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ADOPTION IN AN INFERTILITY CLINIC

ROY A. KAPLAN

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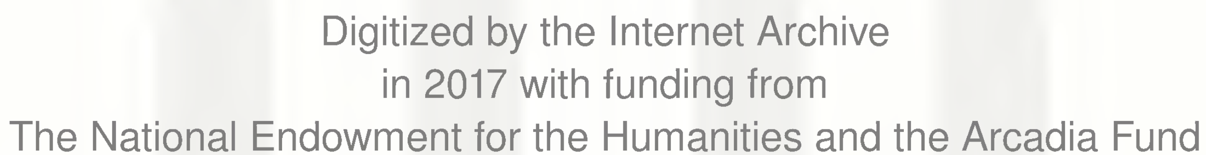
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ADOPTION IN AN INFERTILITY CLINIC

Roy A. Kaplan, B.S.

Brooklyn College 1968

Submitted as Partial Fulfillment of the Requirements for

the Degree of Doctor of Medicine

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School of Medicine

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Department of Obstetrics and Gynecology

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And to Sherri.

TABLE OF CONTENTS

Introduction 1

Methods and Materials 3

Clinic 3

Sample 3

Response 3

Results 5

Demography 5

Adoptive Group 6

Childless Group 14

Fertile Group 16

Discussion 17

Summary 23

Appendix I 25

Appendix II 26

Appendix III 28

Refferences 29

INTRODUCTION

> Most children ask this, ("Will I have a baby too?") or assume it with a flat statement that they intend to have babies when they grow up. You can agree that they will be parents, without going into the complicated ideas of marriage and adult love relationships. Simply tell them "when you grow up, you'll get married and have babies". (9)

Observers have estimated that 10% to 15% of all married couples in the United States, suffer from infertility (16). In other words, about 3,500,000 couples are in a state of involuntary childlessness (16). The magnitude of the problem of infertility has helped to initiate the development of infertility clinics and programs of evaluation and management designed specifically for the infertile couple.

With the expansion of these centers, promise grew for the childless couple. As a 50% "cure" rate for couples attending infertility clinics was reported, optimism increased as noted in a British Medical Journal editorial in 1952 (3). Other investigators noted somewhat less encouraging results, with 30% to 40% of couples achieving a successful pregnancy (4). However, still remaining are the 50% to 70% of married couples, yet infertile. What is their plight?

The alternatives for such a couple are limited to these: (1) therapeutic artificial insemination in cases of male factor infertility, (2) adoption, (3) accepting the future as a childless couple. In recent gynecological texts dealing with infertility and its management (2,10,16,19), the actual investigation naturally receives the most thorough attention. But for couples coming out of the process, still unable to conceive, only therapeutic artificial

insemination is dealt with in detail. Adoption is often either not discussed or discounted for various reasons (5,10,16,19). There are exceptions to this statement, notably a text written for, as well as about, the childless couple (8), a more recent text (2) and a study in 1965 by Michael Humphrey and J.M. MacKenzie on infertility and adoption in couples attending an infertility clinic in England (6). The latter report helped to lay the ground work for this study. It was the intention of this study to follow up by questionnaire, couples discharged from the Yale-New Haven Hospital Infertility Clinic, from 1966-1970 with the diagnosis of "non-pregnant" and to see how these couples fared with adoption.

METHODS AND MATERIALS

CLINIC:

The Yale-New Haven Infertility Clinic draws patients from a wide geographical area as well as from the local community. Patients are referred from private doctors, through resident physicians in the outpatient clinic, from social workers and from adoption agencies.

SAMPLE:

Out of a total of 555 couples seen in the Yale-New Haven Hospital Infertility Clinic, between January, 1966 and December, 1970, 271 couples were discharged and diagnosed as "non-pregnant", i.e. unable to conceive and produce a child of their own. Questionnaires dealing with marital status, fertility status, and adoption processes were addressed to the wives of these non-pregnant couples, though there were no explicit instructions as to whom should answer the questions. (See appendix I).

RESPONSE:

Of the 271 questionnaires sent, 59 were returned by the post office marked "wrong address", leaving possibly 212 couples (78%) that received the questionnaire. Of these, 109 couples responded, yielding a response rate based on the total sent of 40%. Not counting the wrong addresses, the response rate increases to 51%.

In reviewing the responses, and the patients' charts, we realized that an analysis of the group with regard to parental status would be biased by those respondants with 2° infertility, or with children adopted prior to presentation at the infertility clinic.

Thus, 8 couples who had adopted before they attended the clinic, plus 9 couples complaining of 2° infertility, plus 1 childless woman who remarried and gained 2 children from her new husband's first marriage, were all subtracted from the respondents. Some of these 18 couples will be alluded to later in discussion. Hence, we are left with 91 couples, 34% of the 271 questionnaires sent, 43% not including the wrong addresses. Their parental status is shown on Table I.

TABLE I

Parental Status	Number	Per Cent
Childless	24	26
Fertile	7	8
Adoptive	60	66

RESULTS

DEMOGRAPHY:

Racial and religious backgrounds are shown on Table II, with the typical respondent being white, and either Catholic or Protestant.

TABLE II

	Total	%	Childless	%	Fertile	%	Adoptive	%	Adoptive % Total
Caucasian	88	96	22	92	7	100	59	98	
Negro	3	3	2	8	0		1	2	
Catholic	47	52	11	46	3	43	33	55	70%
Protestant	32	35	9	37	3	10	20	33	62%
Jewish	6	7	3	13	1	1	2	3	
Greek Orthodox	2	2	1	1	0	0	1	2	
No response	4	4							

The Catholic couples had the highest percentage of adopters, 70% as opposed to 62% for Protestant couples.

Most of the wives of respondents were between 30 and 35 years old, but as Humphrey and MacKenzie (1965) pointed out, the wife's age at marriage, as shown on Table III, was most significant in determining fertility status (6).

TABLE III

Wife's Age at Marriage (yrs.)	Mean	20 - 24	25 - 29	≥30
Fertile	26.7	2 (29%)	3(42%)	2(29%)
Adoptive*	27.1	11 (20%)	33(60%)	11(20%)
Childless**	31.3	0 (0%)	7(35%)	13(65%)
Combined	28.1	13 (16%)	43(52%)	26(37%)

* 5 couples figures not available
** 4 couples figures not available

As Table III indicates, fertile women married earlier than adoptive women, who married earlier than childless women, the mean wife's age at marriage being 26.7 years old, 27.1 years old, and 31.3 years old, respectively for fertile, adoptive, and childless wives. The most common five year span for marriage is ages 25-29 for the entire 91 women, as compared with 25-29 for the fertile group, 25-29 for the adoptive group, but ≥ 30 for the childless group. In addition, the mean interval between marriage and investigation in the infertility clinic, was 4.1 years, 4.7 years, and 6.1 years, respectively, confirming observations of others (6), that there is no trend in childless couples to compensate for a late marriage by presenting sooner for investigation (See Table IV). To the contrary, fertile couples presented 2 years earlier for investigation than childless couples.

TABLE IV

Mean Time from Marriage to Presentation at Infertility Clinic

Fertile	4.1 years
Adoptive	4.7 years
Childless	6.1 years

ADOPTIVE GROUP:

Couples classified as adoptive included those approved by an agency and awaiting the placement of a child as well as couples that already adopted a child since attending the infertility clinic. There were 60 adoptive couples, representing 66% of the combined 91 couples. Of these adoptive parents, 8 couples (13%) are still

awaiting placement of their first child; 34 couples (57%) have 1 adopted child; and 12 of these couples are in the process of adopting a second child. Eighteen couples (30%) have 2 adopted children and 2 of these couples are in the process of adopting a third. (See Table V).

TABLE V

Adoptive Couples (N=60)	Number	Percent
Awaiting placement of first child	8	13%
One adopted child	34	57%
Awaiting placement of second child	12	20%
Two adopted children	18	30%
Awaiting placement of third child	2	3%

These figures do not include 11 couples -- the 8 couples who adopted before an infertility investigation and the 3 couples with 2° infertility who adopted after investigation. Of these 11 couples, 7 have 2 adopted children, 3 have 1 adopted child, and 1 couple adopted 3 children before attending the infertility clinic! Seven of these 11 couples, not included in the adoptive group, adopted at least 1 child after infertility investigation.

The idea of adopting was originally a joint decision (See Table VI) in 56% of adoptive couples. Naturally, the decision to adopt must be mutual, but where husband and wife were not both checked off on the questionnaire, the wife accounted for 26% and the husband initiated the idea to adopt in only 1 case.

TABLE VI

Initiator of Adoption Idea*	Number	Percent
Husband	1	<2%
Wife	18	26%
Joint Decision	38	56%
Family M.D.	1	< 2%
Infertility Clinic	9	13%
Gynecologist	1	<2%

* Some couples put down more than 1 number.

From the figures above, one would suspect that where a joint decision was made, it was at the wife's initiative, for as others (9) have cited, the guilt and strong disappointment that wives feel in failing to achieve motherhood overshadows the disappointment the husband feels in failing to achieve fatherhood. The infertility clinic, which up until now has had no standard policy toward adoption, accounted for 13% in the decision to adopt. Private doctors (family physician and gynecologist) were responsible for suggesting the idea to 2 couples.

As Connecticut and Delaware are the only 2 states having adoption laws prohibiting third party or gray market adoptions, all adoptions must be done through agencies, either private (no government financial support) or public (state support). Private agencies accounted for 73% of adoptions in the adoptive group and these adoptions were almost equally divided between sectarian and non-sectarian agencies. (A sectarian agency will approve couples for adoption who

are of the agency's religious affiliation only). Public agencies (State Department of Welfare) were used in 16% of the adoptions. The remaining adoptions were out of state agencies, and 1 couple used a third party arrangement in Georgia, adding angrily that Connecticut ought to change its rigid adoption laws with respect to third party adoptions. (See Table VII)

TABLE VII

Type of Agency	Number of Adoptions	Percent
Non-sectarian	27	36
Sectarian	25	33
Public (Welfare)	12	16
Out of State	10	13
Third Party	1	1

A list of agencies has been included in a Appendix II. Some of the local agencies were consulted with respect to their adoption practices, and pertinent information is included in the discussion to follow.

The length of time required for the adoption procedure ranged from 4 months to 33 months. Although more couples required more than 2 years than those couples requiring less than 1 year, the large majority of adoptive couples spent from 12 to 24 months, starting from the first seeking of adoption to final legalization of adoption. The date of placement of the child, not asked for in the questionnaire, but often volunteered, usually precedes legalization by one year, occassionally less, and rarely longer (20-23).

In our study (see Table VIII), 3% of adoptions required less than 6 months, 6% less than 1 year, 40% less than 1½ years, and 79% less than 2 years. Humphrey _et al_ (6) reported in their followup study that 75% of adoptive couples acquired their first child within a year of taking their first step, and considering that time of placement to legalization with few exceptions is one year, our results approximate those of Humphrey _et al_.

TABLE VIII

Length of time for adoption (from seeking to legalization).

Year	6 mo.	6-11 mo.	12-17 mo.	18-23 mo.	24-29 mo.	30-35 mo.
1966			3	3	2	
1967		2	6	4	2	1
1968			4	7	2	
1969			5	7	2	2
1970	1		2	4	2	
1971	1					
Total	2	2	20	25	10	3

Assuming that the time from placement to legalization of the adopted child is more or less constant, the variables determing how long a couple must wait from their first step are (a) the time spent by the agency in evaluating the couple, and (b) the waiting time from approval to placement of a child in the home. In local agencies, evaluation time varies from 3 months in private agencies (23), to 5 months in the State agency, consisting of office interviews and home visits by a social worker. However, the waiting time for placement

of a child is extremely variable due to the shortage of babies available for adoption. Couples have waited from 1 month after approval to over 1 year for a child, and presently, the local public agency is putting prospective couples on an 8 month waiting list before study even begins (22), and Children's Center, a much used local private non-sectarian agency, is not even accepting any more couples on their waiting lists (21)! Though this increase in waiting time is not apparent in our results, the problem for white parents wanting to adopt a healthy white child is becoming an international one (13,21).

In line with this breakdown of time spent in adopting, few couples complained of red tape or delay as a problem they experienced in trying to adopt (see Table IX).

TABLE IX

Problems for couples trying to adopt	Number	Per Cent
Shortage of babies	26	44
Lack of guidance from Infertility Clinic	5	8
Red tape	4	7
Fear of rejection by agency	3	5
Cost	2	3
No problems	19	32

As seen above, shortage of babies available for adoption was the most frequent problem, and 44% includes the 8 couples waiting for their first child, as well as couples who have been trying to adopt their second child. The couples complaining of the lack of guidance

on adoption by the Infertility Clinic wished in retrospect that the doctors had suggested adoption during their evaluation. Other problems cited were fear of rejection by the society and cost. The cost to adoptive parents is 10% of their income in most private agencies, but in the public agency the only cost is a fee of about $40 (22). Significantly, 32% of adoptive couples had no problems in trying to adopt, some volunteering to go through the process all over again, and one couple advised "any couple that could not have a child and that wanted children deeply to try to adopt one."

We include as a footnote to the data on the adoptive couples the post-adoption fertility rate, which was 4/60+3 or 6%. This figure consisted of 3 "fertile" couples that conceived while in the process of adopting, but who withdrew upon conceiving, and also one adoptive couple who successfully conceived after receiving their adoptive child. In contrast, of the 7 fertile couples in toto, 4 conceptions were unrelated to adoption, yielding a non-adoptive fertility rate of 4/24+7-3 or 14%. Hence, our results show that adoption does not facilitate fertility. There has been much said on the controversial folklore that adoption cures infertility (1,7,14,15,17) and the best summary of these studies is by Humphrey (7). The post-adoptive fertility rates ranged from 7.5% to 72%, the latter result obtained by Sandler (17) in a rigorously controlled study of two groups of 25 couples. He concluded that "adoption facilitates conception where organic factors have been adequately treated and where continuing emotional tension is present." (17). Our smallness of sample does not allow for control

criteria to be of any use, and as Humphrey reported in his review of the literature just cited, even Sandler's study is not statistically significant, and concludes, "On a purely statistical basis, therefore, there is not much to be said for adoption as an aid to infertility." (7).

To elaborate on what role the infertility clinic could have or should have played, we asked on the questionnaire, "Could the Infertility Clinic have been more helpful in guiding you with adoption?" (see Appendix I), with the answers tabulated below:

TABLE X

	Total	Adoptive	Childless	Fertile
Yes	21(23%)	19(32%)	1(4%)	1(14%)
No	39(43%)	30(50%)	7(29%)	2(29%)
No Answer	31(34%)	11(18%)	16(67%)	4(57%)

Because of the large number of "No answers" to this question, we wonder whether the question was interpreted to be answered by adoptive parents only. In any event, half of the adoptive couples thought the clinic need not be more active in the adoption decision or process, and about one third of couples felt oppositely. This latter group consisted mainly of couples regretting that adoption was never discussed during their evaluation, and they recommended that the "clinic could provide information on adoption and differences among agencies in the early exploratory phase." Several couples asked us to send them a list of adoption agencies. Some couples, suggesting an even more involved role on the clinic's behalf, formulated arrangements where childless

couples could talk with other adoptive parents and social workers to reduce fears associated with adoption. Finally, a few anxious couples asked if we could help place a child in their home in view of the shortage of adoptable babies.

In general, however, more than not, patients didn't think the Infertility Clinic could have been more helpful with adoption. Possibly these patients were never interested in adoption, and are still concerned more with the possibility of yet conceiving if they haven't adopted. Also, the adoptive patients not needing any more help may have just had a relatively easy time adopting.

CHILDLESS GROUP:

There were 24 couples, representing 26% of the combined group, with neither adopted children nor biologic children. (Couples that were awaiting placement of a child from an adoption agency, as mentioned earlier, were included with adoptive couples.) In addition, 1 childless couple was not included in this group because the wife had divorced and remarried and her new husband had 2 children from his former marriage. Broken marriages were a problem for the childless group with 5 couples (21%) either divorced or separated. We do not say that childlessness inevitably breeds broken marriages, for broken marriages are still a minority problem, even in this group. Indeed, the converse statement would seem more apt. The strain of infertility on a marriage is dealt with in two sociological surveys. (9,11).

Reasons for not adopting are shown in Table XI as they appeared in the questionnaire, and except for the comment about shortage of

babies, were originally taken from Humphrey and MacKenzie's classifications of replies from childless couples in their study (6) (See Table XI).

TABLE XI

Reasons for not adopting	Number	Percent
Still hoping to produce own child	10	23%
Getting too old	6	14
Prevented by family circumstances	6	14
Conflicts and doubts about capacity to love adopted child	5	11
Fear of rejection by adoption agency	5	11
Husband not in favor	5	11
Idea made no appeal	4	9
Too many questions, poor attitude of agency	1	2
Hobbies and other interests will satisfy	1	2
Shortage of desirable babies	1	2

Except for four couples, the childless couples didn't make any efforts to adopt. As in Humphrey and MacKenzie's study (6), "still hoping to produce own child" was the most common reason for not adopting. Interestingly, the mean age of wives with such reproductive optimism was 32.8 years, contrasting with a mean age of 38.0 years for the entire childless group. Twelve couples eliminated themselves by circumstance (getting too old, breaking or broken marriage referred to

as family circumstance). Twenty couples were either ambiguous, neutral or antagonistic to the idea and process of adoption (conflicts and doubts about capacity to love an adopted child, husband not in favor, idea made no appeal, fear of rejection by agency, attitude of agency).

There were 4 couples who were unsuccessful in their adoption efforts and thus are still childless. Three of these couples had never reached the point of being approved by the agency, and one approved couple withdrew because they had waited too long for the placement of a child. Of course, the decision not to adopt is not necessarily permanent, and some of the remaining childless couples may yet reconsider.

Finally, one couple, feeling that none of the given reasons for not adopting applied to them, commented that "we simply adapted and eventually favored a life for the two of us without children."

FERTILE GROUP:

The fertile group included couples with children of their own procreative efforts only, and they amounted to 8% of the combined 91 couples. The correspondingly small fraction of fertile couples, compared with other infertility clinics' results of about 40% to 50% fertility rate in previously infertile couples, is misleading since the couples known to have become pregnant were not sent questionnaires.

DISCUSSION

The unexpectedly large proportion of adoptive couples certainly deserves our attention. Of the 91 couples studied, 66% adopted in order to resolve their childless state. If one excludes those respondents that eventually conceived without adopting (fertile group), we see that 71% of childless couples adopted. This figure compares favorably with Humphrey and MacKenzie's reported adoption rate among childless couples of 48% (6). In another study of infertile couples (14), Raymont _et al_ recorded an adoption rate of 24.6% among 240 patients who had failed to become pregnant in his infertility clinic, and who had been encouraged to adopt.

However, the true adoption rate may not be quite so great in view of several factors. One factor that might diminish the adoption rate are the non-respondents. Of the 271 questionnaires sent, 103 (38%) were not returned, and we assume, unlike the 59 questionnaires returned marked "wrong address", that these couples were reached. Either these couples neglected to or desired not to participate. One can only guess that non-respondents desiring not to participate might not have resolved their infertility problem as well as the respondents did, and thus perhaps feel antagonistic toward the clinic for not helping them achieve parenthood. Consequently, we would suspect more childless couples, more couples unsuccessful in adoption efforts, and fewer adoptive couples, in the non-respondent group. Possibly,for those adoptive parents who did not respond, (if there are any), adoption may not have worked out well.

Humphrey and MacKenzie included only couples with adopted children as part of the adoptive group and excluded 5 couples await-placement of a child, and putting them in the childless group. In our study, those couples with adopted children totaled 52, or 62% of the childless plus adoptive groups combined. The eight agency approved couples that were awaiting placement of a child, though naturally upset with the problem of shortage of babies available, gave no indication of changing their minds about adoption. They may eventually withdraw, but as mentioned earlier with the childless couples, only 1 couple withdrew from adoption after approval because of the waiting involved before the child was placed.

Conversely, the childless group includes potential adoptive couples, who may at another time favor adoption, thus increasing the adoption rate. Time is a limiting factor here, for although Connecticut has no maximum age limit in its adoption laws, private and public adoption agencies will look with disfavor upon couples applying at age 36 (wife's age), and will usually not consider couples over 40 years of age (20-23). The childless group included 20 couples that fell between the ages of 29-35, which is the preferred age range for adoption, other factors being equal (20-23).

Another factor suggested by Humphrey and MacKenzie that may have positively biased the adoption rate in our infertility clinic is that adoption may have been the thrust behind investigation at the clinic for some couples (6). Most private agencies require a medical statement on a prospective adoptive couple's infertility problem, and though state adoption agencies in Connecticut don't

require it, an infertility investigation is preferred.

With all these factors considered, it is still apparent that adoption played a major role in the resolution of childlessness for couples attending an infertility clinic, and as reflected in the comment below, investigation in an infertility clinic can help determine whether a childless couple adopts:

> It took us five years to make up our minds to adopt a child, but because we knew,through the infertility clinic that we could not have children of our own, we decided to go ahead and adopt. If we hadn't gone to the clinic, we might not have our son now.

We therefore can conclude that in some instances the infertility clinic serves the purpose of helping the childless couple understand the nature of their infertility so that they may choose to adopt.

This idea has been suggested by several supervisors of adoption agencies (21,22), as well as in a study by Lawder, et al for the Child Welfare League of America (11), that successful adoptive parents were able to discuss their infertility status with "maturity and no hesitation". Sixty percent of the 200 adoptive couples in the CWLA survey had an infertility investigation revealing absolute sterility or marginal sterility in one or both parents. The 40% of uninvestigated couples were ill at ease in talking about their infertility.

Aside from evaluating and helping a couple understand the nature of their infertility problem where possible, the clinic's involvement with adoption has been primarily indirect, sending letters of evaluation to adoption agencies, discussing adoption on

the couple's initiative, and sometimes, though not in any uniform way, bringing up the subject of adoption. The results of this follow-up study showed that many infertile couples resolved their childlessness after an infertility work-up by adopting a child, and it would seem worthwhile that adoption (and artificial therapeutic insemination) be discussed as an alternative in the event that other treatment is not possible or unsuccessful in bringing about a viable pregnancy. Childless couples could be asked to discuss their thoughts on adoption and what they know about it. The clinic could give useful information on adoption to interested couples and a list of adoption agencies. Simultaneously, the clinic could develop some liaison between itself and community adoption services -- discussion with local adoption supervisors resulted in warm enthusiasm on this idea. As Humphrey and MacKenzie commented, and we agree, "Still less should the clinic aim at running an adoption service . . . (but) many couples are ignorant of adoption procedures and will benefit from informed discussion at the critical stage." (6)

* * *

As noted earlier, current adoption practices were discussed with several local agencies in order to better inform ourselves on what to say to infertile couples unable to achieve a viable pregnancy after evaluation in the clinic. We spoke to supervisors from the Children's Center, the Jewish Family Services, the Catholic Family Services, and the Connecticut Department of Child Welfare, all of which are located in New Haven. What had been apparent from some

of our respondents was all too apparent in talking to adoption supervisors: The shortage of (white, healthy) babies available for adoption is a severe problem, and the prognosis is unpromising.

For example, the Children's Center, the largest private adoption service in New Haven County, placed 46 children* in 1971, 87 children in fiscal year 1970-71, 103 children in 1969-70, and 115 children in 1968-69. The Catholic Family Services in New Haven placed 50 children in 1966, 43 children in 1967, and 20 children in 1970. Finally, the total number of placements by private adoption agencies in Connecticut has fallen from a peak of 968 children in fiscal year 1967-68 to 893 children in fiscal 1969-70, to 792 in 1970-71** (22). Incomplete incoming data since June 1971 shows a much sharper decrease in children placed (22).

In addition, the rate of decrease of adoptible babies is greatest among white babies (13,20-23), as illustrated dramatically by statistics of the Louise Weiss Foundation, a Jewish private adoption agency in New York City. In 1967, the foundation placed 272 children, of whom 235 were white and 37 were non-white. In 1971, the agency placed 130 children, of whom 70 were white and 60 were non-white, a fall of 54% in total placements, and a decrease of 70% in placements of white babies.

The shortage of white babies available for adoption has been attributed to 3 factors: (1) liberalized abortion laws, (2) increaseed use of the birth control pill, and (3) a growing tendency among unwed mothers to keep their illegitimate children. One survey among some hospitals in the Los Angeles area noted boosts of from "2% to 4% among

* All figures refer to children $\leq$ 1 year old.

** Median age of time of placement = 2.5 months (1967-68)
1.9 months (1970-71)

unwed mothers who decline to give up their youngsters for adoption" (13), a phenomenon reflecting our changing mores.

Hence, one is not being fair in discussing adoption with any couple without informing them about the shortage of babies, a subject much publicized already in magazine and newspaper articles. The effect of the baby shortage with its consequent shift in supply and demand can only result in "gray-marketing" of babies with profiteering at the expense of the childless couple. Because of non-uniform state adoption laws, only a national adoption law can stop this exploitation.

In addition, the baby shortage will naturally mean a longer wait for placement of a child, but agencies do not foresee any change in making it more difficult to meet approval standards, though the stress has emphasized certain priorities. A summary of priorities and pertinent facts with respect to race, religion, cost, fertility and length of wait are included in tabular form in Appendix III from information obtained in visiting the 4 agencies in New Haven. Hopefully, it will be of use in dealing with adoption in the infertile couple.

SUMMARY

Follow-up questionnaires were sent to the 271 couples discharged from the YNHH Infertility Clinic form 1966-70 who had not still been able to achieve a pregnancy. Of the 109 couples who responded, 18 couples were excluded from study for reasons of 2° infertility or previous adoptions. The post-clinic adoption rate was 66% including 8 couples waiting to adopt, the childless group accounted for 26%, and newly fertile couples amounted to 8%, and were the earliest marriers. The post adoptive fertility rate was 6%, comparing to a non-adoptive fertility rate of 14%, discrediting the notion that adoption facilitates conception.

Most adoptive couples had only one adopted child, though almost one third had 2 adopted children, the wife usually originally coming up with the idea to adopt, and the private agency being the service responsible for the adoption in most cases. The usual waiting time from the first step to final legalization of the adoption was between 1 and 2 years, and the most common problem for adoptive couples was the shortage of white babies available for adoption, thus creating a longer waiting time. Most of the couples didn't need direct assistance from the infertility clinic with adoption, but some felt some discussion and practical information would be of great help for future adoptive couples.

Childless couples, the latest marriers, had some problems with broken marriage, and various reasons were entertained for not adopting -- usually because they were still hoping to produce their own child.

Finally, the shortage of babies was documented by discussions with several local adoption agencies, and practical current information was included with the intention of benefiting the infertility clinic's handling of the unsuccessful childless couple.

APPENDIX I

INFERTILITY CLINIC FOLLOW-UP QUESTIONNAIRE

Name_________________________ Age_________ Race____________ Religion________

Current Marital Status: ____married _____divorced ____ separated __ remarried
Number of pregnancies since attendint the Infertility Clinic? ____________
Outcome of pregnancies(full-term;premature;stillbirth;miscarriage;abortion):

Date of Conception(s) (Month/Year) Outcome(s)(If pregnant now please indicate)

Number of children adopted before attending the Infertility Clinic?________
Number of children adopted since attending the Infertility Clinic?_________
Are you in the process of adopting now? ________Yes ____________No
Have you been unsucessful in your efforts to adopt? ____ Yes ______ No

Whose idea was adoption originally?
______ husband ______ wife _____ husband's parents ______ wife's parents

______ family doctor _____ Infertility Clinic ______ other (please describe)

____

Which adoption agencies or professional services did you use in trying to adopt?____

____

Which agency finally arranged the adoption, if any? _______________________
How long did the entire procedure of adoption take? (Fill in below)

Month/Year you began seeking adoption(s)_________________________________
Month/Year adoption(s) became fully legal________________________________

What problems did you have in trying to adopt?____________________________

____

____

Could the Infertility Clinic have been more helpful in guiding you in adoption?
_____ yes _____ No If yes, how? ___________________________________
If you didn't adopt a child, what reasons were most important in not adopting?
- ______ still hoping to produce own child.
- ______ conflict and doubts about capacity to love adopted child.
- ______ idea made no appeal.
- ______ fear of rejection by adoption society.
- ______ prevented by family circumstances.
- ______ hobbies and other interests will satisfy.
- ______ husband not in favor.
- ______ getting too old.
- ______ genetic anxiety.
- ______ other ____

  ____

ANY COMMENTS OR ADDITIONAL INFORMATION WOULD BE APPRECIATED AND CAN BE INCLUDED ON THE BACK OF THIS SHEET.

APPENDIX II (18)

LICENSED CHILD-PLACING AGENCIES IN CONNECTICUT

FAIRFIELD COUNTY:

State Welfare Department
434 State St, Bridgeport

Catholic Charities
(Bridgeport Diocese)
250 Waldemere Avenue, Bridgeport
92 Main St., Danbury
606 West Ave., Norwalk
78 Elm St., Stamford

Children's Services of Connecticut
75 West St., Danbury
3 Ann St., South Norwalk

Family and Children's Services of Stamford
79 Worth St., Stamford

Greenwich Center for Child and Family Service
40 Arch St., Greenwich

Jewish Social Service of Bridgeport
1188 Main St., Bridgeport

HARTFORD COUNTY:

State Welfare Department
60 Arch St., Hartford

Diocesan Bureau of Social Service
(Archdiocese of Hartford)
244 Main St., Hartford
259 Main St., New Britain

Children's Services of Connecticut
1680 Albany Ave., Hartford

Family Service of New Britain
35 Court St., New Britain

Jewish Social Service of Hartford
91 Vine St., Hartford

LITCHFIELD COUNTY:

State Welfare Department
352 Main St., Torrington

Diocesan Bureau of Social Service
(Archdiocese of Hartford)
225 Main St., Torrington

Children's Services of Connecticut
105 Church St., Torrington

MIDDLESEX COUNTY:

State Welfare Depatement
Main St. Ext., Middletown

Diocesan Bureau of Social Service
(Norwich Diocese)
50 Washington St., Middletown

NEW HAVEN COUNTY:

State Welfare Department
194 Bassett St., New Haven

Diocesan Bureau of Social Service
(Archdiocese of Hartford)
36 East Main St., Ansonia
69 East Main St., Meriden
478 Orange St., New Haven
56 Church St., Waterbury

Children's Center
1400 Whitney Ave., Hamden

Jewish Family Service of New Haven
152 Temple St., New Haven

Lutheran Social Service
305 St. Ronan St., New Haven

NEW LONDON COUNTY:

State Welfare Department
279 Main St., Norwich

Diocesan Bureau of Social Service
(Norwich Diocese)
42 Jay St., New London
62 Broadway, Norwich

Children's Services of Connecticut
302 State Street, New London

TOLLAND COUNTY:

State Welfare Department
Refer to Norwich office:
279 Main St., Norwich

Children's Services of Connecticut
Refer to Hartford Office:
1680 Albany Ave., Hartford

Diocesan Bureau of Social Service
Refer to Norwich office:
62 Broadway, Norwich

WINDHAM COUNTY:

State Welfare Department
Refer to Norwich office:
279 Main St., Norwich

Children's Services of Connecticut
Refer to Hartford office:
1680 Albany Ave., Hartford

Diocesan Bureau of Social Service
Refer to Norwich office:
62 Broadway, Norwich

In towns where there are no local offices of the agencies above, refer to those nearest in the county.

NOTE: There are other agencies in Connecticut serving unmarried parents but those listed here are the only ones authorized to place children for adoption.

APPENDIX III

	Race	Religion	Cost	Fertility	Length of Wait	Other Factors & Priorities
Children's Center	Parents: all races Children: " " Receptive to inter-racial placements in white home; e.g. 1970: 80 placed 56 white in white 10 black in black 12 inter. in white 2 inter. in inter.	Non-sectarian Religion no factor in placement of child.	Application fee: $25. Home Study fee $50 plus Sliding Scale from 0%-5% to 10% of gross income.	Medical statement required. Full work-up preferred. 1° infertile childless couple given priority, other factors being equal.	Presently, not taking anymore applicants because of backlog. Study to approval: 3 months, varies. Placement: indefinite.	Age: max.age is 40; prefer couple in 30's. Income: prefer adequate income but job not necessary. Marital: Single women allowed to adopt. Placements in 1970: 80.
Catholic Family Services	Parents: all races Children: " " In practice, mostly white, some inter-racial few black adoptions. Need to recruit black adoptive parents.	Catholic. Catholic couples only. Place only Catholic offspring.	Sliding Scale from 8% to 10% of gross income.	Work-up not required; but encouraged in younger couples. Place often c̄ couples c̄ adoptive or natural children	Indefinite. Accepting applicants but not working up because of backlog.	Age: One parent must be ≤40 y.o.; neither >45 y.o.; prefer 30's. Income: limited income can disqualify. Placements in 1970: 20.
Jewish Family Serv.	Parents: all races Children: " " In practice, mostly white, but arranges Open Door discussions encouraging adoption of non-white babies by white couples	Jewish. Jewish couples only. Child of any religious background.	Sliding scale -- 10% of gross income.	Medical statement required. Full work-up preferred.	Indefinite. Study to approval: 3 months (8 meetings)	Age: Prefer 20's, 30's. Income: very flexible. Placements in 1970: 4. history of very small case loads.
al State Agency	Parents: all races Children: " " Encourage black children in black homes rather than in white homes, if possible.	Non-sectarian Religion no factor in placement of child.	Legal fees: $40. Otherwise, no cost to adoptive couple.	No medical statement required. Officially, "parents should be adjusted to their infertility."	8 month waiting list before beginning study. Study to approval: 5 months. Placement: indefinite.	Age: 20's, 30's preferred. Income: no requirements. Placements in 1971: 38. 70% of infants are YNHH.

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