What Happens to the Child Hard To Place for Adoption*

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This article stresses that "what happens to the disadvantaged child depends on the attitudes of the placement worker...the way in which [the worker] uses consulting specialists...the attitudes of the adoption worker...[all this within a constructive] "philosophy and practice in relation to finding adoptive parents for disadvantaged children."

This article is about ten hard-to-place (for adoption) children, who were disadvantaged physically, mentally or emotionally. The adoption program at the Jewish Family Service in Detroit has been a limited one because of the relatively small number of babies available for adoption. On the other hand we have generally had a large number of Jewish couples wishing to adopt—a situation, which seems to be characteristic of Jewish agencies throughout the country. The primary role and responsibility of the adoption worker have been to select permanent parents for normal, healthy infants. Through a process of screening and early evaluation, we have been able to help applicants, for whom adoption seemed unwise, to withdraw. Our sensitive use of the study has enabled us to select good adoptive parents for our babies.

Eighteen years ago, when the agency took on the responsibility of planning for Philip, a "not-normal" infant, my co-worker offered him to ten couples, all of whom turned him down, entirely because of his defect: he had been born with one eye, an anomaly so rare that Children's Hospital in Detroit had never seen a child with this condition. The significance of the rejections is that although each couple contacted had had a complete study and had been evaluated as people with a good capacity for adoptive parenting, all of them had requested, and were waiting for, a normal, healthy infant.

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This brings me directly to the subject of the hard-to-place child. I will be discussing the following:

- What is a hard-to-place (for adoption) child?
- What is the importance of the child placement worker's attitudes about other-than-normal children, that is, children who are limited, defective, handicapped, damaged, disadvantaged?
- How does the child placement worker use other professionals, "specialists", in determining a child's adoptability, and what gets communicated to the adoption worker about the child?
- What is the importance of the attitudes and identifications of the adoption worker when she looks for an adoptive family for a child with "special needs"?
- What is our philosophy and practice around finding the family?

What is a Hard-to-Place Child?

I define a hard-to-place child as one that most adoptive applicants don't want because he or she is one or more of the following: (1) he is physically handicapped or has medical problems; (2) he is mentally handicapped; (3) he is a non-infant, over the age of 2; (4) he has emotional or psychological problems; (5) he is bi-racial; (6) he is drug-addicted at birth.

In this connection, Alfred Kadushin wrote that "the existence of a physical, emotional or mental handicap should make a child hard-to-place is almost self-evident."[1]

[1] Alfred Kadushin, "Child Welfare Services", Chapter 10, *Substitute Care: Adoption*, The Macmillan Co., New York, 1967, p. 492.

Use of Specialists

I cannot overstress that what happens to an atypical child who has been made available for adoption depends almost entirely on the attitudes, both conscious and unconscious, of the child placement worker, who then communicates with the adoption worker regarding a permanent plan. In the ten children I will be presenting, the role of the child's worker was crucial in every instance.

The way in which the placement worker uses the evaluation, recommendation, and ultimately, the "advice" of other professionals is deeply important. The other professionals who played a significant part in the lives of our children were: psychologists, psychiatrists, pediatricians, a team of ophthamologists, an orthopedist, a geneticist, a lawyer, a judge and a rabbi.

The fact that some social work practice is based largely on psychoanalytic theory, has, in some instances, led to a close and positive working relationship between social work and psychiatry. Some caseworkers regard psychiatrists and psychoanalysts as "experts" who have superior knowledge and experience; these workers are, therefore, comfortable in the semi-dependent role of seeking, accepting and following the recommendations of the psychiatric consultants. The role, then, of the psychiatrists and psychologists in relation to planning for the hard-to-place child is set up by the placement worker. When the child's worker seeks psychiatric consultation for the purpose of gaining a better understanding of the child's emotional needs or a diagnosis, if she is either ambivalent or negative about offering the child to an adoptive family, she will welcome the negative evaluation of the specialist, namely, that the child is too damaged, that he should not be offered to an adoptive family, but that he should spend his childhood years in foster homes or institutions.

If the worker is consciously or unconsciously repelled by the child's defect, or if she is indifferent to him as a needy, helpless little human being, she will be poorly motivated to ask the adoption worker to give him permanent parents. Rather, she will rely comfortably on the negative decisions of the specialist and will, in fact, relieve herself of the responsibility of making a permanent plan for him.

Although in the case of some of our children, the other professionals were negative, that is, recommended other than adoptive home placement (long-term foster care of institutionalization), the agency workers had the strength of conviction in their own professional evaluations to place these children into carefully selected adoptive homes.

When the agency takes on the responsibility of planning for an atypical or disadvantaged child, it is appropriate and desirable for the worker, who is uncertain about the child's diagnosis (the extent of damage, for example) and the prognosis, to consult with and/or have the child seen by *that* professional person in the community who is best qualified to help her plan for the child. But, in those cases where the worker does *not* ask for an opinion about, or a recommendation regarding, the child's adoptability, and the specialist takes it upon himself to make such a recommendation, and if he expresses his own prejudices in relation to the child, then the attitude of the agency and the worker toward the child and his handicap becomes crucial.

For example, when one of our couples told their pediatrician that they were being offered a healthy, normal 17-month-old girl, whose only medical problem was that the muscle in one eye was weak and that surgery had corrected this condition almost totally, the physician was appalled. He strongly advised them not to adopt the baby and added: "Why take on somebody else's *tsoris*?" To this pediatrician, the little girl was a throw-away child. The couple subsequently changed pediatricians and adopted her.

Another example: A psychiatrist, who, upon being told about the successful adoptive placement of a 2½-year-old girl who was severely brain damaged and for whom institutionalization had been recommended, said: "In *my* opinion, that child did not *deserve* the professional time and money spent on her; the

whole effort, in fact, was wasted because, when this damaged child becomes an adult, she will never be capable of making a contribution to society.".

Attitudes and Identifications of the Adoption Worker

The role of the adoption worker is complicated by several factors: initially, she does not know the child directly, but only through the placement worker; then there is the subtle matter of her conscious and unconscious identifications. If she is not identified with the child, she will not be motivated to find him permanent parents; if she is ambivalent or negative about him and is identified with the prospective adoptive parents, she might be uncomfortable about offering them a not-normal or problem child because she is afraid that she is inflicting a burden on this "really good" family and that they might be unhappy or suffer in future years because of *her*. In other words, she is not relating to what the family can give to the special, needy child, but rather, she is concerned about what the child can give to the parents.

There is also the possibility that the adoption worker who sees the child as being damaged and therefore as unworthy of having the *best* family, will select for him adoptive parents who are equally unworthy and damaged. She could reason that a second-best child only deserves second-best parents: like one broken book end matched to another.

Then too, the adoption worker, because of her own ambivalence about the child, may be influenced by the negative prognosis and recommendation of the consulting specialist to become consciously or unconsciously resistive to looking for, or finding, *any* adoptive family since it appears that the child is hopeless anyway. At that point, he becomes a throw-away child. However, when the adoption worker is accepting of, sympathetic to, and identified with the child, she will be deeply motivated to find an adoptive family who has the best capacities to meet his needs.

Finding the Right Family

How do we go about finding the best family? A method that has *not* been effective is going to or working from an old list. An old list usually consists of people who are over 40, who have been married a long time, who are childless and say that they might be interested in an older child, by which they generally mean, between ages 2 and 3. But the fact of the matter is that when we interview these couples, we generally find that they are not really interested in adopting *any* child. We have also observed that people who are desperate, who feel that they'll settle for this particular child because they will never be offered a normal, healthy baby, and people who see *themselves* as damaged or unworthy, will not be adequate adoptive parents.

In our search for the right adoptive parents, what *has* proven successful was to explore with families who were currently known to us, their feelings, needs and capacities in relation to a specific child. Several factors become very important in the selection of each family and in the eventual presentation of each child:

1. We have to correctly recognize and understand which atypical aspects of the child were acceptable to the family and which made them uncomfortable.
2. When the couple already has a child, either produced or adopted, we have to evaluate the youngster's emotional health and his psychological readiness to accept an atypical sibling.
3. If they express a preference for a girl or a boy, we want to know why.
4. We need to know and to understand the fantasies of the adoptive applicants regarding a disadvantaged child: For example, the rescue fantasy; or the fantasy of omnipotence: when *they* become the child's parents, they will make him over into a "normal" child.
5. We have to present the child as honestly and as objectively as possible, so that in each presentation we are not "selling" him. For example, even if the child being presented was physically beautiful, as many of our children were, this was not brought to the attention of the prospective adoptive parents.

6. It has to be communicated to each family that if they cannot accept the child, for whatever reason, they would still be good people in the eyes of the worker and the agency. Obviously, it is very important for them and for the worker to understand why they want or did not want to adopt him. If a family chooses not to adopt a specific child, we are supportive of that decision and thereby help relieve the guilt that they might have that they had disappointed us, that they had let us down, or that they had abandoned the child. They have to be reassured that the agency respects their decision and also that the child has *not* been abandoned, but that good parents will be found for him.
7. In selecting adoptive parents for the older child, we look for people who would not be threatened by, but would be able to tolerate and accept the fact that the older child is a child with a past, that he has memories and that he will suffer from time to time from feelings of despair and loneliness. They need to have the capacity to tolerate and understand his grief over his losses, his need to mourn; and, when he is secure enough to vent them, his expressions of anger and rage. They also have to be prepared for the real possibility that he might regress, that he would need to test limits, and that sometimes he would be provocative and make them angry. Furthermore, they had to be people who were able to accept the fact that no matter how giving and understanding and sensitive they were in relation to the child, he would not, overnight, feel like a wanted and valued member of their family. They had to have the patience and the fortitude to wait, because the newly adopted older child would have to live it all out, one painful day at a time, until he knew and felt that he did not have to be good every minute, and that no matter what he said or did, that *they would not throw him out.*

Kadushin states that according to his list of sources, "when the child is so physically, mentally or emotionally handicapped that he cannot live in a normal setting, develop normal relationships with parental figures and function adequately in a family, then adoption is not appropriate. In these cases, the child is unable to fulfill the normal status: 'child' in a family."[2]

On the other hand, David S. Franklin and Fred Massarik state: "Any child can be considered adoptable who needs a family, can develop in it, and for whom a family can be found that can accept his physical and mental capacities."[3] (I would add here: *and his limitations.*)

That is thematic in this article: does the placement worker see the child as being adoptable, and if she does, can the adoption worker find him permanent parents who will meet his needs?

Ten Children

Over a period of 18 years, I have had the professional responsibility of finding permanent families for ten hard-to-place children. There were 5 girls and 5 boys; 4 children had physical problems, 4 had emotional problems, 2 had mental handicaps. The first placement was 18 years ago, and the last, 3 years ago. At the time of placement, the children ranged in age from three weeks to 10 years; two were infants, less than two months old; two were five and nine months old, respectively; two were two years old; three were four years old; and one child was 10 years old.

According to Kadushin, "for adoptive purposes, a child of two is 'middle-aged' and a child of five is 'old'."[4] So, in keeping with this definition, two of our children were "middle-aged", three were approaching "old-age", and one was already "old".

Philip

When he was born, he had two eyebrows, two eyelids, two sets of eyelashes, and when he cried, tears flowed from both sockets; but he had only one eye. According to a team of ophthamologists at Children's Hospital, in the next few years he would have to undergo

2 *Ibid.* p. 439.

3 David S. Franklin and Fred Massarik, "The Adoption of Children with Medical Conditions: Part I—Process and Outcome"; *Child Welfare,* Vol XLVIII, No. 8, (Oct. 1969).

4 Alfred Kadushin, *Op. Cit.,* p. 491.

several surgical procedures in order to keep the two sockets the same size. Eventually, an artificial eye could be inserted. Whether other anomalies would appear later concerned the prospective adoptive parents. The medical specialists were reasonably certain that multiple anomalies would not occur and they were supportive of adoptive planning for the infant. The baby's worker saw him as a physically beautiful child, in spite of his anomaly, and was very eager that we find him adoptive parents who could accept his defect and love him. Philip was placed in his adoptive home at 5 months and is now 18 years old.

Robert

He was not offered for adoption at birth, but was placed in a foster home, because his biological mother was retarded and nothing was known about his biological father. When he was 13 months old, a team of psychologists and psychiatrists observed, tested and evaluated him. One of the child psychiatrists wrote the agency: "He is a mentally retarded boy, who is not capable of benefiting from being raised in a normal family. He is, in fact, a defective piece of protoplasm, and it is our recommendation that he be placed in an institution."

Several months later, the agency psychologist reported: "Robert is a mental defective. He will not be able to adjust to society. Consideration should be made for placement in one of the state schools for the feebleminded."

When Robert was 3 years old he registered an I.Q. of 76 and the child psychiatrist wrote: "You are, of course, aware of the difficulties involved in attempting to find an adoptive home, or even, possibly, a foster home for this child."

As a matter of fact, several placement workers had offered Robert to a number of prospective adoptive parents, all of whom had rejected him. Therefore, when Robert was 2 years old and his foster parents asked to adopt him, the placement worker approved the request and filed a petition for adoption. The foster mother was 48 and the foster father 50. They were really too old to be his permanent parents; but the placement worker had approved them because she was not involved with Robert, did not care about him, or relate to his needs, since she saw him as being a child who was very damaged, both mentally and emotionally. She had relied heavily on the negative diagnosis, prognosis and recommendation of the consulting specialists and believed that Robert was lucky that the foster parents wanted him because, in *her* professional opinion, *no other family would.*

Three months before the adoption would have been finalized, the foster father had a heart attack and died. The foster mother took a full time job, brought in a succession of babysitters for Robert, began to feel overburdened by him, and finally, asked the agency to take him back. When, at the age of 3, Robert was placed with his second set of foster parents, he was, indeed, a severely traumatized little boy: he was depressed, stood for hours looking out of the living room window and crying, gave up speech, ate very little and screamed out in his sleep because of nightmares. By the time Robert became my professional responsibility, he was a four-time loser: He had lost his first foster parents, the only mother and father he had ever known, he was mentally limited, he had severe emotional problems, and he was getting "old"—three-and-a-half. But a psychological miracle happened: because of the quality of care, the devotion and love given to Robert by his new foster parents, he began to feel better. Incidentally, these foster parents were elderly and about to retire from the service of the agency. Robert was to be their seventeenth and last foster child. The foster mother told me: "I cared deeply about all of my children, but I have never loved a child the way I love Robert." Gradually he was able to talk again and to eat again and to sleep again, and one day, he looked at his foster mother and she kissed him, and he remembered how to smile. We enrolled him in nursery school and he made great strides: he interacted with the children and although he was slower than the others, the nursery teacher observed that his ability to retain, to repeat, to learn, was improving. And best of all, he had remembered how to laugh.

Because of the negative evaluations and recommendations of the consulting specialists and because of the uninvolvement and indifference of the placement worker, we had almost lost Robert. He had come close to becoming unadoptable, a child in limbo. We placed him with his adoptive family when he was 4 years old and he is now 20.

Valerie

She was placed in a foster home at birth because her biological mother was retarded and little was known about the biological father. Her development was slow and in the first 18 months of her life, three placement workers had given up on her. They saw her as being severely retarded, and, therefore, "a hopeless case". When Valerie was 20 months old, a new placement worker became responsible for her. Shortly afterwards, the baby was tested by a psychologist who gave her an I.Q. of 56 and recommended that she be removed from the foster home and placed in an institution. The child's worker could not accept the I.Q. as being valid since she did not see her as being that retarded. She felt, that although Valerie was slow, that she did have the potential for learning. She had also observed that Valerie was able to relate to her foster parents with love and affection, felt that the child would do well with the right adoptive parents, and requested a permanent home for her. She was placed in her adoptive home when she was 2 years old and is now 17.

Michael

His adoption, at birth, had been arranged privately through an attorney. When he was six years old, his adoptive father died as a result of a heart attack, and six weeks later, on the last day of school and one month before his seventh birthday, without having made any provisions for her son, the adoptive mother killed herself. Although Michael was a normal, healthy, handsome and bright boy, no one in the family wanted him. As an orphan, he became the responsibility of the Jewish Family Service, was placed in one of our foster homes, and a worker, other than myself, selected adoptive parents for him. This couple had been friends of the deceased parents, knew Michael, and had approached the agency, requesting to become the boy's new adoptive parents. So, it wasn't as if they were adopting "a little stranger". A year and a half later, and after the adoption had been finalized, Michael's new parents threw him out: they gave him back to the agency. What was wrong with that placement was the *motivation* of the adoptive parents: they did not value Michael for himself or care about his needs. They had adopted him because they felt that their only child, a biologically produced seven-year-old boy, who was six months older than Michael, *needed a companion.* The result was a disaster for Michael. It was incredible how much they preferred and loved their own child and how much they rejected and disliked Michael.

The person on our staff, who became Michael's worker, made a total commitment to him. It was more than accepting him as a needy, severely wounded child, who was in terrible pain. Because of her genuine, deep, consistent and open affection for him, and because she made herself available to him evenings and weekends, Michael learned to trust her *absolutely.* The role of that worker in the eventual placement of Michael into his third and last adoptive home was of tremendous importance. He was placed with his permanent family when he was 10 years old; Michael is now 21.

Joel

His biological mother and three members of her immediate family had muscular dystrophy. According to the consulting geneticist, Joel had a 50-50 chance of inheriting the disease; the specialist indicated that there might be some manifestations as early as age six and as late as age 12. The prognosis was that if Joel were afflicted, he would have muscular dystrophy in a mild form. However, the specialist believed that adoption was feasible if the prospective adoptive parents could accept the dread possibility that Joel might end up in a wheelchair.

The child's worker felt strongly that Joel should not be kept in a foster home indefinitely, but that we should look for a family who could accept him, in spite of the terrible risks that were involved. An adoptive family was found for Joel when he was 9 months old; he is now 8 years old.

Carol

Her biological parents were severely disturbed people, who had been in and out of mental hospitals. While Carol was in their home, she was neglected, mistreated, abused, and finally, at 10 months of age, she was abandoned by them. She was made a temporary ward of the court and placed in a foster home. Two months later, we had to move her, which meant that by the age of one year, she had had five sets of parental figures: her own parents, her maternal and paternal grandparents, and the first and second foster parents. Although the biological mother and father were pathetically unfit parents, they would not release Carol for adoption. Because of our placement worker's commitment to Carol and her determined belief that the child needed permanent parents, she obtained the services of an attorney, went into court and fought for her legally.

The consulting psychologist and psychiatrist felt that Carol had been damaged emotionally and that there was the possibility of some future relationship impairment, but they supported an adoption *by the right family.*

Eventually, the judge terminated the rights

of the natural parents and the custody of Carol was given to the agency. We placed the little girl in her adoptive home when she was 26 months old. She is now 6 years old.

Janice

She was a normal, healthy baby, whose biological mother, through a private arrangement, had placed her at birth with a foster family. Although the biological mother gave financial support on a regular basis, she had absolutely no contact with Janice. The little girl, as a matter of fact, did not know of the existence of a biological mother and thought that the foster mother was her "real" mother. When Janice was three-and-a half years old, the natural mother asked the foster parents to adopt her. However, they had 6 children of their own and did not want Janice on a permanent basis. It was at this point that the biological mother asked the agency to find adoptive parents for the child.

The placement worker saw Janice as being a beautiful, bright, special little girl who was very much in need of permanent parents. The consulting psychiatrist felt that the rejection of the foster parents and the loss of the siblings would be traumatic for Janice and that she would have some emotional problems, but that her ego strengths, combined with her superior intelligence, made her "adoptable". She was placed with her adoptive parents when she was 4 years old and is now 8.

Sharon

She was born with a club foot which was so severe that she had to be in a total leg cast, from her tiny foot up to her thigh. According to the orthopedist, the baby would have to be in a cast for at least six months; that at worst, the club foot would require surgery, and that at best she would have to be in the cast for 18 months. Furthermore, he could not guarantee that the club foot was completely correctible. When the placement worker told the specialist that we were planning to find permanent parents for Sharon, he said: "Do you mean that there are actually people who would want to adopt her? *I* wouldn't." The worker was not only unambivalent about the baby's need for permanent parents, but deeply resented the negative attitude and unasked for opinion of the specialist regarding Sharon's adoptability. Sharon was placed with her adoptive parents when she was 6 weeks old and is now 3½ years old.

Donald

His biological mother was a young woman of normal intelligence and good physical health, but she was a drug addict. During her pregnancy, she had used both heroin and methadone. The baby was drug addicted at birth and had withdrawal symptoms. In addition, the baby's biological father was a non-Caucasian, a dark-skinned man of Mexican heritage. So, we had a drug-addicted, bi-racial child. Based both on the treatment given the baby at the hospital and on the medical evaluation of the agency's consulting pediatrician, the placement worker felt, that although there were some medical risks, Donald should not remain in a foster home but should be given permanent parents. The baby was placed in his adoptive home at 3 weeks and is now 3½ years old.

Ann

Her biological mother had been born and raised a Christian and as an adult had converted to Judaism. Ann's parents were divorced and she never knew her father. Her mother had gone back to work when Ann was a baby and this meant that from the first month of life Ann received day-care from a foster mother, a stranger; and eventually, she was being cared for by a series of foster people —strangers—because there was a consistent change in the day-care homes. The child's mother was an emotionally ill person, who, even on a part-time and marginal basis, was not capable of being an adequate parent. The mother had selected all of the foster homes privately and in some of them, Ann was treated badly, brutally, by the foster mothers. For example, if she was a "bad girl", she was punished: she was spanked, or she was sent to bed hungry, without supper, or she was locked up in a dark closet, or she was not given the medicine prescribed for her bronchitis and asthma.

The child's pediatrician recognized that the combination of the poor quality of day-care and the insensitive and often callous handling by the mother was causing serious emotional damage to the little girl and that she had developed some severe physical and psychological symptoms. Eventually, he hospitalized her, partly to get her away, at least temporarily, from her destructive mother, and her equally destructive substitute mothers. The biological mother's wish to be rid of her daughter was supported by the pediatrician, by her psychiatrist, and by the rabbi of the synagogue which she attended. When Ann was 4 years old, the mother released her for adoption to the agency, and thus, finally and

permanently, gave away this bright, lovely, frightened and deeply traumatized child. Ann was placed, temporarily, in one of our best foster homes. The placement worker had her seen and evaluated by a pediatrician, a psychologist, and a child psychiatrist. Ann had the following physical symptoms: night-time enuresis, daytime incontinence, vomiting, stomach disorders, diarrhea, bouts of bronchitis and asthma.

Emotionally, she was a tense, insecure, anxious little girl, who picked at herself; intellectually, she had superior intelligence. In spite of her severe physical symptoms and serious emotional problems, the consensus was that she should be offered for adoption, *if the agency could find the right parents.* Both the child's worker and I were very involved and identified with Ann, and believed, absolutely, that she was adoptable. When this thin, pale, beat-up child looked at me with her sad, blue eyes, and picked at her little-girl-fingers, and thanked me for giving her a candy bar, I had to know that finding the right permanent parents for her might just be one of the most important things I would ever do in my professional life.

The couple, who chose to adopt her, possessed the special capacity for parenting that Ann so desperately needed. As the adoptive father put it so poignantly: "Ann has been hurt, has been made to suffer, and her wounds are deep. We will hold her close and love her and, in time, when she feels that she can trust us and that she will be our daughter always—no matter what—she will heal." He was right and she did. Ann is now 7 years old.

Detailed follow-ups are not within the scope of this article. However, throughout the years, our informal contacts with the couples have indicated that the adoptions have worked out well for the 10 children and their adoptive families.

Summary

This article has stressed that what happens to the disadvantaged child depends largely on the following factors:

The attitudes of the placement worker: Is she involved and identified with the child; does she care about him? Does she see him as being adoptable? Does she believe that, in spite of his handicap, *there is a family who will want to adopt him?*

The way in which she uses the consulting specialists in her planning for the child: Does she ask if the child is adoptable? What does it mean to her if the specialist indicates that adoption is contra-indicated? (As in the case of Robert and Valerie.) How does an unsolicited, negative opinion from the specialist affect her feelings and plans for the child? (As in the case of Sharon.)

The attitudes of the adoption worker: With whom is her basic and primary concern, sympathy and identification: the child or the prospective parents?

Next, we discussed our philosophy and practice in relation to finding adoptive parents for disadvantaged children. The adoption worker has to be motivated to look for permanent parents, which means that she has become involved and identified with the child and *feels responsible for what happens to him.*

Then, based on her knowledge of couples who are professionally known to her currently, or in the recent past, she discusses with one of them their possible interest in adopting a specific child. She is able to do this because she has already explored with each couple the outer limits of their ability to withstand stress, their special capacity to cope and to give and to take risks, and their motivation for wanting to adopt a specific kind of atypical child.

Furthermore, an in-depth study reveals the following about each couple:

The kind of physical handicap that is acceptable, which involves the severity of the handicap, and the degree of correctability. For example, one adoptive applicant indicated that he would be able to adopt a deaf child, but not one who was blind.

How much mental impairment they are prepared to accept. This involves their realistic expectations in regard to an intellectually limited or retarded child.

In relation to an older child who has emotional problems, the kinds of psychological symptoms with which they are willing and prepared to deal.

Whether they have a preference for a girl or a boy and why.

In conclusion, we have seen that the combined efforts of the placement and adoption workers can provide the atypical child with the love and security of his own adoptive family and, thereby, spare him the insecurity and impermanence of a succession of foster homes, or the cold, gray emptiness and loneliness of institutions.

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The Fatherless Boys Project of the Jewish Board of Guardians: Some Therapeutic Implications*

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The Fatherless Boys Project demonstrates that this mode of help has been effective in a number of ways. In its prophylactic aspects it endeavors to forestall the development of more serious emotional problem in a totally new population of maternally headed families. As a nonthreatening form of intervention it sustains some very disturbed children outside of a treatment situation, and helps other children who need it to eventually reach treatment.

The Jewish Board of Guardians is a mental health agency specializing in the treatment and prevention of emotional disturbance in children and their families. The agency operates a number of residential and day treatment centers and child guidance clinics in Greater New York and Westchester County.

The agency's origins go back 80 years, when volunteers went into the criminal courts of New York to help immigrant Jewish prisoners. When the children of these prisoners began appearing in the Family Courts charged with delinquency, the Jewish Big Brothers and Jewish Big Sisters were organized to help them. They have continued this tradition of service to children in trouble for over seventy years. Thus the Jewish Board of Guardians began in voluntarism, and volunteers continue to contribute to its various programs.

The idea of offering an agency service to fatherless Jewish boys was developed in the JB as an outreach program for the single-parent family which was not ready to use traditional social services. This program of providing big brothers to fatherless Jewish boys and concurrent group guidance to their mothers developed about five years ago. Until that time the Big Brother Service was only for children who were in therapy with the agency. Gradually this became seen as a gap in service, inadvertently favoring only those families whose mothers were sufficiently motivated to seek therapeutic help for their sons. Many mothers not so motivated, although equally if not more needful, were applying to us for big brothers but not for therapy. These women felt that their fatherless sons did not need treatment but that they did need a more adequate masculine development and identification, through a relationship with a male adult.

An example of the creative role volunteers play in our work is that it was the Big Brothers themselves, through their Executive Committee, who brought the need for this service to the administration of the agency.

Procedures

Any Jewish mother in the city may call the agency and request a big brother. Criteria for inclusion in the Project are: that the child be Jewish; that no father be available to him; and that both mother and child participate in an intake consultation to determine whether a big brother is an appropriate modality of help. The Big Brother Service becomes contraindicated when serious pathology is present and treatment is deemed necessary.

The application process involves a telephone screening in the central Volunteer Department where the presenting problems and basic eligibility are discussed, and gross ineligibility is screened out. If the family is considered eligible, they are then referred to the Child Guidance Outpatient Clinic in the borough where they reside. There, the caseworker assigned to the project interviews mother and son for a diagnostic evaluation of the situation. Mother or son may be too disturbed to use the service productively. When indica-

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