of the child at placement, and so on, are not necessarily as important as less tangible qualities, such as the parents' attitude toward the child, love, affection, positive discipline and appropriate parent-child boundaries. Such factors lead to normal growth and development in any family, but there are some special factors that enter into positive outcome with adoptive families. These include: openness about adoption, acceptance of infertility (if that is the motivating factor for adopting), and acceptance of intellectual, cultural or other differences. These are some of the factors unique to adoption and the ones that can bring added stress to the adoptive family (Kirk, 1964; Hoopes, 1990).

In a review of adoptive parents for the Child Welfare Services, Kadushin (1980) determined that successful adjustment to the adoptive family is related to two factors: parental attitudes toward the child and the adoption and the nature of the parent-child relationship. Hoopes (1982) found much the same thing in his longitudinal studies of adoptive families. Jaffee and Fanshel (1970) reported lower-problem groups had more previous parenting experience.
This was interpreted as a contributing factor in successfulness of outcome of placement. Leahy (1933) studied the adoptive parents of 2,414 children. Childless couples made up 89 percent of the sample and had a higher average age than biological parents. The average duration of marriage prior to the first child entering the family was 10 years compared with just over two years for biological parents. This is usually understood by viewing the infertile couple as having tried for some years to have children biologically before resorting to adoption.

Similar descriptors occurred in a study of adoptive parents done by the Child Welfare League of America (Bradley, 1966). Most were childless couples who had spent at least 2 years trying to overcome infertility problems and were found to be approximately 12 years older when applying for an adopted child than biological parents having their first child. Maas (1960) compared couples who wished to adopt infants and those who accepted older children or children with physical or psychological handicaps and found the latter group had a lower socio-economic status. Kadushin (1962) found that couples whose age, health or other circumstances prevented them from adopting young children often accepted children who were older or otherwise difficult to place.

Many researchers have found no connection between the adjustment of adopted children and the socio-economic
attributes of the adopters (Theis, 1924; Brenner, 1951; Witmer, et al, 1963; McWhinnie, 1967). Curman (1951) found that development and adjustment of adopted children was most influenced by the emotional climate in the home and by the relationship between the parents.

Differences in Adoptive Parenting

Most authors who have written in the field of adoption see adoptive parenting as being different from biological parenting (Kirk, 1959; 1964; 1967; Reitz and Watson, 1992; Bohman, 1970; Smith and Sherwin, 1983; Brodzinsky and Huffman, 1988; Brodzinsky and Jackiewicz, 1987; Sorosky, Baran, and Pannor, 1978; Melina, 1986; Pelton, 1988; Miroff and Smith, 1981; Brinich, 1980; Blum, 1983; Brazelton, 1990; Berman and Bufferd, 1986; Talen and Lehr, 1984). A pioneer in the field of adoption who was first to write eloquently of the subtle and not so subtle differences of adoptive parenting was Kirk. Kirk (1959; 1964) discussed the incongruent role obligations of the adoptive family. He viewed it as a minority group that lacked the support of social conventions, and was seen as a second-class way of forming a family.

Few or no models of adoptive parenting exist even today. Berman and Bufferd (1986) wrote of the adoptive parents feeling compelled to be perfect parents and not being able to complain about normal things, since they had
chosen to parent, usually with strong conviction. This question of entitlement is an important one to be reckoned with for adoptive parents.

The adoption process itself presents many hurdles and stressors for prospective parents that biological parents do not normally have to face. The couple or single person wanting to adopt must go through an interview and appraisal phase that invades their privacy and leaves them feeling frustrated and not in control of the process or outcome. Brinich (1980) and Blum (1983) discussed the heightened anxiety over the waiting period when the parents cannot choose when the child will arrive. Adoptive parents usually don't have the luxury of eight or nine months of preparation for the arrival of the child that their biological counterparts have. Often, after many months of waiting, the prospective parents are given little notice that a child is available for them.

Miroff and Smith (1981) list several critical ways in which adoptive parenting differs throughout the family life cycle from biological parenting:

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<th>BIOLOGICAL PARENTING</th>
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<tr>
<td>Must have an intermediary</td>
<td>No intermediary</td>
</tr>
<tr>
<td>Proof of readiness required</td>
<td>No proof needed</td>
</tr>
<tr>
<td>Parenting not automatic and unconditional</td>
<td>Automatic and unconditional</td>
</tr>
<tr>
<td>Undetermined length of expectancy</td>
<td>Approximately nine months</td>
</tr>
<tr>
<td>Not feeling entitled to be a parent</td>
<td>Sense of entitlement</td>
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Fiegalman & Silverman (1979) also cite the need for adoptive parents to depend on outsiders for help and to prove their worthiness and acceptability as parents to authorities. Even after the child is placed, there is usually a six or twelve-month period before finalization to ensure that the placement is successful, setting more anxiety for the parents, while at the same time fostering possible ambivalent feelings about their role and the placement. Further, there are laws that allow for the possibility that an adoption, once legalized, can still be terminated, as evidenced by stories in the news media (Seader, 1993). This may keep some parents from bonding or giving themselves to the child as completely as they otherwise would (Kirk, 1964). Katz (1980) specifically states that the family is at increased risk if the aforementioned factors are not addressed and resolved. To add to the stress, adoptive parents are often expected to forget that they are an adoptive family and to "normalize" or become just like an "ideal type" biological family after the decision to adopt and legalization of the adoption have occurred (Eheart & Power, 1988; Hartman, 1984).

Kirk (1964) has proposed a theory of family attitudes about adoption. He surveyed 1,532 adoptive couples and found that adoptive families tend to either acknowledge or reject the fact that their family has intrinsic differences from a biological family. Kirk stated that the
acknowledgement or rejection is fueled by the adoptive parents' attitudes, and that developmental problems are fewer and less severe in the families that acknowledge the differences. He also found that adoptive parents who acknowledge the difference were more likely to be empathic of their adopted child's feelings, think more often of the biological parents, feel greater satisfaction as an adopted parent and communicate more openly with the adopted child. This acknowledgement leaves the child free to explore any curiosity about biological parents and background, particularly during adolescence and its task of identity. If the difference is rejected, the child may feel disloyal about searching for or even expressing feelings or curiosity about the biological parents (Kirk, 1964; Schechter, 1970).

In a study done with Greek parents, Maganiotov and Koussidou (1988) interviewed 108 adoptive parents. Most were reported as defensive about the adoption as 68 percent of the children of the sample group had not been told of their being adopted. Fully 50 percent of the adopted parents stated that they would never tell their children that they were adopted and would deny it if the child were otherwise told. The parents reported great insecurities about the child being harmed by the knowledge or reacting negatively toward the adoptive parent and thus losing the child's love. It should be noted that the authors also
stated that adoption in Greece carries a stronger stigma than in the United States.

Effects of Infertility

One of the most cited reasons that adults adopt is infertility (Leahy, 1933; Maas, 1960; Kadushin, 1962; Jaffee & Fanshel, 1970; Berman & Bufferd, 1982; Blum, 1983). Defining infertility as being unable to produce children after one year of trying, Shapiro (1982) estimated that 15 percent of the population of childbearing age is infertile, or one in six couples. When a couple is diagnosed as being infertile, 40 percent of the time the wife is unable to bear children, while 40 percent of the time it is the husband. Approximately 20 percent of the time, both are diagnosed as infertile (Sorrel & DeChernay, 1985). In an article discussing adoptive parents' differences and difficulties, Blum (1983), stated that while most couples come to adoption because of infertility, typically the adoptive applicants have unresolved grief over the loss.

Psychological stress can be a cause and effect of infertility (Sorrel & DeChernay, 1985). Not only has stress been associated in the inability of otherwise healthy people to conceive, but it can be produced by this very inability to conceive. Infertility is an unanticipated crisis in the developmental life cycle of the family. A period of psychological disequilibrium with associated high levels of
anxiety ensues. This may awaken key unresolved issues from the recent past or childhood (Linderman, 1965). Further, the fact of infertility may be dealt with in the family by denial. This can keep the issues from gaining needed resolution and can help fuel the "rejection of differences" attitude taken by some adoptive families (Kirk, 1964).

Kraft, et al (1980) thoroughly discussed the impact of infertility. For the couple, the treatment process of infertility means being out of control and being humiliated. There are often months of visiting the fertility clinic, months fraught with hopefulness, frustration, letdown and depression. It is also a blow to one's sexuality. There is a loss of control of a bodily function and of physical evidence of marital love. Further, couples may even view their inability to conceive as a punishment from God for some past misdeed.

Rogoff-Thompson and Thompson (1990) wrote of infertility as a symbiotic loss. Besides the loss of the actual birthchild, there is the loss of part of the infertile partner's gender identity. Questions of one's attractiveness and whether one was meant to be a parent arise. The authors stated that how one was taught to handle and express grief is important in the relationship with the adoptive child. An adopted child will usually show many of the birth parents' traits, gifts, nuances and difficulties
before reflecting the adoptive parents' values and teachings. These characteristics may form an exceptionally wide disparity between the dream child and the adopted child and in turn a lack of integration between the mother/father-I-am-becoming and the mother/father-I-thought-I-would-be.

Other Losses

Parents are not only motivated to adopt out of the profound loss of infertility, but sometimes adopt to fill the loss of an emotional cutoff, grown children leaving home, the death of a family member or a family member giving up a child (Berman & Bufferd, 1986). After placement, postpartum depression can come from the reality of "having to adopt". Separations become difficult. The arrival of their adopted child's adolescence brings individuation, sexuality and identity tasks. The adoptive parents may become ambivalent during the child's childbearing years. Pregnancies by the adopted child may be difficult for the infertile parents.

Even parents who have had children biologically can experience loss around adopting a child (Silverstein and Kaplan, 1990). There is the loss of status as a "normal" family. While adoptive families may not see themselves as inferior, their status in society changes after adopting. They may find themselves scrutinized for signs of problems
or dissatisfaction. This can lead to an additional loss—the loss of self esteem (Kirk, 1964).

Fertile adopters are particularly seen as different because they chose what some view as an inferior way of family formation "when they didn't have to" (Silverstein & Kaplan, 1990, p. 3). These parents may be particularly susceptible to denying the loss of biological connection and to looking at the ways parenting by adoption is different because they fear it will result in comparisons between the adopted child and the birth child. Both infertile and fertile adopters may question their identity as the birth parent of a child to whom they didn't give birth and will never be genetically connected. This can be especially true for fertile adopters who, after successfully raising children they conceived, adopt children with behavior problems and find that they cannot "fix" them. The identity that they built up with their biological children as being confident, competent parents can be destroyed. Perhaps this is the biggest loss of all for adoptive parents to acknowledge: the loss of the myth that love is all that is required to raise children. Finally, there is the loss of control and privacy as many parents, whether fertile or infertile, may be questioned and inspected by one or more agencies and governmental bodies.
Loss in Adoption

Silverstein and Kaplan (1990) have devised what they call the core issues of adoption. The issues are: loss/separation, rejection, guilt and shame, grief, identity, intimacy, and power/control/mastery. These issues are common to all parties in the adoption process; adopted children, adoptive parents and birth parents. Inherent in these core issues is the theme of loss.

Loss and separation may be equated with loss of self and immortality. The difficulty in feeling entitled may lead to a fear of losing the adopted child and overprotection.

Feelings of rejection may come from being ostracized because of procreation difficulties. Scapegoating of a partner can occur and an expectation of rejection may be set up. Parents may unconsciously be distant from or expel the adoptee to avoid anticipated rejection by seeking birth parents. Adoptive parents may also be forced to deal with the rejecting attitudes of their adopted children who feel their own sense of rejection from birth parents.

Infertility brings shame and can be seen as a curse or punishment. Parenting out of shame can produce extremes in parenting, from overprotecting and overcontrolling to excessive criticalness and withholding of approval.

Adoptive parents may experience their adopted child's grief as rejection. Any unresolved grief may cause a block
in attachment to the adopted child. The "fantasy" child needs to be grieved before the parents can fully give themselves to the real child.

Infertile adopting parents can experience a diminished sense of continuity of self. They experience role handicap and the confusing feeling of being and yet not being the parents (Kirk, 1964). There is a clouding of identity for these parents, as well as a lack of models to follow.

Intimacy with the adoptive child may be stifled to avoid any further loss. Or pampering and overprotection of the child out of this same fear of loss may be confused with intimacy. Unresolved grief over losses may lead to problems with intimacy in the marital dyad.

The experiences of applying to adopt and adopting itself can lead to learned helplessness. Adopting parents have little or no control over whether they will be accepted to receive a child, when that child will come, and how much advance notice they will have. A loss of control of the body and its innate abilities to procreate is also a profoundly personal issue with which parents have to cope.

Locus of Control

The concept of locus of control, as described by Rotter (1966), suggests that people have a tendency to see control of events in their lives as either internal or external. Internal people tend to believe in their own ability to
control events, while external people tend to believe other people, events, or fate are the primary influences on their own circumstances.

Archer (1979), in a review of research focused on locus of control and various measures of general trait anxiety, found significant relationships between these two variables in 18 of 21 studies. Typically these samples were of undergraduate college students, but groups of adolescents, emotionally disturbed children, male alcoholics and army recruits were also utilized in the studies. The magnitude of the correlation between anxiety and locus of control scores was estimated to vary from $r = .30$ to $r = .40$.

Life-Event Stress

The positive relationship between the occurrence of stress or life events and the onset of physical illness and/or the presence of psychiatric symptoms has been demonstrated in numerous studies (Brown & Birley, 1968; Spilken & Jacobs, 1971; Rahe, 1969). There is reasonably strong evidence that adults' stressful life events are significantly related to depressive conditions, anxiety and psychological dysfunction (Andrews & Tennant, 1978; Dohrenwend & Dohrenwend, 1980; Jones, 1989; Meyers, Lindenthal, Ostrander, & Pepper, 1972). In one study, Myers, et al (1972) found a relationship between changes in reported life events experienced and psychiatric
symptomatology over a two-year period. The greater the
number of changes in life events, the more likely the mental
status of the individual was to have changed substantially.
More specifically, a net increase in life events was
associated with a worsening of symptomatology, a decrease in
improvement.

Family Stress in Adolescence

The fact that adolescence is a stressful phase of a
family's life is well-documented (Carter & McGoldrick, 1980;
Silverberg & Steinberg, 1987). There are several tasks of
adolescence with which a family is presented. These include
individuation/separation and identity (Carter & McGoldrick,
1980; Silverberg & Steinberg, 1987; Youniss, 1983). How
parents of adolescents respond to their adolescent's
behavior around these tasks plays a large part in how well
the family moves through this phase (Carter & McGoldrick,

The importance of parenting as a key factor in child
development has been underscored by Hauser, Vieyra, Jacobsen
and Wertlieb (1985), who report that the parents' ability to
allow autonomy is a key factor in their children growing up
to enjoy productive, normal lives. Parents of
"invulnerable" children are less possessive and anxious and
are more likely to sanction positively the child's own path
to individuation. By comparison, parents of disturbed adolescents interfere with the child's autonomy and differential functioning (Hauser, et al., 1985). Such parents engage in more binding interactions with their children. Stress may mount when the child pushes for more autonomy than the parent is capable of allowing.

Fischer (1980), comparing families with disturbed adolescents, found that although parents of disturbed adolescents recognize and identify the needs of their adolescents, they are less involved in meeting those needs than are parents of nondisturbed adolescents. In addition, less open communication profiled families with a disturbed adolescent, as compared with families with nondisturbed adolescents. Often in an adopted family the adolescent may be subtly or openly discouraged from talking about feelings of being adopted, not being born into this family like everyone else, and expressing curiosity about birth parents. This may be interpreted as a rejection of the adopted family and being disloyal to the adopted parents. A family "no talk" rule can hinder the adolescent's need to continue forming identity so critical at this stage (Kirk, 1964; Schechter, 1970). This stifling of feelings and curiosity can have the effect of exacerbating any behavioral conflict and increasing stress in the family (Koch, 1985; Weber & Fournier, 1985).
Summary

Much of the research done concerning adoption has been with clinical populations. This may have led to a tendency to overpredict psychological difficulties in adopted children. Further, much of this clinical study has been on how the adopted child has "turned out". What prospective adoptive parents bring into the family dynamics and how they perceive the inherent stress of adolescence has been neglected in the literature and research and needs study. Therefore, an attempt was made to explore the levels of adoptive parents' perceived stress, anxiety and locus of control in their families during the child's adolescence. By examining these, it was hoped that a better prediction for outcome of adoption could be made as well as improved therapeutic strategies devised to enhance adoptive families' potentials and guide them through the unique adoptive family life cycle.
CHAPTER 2

PROCEDURES

Hypotheses

In carrying out this research, the following hypotheses were tested:

1. There will be significant differences between the levels of anxiety reported by adoptive and biological parents as measured by the State-Trait Anxiety Inventory.

2. There will be significant differences between the levels of perceived locus of control between adoptive and biological parents as measured by the Rotter Internal-External Scale.

3. There will be significant differences between the levels of stressful life events reported by adoptive and biological parents as measured by the Life Events Survey.

4. There will be a positive correlation of the levels of stressful life events as measured by the Life Events Scale and the levels of anxiety as measured by the State-Trait Anxiety Inventory for adoptive parents.
5. There will be a positive correlation of the levels of stressful life events as measured by the Life Events Scale and the levels of anxiety as measured by the State-Trait Anxiety Inventory for biological parents.

6. There will be a positive correlation of the levels of stressful life events as measured by the Life Events Scale and locus of control scores as measured by the Rotter Internal-External Scale for adoptive parents.

7. There will be a positive correlation of the levels of stressful life events as measured by the Life Events Scale and locus of control scores as measured by the Rotter Internal-External Scale for biological parents.

Subjects

The subjects for this study were 44 adoptive parents and 44 biological parents of at least one child age 12-18. The adoptive parents (Group I) were contacted by the adoption agencies that helped place their child. The 30 largest adoption agencies in Texas were contacted and sent letters asking parents for their participation. The agencies addressed envelopes and mailed letters to the adoptive parents. Parents who were interested were asked to call an 800 toll-free number. Those who called were sent a packet of questionnaires and a demographic survey which they
filled out and mailed back in the postage-paid envelopes provided.

Parents who indicated on the demographic questionnaire that their child had a significant disability at birth or was of a different race were not used in the study. Further, those who indicated that they had more than four children, had any biological children or were the non-custodial parents (if divorced) were also not used. All of the Group I parents reported that their children were adopted within three months of birth and that they had at least one child who was between the ages of 12 and 18 at the time of participation in the study.

Of the 44 Group I parents who qualified, there were 36 women and 8 men. Ages for the sample ranged from 40 to 59. For matching purposes, respondents were divided into three age groups: 45 and below, 46-50, and 51 and older. There were 39 married and five divorced adoptive parents. Forty-two of the participants identified themselves as white, while two identified themselves as Hispanic. The range of annual family income for Group I parents was $19,000 to $250,000. For matching purposes, respondents were divided into four income groups: $50,000 and below, $50,000-$75,000, $75,000-$100,000, and $100,000 or more. The biological parents (Group II) were obtained by placing notices in church bulletins and making oral announcements in church services, asking for participants from graduate classes at
the University of North Texas and through word of mouth. Those who expressed an interest were given identical packets to those of the Group I parents with the exception of the omission of several questions about adoption specifics on the demographic survey.

Group II subjects who indicated on the demographic survey that they had a child with a significant disability or more than four children were omitted. Further, those who indicated that they had an adopted child in the home or were the non-custodial parents (if divorced) were also omitted. All of the Group II parents indicated that they had at least one child between the ages of 12 and 18 at the time of participation in the study.

Of the 44 biological parents used to match the adoptive sample, there were 36 women and 8 men. Ages for the biological sample ranged from 39 to 62. There were 39 married and five divorced biological parents. Forty-two of the respondents from Group II identified themselves as white, while two identified themselves as Hispanic. The range of annual family income was from $25,000 to $250,000.

Limitations

Subjects in Group I were limited to those adoptive parents who had adolescent children and who received their adopted children at less than three months of age. Subjects in Group II were limited to parents of nonadopted
adolescents. Additionally, the investigation was limited to adoptive and nonadoptive parents who volunteered to participate in this research. Further, the investigation was geographically limited to Texas during the time period of Spring 1994 through Spring 1995.

Purpose of the Study

The purpose of this study was to identify differences in levels of anxiety as reported on the State-Trait Anxiety Inventory, stress as reported on the Life Event Survey, and locus of control as reported on the Rotter Internal-External Scale for adoptive and biological parents of adolescents. It was hoped to determine whether raising adoptive adolescents is more stressful or anxiety-producing than raising nonadopted adolescents.

Instrumentation

The State-Trait Anxiety Inventory (STAI) (Spielberger, 1970) was used to measure anxiety because it is widely utilized to evaluate anxiety in a multitude of settings. It is a 40-item measure which provides information about a person's level of both state anxiety (transitory feelings of fear or worry which most of us experience from time to time) and trait anxiety (the relatively stable tendency of an individual to respond anxiously to a stressful situation). Thus, the level of trait anxiety reflects the proneness to exhibit state anxiety. The 20 state-anxiety items are each
rated on a four point intensity scale, labeled "Not At All", "Somewhat", "Moderately So" and "Very Much So". The 20 trait-anxiety items are also rated on a four-point frequency scale that is labeled "Almost Never", "Sometimes", "Often" and "Almost Always". Scores on both scales can range from 20 to 80, with higher scores reflecting more anxiety. Used in more than 2,100 citations in articles and translated into more than 30 languages (Chaplin, 1986), the STAI has been received as one of the best indices of anxiety (Katkin, 1978). The instrument was also chosen for its ease of administration and short length. For this research, only the trait-anxiety scale was utilized.

Test-retest reliabilities for the A-trait scale for male and female college undergraduates over a six-month period are .73 and .77, respectively. Test-retest reliabilities for the A-trait measure are low, as might be expected. This is due to the fact that the state scale conceptually does not measure a persistent characteristic of the individual (Katkin, 1978). The internal consistency of the A-state scale, as measured by K-R 20, ranges from .83 to .92. Chaplin (1986) found internal consistency of the A-trait scale, as indexed by alpha coefficients, ranging from .89 to .91 across male and female samples of working adults, military recruits, and college and high school students. For the A-state scale this range is from .86 to .95.
The A-trait scale correlates very highly with the Taylor and IPAT anxiety scales, indicating that the A-trait scale measures essentially the same concept and may be interpreted in the same context (Spielberger, 1989). For 126 college women, coefficients were .75, .80 and .52, respectively. For state measure, both item and total score comparisons between presumably stressful states are given, with mean scores reflecting changes in the appropriate directions. Alpha coefficients reported for stressful and nonstressful conditions remained substantially the same, again indicating internal consistency (Dreger, 1978).

The Life Event Survey (LES) (Sarason, et al, 1978) was used to measure reported life events. The LES is part of a second generation of life event scales fashioned after the Schedule of Recent Events developed by Holmes and Rahe (Zimmerman, 1983). The LES is a 57-item self-report measure that asks respondents to indicate events that they have experienced in the past year. These events refer to life changes that are common to individuals in a wide variety of situations. Many of these items were based on existing life stress measurements. The scale has two parts. One contains 10 items specifically designed for a student population and will not be utilized here.

The format of the LES calls for subjects to rate separately the desirability and impact of events that they have experienced. They are to do this by checking events
they have experienced in the past year and indicate whether they had a negative or positive impact or no impact on their life. Ratings are on a seven-point Likert-type scale ranging from extremely negative (-3) to extremely positive (+3). Summing the impact ratings of those events designated as positive by the subject provides a positive change score; summing negative ratings gives a negative change score. By adding these two values, a total change score can be obtained (Sarason, et al, 1978).

Reliability for the LES was shown to be adequate in research involving subjects from undergraduate psychology courses. Pearson product-moment correlations were computed to determine the relationships between scores obtained from testings five to six weeks apart. Test-retest correlations for the positive change score were .19 and .53 (p< .001). The reliability coefficients for the negative change score were .56 (p<.001) and .88 (p<.001). The coefficients for the total change score were .63 (p<.001) and .64 (p<.001). Test-retest studies are more likely to underestimate reliability with life-event scales (especially with a time interval of five-six weeks) as subjects may actually experience certain life events that could alter scores at the time of retesting.

To the extent that life-event scales measure life stress, their scores should correlate with relevant personality indices. Sarason, et al (1978) administered the
LES, State-Trait Anxiety Inventory (Spielberger, et al., 1970) and a short form of the Marlowe-Crowne Social Desirability Scale (Strahan & Gerbasi, 1972) to 100 male and female subjects drawn from psychology courses. The authors found that the total and negative-change scores correlate significantly and in a positive direction with state and trait anxiety whereas the positive change score is not significantly related to either measure. The relationships between life-change scores and the social desirability measure were non-significant. Correlations between positive, negative and total change scores and social desirability were .05, .05 and .01, respectively. This suggests responses to the LES are relatively free from the influence of social desirability response bias.

The Rotter Internal-External Scale (I-E) (Rotter, 1966) was utilized to measure perceived locus of control for subjects in this study. The I-E is designed to measure locus of control by using 29 forced-choice items, with six items being used as filler. The range of scores possible scores is 0 to 23. Higher scores indicate a belief in a more external locus of control.

Reliability measures reported for the I-E have been shown to be consistent. In a review of the I-E, Joe (1971) reported test-retest reliability for varying samples and intervening time periods ranged between .49 and .86. Internal consistency estimates of reliability have ranged
from .65 to .79, with nearly all correlations in the .70s (Rotter, 1966).

Rotter (1966) also reported good discriminant validity for the I-E indicated by low correlations with such variables as intelligence, social desirability and political affiliation. Similarly, Hersch and Scheibe (1967) found nonsignificant correlations between I-E total scores and three different measures of intelligence, while Minton (1967) reported that I-E scores of 69 males were unrelated to political liberalism or conservatism, "left" versus "right" ideology, or attitudes on international relations. Most of the evidence of the construct validity of the I-E comes from predicted differences in behavior for individuals above and below the median of the scale or from correlations with behavioral criteria (Rotter, 1966).

Data Collection

Subjects in Group I were obtained through the adoptive agencies the parents had worked with in adopting their child. These agencies were comprised of the 30 largest agencies in Texas. Letters asking adoptive parents for their participation and unaddressed envelopes were sent to the agencies that agreed to assist. The agencies then addressed these and sent them, along with a cover letter, to families that had adopted children with them 12 to 18 years ago. Parents were invited to call an 800 toll-free number
and give their address to the researcher. A packet of the questionnaires and a demographic survey were then mailed. A self-addressed, stamped envelope was included to return the questionnaires.

Of the approximately 1,400 letters sent to the agencies, more than 120 potential participants called and were mailed packets. Of these, 44 fit the criteria needed to participate in the research.

Subjects in Group II were obtained by asking for participants from Graduate classes at the University of North Texas and by placing announcements in several area churches. Those biological parents who were expressed an interest were given packets identical to those given the adoptive parents, with the exception of the demographic sheet. The parents were asked to fill out the questionnaires in the packet and return them using the self-addressed, stamped envelope included. Approximately 150 parents responded. Using these, all 44 of the Group I subjects were matched according to age, race, marital status and income. All of the inventories were hand scored and each matched with a respondent's scores in Group I.
CHAPTER 3

RESULTS AND DISCUSSION

Data Analysis

To test hypotheses 1, 2 and 3, Hotellings T2 multivariate analysis was employed, using the adoptive/biological status as the independent variable and the test scores as dependent variables. This was done to discern whether there was a significant difference between the independent variables on the measures of stress, locus of control and anxiety. An alpha level of .017 (.05/3) was established for this test.

Hypothesis 1 stated that the profiles of scores on the State-Trait Anxiety Inventory would differ significantly between Group I and Group II.

Hypothesis 2 stated that the profiles of scores on the Rotter Internal-External Scale would differ significantly between Group I and Group II.

Hypothesis 3 stated that the profiles of scores on the Life Events Survey would differ significantly between Group I and Group II. These hypotheses were tested by utilizing Hotelling's multivariate analysis of variance. Table 1 shows the means and standard deviations of both groups of
parents on the State-Trait Anxiety Inventory, Life Event Scale and Rotter Internal-External Scale.

**TABLE 1**

MEANS AND STANDARD DEVIATIONS FOR THE STAI TRAIT SUBSCALE SCORES AND FOR THE LES SCORES AND I-E SCORES FOR GROUP I AND II

<table>
<thead>
<tr>
<th></th>
<th>Group I N=44</th>
<th>Group II N=44</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STAI Trait Subscale:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>32.91</td>
<td>32.23</td>
</tr>
<tr>
<td>SD</td>
<td>9.31</td>
<td>6.43</td>
</tr>
<tr>
<td><strong>LES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td>8.32</td>
</tr>
<tr>
<td>SD</td>
<td>9.43</td>
<td>7.60</td>
</tr>
<tr>
<td><strong>I-E:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>9.05</td>
<td>3.53</td>
</tr>
<tr>
<td>SD</td>
<td>8.20</td>
<td>3.93</td>
</tr>
</tbody>
</table>

Table 2 shows the results of the multivariate analysis of variance of scores on the three inventories.

**TABLE 2**

HOTELLING'S T2 TEST OF SIGNIFICANCE FOR THE STAI, LES AND I-E

<table>
<thead>
<tr>
<th>Exact F</th>
<th>Hypoth DF</th>
<th>Error DF</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>.63188</td>
<td>3.00</td>
<td>84.00</td>
<td>.596</td>
</tr>
</tbody>
</table>

The data from the multivariate analysis of variance indicate that differences in the profiles of scores on the STAI, LES and I-E between adoptive and biological parents
are not statistically significant. Therefore, Hypotheses 1, 2 and 3 are not supported.

A Pearson-R correlational coefficient was used to test hypotheses 4 through 7. A .05 level of significance was set for each of the correlations.

Hypothesis 4 stated that there would be a positive correlation of the levels of stressful life events as measured by the Life Events Scale and the levels of anxiety as measured by the State-Trait Anxiety Inventory for adoptive parents. Table 3 shows the results of the correlation of scores on the LES and the STAI for Group I.

**TABLE 3**

**CORRELATION OF SCORES ON THE STAI AND LES FOR GROUP I**

<table>
<thead>
<tr>
<th></th>
<th>STAI</th>
<th>LES</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAI</td>
<td>---</td>
<td>.157</td>
</tr>
<tr>
<td>LES</td>
<td>.157</td>
<td>---</td>
</tr>
</tbody>
</table>

Hypothesis 5 stated that there would be a positive correlation between the levels of stressful life events as measured by the Life Events Scale and levels of anxiety as measured by the State-Trait Anxiety Inventory. Table 4 shows the results of the correlation of scores on the STAI and the LES for Group II.
TABLE 4
CORRELATION OF SCORES ON THE STAI AND LES FOR GROUP II

<table>
<thead>
<tr>
<th></th>
<th>STAI</th>
<th>LES</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAI</td>
<td></td>
<td>-.118</td>
</tr>
<tr>
<td>LES</td>
<td>.118</td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis 6 stated that there would be a positive correlation of the levels of stressful life events as measured by the *Life Events Scale* and locus of control as measured by the *Rotter Internal-External Scale* for adoptive parents. The results of the correlation of scores on the LES and the I-E for Group I is shown in Table 5.

TABLE 5
CORRELATION OF SCORES OF THE LES AND I-E FOR GROUP I

<table>
<thead>
<tr>
<th></th>
<th>LES</th>
<th>I-E</th>
</tr>
</thead>
<tbody>
<tr>
<td>LES</td>
<td></td>
<td>-.034</td>
</tr>
<tr>
<td>I-E</td>
<td>-.034</td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis 7 stated that there would be a positive correlation between the levels of stressful life events as measured by the *Life Events Scale* and locus of control as measured by the *Rotter Internal External Scale* for biological parents. Table 6 shows the results of the correlation of scores on the LES and the IE for Group II.
TABLE 6
CORRELATION OF SCORES OF THE LES AND I-E
FOR GROUP II

<table>
<thead>
<tr>
<th></th>
<th>LES</th>
<th>I-E</th>
</tr>
</thead>
<tbody>
<tr>
<td>LES</td>
<td>---</td>
<td>.024</td>
</tr>
<tr>
<td>I-E</td>
<td>.024</td>
<td>---</td>
</tr>
</tbody>
</table>

The correlational studies of hypotheses four through seven does not reveal any significance at the .05 level. Therefore hypotheses four through seven are not supported.

The distribution of scores for all three inventories was somewhat positively skewed. To further understand this, a test for independence between parenthood and classification in a normal or high range of scores was done for each inventory using a 2x2 distribution of Chi-Square. Table 7 shows the results of the Chi-Square distribution test with the STAI, LES and I-E scores for Group I and Group II.

Results of the Chi-Square test of independence between the variable of parenthood and classification of normal or high scores indicates independence.
TABLE 7

CHI-SQUARE TEST OF INDEPENDENCE BETWEEN ADOPTIVE/BIOLOGICAL PARENTING AND NORMAL/HIGH SCORES FOR THE STAI, LES AND I-E

<table>
<thead>
<tr>
<th></th>
<th>CHI-SQUARE STATISTIC X2</th>
<th>DEGREES OF FREEDOM</th>
<th>LEVEL OF SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAI</td>
<td>.000</td>
<td>3</td>
<td>N.S.</td>
</tr>
<tr>
<td>LES</td>
<td>.001</td>
<td>3</td>
<td>N.S.</td>
</tr>
<tr>
<td>I-E</td>
<td>.001</td>
<td>3</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

The Chi-Square test was done to determine whether there was an association between the variables of parenthood and high/normal classification for the scores on each inventory. Norms used for the STAI were provided in the manual for administration of the inventory (Spielberger, 1983). Norms were also provided for the LES and I-E in their respective articles in which they were published (Rotter, 1966; Sarason, Johnson and Siegel, 1978). Since none of the inventories differentiated between normal anxiety, locus of control or stress, it was decided to use scores in excess of one standard deviation above the mean as criteria to be in the high group. Likewise, scores that were below the level of one standard deviation above the mean were considered part of the non-high group.

Discussion

The intent of this study was to examine whether adoptive parents experience more stress and anxiety and less
internal locus of control during the raising of their adolescents than biological parents do. The literature has indicated a higher incidence of emotional distress and acting out among adopted adolescents (Menlove, 1965; Brinich & Brinich, 1982; Weiss, 1985; Jerome, 1986; Brodzinsky, 1987; Kotsopoulus, 1988).

This study compared one group of adopted parents and a matched group of biological parents. The findings of this study do not support the general beliefs in the literature that adoptive parents of adolescents may experience any more stress or anxiety or any less internal locus of control than their biological counterparts. This would appear to be contrary to studies showing adolescents to be more at risk for emotional and behavioral problems, if one could assume that these will bring increased difficulties for adoptive parents. Based upon the results of this study, it may be concluded that the adoptive parents experienced no more stress or difficulty during their children's adolescence than their biological counterparts.

There are other factors not accounted for in this study that may have affected the outcome. It may be that adoptive parents, by their need to be involved with social service agencies and professionals, are more likely to seek these out if they are experiencing difficulty. This possible involvement with mental health professionals may have effected any levels of stress and anxiety this group of
adoptive parents could have experienced. It may prove helpful to include in the demographic survey questions about the families' history with any counseling or mental health agency. Further an inquiry as to whether adoptive family status was a focus of the counseling could also be included.

It may be that in this study, the groups studied were simply within the statistical norms. Spielberger (1983) reported norming means of working adults for the STAI at 34.89 for males and 34.79 for females. The Group I and Group II scores for the STAI were 32.91 and 32.23 respectively. (Lower scores denote lower levels of anxiety.)

Holmes and Rahe (1980) reported norming means of 20.6 for the LES. In this study the Group I and Group II means for the LES were 9.4 and 8.3, respectively. Higher scores indicate more stressful life events.

Finally, Rotter (1980) reported norming means for the I-E of 10.87 for males and 11.70 for females. The Group I and II scores for the I-E were 8.20 and 9.05 respectively. Lower scores indicate a more internal locus of control. Each of the scores for both groups reflect scores of less anxiety and stress and a more internal locus of control. These are hardly indicators of high stress in general, especially when compared to the norming means.

Individuals with a more internal locus of control have been found to have lower anxiety and stress (Joe, 1971).
They may be better defended against conflict and stressors. They may also be better equipped to handle this stress through having experienced difficulties in the past.

Possible factors within the study itself should be investigated for an explanation of the unsupported hypotheses. An examination of the instruments used may be a place to start.

The State-Trait Anxiety Inventory measures the general trait stress level of the individual (Spielberger, 1983). Actions of children during adolescence can bring about anxiety for their parents. This anxiety may not show up on an inventory of general trait stress. Another inventory measuring specific stress with regards to parenting may produce more significant or usable results in future studies.

The same can be said of the Life Events Scale. This scale measures stressful life events in a general manner. It may be that use of a scale of this type with specific regard to parenting or adolescents in general may be more appropriate.

The adoptive sample in this study was limited to those parents who adopted through state licensed agencies. Many parents who adopt do so through a lawyer or other ways that do not involve adoption agencies. To include them in a study may give a broader, more comprehensive view of an adoptive parent sample.
In an attempt to reduce any differences between the two samples by limiting number of children in the family and not including families whose children had handicaps, were not of the same race, and had both biological and adoptive children, this study may have examined a population that was not representative of adoptive families. In future research, allowing these differences and letting more sophisticated statistics explain the findings may be more significant or useful in predicting the adoptive parents' experience.

The fact that this study consisted solely of volunteers may have affected scores recorded in this study. Volunteers may be more likely to represent themselves as "healthy". If possible, gaining a sample from non-volunteers may more realistic.

Many adoptive parents adopt due to infertility (Maas, 1960; Jaffe and Fansheel, 1970; Blum, 1983). Sometimes an issue of unresolved grief may produce anxiety for adoptive parents (Sorrel and DeChernay, 1985). While using an inventory to measure anxiety is useful, it may be helpful to include an inventory that assesses grief as well. In this manner, it may be better determined whether grief is a factor in the parenting experience of adoptive parents.

While attempting to find subjects for the adoptive sample, many adoptive parents with biological children volunteered. In order to keep the adoptive sample purely
adoptive, these parents were not included in this study. However, further studies on adoptive parents could include those who have both biological and adoptive children. This separate group could be matched to the adoptive and biological groups and studied to see if there is any difference in anxiety, locus of control or stress for these parents. Further questions of interaction between the children or concerns of parents treating the children differently could be explored.

Finally, as was stated earlier, many letters were sent out with no response. A study of this nature may require some funding in order to offer an incentive to potential subjects to participate. A grant to study adoptive parents may be useful in this endeavor.

Many writers in the field of adoption cite differences between adoptive and biological parenting. Many also have found more incidence of behavioral difficulties and higher percentages of adopted adolescents in therapy and treatment than the national average. Clearly, there are more answers to be found and increased understanding of adoptive parenting to be obtained through continued research.
APPENDIX A

QUESTIONNAIRES
<table>
<thead>
<tr>
<th>Check here</th>
<th>Time period experienced</th>
<th>Extent of impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-6 months</td>
<td>7-12 months</td>
</tr>
<tr>
<td>4.</td>
<td>Major change in sleeping habit (much more or much less sleep)</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Death of a close family member:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. mother</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. father</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. brother</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. sister</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. grandmother</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. grandfather</td>
<td></td>
</tr>
<tr>
<td></td>
<td>g. other (specify)</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Major change in eating habits (much less or more food intake)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Foreclosure on mortgage or loan</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Death of a close friend</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Outstanding personal achievement</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Minor law violations (traffic tickets, disturbing the peace, etc.)</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Male: Wife/girlfriend's pregnancy</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Female: Pregnancy</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Changed work situation (new work responsibility, major change in working conditions, hours, etc.)</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>New job</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Serious illness or injury of close family member:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. mother</td>
<td></td>
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<tr>
<td></td>
<td>b. father</td>
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<td></td>
<td>c. sister</td>
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<tr>
<td></td>
<td>d. brother</td>
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<td></td>
<td>e. grandmother</td>
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<td></td>
<td>f. grandfather</td>
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<td></td>
<td>g. spouse</td>
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<tr>
<td></td>
<td>h. other (specify)</td>
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</tr>
<tr>
<td>16.</td>
<td>Sexual difficulties</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Trouble with employer (in danger of losing job, being suspended, demoted, etc.)</td>
<td></td>
</tr>
<tr>
<td>Check here</td>
<td>Time period experienced</td>
<td>Extent of impact</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>18. Trouble with in-laws</td>
<td>0-6</td>
<td>7-12</td>
</tr>
<tr>
<td>19. Major change in financial status (a lot better off or worse off)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Major change in closeness of family members (increased or decreased closeness)</td>
<td></td>
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<tr>
<td>21. Gaining a new family member (through birth, adoption, family member moving in, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>22. Change of residence</td>
<td></td>
<td></td>
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<tr>
<td>23. Marital separation from mate (due to conflict)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Major change in church activities (less of greater attendance)</td>
<td></td>
<td></td>
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<tr>
<td>25. Marital reconciliation with mate</td>
<td></td>
<td></td>
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<tr>
<td>26. Major change in number of arguments with spouse (a lot more or a lot less)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Married Male: Change in wife's work outside the home (beginning work, ceasing work, changing to new job, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>28. Married Female: Change in husband's work (loss of job, start of new job, retirement, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>29. Major change in usual type or amount of recreation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Borrowing more than $10,000 (buying home, business, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>31. Borrowing less than $10,000</td>
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<td></td>
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<tr>
<td>32. Being fired from job</td>
<td></td>
<td></td>
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<tr>
<td>33. Male: Wife/girlfriend having abortion</td>
<td></td>
<td></td>
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<tr>
<td>34. Female: Having abortion</td>
<td></td>
<td></td>
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<tr>
<td>35. Major personal illness or injury</td>
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</tr>
<tr>
<td>Check here</td>
<td>Time period experienced</td>
<td>Extent of impact</td>
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<td>------------</td>
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<tr>
<td></td>
<td>0-6 months</td>
<td>7-12 months</td>
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<tr>
<td>__ 36. __</td>
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<tr>
<td>Major change in social activities e.g., parties, movies, visiting (less or greater participation)</td>
<td></td>
<td></td>
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<tr>
<td>__ 37. __</td>
<td></td>
<td></td>
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<tr>
<td>Major change in living conditions of family (building new home, remodeling, deterioration of home or neighborhood, etc.)</td>
<td></td>
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<tr>
<td>__ 38. __</td>
<td></td>
<td></td>
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<tr>
<td>Divorce</td>
<td></td>
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<tr>
<td>__ 39. __</td>
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<tr>
<td>Serious illness or injury of close friend</td>
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<td>__ 40. __</td>
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<td></td>
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<tr>
<td>Retirement from work</td>
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<td>__ 41. __</td>
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<tr>
<td>Son or daughter leaving home (due to marriage, college, etc.)</td>
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<td>__ 42. __</td>
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<tr>
<td>Ending formal education</td>
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<td>__ 43. __</td>
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<tr>
<td>Separation from spouse (due to work, travel, etc.)</td>
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<td>__ 44. __</td>
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<td></td>
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<tr>
<td>Engagement</td>
<td></td>
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<tr>
<td>__ 45. __</td>
<td></td>
<td></td>
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<tr>
<td>Breaking up with girl/boyfriend</td>
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<tr>
<td>__ 46. __</td>
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<td></td>
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<tr>
<td>Leaving home for the first time</td>
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<tr>
<td>__ 47. __</td>
<td></td>
<td></td>
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<tr>
<td>Reconciling with girl/boyfriend</td>
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<tr>
<td>Other recent experiences which have had an impact on your life. List and rate.</td>
<td></td>
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<tr>
<td>__ 48. __</td>
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<tr>
<td>__ 49. __</td>
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<td>__ 50. __</td>
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</tbody>
</table>
I-E Scale

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered a or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true.

Your answers to the items on this inventory are to be recorded by placing a circle around the letter corresponding to your answer.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be true. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

1. a. Children get into trouble because their parents punish them too much.
   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.
   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons we have wars is because people don't take enough interest in politics.
   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run people get the respect they deserve in this world.
   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students is nonsense.
   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
6. a. Without the right breaks one cannot be an effective leader.
b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. a. No matter how hard you try some people just don't like you.
b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays a major role in determining one's personality.
b. It is one's experiences in life which determine what they're like.

9. a. I've often found that what is going to happen will happen.
b. Trusting in fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student, there is rarely if ever such a thing as an unfair test.
b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.
b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain I can make them work.
b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyway.

14. a. There are certain people who are just no good.
b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.
b. Many times we might just as well decide what to do by flipping a coin.
16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
b. Getting people to do the right thing depends on ability, luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
b. By taking an active part in political and social affairs, the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
b. There is really no such thing as "luck".

19. a. One should always be willing to admit one's mistakes.
b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.
b. How many friends you have depends on how nice a person you are.

21. a. In the long run, the bad things that happen to us are balanced by the good ones.
b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort, we can wipe out political corruption.
b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.
b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.
b. It is impossible for me to believe that chance or luck plays an important role in my life.
26. a. People are lonely because they don't try to be friendly.
b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too much emphasis on athletics in high school.
b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.
b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.
b. In the long run, the people are responsible for bad government on a national as well as on a local level.
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Appendix A
STAI Form Y-2
Page 56
## SELF-EVALUATION QUESTIONNAIRE
STAI Form Y-2

<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. I feel pleasant</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. I feel nervous and restless</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>23. I feel satisfied with myself</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>24. I wish I could be as happy as others seem to be</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25. I feel like a failure</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26. I feel rested</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>27. I am &quot;calm, cool, and collected&quot;</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>28. I feel that difficulties are piling up so that I cannot overcome them</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>29. I worry too much over something that really doesn't matter</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>30. I am happy</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>31. I have disturbing thoughts</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>32. I lack self-confidence</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>33. I feel secure</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>34. I make decisions easily</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>35. I feel inadequate</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>36. I am content</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>37. Some unimportant thought runs through my mind and bothers me</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>38. I take disappointments so keenly that I can't put them out of my mind</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>39. I am a steady person</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>40. I get in a state of tension or turmoil as I think over my recent concerns and interests</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

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APPENDIX B

DEMOGRAPHIC SURVEYS
Please answer all the items that pertain to you.

Male _____ Age _____
Female _____

Marital Status:

Single _____
Married _____
Divorced _____ Custodial Parent _____ Non-
custodial Parent _____

Race:

Afro-American _____
Asian-American _____
Hispanic _____
White _____
Other (list) ____________________________

Approximate Family Annual Income: $________

I am the biological parent of an adolescent:

Son _____ Daughter _____ whose age is _____.

Total number of children in the family: _____.

I have an adopted child living
in my home: Yes _____.

No _____.

Do any of your children have any significant disability? Yes _____.

No _____.
Please answer all the items that pertain to you.

Male _____ Age _____
Female _____

Marital Status:
Single _____
Married _____
Divorced _____ Custodial Parent _____ Non-custodial Parent_____

Race:
Afro-American _____
Asian-American _____
Hispanic _____
White _____
Other (list): _______________

Approximate Family Annual Income: $___________

I am the biological parent of an adolescent:
Son _____ Daughter _____ whose age is ______.
Total number of children in the family: ______.

I am the adoptive parent of an adolescent:
Son _____ Daughter _____ whose age is ______.
Total number of children in family: ______.

What age were your adopted children at the time of placement in your home? ______.

Did any of your adopted children have any significant disability at the time of placement? Yes ______.
No ______.

Are your adopted children the same race as both you and your spouse? Yes ______.
No ______.
APPENDIX C

INTRODUCTORY LETTER
Dear potential participant:

I am asking for your help. Please take a minute to read this letter. I am a doctoral student at the University of North Texas doing research in the area of adoption. I am asking for your participation in a study which may eventually help those who choose to adopt, as well as professionals who work with adoptive families. The object of this research is to better understand stresses that adopted and biological families face during adolescence.

Letters like this were given to adoption agencies throughout the metroplex who agreed to address and mail them out to adoptive parents with whom they've worked. If you choose to participate, you will be asked to complete three, brief questionnaires. This will take approximately one hour. Your name will not be used on the questionnaires. The results of this research will be summarized and an explanation of the findings shared with you.

Please call me toll free at 1-800-484-9416, (code 9559) so that I may contact you with further information. Or you may contact your adoption agency and obtain information directly through them. Thank you in advance for your help in this project to assist others planning to adopt in the future.

Sincerely,

Tom Larussa MS
APPENDIX D

PARTICIPANT INSTRUCTIONS
Dear Participant:

Thank you for taking time out to be part of this research. I am hoping it will be of assistance in helping all of us understand adoption better.

Enclosed you should find three questionnaires and a brief survey. Please complete all of these, with no input from others. It should take about half an hour of your time.

You should also have an envelope with my name and address on it. Please place the completed forms in it and mail it to me.

Thank you again. I know your time is valuable to you.

Sincerely,

Tom Larussa
APPENDIX E

NOTICE OF CONSENT
Notice of Consent

I,______________________, agree to participate in a study of various groups of parents. The purpose of this research is to study the adolescent phase of both biological and adoptive families. It is hoped that the information gained in this study will better serve professionals who work with parents. As a participant, I understand that my involvement in this research is on a voluntary basis. I understand that I will be asked to fill out three inventories.

I have been told there is no personal risk directly involved with this research and that I am free to withdraw my consent and discontinue participation in this study at any time. All information obtained in this study will be kept confidential. No names will be used on the tests. If I have any questions in connection with my participation in this study, I should contact Tom Larussa at (800) 484-9416 #9559

__________________________________________
Date Participant Date Investigator

THIS PROJECT HAS BEEN REVIEWED BY THE UNIVERSITY OF NORTH TEXAS COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS (PHONE 817/565-3940)
APPENDIX F

TELEPHONE CONTACT EXPLANATION
Explanation of Study

Telephone communication

I am a doctoral student in the process of studying adoptive families. I am especially interested in learning about the period of adolescence in adoptive and biological families.

Your participation in this study would help me to better understand adoptive parenting. If you agree to participate, the study will require approximately 1 hour of your time. The questionnaires will be mailed out to you.
APPENDIX G

ANNOUNCEMENT FOR CHURCH BULLETIN
I am asking all interested parents to participate in a study of parenting and adolescence. If you are the parents of an adopted adolescent, age 13-17, I need your help. If you would like to participate in the research, you will be asked to complete three questionnaires. Approximately one hour of your time is asked.

This is part of a doctoral research project conducted by Tom Larussa, at the University of North Texas. If you are interested, please call him at 1-800-484-9416 (code 9559). Thank you!
BIBLIOGRAPHY


